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Evaluation of Community Voices Miami

Affecting Health Policy for the Uninsured

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PREFACE

In response to continuing concerns about access to health care for the uninsured, the W. K. Kellogg Foundation in 1998 launched a five-year initiative called Community Voices. The goal of the initiative was to assist local organizations in strengthening community support services, giving the underserved a voice in the debate over health care access, and identifying ways to meet the needs of those who now receive inadequate health care. One of the Community Voices grants went to Camillus House, a Catholic social service agency and health care provider for the homeless located in Miami, Florida. Camillus House asked United Way of Miami-Dade and RAND Health to join in the effort. United Way led the community outreach activities, and RAND provided technical assistance and policy analysis and evaluated the five-year effort. As the project developed, the Camillus House-based Community Voices Miami (CVM) staff invited a number of other community partners to participate in the initiative. In May 2003, CVM moved to the Collins Center for Public Policy, Inc. and continued to engage community partners from there.

This report is the final product of RAND's evaluation of CVM during its first phase, 1988-2003. The evaluation draws on information collected through three waves of stakeholder interviews, document review, on-going project documentation, a mail survey of all CVM participants, and multiple site visits. Data from these multiple sources have been triangulated to assess CVM's progress toward its goals of improving access to health care. This report should be useful not only to CVM as it continues its work in Miami,[1] but also to others undertaking similar endeavors.

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[1] CVM was funded for an additional four years (2003-2007) by the Kellogg Foundation.

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SUMMARY

Health care insurance coverage has been part of the national debate for a long time. After the failure of the Clinton Administration's Health Security Act, many in the health policy community acknowledged that achievement of universal health coverage in the next five years was unlikely. Without a solution in sight and the prospect of an increasing number of persons losing Medicaid coverage as a result of welfare reform, many communities were concerned about the survival of safety-net providers and their ability to continue to provide health care to the uninsured and underinsured.

Community Voices Miami (CVM) is one of 13 sites that constituted Community Voices: Health Care for the Underserved, the five-year Health Care Initiative (1998—2003) sponsored by the W. K. Kellogg Foundation to address these concerns. The purpose of the initiative was to support safety-net providers and bolster community support services with the ultimate goal of enhancing health care access and quality for the underserved. The 13 Kellogg sites, or learning laboratories, were tasked with assessing effective ways of meeting the needs of those who receive inadequate or no health care. The Kellogg Foundation's grant to Miami-Dade County, Florida, was administered by Camillus House, a Catholic social service agency and health care provider for the homeless.

Camillus House invited two partners to participate in CVM. The first partner, United Way of Miami-Dade, a local community organizer and funder of social services, was responsible for obtaining community input into the project (i.e., the community voices) through group discussions with clients of local social service agencies and residents, as well as for managing CVM-funded capacity-building grants to neighborhood coalitions. The second partner, the RAND Corporation, a nonprofit research organization that provides policy analysis to help improve decisionmaking, was responsible for evaluating CVM and providing analytic assistance throughout the course of the project.

This report is the final product of RAND's evaluation of CVM. The RAND team conducted this evaluation by developing a conceptual framework with our project partners at Camillus House and United Way, identifying principal evaluation questions and drawing on multiple data sources, including three waves of stakeholder interviews, document review, on-going project documentation, a mail survey of CVM participants, and multiple site visits. RAND researchers were involved from CVM's inception and collected data throughout the course of the project.

CVM Goals and Strategies

The specific goals of CVM were to
- Improve access to care for the medically uninsured and underinsured by effecting health care policy and systems change in Miami-Dade County; and

- Develop and implement an evaluation system for measuring the health care outcomes and access to care of the uninsured and underinsured in Miami-Dade County.

Although the overall goal of improving access to care for the uninsured remained fairly constant throughout the five years, the strategies (those perceived by stakeholders and the actual strategies undertaken) for reaching this goal varied. Early in the process, there was a perception on the part of some CVM participants and observers that CVM aimed to force a reallocation of county surtax funds away from the county-run Jackson Health System (JHS) to a broader range of providers (e.g., to let the funds follow the uninsured patient). However, as a wider range of stakeholders began to participate in CVM (including representatives from JHS), the focus broadened to that of developing a new model of health care delivery and, later, a series of recommended policies and pilot projects to improve access and appropriate utilization of health care. By the end of the project, the focus of CVM again became sharper, concentrating on the establishment of an independent health care planning body to monitor and evaluate the health care system for the uninsured in Miami-Dade County, consistent with the second goal. Establishment of this new body would effectively diminish the role played by the Public Health Trust (PHT), the entity that oversees JHS, in setting countywide health care policy and planning.

The general theory behind CVM, according to project partners and leaders, was that mobilizing community stakeholders (health care providers, neighborhood residents or consumers, and community leaders) around issues of access to health care for the uninsured would produce a groundswell of support sufficient to compel policymakers to introduce policies and/or programs that would improve access to health care for this population. In practice, CVM took a three-pronged approach to achieve its goals, with efforts to build community capacity, promote collaboration, and influence local policy all proceeding somewhat concurrently. This report focuses primarily on CVM's efforts to promote collaboration through the Multi-Agency Consortium (MAC), a body of stakeholders formed by CVM, and CVM's efforts to influence local health policy through CVM-commissioned reports and by participating in the Miami-Dade County Mayor's Health Care Access Task Force.[2] These efforts and their respective accomplishments are summarized below, and the limitations and shortcomings of the project are briefly discussed.

Efforts to Promote Collaboration

CVM invested much time and effort in developing the infrastructure and trust necessary for collaboration around health access issues. The principal mechanism it used was the Multi-Agency Consortium (MAC), in which invited community stakeholders (health care providers, planners, advocates, and policymakers) were asked to participate in developing *feasible* health policy for the county. CVM sponsored informational meetings of the MAC approximately quarterly, and convened additional subcommittee and task force meetings around specific tasks. The MAC came to include over 90 individuals, and much work went into trying to manage, inform, and communicate with members.

The most frequently mentioned accomplishment of CVM throughout the project was that of getting divergent interests around the table and engaging people in constructive dialogue. CVM's strengths in convening

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[2] For this evaluation, we do not focus on the third prong, efforts to build community capacity to improve access to care through funding neighborhood coalitions, largely because these projects began at the end of CVM's five years and had their own evaluations. However, given the importance of these activities for CVM's overall vision, we include an update on their developments in an epilogue to this report.

seemed to come from both the high-profile persons and organizations involved with CVM and the consensus-building and facilitator skills of the CVM project team. However, the move from convening (i.e., getting divergent interests around the same table) to collaboration (i.e., a mutually beneficial and well-defined relationship to achieve common goals) was not as easy for CVM. Some of the difficulty was caused by the contentious financial environment[3] and problematic history surrounding indigent health care in the county, and some was due to other factors, such as the broad array of partners and agendas present throughout CVM's five years. For example, the MAC had a very large list of members, but a relatively small core group of persons and agencies participated consistently throughout the five years of the initiative (e.g., only 13 agencies participated in at least half of the CVM-sponsored meetings). Moreover, the MAC did not entirely meet the definition of collaboration offered in Chapter 5,[4] mostly because there was little mutual authority and accountability for success and no financial bond among organizations. This observation was supported by evaluations of CVM by its participants which found that on many of the factors that are thought to lead to successful collaborations, CVM was somewhere in the middle, not particularly deficient but also not particularly strong.[5]

It is perhaps because of CVM's strong convening role, however, that it was able to effect some degree of collaboration among local safety-

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[3] Much of this had to do with funding issues, in particular, the distribution of the county surtax for health care. This is discussed further in Chapter 2 and also in previous reports (Jackson et al., 2002; Jackson et al., 2003)

[4] "Collaboration is a mutually beneficial and well-defined relationship entered into by two or more organizations to achieve common goals. The relationship includes a commitment to mutual relationships and goals; a jointly developed structure and shared responsibility; mutual authority and accountability for success; and sharing of resources and rewards" (Mattessich et al., 2001).

