GRANT MAKERS IN HEALTH

IMPROVING HEALTH ACCESS IN COMMUNITIES

Lessons for Effective Grantmaking

FEBRUARY 2005

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Foreword

This monograph is the final product of an effort by Grantmakers In Health (GIH) to share with health philanthropy the lessons learned from two major community-based initiatives, *Community Voices* and *Communities in Charge*, to improve the delivery of care for the uninsured and underserved. With support from the W.K. Kellogg Foundation and The Robert Wood Johnson Foundation, GIH also convened several meetings for funders to share their insights on these and other programs.

This product is based primarily on extensive interviews with leaders from foundations, private industry, academics, and community organizations who have worked on projects aimed at improving access for the uninsured: Yvonne Abel, Sharon Baskerville, Kathy Bradley, Rahn Dorsey, Andrew Dreyfus, Jennifer Edwards, Paul Gionfriddo, Laura Hogan, Jack Meyer, Karen Minyard, Margaret O'Bryon, Leda Perez, Rhonda Poirier, Barbara Sabol, Beth Stevens, Terry Stoller, Linda Thompson, Henrie Treadwell, Anne Weiss, Elizabeth Whitley, and Deborah Zahn. We thank them for their time and candor. Katie Merrell of the University of Chicago conducted the interviews and authored the first draft with support from research assistant Candace Williamson. Anne Schwartz, vice president of Grantmakers In Health, supervised the work and contributed to the final report. Julia Tillman also contributed to the project.

About GIH

The mission of Grantmakers In Health (GIH) is to help grantmakers improve the nation's health. GIH seeks to build the knowledge and skills of health funders, strengthen organizational effectiveness, and connect grantmakers with peers and potential partners. We help funders learn about contemporary health issues, the implications of changes in the health sector and health policy, and how grantmakers can make a difference. We generate and disseminate information through meetings, publications, and an on-line presence; provide training and technical assistance; offer strategic advice on programmatic and operational issues; and conduct studies of the field.

As the professional home for health grantmakers, GIH looks at health issues through a philanthropic lens, sorting out what works for health funders of different missions, sizes, and approaches to grantmaking. We take on the operational issues with which many funders struggle (such as governance, communications, evaluation, and relationships with grantees) in ways that are meaningful to those in the health field.

Expertise on Health Issues

GIH's Resource Center on Health Philanthropy maintains descriptive data about foundations and corporate giving programs funding in health and their grants and initiatives, and synthesizes lessons learned from their work. The Resource Center's database is available on-line on a password-protected basis to GIH Funding Partners (health grantmaking organizations that provide annual financial support to the organization). The database contains information on thousands of grants and initiatives made by more than 300 foundations and corporate giving programs. It can be searched by organizational characteristics (such as tax-exempt status, geographic focus, or assets); health programming areas (such as access, health promotion, mental health, and quality); targeted populations; and type of funding (such as direct service delivery, research, capacity building, or advocacy).

Advice on Foundation Operations

GIH also focuses on operational issues confronting health grantmakers through the work of its Support Center for Health Foundations. We advise foundations just getting started (including dozens of foundations formed as a result of the conversion of nonprofit

hospitals and health systems) as well as more established organizations. The Support Center's activities include:

- The Art & Science of Health Grantmaking, an annual two-day meeting offering introductory and advanced courses on board development, grantmaking, evaluation, communications, and finance and investments;
- sessions focusing on operational issues at the GIH Annual Meeting on Health Philanthropy;
- individualized technical assistance for health funders; and
- a frequently asked questions feature on the GIH Web site.

Connecting Health Funders

GIH creates opportunities to connect colleagues to one another and with those in other fields whose work has important implications for health. GIH meetings, including the Annual Meeting on Health Philanthropy, the Fall Forum (when we focus on policy issues), and Issue Dialogues (intensive one-day meetings on a single health topic) are designed for health funders to learn more about their colleagues' work; talk openly about shared issues; and tap into the knowledge of experts from research, policy, and practice. Our audioconference series allows smaller groups of grantmakers working on issues of mutual interest, such as access to care, overweight and obesity, racial and ethnic disparities, patient safety, or public policy, to meet with colleagues regularly without having to leave their offices.

Fostering Partnerships

The many determinants of health status and the complexity of communities and health care delivery systems temper health grantmakers' expectations about going it alone. Collaboration with others is essential to lasting health improvements. Although successful collaborations cannot be forced, GIH works to facilitate those relationships where we see mutual interest. We bring together national funders with those working at the state and local levels, link with other affinity groups within philanthropy, and help connect grantmakers to organizations that can help further their goals.

GIH places a high priority on bridging the worlds of health philanthropy and health policy. Our policy portfolio includes efforts to help grantmakers understand the importance of public policy to their work and the roles they can play in informing and shaping policy. We also work to help policymakers become more aware of the contributions made by health philanthropy. When there is synergy, we seek to strengthen collaborative

relationships between philanthropy and government. GIH has established cooperative relationships, for example, with a number of federal agencies, including the Agency for Healthcare Research and Quality and the Centers for Disease Control and Prevention.

Educating and Informing the Field

An aggressive publications effort helps GIH reach many grantmakers and provide resources that are available when funders need them. Our products include both in-depth reports and quick reads. Issue Briefs delve into a single health topic, providing the most recent data, sketching out opportunities for funders, and offering examples of how grantmakers are putting ideas into action. The *GIH Bulletin*, a newsletter published 22 times each year, keeps funders up to date on new grants, studies, and people. GIH's Web site, www.gih.org, is a one-stop information resource for health grantmakers and those interested in the field. The site includes all of GIH's publications, the Resource Center database (available only to GIH Funding Partners), and the Support Center's frequently asked questions. Key health issue pages on access, aging, children/youth, disparities, health promotion, mental health, public health, and quality provide grantmakers with quick access to new studies, GIH publications, information on audioconferences, and the work of their peers.

Diversity Statement

GIH is committed to promoting diversity and cultural competency in its programming, personnel and employment practices, and governance. It views diversity as a fundamental element of social justice and integral to its mission of helping grantmakers improve the nation's health. Diverse voices and viewpoints deepen our understanding of differences in health outcomes and health care delivery, and strengthen our ability to fashion just solutions. GIH uses the term, diversity, broadly to encompass differences in the attributes of both individuals (such as race, ethnicity, age, gender, sexual orientation, physical ability, religion, and socioeconomic status) and organizations (foundations and giving programs of differing sizes, missions, geographic locations, and approaches to grantmaking).