[5] These factors include such things as having a history of collaboration or cooperation in the community, a favorable political and social climate, mutual respect, understanding and trust, flexibility, development of clear roles and policy guidelines, and skilled leadership. See Chapter 5 for more information on our mail survey of CVM participants, in which we used an adapted version of the Wilder Collaboration Factors Inventory.

net providers. Data collected by RAND suggest that CVM played an important role in a coalition of safety-net providers led by JHS that received a Community Access Program (CAP) grant.[6] CVM convened the group of providers for an unsuccessful first grant application and convened initial meetings for the successful second application. Although CVM did not have any operational role in Miami-Dade's CAP programs (e.g., in disease management or eligibility screening), CVM project team members did remain active on CAP subcommittees and were asked during the second year to reach out to community mental health centers that had traditionally been alienated from JHS. In a similar fashion, CVM played a convening role in the Miami Coalition for School-Based Health, which formed during the last of CVM's first five years. CVM had made school-based health a priority (first in its MAC subcommittee recommendations and then as an objective of CVM's Miami Action Plan for Access to Health Care) and helped pull together various stakeholders in the community around this issue. Furthermore, CVM assisted staff meetings of this coalition during its formation and contributed to a grant proposal that was funded by the Health Foundation of South Florida to support expansion of school-based health programs. Therefore, although CVM's work through the MAC did not always represent collaboration per se, the CVM project team became known in the community as good facilitators who were able to build bridges between organizations that might not otherwise work together.

Efforts to Influence Local Health Policy

In addition to promoting collaboration, another central focus of CVM was that of influencing local policy. CVM attempted to achieve this through commissioned reports and by participating in initiatives related to indigent health care policy, such as the Mayor's Health Care Initiative and the subsequent Mayor's Health Care Access Task Force. CVM commissioned RAND to prepare a report on hospital financing and the travel patterns of the county's uninsured patients (Jackson et al.,

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[6] CAP is a federally funded program to support coordination of safety-net services. CAP brought $1.3 million to Miami in the first year (2002—2003) of the CVM project to support coordination among safety-net providers.

2002) and another report on principles of good governance applied to health policy in Miami-Dade (Jackson et al., 2003). CVM also commissioned United Way to produce a report on the findings from community dialogues addressing the access of the uninsured to care in the county (Community Voices Dialogues About Health and Health Care, 2002). The CVM project team at Camillus House, with input from community partners participating through the MAC, produced the Miami Action Plan for Access to Health Care (MAP), which was designed to serve as a roadmap for changing local health care policies and improving access to health care for the uninsured and underserved in Miami-Dade County.[7]

All of these reports were released in press conferences, and the MAP was also presented during a special community luncheon. The first press conference (February 14, 2002), where the United Way report, RAND's first report, and the draft MAP were presented, received the most press coverage (front-page articles in *The Miami Herald* Metro section and *El Nuevo Herald* and subsequent op-ed pieces on issues of indigent care). This extensive coverage probably was the result of CVM timing the release of the documents to coincide with the Miami-Dade County Mayor's Health Care Initiative, a one-day community meeting involving 150 participants that was convened to address access to care for the uninsured. The Health Care Initiative and the subsequent Mayor's Health Care Access Task Force, which was appointed to further study the issue and propose recommendations, represented political openings that CVM helped create and that allowed CVM to move its agenda forward.

CVM's principal investigator and several Oversight Team members played an important behind-the-scenes role, encouraging the mayor to address health care for the uninsured and to expand his initial focus on coverage for children to include coverage for adults as well. The principal investigator and project team members participated in both the Mayor's Health Care Initiative and the Task Force on Health Care Access and played an important public role in drawing attention to issues of health care governance in the county. The task force, which included an

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[7] Available from
http://www.communityvoicesmiami.org/map/Miami_Action_Plan.pdf.

array of 60 community leaders, presented its recommendations in March
2003. The recommendations included reforming the governance of the
county's responsibility for publicly funded health care. Specifically,
this recommendation called for the establishment of an office to address
countywide health care policy issues, independent of the PHT.

Many of the stakeholders we interviewed saw as an accomplishment
CVM's success in raising awareness about the uninsured and their health
care access difficulties and showing that these issues could not be
solved by the current system and funding. Some saw CVM's focus on
governance issues as negative because it politicized the CVM agenda and
made CVM less effective as a convener and collaborator. Others,
however, felt that advocating for the governance issue was useful, as it
challenged the status quo and forced a dramatic rethinking of the PHT
and how the county could best serve its uninsured residents.

Limitations of CVM

CVM had several limitations or shortcomings. The first concerned
participation and outreach. Certain important constituencies (business
and labor communities) were largely absent from CVM, and others (health
care providers) had limited participation. Moreover, several
stakeholders felt that some key factions of the community were allowed
to disengage at different times during the process, and that no overt
efforts were made to re-engage them. Finally, despite a strong
connection to the mayor, CVM was seen as lacking in political clout.
Respondents indicated that CVM should develop relationships with a
broader range of political leaders, such as county commissioners and
Florida legislative members, and that it should become more politically
savvy to accomplish its objectives.

Other CVM shortcomings had to do with leadership, goal-setting, and
operational strategies. As noted above, CVM strategies for improving
access to health care (perceived and real) varied over time, and this
produced confusion and misplaced expectations among CVM participants.
Some participants and observers felt that the CVM leadership had
overestimated what could be accomplished given the political realities
in the county, while others felt that CVM had misguided, biased
leadership that sought only to take away power and money from the

PHT/JHS. Even those generally supportive of CVM's approach felt that it placed too much emphasis on governance of the PHT, to the neglect of making measurable progress in improving access to care.

Conclusion and Lessons Learned

CVM was conceived in a contentious environment, where safety-net providers remained fairly polarized and efforts to address the uninsured's barriers to care, at least on a countywide basis, had been thwarted by political opposition. Although CVM originally seemed to focus on reallocating the surtax revenues from the PHT/JHS to other providers, the CVM project staff went to great lengths to involve representatives of the PHT/JHS in the project. This is not surprising given the role of the PHTJHS in caring for the uninsured of Miami-Dade County. However, the involvement of PHT/JHS representatives in CVM came at a cost, as it alienated or at least disappointed some who had hoped for more radical change. By the time CVM began to increase its focus on issues of health care governance (in year four), most of the PHT/JHS representatives had ceased to participate actively. In many ways, the focus on governance issues was a turning point, with CVM no longer perceived as neutral. This new focus also provided a specific policy target, the establishment of a truly independent body for countywide health care planning, for which CVM could advocate through participation on the mayor's task force and its subcommittee on governance.

Through CVM's involvement in the mayor's task force, many of the issues the CVM members had been trying to raise over the first four years of the project were immediately raised to a policy-level discussion. At this level, there were established mechanisms such as the Board of County Commissioners through which change could occur. However, some stakeholders noted in the final interviews that involvement with the mayor's task force came at a time when CVM had concluded its long planning phase and was poised to work for the implementation of the MAP recommendations. The year-long process of the task force required many of its participants (a number of whom had participated in CVM) to go through a process similar to that of CVM's earlier work, i.e., of studying the problem and proposing

recommendations, and indeed might have delayed progress by CVM and others in implementing MAP objectives and key actions.

In many ways, only time will tell whether CVM has been effective in improving access to health care for the uninsured and underserved of Miami-Dade County. Working to effect policy change is by its nature a long-term effort. Certainly, CVM and its partners set the stage for change by affecting intermediate outcomes, e.g., raising awareness of the issue, getting safety-net providers to collaborate on specific programs, nurturing neighborhood-based solutions, and advocating for the establishment of an independent health care planning body. However, the measurement of ultimate outcomes of CVM--access to health care--remains for a future study.

ACKNOWLEDGMENTS

GLOSSARY

BCC	Miami-Dade County Board of County Commissioners
CAP	Community Access Program
CV	Community Voices
CVM	Community Voices Miami
HPA	Health Policy Authority
JHS	Jackson Health System (includes JMH)
JMH	Jackson Memorial Hospital
MAC	CVM Multi-Agency Consortium
MAP	Miami Action Plan for Access to Health Care
OT	CVM Oversight Team
PHT	Public Health Trust
RFP	Request for proposals

1. INTRODUCTION

Health care for the uninsured continues to be a national policy problem, with recent estimates indicating that over 43 million non-elderly Americans-- 17 percent of the total non-elderly population--lack health insurance coverage.[8] Health insurance is an important determinant of health care access and utilization (Hoffman and Scholbohm, 2000), and the lack of adequate coverage can lead to poorer health outcomes (Franks et al., 1993; Hadley et al., 1991). Moreover, when illness occurs, individuals and families are put at risk for significant economic losses. Unfortunately, obtaining health insurance is a financial impossibility for many, as evidenced by the fact that the poor and near-poor constitute almost two-thirds (65 percent) of the uninsured population (Hoffman and Scholbohm, 2000). However, recent policy discussions have noted an increased prevalence of uninsurance among the middle class, a group believed to been previously immune from such loss. The costs of providing health care to the uninsured accrue to society generally, as providers, governments, and, ultimately, employers, employees, and other taxpayers ultimately pay for uncompensated care provided to the uninsured.

In response to this situation, the W. K. Kellogg Foundation in 1998 launched a five-year initiative called Community Voices (CV). CV was born out of the concern that universal health insurance was unlikely to be passed in the near term, leaving communities and local safety-net providers to continue to face an increasing financial burden of providing health care to the uninsured. Thus, as a nationwide initiative, CV was

> to help ensure the survival of safety-net providers and to
> strengthen community support services ... Building from the
> community level, the initiative gives the underserved a voice to
> help make healthcare access and quality part of the national
> debate.[9]

The Kellogg Foundation invited communities across the country to apply for grants, 13 of which were awarded in late summer of 1998. In receiving the

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[8] Mills RJ, Bhandari S. "Health Insurance Coverage in the United States: 2002," *Current Population Reports*, September 2003, http://www.census.gov/prod/2003pubs/p60-223.pdf.

[9] http://ww.wkkf.org/Initiatives/Initiative.asp?ID=1&Section=1, accessed May 17, 2001.

grants, the 13 communities pledged to serve as learning laboratories to identify local solutions for meeting the needs of those who receive inadequate or no health care because of lack of insurance or financial means.

CV, as envisioned by the Kellogg Foundation, was designed to address local concerns about the uninsured and develop local solutions. This report presents an evaluation of one of the CV sites, Miami-Dade County, Florida. Camillus House, a Catholic social service agency and health care provider for the homeless, located in downtown Miami, was the lead agency for the grant and worked with two contracted partner agencies. The first, United Way of Miami-Dade, brought experience and knowledge of the communities in Miami-Dade County. The second, the RAND Corporation, brought objective research capability to both provide technical assistance and conduct an evaluation of the project. Together, these three organizations worked as partners throughout the life of the five-year grant.

The overall purpose of RAND's evaluation was to assess CVM's progress toward its goals and to identify lessons learned that might be helpful for others undertaking similar endeavors. In addition, because CVM was subsequently funded by Kellogg to continue its work for four additional years (2003—2007), the evaluation specifically identifies areas for improvement.[10] We focus principally on the documented activities of Community Voices Miami (CVM) and the external impressions of community participants and stakeholders. This focus is appropriate for a project that was designed to affect policy through community input. However, CVM also contributed to the on-going process of policy development at the county level. We therefore identify points at which such activities, often conducted behind the scenes and undocumented, contributed to moving the dialogue forward to affect policy change.

Our evaluation paradigm addresses CVM as a collaboration. Collaboration was most visibly present in the establishment of the Multi-Agency Consortium (MAC) that brought providers and stakeholders to the table to discuss policies to improve access to health care for the uninsured. In support of these collaborative activities, policy change was promoted through the publication

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[10] In its second phase (2003—2007), CVM operates out of the Collins Center for Public Policy, Inc. (www.collinscenter.org). Project leaders felt that this was a better base for CVM's objectives during phase two because the Collins Center focuses exclusively on informing policy in Florida.

of various CVM-commissioned reports and the participation of project team and
MAC members in local health policy activities. The evaluation covers the
period from the inception of CVM in fall 1998 through March 2003. However,
because collaborative efforts are more a process than a well-circumscribed
event, a number of CVM activities have occurred since the evaluation was
completed, in particular, activities concerning funding neighborhood
coalitions to build community capacity to improve access to care through local
policy change. We discuss these in an epilogue to the report.

Chapter 2 provides a brief discussion of the background of CVM, including
the overall initiative and the health policy context in which CVM worked.
Chapter 3 presents an overview of CVM, including organizational issues
(project team, partners, approach) and a timeline of CVM activities from 1998
to 2003. In Chapter 4, we discuss our evaluation approach, including our
conceptual framework, evaluation questions, evaluation design, and data
sources. In Chapter 5, we provide an overview of CVM efforts to promote
collaboration through the MAC. Chapter 6 discusses our collaboration survey of
CVM participants, which examined the strengths and weaknesses of CVM in terms
of the factors thought to lead to successful collaboration. In Chapter 7, we
examine CVM efforts to influence local health policy, including a discussion
of the policy context, how CVM tried to influence local policy, and its role
in policy developments. Chapter 8 examines the overall accomplishments and
shortcomings of CVM; it also discusses lessons learned from CVM and how these
contribute to the broader literature of other community-based initiatives.
Finally, we describe in an epilogue some of the on-going work of CVM and
discuss future directions.

2. BACKGROUND OF COMMUNITY VOICES MIAMI

In this chapter, we provide the background of CVM. First, we discuss briefly the overall CV initiative, including the national health policy climate that provided the impetus for the initiative and its overall goals. Second, we discuss the health policy context within Miami-Dade, in particular, historical attempts to provide health care to the uninsured that set the stage for CVM.

Health Policy in the 1990s

After the failure of the Clinton Administration's Health Security Act, many in the health policy community acknowledged that it was unlikely that universal health coverage would be achieved in the following five years. Moreover, without a solution in sight and with the anticipated growth in the number of uninsured due to losses of Medicaid coverage as a consequence of welfare reform, many communities were concerned about the survival of their safety-net providers and the continued ability of the public and private sectors to provide health care to the uninsured.

Uninsured individuals often lack access to primary care and preventive services, so they rely on publicly funded health programs and hospitals or emergency rooms for their health care. State and local communities bear the fiscal burden of providing care for those without insurance. When state or local tax revenues decline, funding for health care programs is often cut. Local policymakers are challenged to provide services, and private sector health care providers must bear the financial burden of providing health care without any compensation.