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Introduction

The large and growing number of people without health coverage has strained systems of health care delivery and financing to the breaking point in many communities. Although the effects vary somewhat depending on the structure of local systems, their consequences are serious for individuals, institutions, and communities. For example, urban areas with high levels of uninsured people generally have fewer trauma centers, lower inpatient capacity, and fewer services available for vulnerable populations. Conversely, rural areas with high levels of uninsurance struggle with providing high-technology services, intensive care units, and psychiatric inpatient services (Institute of Medicine 2003). Moreover, in its analysis on the community effects of uninsurance, the Institute of Medicine's study panel concluded that the ad hoc redirection of funds away from public health programs to finance care for the uninsured can compromise broader community health activities, such as controlling the spread of communicable diseases and emergency preparedness (Institute of Medicine 2004).

Communities nationwide have responded to these pressures with initiatives that reflect new types of collaboration and cooperation among health care providers, community-based organizations, government, and philanthropy. Some of this activity was spurred by the success of an effort undertaken in the early 1990s in Hillsborough County, Florida. With the levy of a new local half-cent sales tax, the Hillsborough County Health Care Plan (HCHCP) was created as a comprehensive managed-care plan for county residents with incomes at or below the federal poverty level. HCHCP is credited with reducing emergency room (ER) visits and inpatient admissions for patients with diabetes and asthma. Despite these successes, the program continues to reach only a small share of the county's uninsured population and its local financing mechanism has not been replicated elsewhere.

Another experience that is often cited as a success took place in Buncombe County, North Carolina. Project Access, an effort of the Buncombe County Medical Society in Asheville, grew out of local physicians' frustration with the inadequate system of health care delivery for the county's 15,000 uninsured residents. They saw people delaying needed care for financial reasons, while others suffered from conditions that were not being properly managed because they could not obtain specialty treatment or medications. What began as a volunteer physician effort eventually grew into a countywide partnership involving local government, community clinics, pharmacies, and area hospitals. The result was an integrated health care delivery

system for uninsured area residents. Even so, the Buncombe County experience has been effective primarily as a stopgap measure for individuals in need of acute care.

Other community responses to strained local health systems have varied in strategy and scope. Some, like Hillsborough County, have sought to develop new insurance products for those without insurance. Others have focused on changing the service delivery system to create new ways for people to receive health services in their community, regardless of financial resources or the source of their health care coverage. For example, one approach has been to develop mechanisms that allocate uncompensated care equitably across local providers.

Health grantmakers have played a major role in supporting community-based initiatives to reknit local safety nets and improve access to care for the underserved. In the late 1990s, The Robert Wood Johnson Foundation (RWJF) and the W. K. Kellogg Foundation (WKKF) each launched large, multiyear national programs aimed at encouraging communities with high uninsurance rates to develop strategies for expanding access or health care coverage. Kellogg's *Community Voices* effort, begun in 1998, was intended to develop practical and actionable solutions for improving access to care and strengthening local service systems in its 13 sites that it called learning laboratories. RWJF's *Communities in Charge* initiative made grants to 12 communities to foster the development by broad-based community consortia of sustainable, new delivery systems that manage care, promote prevention and early intervention, and integrate services. At the federal level, the Health Resources and Service Administration (HRSA) created the Community Access Program (CAP), which was succeeded by the Healthier Communities Access Program (HCAP). These efforts augmented other federal grant programs, such as grants to community health centers, that fund the provision of direct services but not the work involved in reorganizing local relationships and networks of care.[1] Many grantees of the two philanthropic programs were subsequently awarded HCAP grants.

The major investments made by RWJF and WKKF under these initiatives are now coming to a close. They leave behind real accomplishments, in providing direct services, strengthening community infrastructure, and helping create system and policy changes.

Each has developed replicable models and generated a wealth of information on efforts to strengthen health systems and connect the uninsured and underserved to health care services. Both have produced publications documenting the activities of specific project sites, focusing on specific health issues (for example, oral health and mental health), and

[1] The Community Access Program began in September 2000. In the fall of 2003, the Healthy Communities Access Program replaced CAP, augmenting its focus on improving the coordination and integration of health care services for the uninsured and underinsured with the additional goal of improving care for those with chronic health conditions.

considering the nexus between community-based programming and policy activities taking place at the local, state, and federal level. This knowledge base will grow when formal evaluations of these initiatives are completed and disseminated. Because this monograph focuses primarily on lessons for grantmaking, such issues are not considered here. Those interested in learning more should consult the resources in Appendix I.

This monograph highlights the grantmaking lessons learned to date from these two initiatives. While our original intent was to help other health funders focused on improving access and health care coverage, it became clear as our work proceeded that many of the lessons have much broader application. Lessons related to developing community coalitions, creating successful grantor-grantee relationships, and understanding the comparative advantages of national and local funders are relevant to grantmakers working on other health issues and beyond.

The information in this report draws upon published materials generated by *Community Voices* and *Communities in Charge*, as well as interviews with funders, grantees, consultants, and evaluators. Our inquiry also extended beyond these two initiatives to include those involved in locally directed access or coverage initiatives across the nation that could shed light on effective grantmaking strategies.

The first section of this report provides a brief overview of the two national initiatives. The rest discusses lessons learned for health funders. These relate to community readiness, fidelity to program mission, the role of evaluation, the importance of strong trusting relationships between grantmakers and grantees, the policy environment, and the comparative advantages of local and national funders.

When GIH first embarked on this project, we intended to use case examples to illustrate our points. During our conversations, however, we found that some grantees, particularly those whose projects were still highly dependent on one foundation, were hesitant to see their stories in print. In other cases, the grantee anticipated that the organization would likely seek funding from that foundation in the future, although perhaps under other initiatives. Under these circumstances, interviewees were candid about their experiences, but asked to remain anonymous.

We also found that some of the best learning experiences occurred in projects that did not achieve their desired ends. Even so, people found it hard to talk about these so-called failures. As it has been said, “success has a thousand fathers; failure is an orphan.” In an effort to encourage open discussion about both successes and failures, project-specific references are presented anonymously.

The National Programs

To help give a sense of the types of activities that communities undertake to improve access for the uninsured, this section describes The Robert Wood Johnson Foundation's *Communities in Charge* and the W. K. Kellogg Foundation's *Community Voices* programs. Each program solicited proposals from communities across the nation and ultimately supported projects in more than a dozen communities. Based primarily on each foundation's original request for proposals and subsequent program reports, the rest of this section describes each program. These programs represent a major resource for helping communities prepare for and create change in local care systems strained by high uninsurance rates. All but one community that received funding under each program eventually received support under the federal HCAP program (Table 1). Typically, the HCAP grantee had been either the grantee or a consortium member of the previous initiative.