It was this troubling scenario that led the W. K. Kellogg Foundation to fund the nationwide Community Voices: HealthCare for the Underserved initiative. The 13 participating communities (see Table 2.1) agreed to act as "learning laboratories" to serve "as working centers that will sort out what works from what does not in meeting the needs of those who receive inadequate or no health care."[11] Building from the community level, the initiative was intended to give the underserved a mechanism that could help in developing

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[11] Community Voices website, http://www.communityvoices.org/.

local solutions to health care access concerns.[12] Acknowledging the
challenges being faced by the communities, the foundation provided funding for
five years (July 1998 through June 2003) in the hope that innovative
approaches to increasing access to care would be developed.[13]

Table 2.1

Community Voices Sites: 13 Learning Laboratories

Community	Host Agency and Community Voices Program Name
Albuquerque, New Mexico	University of New Mexico Health Sciences Center Community Voices New Mexico
Baltimore, Maryland	Vision for Health Consortium/Baltimore City Health Department Baltimore Community Voices
California	California Rural Indian Health Board (CRIHB), Inc. Community Voices (CRIHB)
Denver, Colorado	Denver Health Denver Health Community Voices
Detroit, Michigan	Detroit Health Department, Detroit Medical Center, Henry Ford Health System, St. John Health System Voices of Detroit Initiative
El Paso, Texas	El Paso County Hospital District Thomason Hospital Community Voices El Paso
Ingham County, Michigan	Ingham County Health Department Ingham Community Voices
Miami-Dade County, Florida	Camillus House, Inc. Community Voices Miami
North Carolina	FirstHealth of the Carolinas, Inc. FirstHealth Community Voices

North Manhattan, New York	Alianza Dominicana, Inc., Columbia University
	   School of Dental and Oral Surgery, Harlem
	   Hospital Center
	Northern Manhattan Community Voices

Oakland, California	Asian Health Services & La Clínica de la Raza Community Voices Oakland
Washington, D.C.	District of Columbia Department of Health District of Columbia Community Voices Collaborative

West Virginia	West Virginia Higher Education Policy Commission,
	   Office of Health Sciences, Governor's Cabinet on
	   Children & Families, LifeBridge, Inc., & the
	   Regional Family Resource Network
	West Virginia Community Voices

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[12] The foundation's language was not explicit, however, as to whether
local initiatives were *required* to have underserved populations directly
involved in the initiative.
[13] http://www.wkkf.org/Initiatives/Initiative.asp?ID=1&Section=1,
accessed May 17, 2001.

The initiative began in the summer of 1998 with a kick-off meeting in Stowe, Vermont, for all the sites. At that meeting, plenary presentations and discussions provided the opportunity for funded sites and the foundation to discuss the initiative and the issues faced by each site. To emphasize health care reform as a national issue, then presidential candidate Bill Bradley spoke about the need for greater access to health insurance coverage.

The foundation was very specific about what it expected of the community awardees (see Appendix for nine core elements that all sites were to address).[14] It also was specific about the particular health care issues-- primary care, oral health, public health, and prevention--that each site must include in its plans.

The foundation contracted with three organizations to provide technical assistance to the local CV sites: the Lewin Group, the Center for Policy Alternatives, and IssueSphere. The Lewin Group was responsible for conducting a national, cross-site evaluation of CV;[15] the Center for Policy Alternatives provided assistance with policy development; and IssueSphere offered assistance with communications and public relations. Many of the activities of these consulting organizations occurred at the annual meetings, although each site could independently draw on the expertise of the consultants. Over time, the presence of these groups in site activities varied. The Lewin Group was replaced by Abt Associates two years into the project. The Center for Policy Alternatives was involved in the early stages, providing information about current health policy issues and affecting policy change, but as the sites matured in their efforts, the center was a less visible resource. IssueSphere, later renamed Hyde Park Associates, was more involved in the later period of the initiative as sites developed materials and policies that needed dissemination.

To facilitate communication between and among the various sites, the foundation continued to have annual retreats (networking meetings) for project team members, as well as annual meetings for the project directors.

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[14] http://www.communityvoices.org

[15] Each site had its own evaluation and evaluators, and there was no formal agreement for data sharing between the site and cross-site evaluations. However, to the extent possible, we shared de-identified information, such as our summary reports of findings, and the national evaluators asked to interview the RAND evaluators periodically.

Throughout the five years, the foundation provided project leaders and select members of the funded initiatives the opportunity to participate in activities such as site visits to various Latin American model health care programs and the April 2000 Salzburg Seminar on Social and Economic Determinants of the Public's Health. The foundation made annual site visits, as did the national evaluator. Thus, throughout the five years, the foundation and its contracted organizations interacted often with the various local initiatives.

The Uninsured in South Florida and the Political Context of Miami-Dade County

Like other areas of the United States with large immigrant and low-wage populations, South Florida has a significant presence of persons lacking health insurance. Miami-Dade County and the state of Florida have a history of attempting to address this issue. In 1991, with considerable backing of leaders in Miami-Dade County, the state of Florida passed legislation permitting local taxing districts to hold referenda for approval of tax levies to finance health care for the indigent.[16] This opened the way for Miami-Dade County voters to approve a surtax of 0.5 percent, the proceeds of which were earmarked for the county's sole public hospital, Jackson Memorial Hospital (JMH).[17] Many voters supported the measure largely because they believed it would cut waiting lists for poor patients (Petchel, 1991). However, the funds were needed to provide financial stability to JMH, which was then operating at a loss, in part because of its provision of large amounts of uncompensated care. Other hospitals in the county also provided charity care, but without any direct financial support.[18]

Concurrent with the passing of the surtax in Miami-Dade, the Miami-Dade Board of County Commissioners (BCC) created the Indigent Health Care Task Force to develop mechanisms to improve the delivery of health care to the uninsured. This task force included a variety of stakeholders, including employees of the Miami—Dade County Public Health Trust (PHT), a county-

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[16] Title XIV, Taxation and Finance, Chapter 212, Tax on Sales, Use and Other Transactions. For Miami-Dade, the law assigned surtax revenues to the sole public hospital, with no restriction to indigent care. The surtaxes applying to other large counties and to small counties were designated for indigent care, not the local county hospital.

[17] The ballot language indicated that the funds were to be used "for the operation, maintenance and administration of Jackson Memorial Hospital to improve health care services."

[18] There has been a considerable amount of controversy between JMH and other community providers on the distribution of the surtax revenues. We discuss this further in Chapter 6.

appointed board of community member volunteers that had been established to oversee JMH.[19] Pedro José Greer, the principal investigator of CVM was the Chair of this task force. The task force produced an extensive plan for improving care for the uninsured and underinsured which included 39 goals and specific recommendations for how to achieve them ("Report of the Dade County Indigent Health Care Task Force," 1992). Among the recommendations were the following:

- Establish an independent board to plan, control financing, and monitor the indigent health care system.
- Develop a system that is decentralized and reflects a community-based responsibility for indigent health care.

The BCC did not officially accept the task force report, but eventually action was taken on the first recommendation. In 1995, the commission created the Dade County Health Policy Authority (HPA) to advise them on health care needs within the county. However, the language of the implementing resolution required the HPA to make its recommendations first to the PHT, which would then decide whether to request that these be put on the BCC's agenda (where they could be acted upon).

The second recommendation was more difficult for the BCC to address. The configuration of the publicly funded health care system was very centralized, with the mass of services being provided in the northern, more urbanized region of the county. In addition, Hurricane Andrew caused over $25 billion in damages in 1992, creating numerous problems in the social services infrastructure as well as in commercial and private structures.[20] Persons living in the southern region of the county were most affected, and efforts were made to raise awareness about the needs of the uninsured in South Dade, the most remote part of the county.[21] From 1997 to 1998, the HPA, together with the Health Council of South Florida and many community partners, conducted the South Dade Community Health Initiative. This multi-agency effort produced a report (South Dade Community Health Initiative, 1998) that contained a series of recommendations to the BCC via the PHT on how to improve

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[19] The board has included as ex officio members administrators and staff from JMH as well as from the University of Miami.