Communities in Charge

Inspired by the success of Hillsborough County's efforts at expanding health care coverage and access to the poorest among the uninsured population through a new sales tax, The Robert Wood Johnson Foundation created *Communities in Charge*. The aim of this initiative was to provide financial and technical support to communities that were interested in expanding access and health care coverage through innovative health care delivery programs. This $16.8 million, multiphase program supported communities of at least 250,000, with an uninsured population of at least 37,500, to design and implement sustainable, new delivery systems that manage care, promote prevention and early intervention, and integrate services across the continuum of care.

Phase One, begun in January 2000, provided one-year grants up to $150,000 to 20 communities across the country. The goals of these organizational and planning grants were to:

- research the extent of the uninsured problem within the community,
- develop an inclusive consortium of community stakeholders,
- develop an innovative framework and strategy for coordinating services and creating a new approach to health care delivery, and
- begin the design of a delivery and financing system.

Table 1. *The Community Access Program and Healthy Communities Access Program: Program Summary and Overlap with Initiatives of National Foundations*

Funding Cycle Number of Communities Served (Amount Awarded)	HCAP Communities Previously Supported Under:	
	Community Voices	Communities in Charge
CAP 2000 23 communities ($21,989,454)	Detroit, MI* New York, NY El Paso, TX*	Portland, OR* Austin, TX*
CAP March 2001 53 communities ($46,348,941)	Denver, CO* Alameda County, CA Ingham County/Lansing, MI* Albuquerque, NM*	Birmingham, AL Alameda County, CA Portland, ME* Brooklyn, NY Spokane, WA*
CAP September 2001 60 communities ($54,073,486)	Miami, FL Charleston/Kanawha County, WV	Jacksonville, FL Jackson, MS* Wichita, KS Macon, GA
CAP September 2002 22 communities ($18,986,779)	North Carolina	Louisville, KY*
HCAP 2003 35 communities ($34,340,231)	Washington, DC* New York, NY	Washington, DC* Austin, TX* Portland, OR*

* Indicates that the Community Access Program (CAP) or Healthy Communities Access Program (HCAP) grantee was the Communities in Charge (CIC) or Community Voices (CV) grantee or an organization directly involved in local CIC or CV community consortium.

Source: Compiled from grantee information on the Healthy Communities Access Program Web site, http://bphc.hrsa.gov/cap/Default.htm, 2004.

Note: In many cases, key individuals involved with a CIC or CV grantee organization were subsequently employed by organizations that received HCAP grants.

This phase helped RWJF determine which communities were ready to move into the second phase of the program.

Phase Two focused on development and implementation of a new system of financing and delivering care to the uninsured. A total of 14 three-year grants were awarded in January 2001. Communities that received these grants were required to match RWJF funds dollar-for-dollar, and to implement a new, enrollment-based program or significantly expand an existing program for the uninsured in which enrollees have access to a full continuum of services including primary and preventive care. To successfully accomplish this mission, communities were expected to:

- establish comprehensive delivery networks that emphasize primary care, early intervention, and reduced inpatient and emergency room use, paying special attention to traditional providers of care for the uninsured population;
- develop a detailed implementation plan for the operational infrastructure of the project, including utilization management, quality assurance, and management information services;
- implement an outreach, marketing, and enrollment program that identifies and seeks out the uninsured;
- initiate member enrollment and delivery of services; and
- collect the appropriate baseline and operational data to permit monitoring and evaluation of the impact and success of the delivery system and financing mechanism.

Realizing that many communities do not have the resources or expertise to perform the above tasks on their own, RWJF provided technical assistance through the health care consulting firm Medimetrix and experienced program evaluators at Mathematica Policy Research, Inc. Medimetrix also acted as the national program office for this initiative.

Community Voices

W.K. Kellogg Foundation's *Community Voices* initiative was created to help ensure the viability of existing safety-net providers and strengthen community support services. This effort, begun in August 1998, provided funding to 13 communities to act as learning laboratories. Some of these communities had funding into 2004. Eight communities are being funded through 2007. The stated goals of this project were to:

- sustain an increase in access to health services for vulnerable populations, with a focus on primary care and prevention;
- preserve and strengthen health care safety nets in communities;
- change delivery systems so they provide quality care in a cost-effective way; and
- create models of best practice that can be adapted to a community's unique circumstances.

To help communities reach both the larger program goals and their individual community objectives, each project was expected to develop nine core elements:

- a plan and capacity for informing public and marketplace policy;
- a plan and strategy for development or refinement of a cost-effective delivery system;
- linkages to public health;
- community involvement that includes all the key community members;
- clear plans and capability to hold the provider and community network together through infrastructure that includes management information systems, legal agreements, and established and expanded relationships;
- explicit responsiveness to community culture and environment for creating health and wellness;
- effective use of resources to affect and to attain systems change;
- demonstrated readiness of the organization spearheading the project; and
- the capacity to serve as a laboratory for systems change in which new approaches could be tested and through which others could learn.

WKKF also provided technical assistance and evaluation services to its grantees via contracts with several organizations. It contracted with Abt Associates, Inc. to provide both technical assistance and evaluation services. The foundation also hired the Economic and Social Research Institute to write policy briefs and to help grantees understand the relevance of their work to broader health policy. Hyde Park Communications developed the initiative's Web site and provided communications support to the foundation and its grantees. Other contractors early in the project included the Lewin Group and the Center for Policy Alternatives. The project was housed within the foundation until late 2003, when a national program office was created at the National Center for Primary Care at the Morehouse School of Medicine.

This initiative is unique in that it attempts to incorporate the social determinants of health in the design of each community initiative. Based on reports from grantees and others, for example, the foundation concluded that certain important services were underprovided, including oral health, mental health, and men's health services. Consequently, grantees were encouraged to incorporate these services in their efforts to create more comprehensive community access programs and to identify policy and practice barriers.

Lessons Learned

Community Voices and *Communities in Charge* leave behind a wealth of information and experiences. Their work will shape the course of future efforts by health care providers, local policymakers, advocates, and others. For example, potentially replicable strategies emerging from *Communities in Charge* include models for assessing engagement and securing commitment of local leaders, creation of Web-base screening systems for public coverage and charity care eligibility, and methods for sharing clinical records among community providers. Similarly, *Communities in Charge* grantees did not find success with small business coverage models or ER diversion projects when not accompanied by other systems changes in ambulatory care systems. Across the board, grantees became more sophisticated in their ability to describe the strengths and weaknesses of local systems and to identify the types of solutions most appropriate given local history, politics, and policy.

Other lessons will likely emerge as the evaluation of *Communities in Charge* becomes available and *Community Voices* grantees continue to mature. The following lessons are particularly relevant to grantmakers considering how to build community responses that improve access to care and strengthen systems of serving the uninsured and underserved.