[20] http://www.nhc.noaa.gov/HAW2/english/history.shtml#andrew.

[21] South Dade refers to the southern part of Miami-Dade County. It begins at Kendall Drive (also known as SW 88th Street).

access to health care for the uninsured and underserved in South Dade. In
February 1999, the PHT issued a Staff Response to the Community Health
Initiative report indicating that it was addressing issues similar to those
raised in the report (Hoo-You and Lucia, 1999). The PHT also stated that it
should not bear full responsibility for addressing the unmet need for health
services in all of Miami-Dade County, since other providers in the county
received a financial benefit from their tax-exempt status and therefore should
provide uncompensated care commensurate to this benefit. The PHT requested
that the HPA collect additional data to identify and quantify the
contributions of voluntary, not-for-profit providers to South Dade and to
identify how these providers could contribute toward the recommendations in
the initiative report (Hoo-You and Lucia, 1999).

CVM was thus conceived in a period where concern about the uninsured and
their access to health care was publicly debated. The project worked within a
fairly contentious environment, with the public hospital system trying to keep
the funding stream provided by the surtax revenues intact and the private
hospitals trying to gain some redress for the uncompensated care they
provided. In the next chapter, we present an overview of CVM and the approach
it took within this environment.

3. AN OVERVIEW OF COMMUNITY VOICES MIAMI

In this chapter, we introduce Community Voices Miami (CVM), including the principal organizations involved, the project's overall goals, its organizational structure, and other organizations that were involved in efforts to improve health care access for the uninsured. We then present a narrative of the activities of the CVM project throughout its first five years to acquaint the reader with the CVM story and to anchor the evaluation discussed later in this report.

The Project Team and Partner Organizations

CVM was led by project staff at Camillus House, with contracted partners United Way of Miami-Dade and the RAND Corporation. Camillus House itself has served the Miami-Dade community for more than 40 years, providing fully integrated services through multiple program areas, including intensive substance abuse treatment; health care, mental health, and social services; and housing for homeless men and homeless women and their families. The principal investigator of the project, Pedro José Greer, has a long association with Camillus House, having been Chair of the Board and also the volunteer medical director at Camillus House's sister agency, Camillus Health Concern. Dr. Greer is a physician in private practice and is also on the faculty of the University of Miami Medical School, where he is an Assistant Dean for Homeless and Poverty Affairs. In addition, he is a trustee of the RAND Corporation. He is well known in the community for his work as a physician and an advocate for the underserved. However, he is somewhat controversial, since he was a very vocal critic of the county's public hospital, JMH, which is staffed by University of Miami physicians.[22] Finally, Greer has national recognition as an advocate for the uninsured, having advised both the Bush and Clinton administrations. In 1993 he received a MacArthur Foundation Genius Award to further his advocacy efforts.

As the project's principal investigator, Greer acted in a volunteer capacity but was intimately involved with CVM throughout its five years. He

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[22] Dr. Greer's autobiography (Greer and Balmaseda (Contributor), 2000), *Waking Up in America: How One Doctor Brings Hope to Those Who Need It Most*, dedicated nearly an entire chapter to criticizing the public hospital for its unfair treatment of poor patients.

stayed in close contact with the project director to assess and troubleshoot issues as they came up.

The full-time project team at Camillus House consisted of four persons: a project director, two program managers, and an administrative assistant. The team had considerable staff turnover and in addition had relatively little prior experience in health policy. The first project director was Peter England, an employee of Camillus House who had been Director of Program Development. England's involvement with CVM was limited, and within the first year of the project, he was replaced by Leda Pérez, who was recruited from outside the Camillus House staff. Pérez is a native of Miami with academic training in international affairs, with a focus on Latin America. The original program managers were Jay Carrión and Elise Linder, who were on staff at Camillus House. Linder, a social worker by training, stayed with the project the full five years. Carrión left the project after two years to take another job with Camillus Health Concern and was eventually replaced by Heather Harrison, a former Peace Corps volunteer with training in public health. The administrative assistant position experienced the most turnover, with three individuals filling the position over the project's life. After the second administrative assistant left, the position was redefined to include research assistant activities. In addition to the fully dedicated team, other staff at Camillus House played supporting roles when their expertise was required.

The CVM project was conducted somewhat independently of the activities of Camillus House and its affiliate Camillus Health Concern. The CVM project director reported to the executive director of Camillus House, and ultimately there was some coordination of activities. For example, midway through the project, the CVM project team facilitated Camillus House receiving a W. K. Kellogg Foundation grant to promote men's health. However, there was little direct contact between Camillus House service providers and the CVM project team, and CVM activities were not integrated into the host organization's activities.

The United Way team also experienced some turnover. Two senior members, Tanya Dawkins and María Baeza, left United Way approximately two years into the project. Cathryn Evanoff, a former Peace Corps volunteer and international health worker with training in public health, was recruited to lead the community outreach efforts in the second year but left after two

years. She was replaced by Jessica Perlmutter, who had previous experience in Miami-Dade in HIV and AIDS prevention. Perlmutter led the second phase of the United Way activities, which involved community capacity-building efforts. She had two assistants (consecutively) who supported the outreach activities.

The RAND team consisted of three researchers, all of who had prior experience with health policy issues. The co-principal investigators were José Escarce, a physician and health economist, and Catherine A. Jackson, also a health economist. Three years into the project, Escarce left the project, leaving the leadership to Jackson. Jackson also led the technical assistance activities. Kathryn Pitkin Derose, a health services researcher specializing in community-based projects, was asked to lead evaluation activities starting at the end of the first year, and she remained with the project throughout its duration. The evaluation component benefited from research assistance, first from Sarah Remes and then from Amanda Beatty.

Because the RAND team was tasked with both technical assistance and evaluation activities, it made a conscious effort to separate these two activities in order to reduce bias. Jackson did not participate in much of the data collection for the evaluation and in fact was interviewed by the evaluation team as a CVM participant.

Project Approach

From the start, it was obvious that CVM differed from several of the other CV sites in that it was not housed within an institution that could directly implement changes in health care services, outreach, or health policy.[23] Indeed, Camillus House was itself one of the independent and charitably funded safety-net providers the initiative was created to support. And whereas CVM could have tried to implement new approaches to the direct provision of health care services within Camillus House's clinic and outreach programs for the homeless, the purpose of the grant was to affect access to care for the uninsured more broadly.[24] In general, CVM operated fairly independently from Camillus House activities.

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[23] For example, as shown in Table 2.1, the CV site in Denver was based at Denver Health, a public hospital system, and the Ingham County, Michigan, site was based at the Ingham County Health Department.

[24] It could be said that CVM did facilitate the start of some specific programs within Camillus House and Camillus Health Concern. For example, CVM's reports on oral health were used by Camillus Health Concern to obtain funding for dental services (a new program). Also, CVM facilitated Camillus

CVM focused most of its activities on trying to affect local policy. CVM adopted the role of convener to bring community stakeholders together to discuss the issues of health insurance and the uninsured, develop consensus, and design programs and policies to increase access to health care for the indigent in the county. It was felt that such a strategy, given the overall political context of health care for the indigent in Miami-Dade, held the most promise. The emphasis on policy development was also consistent with Greer's previous advocacy activities.

To guide the CVM effort, project leadership established two broad goals:

- Improve access to care for the medically uninsured and underinsured by effecting health care policy and systems change in Miami-Dade County; and
- Develop and implement an evaluation system for measuring the health care outcomes and access to care of the uninsured and underinsured in Miami-Dade County.

These goals were similar to those in the original project proposal and were refined during CVM Oversight Team (OT) meetings in November 1998 and February 1999.[25]

The Project's Organizational Structure

The initial task of the project team was to define an organizational structure that would facilitate its activities and at the same time illustrate the anticipated linkages between the project team, the contractors, and the community. The original structure is shown in Figure 3.1.

As illustrated, the project team was to be the central player, with United Way and RAND generally working through it. There was one exception: United Way was to work directly with the community. Two project-specific bodies would be created, the Multi-Agency Consortium (MAC) and the Leadership Council. The MAC would be the main community representative body for the project. Made up of health care and social services providers, community leaders, and policymakers, this group was organized to develop policy options and an overall implementation plan for improving health care for the

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House getting a grant to do work in men's behavioral health from the W. K. Kellogg Foundation. CVM was expected to play a role in the policy issues raised by the programs, but there was little contact between CVM and program implementers.

[25] Oversight Team meeting minutes, November 13, 1998, and February 17, 1999.

underserved. For much of the project, project team members referred to the MAC as the engine that drove the policy development activities. The Leadership Council was planned to assist with informing public policy decisionmakers. Specifically, the council was to bring together local power brokers to assist with the adoption and implementation of MAC plans. However, the council never materialized. It was felt that to some degree the OT filled the role of the Leadership Council, and that the Mayor's Health Care Access Task Force, which we discuss later in the report, made the council unnecessary. The OT included representatives from the project team and the contractors, as well as prominent people in the health care and policy communities. As CVM's advisory body, the OT periodically reviewed the efforts of the project and offered recommendations for future activities. As the CVM progressed, some regular MAC attendees who felt excluded from participating in project decisions and agitated for a greater role were invited to participate on the OT.
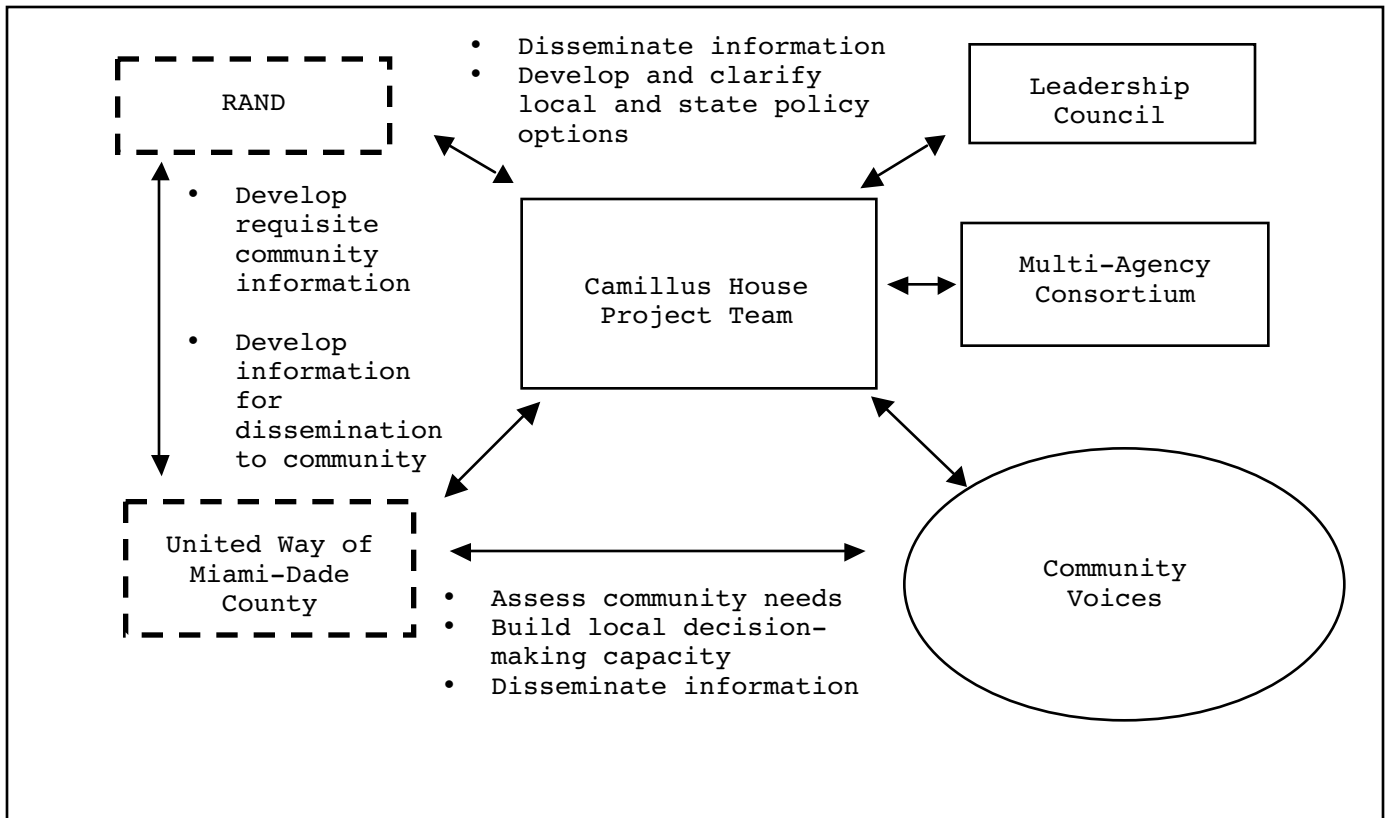
Figure 3.1 CVM's Proposed Model of Interaction Among Project Participants, Presented to the MAC in 1999

Membership in the MAC and the OT was voluntary and varied throughout the life of the project, as members dropped out or new ones were added to address particular issues. As a clear signal to the community of the inclusiveness of CVM activities, throughout the project, advocates and dissenters were asked to participate on one body or another in order to contribute to the larger process.

Initially, the MAC was co-chaired by Sergio González (while he was Chief of Staff for Alex Penelas, Mayor of Miami-Dade County) and Annie Neasman (while she was Executive Administrator of the Miami-Dade County Health Department). These two leaders were well known within the community as effective conduits to policymakers. When Neasman and González moved to other positions in the middle of the five-year project--Neasman to a state agency in Tallahassee and González to the University of Miami--the leadership of the MAC was transferred, with approval of its members, to the CVM project director, Pérez.

Interfacing with Other Organizations

Many CVM participants represented agencies that also were studying and advocating change in the way health care was being provided to the uninsured in Miami-Dade County. Indeed, CVM project team members participated in these parallel efforts (e.g., by attending meetings, serving on task forces) and also interfaced with the other organizations informally through shared membership. As noted earlier, the Health Policy Authority is a quasi-public agency created to advise the BCC (through the PHT) on the provision of countywide health care and to implement programs to increase access to care without regard to financial status (Miami-Dade County Ordinance 95-71). The Health Council of South Florida, the county's former Health Services Agency, is mandated to provide information and statistics documenting the health care sector in South Florida. The Human Services Coalition (HSC) is a membership-based coalition of over 6,000 members, including community groups, faith-based organizations, policymakers, businesses, and individuals, committed to advocating for a more just society, including access to health services. During CVM, the HSC organized the Union of the Uninsured and also conducted workshops and held forums so that the community could learn more about the health care system and could express their concerns. Another group concerned with the provision of health care to the uninsured, the Alliance for Human Services, is a non-profit organization dedicated to the development of a health and social services master plan for Miami-Dade County. The Alliance board includes all major funders of health and social services as well as representatives from the business community, service providers, consumers, caregivers, advocates and faith-based organizations.