Perhaps the key lesson from these various initiatives is that there is no particular best strategy or approach to shore up local service systems taxed by high local levels of uninsurance. By definition, these community-based projects are each unique, tailored specifically to exploit the resources and bridge the gaps in each target community. As a result, this report does not offer templates for specific program designs or lists of services that programs should incorporate. Rather, it describes some of the characteristics that underlie the grantmaking, partner development, and project implementation processes of successful projects. The lessons are intended to help grantmakers reflect on how they organize their work, both within and across organizations, as they strive to maximize its effects.

Community Readiness Makes a Big Difference

The experiences of *Community Voices* and *Communities in Charge* clearly show it is possible to build new community-based and communitywide programs that are shaped by the community. But communities that are similar in their demonstrable need for improved access for the uninsured may not be comparably prepared for making the types of structural changes that may be necessary for system improvement. Communities diverge in their level of readiness; successful projects are those where the level of community readiness matches the project's timeframe, resources, and goals.

There is no clear way to measure objectively the level of readiness for making local system change in a particular community. But interviewees talked about various dimensions of readiness, particularly the involvement of key leaders and consensus about a sensible approach to change. For example, several commented that the nominal involvement of specific types of leaders (such as the mayor or leaders of large local community groups) is not nearly as important as the level of commitment by leaders of specific organizations that must be part of the change.

Others noted the need to be cautious about assessing readiness based on past history of collaborative work among community stakeholders. At the outset of these efforts, it became clear that communities did not always speak with a unified voice. In some cases, not all voices that should have been heard were being heard. Moreover, collaboration itself does not necessarily mean readiness. Situations where there is a lot of agreement about what should happen can raise red flags. Why, for example, have community leaders not been able to effect change given their apparent good relationships and high level of agreement about what needs to be done? Apparent consensus could also result from the lack of true engagement by key leaders. Some degree of disagreement might indicate a high level of involvement by thoughtful leaders.

There is no right level of community readiness. Instead, funders need to look for good matches between the existing level of readiness and project resources and goals. That is, the challenge for grantmakers is determining whether they want to help increase community readiness or whether they expect some level as a necessary condition when choosing grantees.

For simplicity, consider the two extremes: one community with many stakeholders or groups of stakeholders, each with its own favored approach to change, and another where local leaders are committed to work together on a consensus approach. In the first case, a

funder might choose to provide resources to start a process of constructive engagement and coalition building. The second community, by contrast, could be an appropriate recipient of a large multiyear grant to support the proposed innovation.

Funders will have different views on the attractiveness of these two types of investments. What is important is that the funder be clear about whether a particular level of community readiness for change is expected as a program input or is an appropriate program product. Program announcements and guidance, grantee selection, implementation support, and evaluation must all be consistent with the level of community readiness that is expected from grantees. Funders working in communities that are just beginning to talk about system change should not expect the same level of specificity and completeness in the proposals they receive as those in communities that have already gone through the messy work of coming to an agreement on the method and design of system change.

Acknowledgement of community readiness is a critical ingredient of success. In fact, it may be the single most important predictor of the types of change a particular community can expect to create over a specified period of time. Assumptions about readiness affect grantmakers' goals (including expectations about the magnitude of expected change), proposal assessment, technical assistance resources, and evaluation: these should be explicitly discussed at the very outset of program design. These ingredients must be synchronous in order for there to be a high correlation between what funders expect and grantees can deliver.

Funders that work in multiple communities do not need to make a definitive decision about whether to build or to require community readiness. The decision can be community specific. The federal Office of Rural Health Policy (ORHP), through its Network Development Grants, for example, works to support creation and maintenance of viable service delivery networks in rural areas and has thus faced the tension between working with areas that seem ready for system change and working with those that need help to get ready. Researchers at Georgia State University's Georgia Health Policy Center worked closely with ORHP to develop a strategic plan for its grantmaking. The approach creates two distinct funding mechanisms, allowing the agency to help create either community readiness or system change, as appropriate. By tailoring the granting mechanisms to different levels of readiness, the agency is able to support initiatives in communities with similar delivery system needs but different levels of readiness.

Decide What the Program Is and What It Is Not

Any grantmaking endeavor must start with a clear statement of program goals that are endorsed by the foundation's board of directors and understood by staff, consultants, grantees, and community partners. Such statements must reflect the foundation's core mission, values, and priorities. Community-led initiatives are, by definition, shaped by grantees that have a strong sense of what program elements are most appropriate at the ground level. Under these circumstances, the foundation's statement of program goals is its strongest signal to applicants of its vision for the program. That statement must be developed in a way that helps everyone remain faithful to the foundation's original intent over time when tensions over program resources and direction will inevitably arise. The statement of goals should also guide evaluation.

In the case of efforts to create access for the uninsured, funders need to determine whether the emphasis should be on remediating access problems or expanding health care coverage rates. In communities facing disruptive levels of uninsurance, shoring up the service system in the short term and long-run improvement of coverage and delivery systems may both seem like high priorities. The reality is that few funders have the resources to focus on both improving service availability and expanding the availability of health care coverage. This choice requires balancing a desire to help people now against the idea that systematic change might not yield results for several years or that the success of such change may not, in fact, be demonstrable by traditional standards.

One way to think about the challenge of picking a clear focus for these programs is to consider service providers and revenue streams as two distinct sets of silos, even though, in some cases, there is substantial overlap. For the uninsured to have appropriate access to care in a strained delivery system, either the service silos or the coverage silos need to be dismantled to ensure that those who need care can get it when they need it. Funders face an initial decision about whether they are more interested in rearranging the service silos or the coverage silos. While, ultimately, both might need to change, leaders from effective programs assert that it is difficult to take them on at once, so they recommend starting with just one.

As a practical matter, people tend to view tackling the service silos as more tractable, affordable, and likelier to have demonstrable effects in a shorter time frame than taking on the coverage silos. At the same time, experts suggest that short-term gains in service provision can be illusory and might not be indicative of long-term system change. In the end, most agree that what really matters is the capacity and effectiveness of both local

service and coverage systems, not the number of people who are served or who have health care coverage. But if this is the focus, programs cannot sensibly be expected to effect meaningful change in fewer than three years, once the community is truly ready to implement serious reforms. A shorter time frame could be appropriate for a project aimed at advancing community readiness rather than at effecting system change.

Thus it may be sensible to have a vision that includes short-run increases in service provision and in the number of people enrolled in existing sources of public coverage, middle-term permanent changes in care systems and development of additional coverage or financing strategies, and long-run changes in patterns of insurance status and receipt of services. The overall vision can be staged into a series of shorter term accomplishments. The work can be undertaken in stages or even in concert with other funders.

Implicit in decisions about what the program is and what it is not, though, is whether the foundation and the community buy into it as an appropriate use of limited resources. Making this case can be problematic, however. Efforts to make the business case for an intervention often focus on demonstrating the return on investment that will accrue to those who make a financial investment in the endeavor. In the case of community initiatives, this arithmetic often focuses on direct cost savings, ultimately resulting in final estimates that do not measure up to the initial claims of the program's proponents. Recently, the notion of return on community investment (ROCI) has emerged as one way to make the business case that can account more fully for program effects over the long term. In particular, ROCI aims to account for more distant program effects, such as indirect cost savings, inflow of new money into the community, and improvements in morbidity and mortality, with their attendant gains in labor force productivity.[2]

Cultivate Social Entrepreneurs

Creating and sustaining an effective program requires visionary ideas, communication skills, patience, working relationships, and hard work. These can come from many sources including funders, grantees, community partners, and consultants. But, in many cases, the success of community projects can be directly tied to the presence of a social entrepreneur. Social entrepreneurs find ways to get around old barriers, forge new relationships, and create buy-in among stakeholders. In building a community response to access, an effective project leader is someone who can, for example, convince the head of a local hospital that

[2] For more on this topic, see Rogoff 2003.

the hospital has such compelling long-run interests in the program's success that it is willing to commit real resources to participating in the program and will come to the table ready to consider solutions that may require demonstrable costs to the hospital.

Foundations are in a unique position to help establish and support the expectations and roles of such social entrepreneurs. To be effective, social entrepreneurs need to develop a unique set of communication, negotiation, and management skills as they work to create change across organizations and sectors. Throughout the process of soliciting and evaluating proposals, developing program activities, and supporting programs as they mature, foundations can help these leaders acquire and refine these various skills. That can happen explicitly through training or other focused activities or implicitly through the way that foundation staff conduct their own work. The strong personalities and "can-do" attitudes associated with many social entrepreneurs can create unique management challenges for program staff (both at foundations and community grantees), who have to make sure that the project stays faithful to its mission and within its budget.

Communitywide Problems Require Input from Community Leaders at the Highest Levels

Everyone wants to have the right people involved. In fact, getting the right local leaders involved is essential to long-run success of communitywide projects. These are top-level leaders from the local institutions and populations that must change for the program to be successful.

It is critical to involve leaders from local providers who have a long-run commitment to their institution and to the community. Their involvement is important for ensuring that program activities make sense over a 5-to-10 year planning horizon. There is no specific list of people (by role) that applies to every community, since the relative importance of public hospitals, public health departments, academic medical centers, and others differs across communities. In each community, leaders need to be involved from large providers that serve the uninsured, that the insured need to be served by (such as for specialty services), and that may lose current insured patients (or funding streams) as system changes occur. The commitment of these organizations is signaled by the ability of the representatives they include in the project to commit to substantial financial and programmatic changes on behalf of the organization.

One interviewee commented that one of the projects had gotten off to a weak start because the right people from key local institutions were not involved. Mid-level staff members were participating instead of those able to make important commitments on behalf of their organizations. The lackluster performance of the project was becoming a source of concern for national program staff. In an effort to turn things around, the grantee was encouraged to develop a mechanism for supporting more constructive engagement among key local leaders. As they tried to pull this new initiative together, a change in state policy led to an immediate threat to the local public hospital's financial viability. Consequently, the people who needed to be involved suddenly wanted to be involved, and top leaders became actively engaged in project discussions and made the kinds of institutional commitments needed to reorganize the local safety net. In this case, the external policy change helped motivate local leaders to buy in to the program's work more seriously than they had initially. The change from mid-level to senior managers, even though they were representing the same institutions, got the program moving.

The importance of including potential losers was highlighted by the problems faced by a program that failed to do that. In this community, a grantee coalition proposed a strategy for reorganizing safety-net providers in a way that it thought would expand capacity and access for underserved residents. It did not recognize, however, that its plan to redistribute charity care from an overburdened safety net hospital would also likely siphon off some of its paying patients and challenge some long-standing racial and political equilibria in parts of the community. Overlooking top leaders of the provider most directly affected, the coalition could not implement its plan as proposed and alienated many of those it had hoped to help.

There are also key leaders from the broader population who are knowledgeable about residents' needs (met and unmet) and expectations of the system. Among this category of leaders, the right individuals are those who not only can represent perceived community needs and interests but also can help create change in these needs and interests. Just as institutional leaders must come willing to commit to make changes within their organizations, these community leaders need to be ready to help create change in how residents view and use the local health system. Again, there is no list of the right community leaders, since the roles of public officials, church leaders, service organizations, and others differ across communities.

At the same time, program leaders point out that there are people who do not need to be included in the program's direction and oversight. Funders and grantees often make the mistake of welcoming any local group interested in participating in community oversight groups or similar program steering boards. Such inclusiveness can be counterproductive for several reasons beyond the simple challenge that sheer numbers present to productive meetings and project management. Every aspect of program design and implementation needs to signal unwavering commitment to the program's goals and the importance of using limited resources, including people's time, as effectively as possible. Including actors who are not able to create change among community providers and residents dilutes the group's effectiveness. It may also reduce the buy-in of the people whose involvement is essential to the program's success.

One program leader commented that the effective creation and management of community consortia demand the ability to say no in a variety of circumstances. Both funders and grantees need to be able to say no to:

- people who want to play a central role but who are not in a position to commit key institutions to make real changes;
- proposals that arise in the course of project discussions that, while possibly important to the target community, are off-mission for the project; and
- so-called goal creep on the part of the foundation (particularly when there is no additional funding).

Perhaps the best way to support staff to say no is to give them a constructive alternative. For example, the local leader who tries to move into the inner circle of the local consortium (despite the fact that he or she does not belong there) can be included in the program in a more appropriate, peripheral way. Similarly, when an active consortium member proposes an idea that is off-mission, staff can help identify additional funding opportunities to support it outside of the project.

Expect Problems and Plan for Them

Even well-planned, appropriately staffed, and well-funded programs will encounter problems along the way, whether it is in the design of the request for proposals, selection of grantees, or assessing how a project is doing. In the context of building community-based models for improving access to health services, planning for problems involves identifying the key assumptions about public policy, local institutional buy-in, economic growth, and

staff competencies that underlie program plans and anticipating what will happen if one or more of these assumptions prove wrong.