More recently, the HSC organized volunteers from a variety of consumer and advocacy groups and the community into the Immigrant Health Task Force to address the health care concerns of immigrants, many of whom are undocumented. Specifically, this group worked with the PHT and JMH to reduce the amount of documentation required of immigrants before they can receive subsidized care at the hospital and to provide information and post signs in English, Spanish, and Creole (Doonan, 2002). Finally, the Growing Healthy Task Force of the HSC was renamed the Partnership for a Healthy Community; this group brought together various agencies concerned with improving health broadly in the community, including the CVM project team.

Thus, numerous quasi-public and advocacy groups called for improvements in how Miami-Dade County and the PHT provided health care services to the uninsured. While many of their efforts were largely absent from the public debate, they were often very well recognized by those in the health and social services sector. Because the political environment with respect to the issue of publicly funded health care services was often contentious, CVM explicitly established for itself a niche in the polity of Miami-Dade, choosing to play the role of convener, bringing together different sectors of the community to raise awareness about the uninsured and explore ways to improve access to care in the county.

Overview of CVM Activities

Over the five years of the project, CVM initiated and was involved in a number of activities related to improving health care for the uninsured and underserved. An overview of the activities for each year is given below.

Year One (July 1998 to June 1999)

In its first year, CVM focused on developing its organizational structure, including hiring the project team, developing relationships among project partners, and recruiting members for the MAC, its major working body. Because of the broad scope of the problem to be addressed and the contentious nature of past efforts to address it, CVM tried to make the MAC inclusive and invited a range of health care providers (e.g., PHT/JHS, community health centers), health care planners, political leaders, and community advocates to participate. The OT, which had started to form when the proposal was written, met quarterly during the first year to discuss project goals and focus. The MAC met for the first time in April 1999, and shortly thereafter, Miami-Dade County's mayor, Alex Penelas, officially introduced CVM to the community and media at a press conference. Unfortunately, some of the impact of the announcement was lost because the mayor also announced his proposal for a living-wage statute requiring all contractors working for the county to provide health insurance or higher wages.[26] Moreover, the concept of a project *to help develop health policy options* was lost on some members of the media who recognized a need for services. Questions and comments made to RAND

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[26] Unfortunately, there has been no monitoring of contractors' wage or benefit packages to assess the extent to which the living-wage ordinance succeeded.

researchers at the press conference demonstrated that they mistakenly thought CVM would be providing health care services to the uninsured.

Year Two (July 1999 to June 2000)

The second year focused primarily on three activities: (1) continuing to recruit members for the MAC; (2) studying the problem, that is, developing an understanding of the major issues involved in health care for the uninsured; and (3) beginning to examine possible solutions.

There was particular interest in recruiting more members of the general community ("consumers") to participate regularly on the MAC. Two community roundtables were held in the beginning of year two to recruit consumers. The effort proved unsuccessful, as only one consumer was recruited and his participation lasted only a couple of meetings. Numerous discussions about consumer participation were held by the project team, its partners, and members of the MAC. Ultimately, the project leaders decided that a better way to involve consumers was to rely on the community engagement effort led by United Way to build neighborhood capacity to address local health care issues.

To learn more about the major issues to be addressed, CVM took two parallel approaches, one involving the MAC and RAND researchers and the other involving United Way and community-based partner agencies. In the MAC effort, the project team first conducted a brief survey of MAC members to assess their knowledge of the health care delivery system for the uninsured and underinsured in Miami-Dade County, identify areas of consensus, and clarify initial targets. Among other issues, the survey identified centralized funding (the surtax earmarked for PHT/JMH) as an impediment to access and suggested that improvement would result if "resources follow the consumers."[27] After hearing the results, the MAC requested that RAND conduct a study of the financing of indigent health care and its repercussions on access to care for the uninsured. During year two, the MAC meetings were a forum for both exchanging ideas and disseminating information. In its capacity as a technical advisor, RAND presented information and analysis at nearly every MAC meeting on issues related to health care for the uninsured. This influx of objective information into the discussion seemed to defuse what might have otherwise been contentious debate. In addition, through the presentation of

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[27] MAC meeting minutes, July 21, 1999.

available data, the MAC members became acquainted with which issues could be documented and which could not.

United Way organized a community engagement effort consisting of a series of dialogues at various agencies (called community partners). A total of 18 community dialogues were held between February and June 2000, with over 700 persons participating.

Finally, to begin to explore solutions, the MAC Subcommittee on Health Care Model Development was formed in February 2000. This subcommittee was tasked to review and analyze existing health care delivery models and to create a long-term strategic plan or creative model(s) for improving health care for the underserved. The MAC subcommittee worked intensely throughout 2000 and 2001, meeting on a weekly basis over the summer of 2000.

Year Three (July 2000 to June 2001)

The third year, CVM focused on analyzing the results of the two parallel efforts, the community dialogues and the RAND health care financing and access study, and continuing the work of the MAC subcommittee to propose solutions. In addition, several efforts were made at the state and local levels to examine the issue of the uninsured.

Analyzing the results of the community dialogues and the finance and access study involved intense participation by multiple stakeholders. Preliminary results were presented multiple times at MAC and OT meetings, where requests for additional analyses and clarification were made. Pre-publication drafts were distributed widely throughout the fall to all MAC and OT members (a group much larger than the group of meeting attendees), inviting their feedback. In addition, a follow-up meeting was held with the community partners to share the results of the dialogues (May 2001). Throughout year three, the issues identified in the community dialogues and the finance and access analyses were discussed actively at MAC and OT meetings and informed CVM activities.

At the outset, the MAC subcommittee set a goal of developing health care delivery model components to present to the MAC by September 2000. The subcommittee's efforts expanded into researching and reviewing current information on the uninsured and underserved and developing "key policy questions that set the stage/approach for model design."[28] It was anticipated

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[28] Ibid.

that the report from the community dialogues would inform the subcommittee on access issues and barriers to care. Additionally, the subcommittee focused on reviewing indigent health care planning in Miami-Dade County, looking at accomplishments and setbacks. Subcommittee work intensified over the summer, with members meeting weekly during August and September. By September 2000, the subcommittee determined that there was no one single solution for the uninsured but, rather, different solutions for various segments of the uninsured population: the "uninsurable"[29] or the uninsured and not eligible for state and federal programs; the "uninsured but eligible;" and the "insured and underinsured who are not accessing care properly."[30]. Thus, the subcommittee refocused its efforts onto developing programs to address the needs of the three subpopulations of the uninsured and underinsured.

About this same time, an important source of information about the uninsured became available, the Florida Health Insurance Study (FHIS).[31] Commissioned by the state, this was the first extensive survey of health insurance coverage for the population under 65 years of age in Florida. The state was divided up into 17 geographic areas for sampling, one of which was Miami-Dade County. The estimates generated for Miami-Dade County were therefore quite precise. The FHIS found that 25 percent of the non-elderly population of Miami-Dade, or nearly one-half million persons, were uninsured (Agency for Health Care Administration, 2002), well above the national average of 16 percent in the same year (Moyer, 1999). The report also vividly documented that the majority of the uninsured were from minority populations. However, among Hispanics, the rate of uninsurance in the county, 29 percent, was less than the national rate of 34 percent. In addition to the simple ethnic distribution of the uninsured, the survey also showed that 61 percent

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[29] The use of this term by the MAC subcommittee is different from its usual use, i.e., referring to people who are denied private health insurance because they do not belong to an employer group plan or have a past or present medical condition (usually high-cost). The subcommittee used "uninsurable" to refer to people who are not eligible for state and federal health insurance programs (e.g., because of immigration status).