Grantmakers must pay careful attention to the implications of their efforts for the entire local system, not just those portions they are funding. Changing the way that safety-net providers provide care and work together can have unintended consequences, negative as well as positive. In one community, access initiatives aimed to reduce wait times at emergency rooms and to reduce use of ERs by uninsured residents. The ER wait-time initiative was an impressive success, reducing waits to less than an hour in most cases. At the same time, new caseload volumes started to overwhelm local ambulatory clinics, where waits grew and easily exceeded those in the newly efficient ER. As a result, patients became reluctant to bypass the ER in favor of the clinics, and both initiatives were challenged.

In another community, efforts to get newly insured residents to use different providers than they were used to met with strong resistance because the providers they were being encouraged to go to were not perceived to be culturally competent. Observers also note that when people gain health care coverage for the first time and flee safety-net providers in large numbers, these providers can face challenges in maintaining adequate staff and resources for their remaining patients.

Sometimes the problems are big enough to derail the entire project. A program that aims to build a new managed-care plan from a new local tax, for example, may be fundamentally compromised if the tax is not approved by voters. Grantees of the two national programs experienced all sorts of external shocks, from loss of an anticipated key public funding stream to wholesale turnover of local public officeholders. In some cases, these changes proved insurmountable for grantees. In others, where there was a high level of community readiness and a strong social entrepreneur in charge of the project, it was possible to reconceptualize the program and take a different tack.

Planning for problems means thinking ahead about what might go wrong and what to do if it does. Funders and grantees alike believe that a clear, well-understood mission, mutual respect, and a pattern of frank talk make it easier to deal with challenges when they arise, whether it is to agree to discontinue the project or to identify a feasible alternative. With these attributes in place, the decision to discontinue a project can be constructive and minimize the damage to future work that can occur if a funder unilaterally concludes it must discontinue what it views as an unsuccessful program.

Be Realistic About Evaluation

Both *Community Voices* and *Communities in Charge* are the subject of extensive evaluations by national research firms. These evaluations will provide funders and others with information about the strengths and weaknesses of the various approaches used to improve access for the uninsured. They are also intended to offer insight on which models might be replicable elsewhere. At the same time, given that under both programs the interventions were specifically tailored to each target community, it will be difficult for evaluators to draw strong conclusions about what might work or fail in other communities.

That said, there are additional roles for evaluation in projects of this nature. Several grantees noted the importance of systematic, real-time feedback that could be used to help refine and improve program activities and operations. Such feedback is qualitatively different from large, traditional program evaluations that aim to attribute specific program outcomes to particular program characteristics. In some cases, grantees thought that traditional formal evaluation methods and measures were not particularly helpful to them as they tried to refine their evolving programs. While systematic evaluation aims to find common threads across programs in order to figure out what might be generalizable, these grantees also wanted individualized advice about their particular strengths, weaknesses, opportunities, and threats. Such feedback could be provided by technical advisers or others, or it could be part of an evaluation activity that includes evaluators as part of the project rather than as observers.

In any case, evaluation activities, measures, and expectations need to be built into each project from its inception. Evaluation experts, grantees, and funders all related frustrating problems associated with evaluations that were added or changed after the project was undertaken. Data requirements are a consistent source of problems with evaluation of this type of project, particularly when evaluation is built around extensive grantee-provided data. If information needs are not clear from the outset and do not dovetail with what is being collected for project management, they are likely to become a source of anxiety and extra burden for grantees. Ultimately, grantees need to understand and value any evaluation-related data requirements if the data are going to be reliable and valid. Including specific expectations with regard to data and other evaluation needs in the initial program announcement (or final award negotiations) helps grantees understand what will be expected of them and will help create good fits between their individual work and the broader goals of the program.

Evaluation requires trust between funder, evaluator, and grantee. The challenge is to develop a mechanism for evaluation that creates an open, trusting environment in which funders and grantees share and analyze information with an eye toward improving programs, whether their focus is improving those programs under study or those yet to be undertaken. When grantees regard evaluation as simply an additional burden of little value to them — but with the potential of finding them lacking or inadequate — the project itself, not just the evaluation, can be undermined.

Make Sure Grantees Have Access to the Tools They Need

Foundation staff, consultants, and contractors need to offer a set of skills and abilities that in many ways mirror those of the community grantee and consortia. Among these are having the required mix of knowledge and expertise to support grantees and the ability to work collaboratively across organizational borders. Experts do not agree on a perfect model of the specific roles of project officer and technical experts — if foundation staff members have the necessary expertise, they can offer technical advice. Otherwise, appropriate consultants need to be identified and brought on board.

Both *Community Voices* and *Communities in Charge* invested heavily in technical assistance, ranging from communications to evaluation to financial expertise. National grantee meetings gave grantees a chance to learn from technical assistance providers; in other cases, consultants were on call to answer questions and help solve problems. These mechanisms certainly opened up the doors to national experts. Grantees also used each other as technical assistance resources, sharing insights and making referrals to individuals who had helped them.

The logic for providing technical assistance also applies to project management and oversight. If there is a staff member who has actual experience managing this type of community project, there is no need to hire an outside expert to provide program oversight. Conversely, if no staff member has this type of experience, then it may be worth using project resources to hire an outside program officer who provides day-to-day program oversight on the foundation's behalf. Grantees can tell if their project officer can really "walk the walk" and consistently reported that those who cannot may ultimately compromise the project's effectiveness.

Smaller foundations may not be in a position to augment foundation staff expertise with outside consultants or experts. In this case, they need to make sure that they develop program missions and pick grantees that can be effectively supported by the specific knowledge and experience of foundation staff.

Develop Strong Trusting Relationships with Grantees

Most grantmakers place a premium on developing strong working relationships with their grantees. At the same time, there is inherent tension in being supportive of grantees and ensuring accountability to the foundation. Foundations can foster strong relationships with their grantees by setting clear expectations, sticking with them, and providing whatever level of support was indicated, in terms of both money and expertise. Making sure that program mission, funding, expert resources, and evaluation are all internally consistent is the funder's primary contribution to the program's success.

Foundation leaders, grantees, and others involved in community-based projects have identified a number of things that foundations can do (and not do) in their interactions with grantees and community consortia to help create success. Above all else, grantees stressed concerns about funders coming to communities with prescriptive program plans. In the best of all worlds, funders will engage community actors as true peer partners.

Several funders and grantees raised the importance of being faithful to the mission throughout the project period. Stress and opportunities for failure are created when funders begin layering new expectations and requirements onto grantees once a project is under way, particularly without additional funding. Even when properly funded, however, these additional expectations can compromise the original project's likelihood of success. Just as community grantees need to avoid overextending consortium membership to too many and too distant actors, grantmakers need to avoid overextending a program beyond its core mission. One of the ways funders show respect and support for their grantees is to help them stay on task and on budget by avoiding putting them in this awkward position. The right program staff are people who can effectively say no as appropriate, without alienating people or missing new opportunities.

At the same time, however, grantees welcome opportunities to learn from others and to modify program features and strategies in response to new information about what works. Thus, when grantmakers find new information that compels them to want to modify an existing program, their programs are more likely to benefit from that information if it is shared directly with grantees, rather than if it used by staff to create new program requirements that are then imposed on grantees. In cases where the new information being disseminated is based on

the experience of another grantee, other grantees are more likely to benefit from it if it is not presented to them in a way that makes them feel like an unfavored stepchild. Several grantees, including those whose programs were regarded as quite successful, thought that there were clear favorites and admitted that they became resentful of being told constantly how successful the pet project was (or of being held up as an example, in the case of the pet project).

One of the most important ingredients for success is an environment characterized by frank talk. Grantees may be constantly seeking new ideas and strategies for solving problems or improving program operations, but they also feel pressured to convey a level of mastery and success to funders. It can be challenging to figure out what to say to whom for fear that efforts at improvement are mistaken for signs of serious problems or failure. At the same time, foundation staff members should have a clear picture of how their grantees are doing. Frank talk is essential between grantee and project officer, project officer and executive, and executive and the board. Whether that is best achieved by having the project officer report directly to the board depends on the experience and management skills of available staff, as well as on foundation norms and expectations.

Some strategies for ensuring frank talk include periodic grantee meetings (with scheduled time or specific activities for grantees to talk together in the absence of program staff), having technical advisers who work closely with a grantee throughout the project and track down specialist advisors as needed, and matching grantees with peer buddies with whom they can talk regularly about project successes and challenges, advising and supporting each other. Frank talk is also facilitated when reporting requirements are sensible and there is a good fit between grantee and funder in terms of community readiness, project mission, and project support.

For large projects, some believe that frank talk can be enhanced through the use of a program office external to the foundation. That is the model that The Robert Wood Johnson Foundation used in contracting with Medimetrix to serve as the national program office for *Communities in Charge*. This model provided program management and technical assistance for grantees without directly involving the foundation in day-to-day problems. One disadvantage of this approach, besides the extra expense, is that foundation staff and boards are not as knowledgeable about program developments or problems that they could help solve. *Communities in Charge* also had an ombudsman to provide yet another avenue for grantees to air issues. It was not always clear to grantees, however, how the functions of the ombudsman and the national program office differed.

The W. K. Kellogg Foundation chose to have foundation staff oversee *Community Voices* directly. Under this approach, foundation staff helped grantees address problems as they arose. Critics of keeping program oversight in-house argue that it forces grantees to be guarded in seeking help for problems, possibly compromising project success. There does not appear to be any consensus about when or whether to create an independent national program office. Instead, that decision should reflect foundation staff expertise and skills and must be consistent with other program elements, such as strategies for accessing external experts for grantees, communicating with staff and other grantees, and assessing project progress.

Foundations must also recognize that, when they expect grantees to secure additional funding from other sources, such funding may come with goals and priorities that are slightly different from their own. To the extent that funders explicitly try to leverage their support by requiring concurrent support from other sources, they need to help the grantee reconcile different goals, priorities and even reporting cycles and evaluation measures. In the worst case, each funder of a common program has a unique set of expectations and requirements of the grantee, creating unproductive reporting and administrative burdens on limited resources.

Finally, funders must model good behavior. One grantee organization described its confusion when a funder sent mixed and unclear signals about program goals, while at the same time admonishing the grantee for not being clear in its communications with community partners. In itself, this episode was not significant. Over time, however, the foundation compromised its rapport with the grantee with its inconsistent behavior.

Recognize the Comparative Advantages of Funders Working at the Local, State, and National Levels

The design of *Community Voices* and *Communities in Charge* naturally raises questions about the relationship between national funders and those rooted in specific states or communities. The implementation in different communities also spotlighted some of the tensions. In many communities, local funders were thrilled to have an infusion of new resources to tackle longstanding problems. In others, local funders were less enthusiastic because they had misgivings about the choices being made by national funders.

In general, local foundations may be better poised to help create community readiness, while larger national funders may be in a good position to leverage high levels of readiness into system change. For local foundations, assessing and investing in readiness may occur

at the organizational level rather than at the community level. Local foundations need to decide if they want to help develop organizations that could become part of a community-led systems change initiative or if they want to work with organizations that are ready to be part of such change.

National foundations can face particular challenges in vetting applications from various communities. For example, sometimes two different groups from one community might apply, each claiming to have buy-in from local leaders but offering different visions of what needs to be done. When this happened in one of the national programs, program staff went for a site visit and met with, among others, several local health funders. A local expert predicted that one of the candidates was on the verge of collapse and recommended that the other be chosen. Unfortunately for the national foundation (which did not follow this advice), the prediction proved to be accurate despite the added resources of the national program. While local foundations are not omniscient, they are likely to have insights into local politics and the relative effectiveness of local bureaucracies that are difficult for outsiders to understand.

National, regional, and local foundations bring different resources, skills, and knowledge to community-based access initiatives, differences that, if well-coordinated, can greatly increase the effectiveness of everyone's work. At the risk of oversimplification, national foundations often have more resources in terms of money and particular substantive expertise (for example, access to national experts in some of the areas where grantees may need technical assistance). Smaller regional and local foundations often have true insider's knowledge about the local scene, from political power to clinic-specific service strengths and weaknesses. Local foundations can typically assess, and possibly improve, community readiness for change more effectively than regional or national foundations.

By capitalizing on these comparative advantages, programs can get the best of both worlds. In one of the national program sites, for example, a local foundation stepped in and helped reignite local leadership interest in the program. By funding and facilitating a series of local forums that key local leaders agreed to attend, the local foundation helped put the national foundation's program back on track. At the same time, the national foundation brought in national experts who were unknown to the local foundation, but helped the grantee address some of the problems that were compromising the project. Foundations can support each other's work in other ways, such as developing a campaign around a common interest, even if a tightly integrated program is not feasible.

The roles of national, state, and local funders also come into play around the issue of sustainability. *Communities in Charge* had a specific requirement that grantees match RWJF funds with funds from other sources. Moreover, both *Community Voices* and *Communities in Charge* expected grantees to develop plans for sustaining project activities, as appropriate, once the foundation's project period ended. The involvement of other funders sometimes helped grantees focus and refine their vision and get feedback from others. Yet, meeting expectations about sustainability sometimes made it difficult for the grantee to focus on the core program goals, especially if they had to expand or modify these goals to meet the expectations and requirements of other funders. Grantees were sometimes puzzled about whether the national foundations were most interested in leveraging their investments (that is, seeing projects continue with additional revenue sources) or achieving particular programmatic goals.

Funders must realize too that sustainability is not always desirable. Sometimes program success means that the activities supported by the foundation are no longer needed. For example, if the grantee aims to create new relationships among existing providers to rearrange referral patterns and data sharing, its particular activities may not be necessary if it is successful in creating these relationships and collaboration. At other times, success must be defined as the learning gained from trying to implement an ultimately unworkable project.

Understand the Limits of Community Activities in an Environment Defined by State and Federal Policy

Much has been written about state and national policy reforms that could address the challenges that local health systems face in communities with high levels of uninsurance. Local providers and communities are strongly affected by a broad mix of policy changes, from state initiatives to expand the State Children's Health Insurance Program to include uninsured adults to expansion of federal support for community health centers. A particular policy change can affect similar communities differently, depending on whether local governments provide or finance care, the mix of for-profit and nonprofit providers in the area, and the level of concentration of uninsured patients among local providers.

Given the continued evolution of the policy environment and the possible effect of policy changes on local systems, initiatives designed to improve access for those without health care coverage must be designed with regard to both the existing and impending policy

environment. Some initiatives might be designed specifically to exploit opportunities or resources created by a new policy change. Others might work effectively only if the status quo is maintained. In all cases, funders and grantees should review relevant policies and the probability of change, developing alternative strategies if there are assumptions about continuing (or changing) policies that are essential to the proposed project. In some cases, certain laws may be particularly important to creating or limiting program activities. For example, several projects that aimed to create coverage opportunities had to conform to state insurance laws. Typically, they were able to work with state regulators to address such issues as meeting the large cash reserve requirements demanded of commercial insurers.

Leaders of effective community initiatives thought that their experience was critical to shaping and improving local, state, and, in some cases, federal policy, primarily through working to make sure that policymakers understood the implications of uninsurance for local care systems. Short of wide-reaching reform, however, there does not appear to be a list of specific policies that are essential to helping communities shore up fraying safety nets. Instead of advocating for specific legislative changes, many of these leaders saw their most important job as educating policymakers. As one said, the immediate challenges and potential solutions might change, but the fundamental problems persist. An experienced policymaker himself, this interviewee shared his view that educating policymakers about the underlying problems will ultimately yield better solutions than aligning his program with one particular legislative change.

Grantees welcomed the chance to learn about policy and how it affects their local service environments, including the different effects on providers within a single community. Several commented that their increased awareness of policy as framing both the present situation and the possible solutions in their communities may be the most important lasting product of their projects. In their view, funders that provided both the incentive and resources to understand and participate in policy formulation were greatly enhancing their investment in the community program.

Like community readiness, savvy about the policy environment is something that funders can expect from grantees before undertaking a project, help create among emerging social entrepreneurs, or augment with internal foundation expertise or through external consultants. Ultimately, change is not sustainable without this savvy.

Many funders worry about whether the policy work undertaken by grantees crosses the boundaries of the foundation's legally permissible roles. There was consensus among those interviewed that this should not be a problem for private foundations, particularly if grantees aim to provide information to policymakers about general issues rather than lobbying for specific pieces of legislation.[3]

Conclusions

Projects can be successful in communities without a history of collaborative efforts, as well as in those with a proven social entrepreneur and consortium, if funders and others have an accurate assessment of the level of readiness and therefore develop missions, partnerships, and expectations that conform to each community's readiness. They are successful not because of their particular attributes, but because of the concordance among their attributes.

In all instances, successful projects of this type take the concerted efforts of many local leaders working together toward a common goal of improving peoples' abilities to use health services appropriately, ultimately reducing excess morbidity and mortality. They require social entrepreneurs – leaders who can simultaneously garner resources from numerous sources, work closely with a variety of people, and keep sight of the program's core mission. These new leaders can work effectively across organizations, including historical rivals, to craft new sustainable health care delivery and coverage systems.

The lessons described here are not new: decide what the program is and stick to it, involve the people who need to be involved, plan for the problems that will inevitably arise, give grantees the tools they need to succeed, and encourage frank and open communication. Funders also need to be mindful of their own comparative advantages and how much they can accomplish in the community when the rules are often set in state and national policy. Taking the time to reflect on them and to live by them, however, is the ongoing challenge for all health grantmakers.

[3] Those interested in learning about the rules for foundation engagement in public policy should consult Grantmakers In Health, *Strategies for Shaping Public Policy* (Washington, DC: 2000) and Grantmakers In Health, *Funding Health Advocacy* (Washington, DC: 2005).

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Institute of Medicine, *A Shared Destiny: Community Effects of Uninsurance* (Washington, DC: National Academy Press, 2003).

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Appendix I. Additional Resources

For more information about the specific grantees of *Community Voices* and *Communities In Charge* and their experiences, see the following publications and Web sites.

Community Voices

www.communityvoices.org

Meyer, Jack A., and Sharon Silow-Carroll, *Increasing Access: Building Working Solutions* (June 2000).

Meyer, Jack A., Sharon Silow-Carroll, and Emily Waldman, *Community Voices: Lessons for National Policy* (February 2004).

More than a Market: Making Sense of Health Care Systems. Lessons from Community Voices: Healthcare for the Underserved. A Report Covering 1998-2002 (September 2002).

Silow-Carroll, Sharon, Tanya Alteras, and Heather Sacks, *Community-Based Health Coverage Programs: Models and Lessons* (February 2004).

Silow-Carroll, Sharon, Stephanie Anthony, Paul A. Seltman, and Jack A. Meyer, *Community-Based Health Plans for the Uninsured: Expanding Access, Enhancing Dignity* (November 2001).

Communities in Charge

www.communitiesincharge.org

Communities in Charge Compendium of Products
This compendium includes products from the national program office as well as strategies and byproducts that the CIC communities developed in their efforts to improve and expand community-based health coverage. The compendium serves as a single source of information and resources for other communities to access.

Communities in Charge Gifts
In Phase 2 of this initiative, each grantee was required to submit a gift to share with others. These includes forms, fact sheets, strategy documents, bylaws, and other documents that can be adapted for use by others.

Improving Access to Health Care: Building a Community-Based Program. A Manual Based on Experiences From The Robert Wood Johnson Foundation's Communities in Charge Program (January 2005).

Lessons Learned from Community-Based Models of Care for the Indigent/Uninsured: Financing Mechanisms and Strategies for Integrating Healthcare Services (December 2001).

Stevens, Beth and Larry Brown, *Case Study Evaluation of the Communities in Charge Program*, presentation at 5th annual Communities in Charge project directors meeting, Austin, TX, January 16, 2004.

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