[30] These groups were identified because their different statuses implied different approaches. For example, the "uninsured but eligible" group suggests the need for outreach strategies to enroll these persons into state and federal programs. Likewise, the "insured and underinsured" group suggests the need for education about the importance of preventive and primary care.

[31] For a summary of this study, see http://www.fdhc.state.fl.us/Publications/FHIS/index.shtml

of the 18- to 64-year-old population worked full-time, and 20 percent lacked health insurance. Among those working full time, 50 percent were employed in firms with fewer than 25 employees, and half of these were uninsured.

The results of the FHIS were featured at the Florida Governor's Summit on Health Care for the Uninsured held in Miami in September 2000. The summit was held to discuss the situation of the uninsured in Florida and to consider possible solutions. Hundreds of people attended the summit, including health care professionals, academics, policymakers, and advocates. Governor Bush addressed the group and emphasized working together to solve the health insurance crisis. Citing statistics from the FHIS, editors at *The Miami Herald* urged, "All that's needed is for lawmakers to muster the will to make health care the priority it needs to become."[32] Cathryn Evanoff from United Way made a plenary presentation about CVM's community dialogues, and Pedro José Greer was a panelist at a workshop on community health clinics. Therefore, CVM's work was featured in both plenary and workshop sessions, and there was a highly charged exchange between Greer and Sandy Sears of the PHT, who at the time was also an active MAC Subcommittee member.[33] Many other MAC members also attended the summit. The summit demonstrated that momentum was growing around finding solutions to the health care problems of the uninsured, and this public recognition seemed to bolster CVM's agenda.

Soon after the summit, the MAC subcommittee presented its recommendations to the MAC (September 27, 2000) and subsequently to the OT.   Policy recommendations and pilot projects were identified for each subgroup (see Table 3.1). Following these recommendations, the project team and collaborators decided to form two task forces with the goals of exploring in greater detail the possibility of establishing a 211 helpline (a full information hotline for all publicly funded and predominantly non-profit health and social service agencies)[34] and a small group health purchasing alliance. These task forces met approximately monthly through the rest of

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[32] *The Miami Herald*, September 21, 2000, Page 6B.

[33] Sears believed that Greer had attacked her institution with his comments about community residents' criticisms of a community health center that had been taken over by the PHT. These criticisms came up in one of CVM's community dialogue sessions facilitated by United Way.

[34] There is a concurrent national movement to establish 211 lines in communities, and United Way has been involved in these efforts. Therefore, this seemed an appropriate project for CVM to be involved in, given the connection with United Way of Miami-Dade.

2000. By April 2001, the project team had concluded that forward progress
could not be made under the current circumstances in Miami-Dade, because (1)
experiences of small group health purchasing alliances, both nationally and
locally, suggested that such strategies are rarely effective, and (2) funds
for implementing the 211 line were not obtained. However, these items
remained in the background of CVM's agenda and appeared later in CVM's action
plan.

Table 3.1

MAC Subcommittee Recommendations Presented in Fall 2000

Recommendation	Uninsured but Eligible for State or Federal Public Programs	Uninsured and Not Eligible for State or Federal Public Programs	Insured and Underinsured Who Are Not Accessing the Health Care System Effectively
Expand Titles 19 and 21 to include parents and immigrants	X		
Expand coverage to include transportation, mental health, oral health, and pharmacy			X
Create small employer incentive programs for employee health insurance			X
Target outreach and education	X		X
Establish health hotline for information and education	X	X	X
Implement school nurse programs	X	X	X
Improve disease management			X

Behind the scenes, Greer was disappointed that the subcommittee's recommendations were not stronger and did not suggest a fundamental restructuring of the way indigent care is delivered in Miami-Dade. This created some tension between him and the project team. The project team recognized that the recommendations had been developed with broad participation, including that of members of the PHT, and represented significant progress in that consensus had been reached. Therefore, the team felt that unilateral modification of the recommendations would undermine the MAC's work. Consequently, the project team spent a considerable amount of effort trying to identify ways that the MAC recommendations could be made to be more specific and stronger.

Year Four (July 2001 to June 2002)

The fourth year of the project focused on refining the policy targets of the MAC, in particular, by developing the Miami Action Plan for Access to Health Care (MAP), starting to disseminate CVM's message more broadly, and expanding the community engagement process through United Way.

As the project team considered how to strengthen the recommendations, they received the action plan of another CV site, Ingham County, Michigan. The structure of that document provided a good model for putting the recommendations made by the subcommittee into a bolder and more actionable format. The report or plan, as envisioned, would detail action steps required to meet the MAC's recommendations and would identify lead agencies that would take responsibility for seeing that the actions were carried out. A process began whereby the project team drafted the MAP, based on the MAC subcommittee's work, and elicited extensive feedback from CVM participants and community collaborators.

Although many of the findings of CVM-commissioned reports had been shared with the MAC and the OT, the reports had not been officially released, nor had there been wide discussion of the MAP. On February 14, 2002, CVM held a press conference in anticipation of the Miami-Dade County Mayor's Health Care Initiative to announce the availability of two reports: United Way's report summarizing the findings from the community dialogues, *Community Dialogues about Health and Health Care*,[35] and the RAND report on uncompensated hospital

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[35] Community Dialogues about Health and Health Care, February 2002 (available from United Way of Miami-Dade).

care and patient travel patterns, *Hospital Care for the Uninsured in Miami-Dade County: Hospital Finance and Patient Travel Patterns* (Jackson et al., 2002). A draft of the MAP was also presented. At this point, the MAP consisted primarily of a set of objectives to address access issues. More work needed to be done, but it was important that the concept of the MAP be publicly announced before the Mayor's Health Care Initiative that was scheduled for the following day. The press conference generated substantial interest and visibility for CVM.[36] Moreover, it helped set the agenda for the discussion at the mayor's initiative by providing data and recommendations.

The Mayor's Health Care Initiative was held on February 15, 2002, with 150 persons participating, including a number of CVM members. At the close of the initiative, the mayor announced the formation of a health care access task force, which would meet monthly for a year to analyze the problems and propose solutions to address the health care needs of all Miami-Dade residents. In addition, Greer introduced governance of the PHT as an issue that the task force should address.

One of the MAP objectives focused on governance issues, particularly on the establishment of an independent body to continuously monitor and evaluate the health care system for the uninsured and underserved in Miami-Dade County. This became a focus of CVM during the fifth year. Both Greer and Pérez were appointed as members of the Mayor's Health Care Access Task Force, and both volunteered to participate on the governance subcommittee.

Community engagement efforts were put on hold temporarily in the summer of 2001 when the first community outreach director from United Way left and a new director was hired. The new director spent several months doing outreach to reconnect with the community partner agencies and to conduct key informant interviews; she also shared with the community partners CVM's plans for improving access to care (the MAP). In the latter part of year four, community engagement activities picked up again, when CVM, through United Way, released a request for proposals (RFP) soliciting neighborhood coalitions to conduct projects aimed at improving access to health care. The purpose of these capacity-building grants was to (1) build or strengthen community coalitions and their partnerships with safety-net health care providers, and

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[36] Two newspaper articles specifically discussed the reports (Driscoll 2002; Muñoz 2002). Subsequently, a number of op-ed pieces appeared on the use of the surtax and the services provided by the Jackson Health System.

(2) fund the efforts of existing community coalitions to increase access to health care for uninsured and underserved populations in the target neighborhoods.[37] In the RFP, coalitions were requested to address at least one action step from the MAP in their proposals (a copy of the MAP was sent to each prospective applicant). United Way received 28 letters of intent and invited 16 applicants to submit full proposals. Six capacity-building grants ($30,000 to $75,000 each) were awarded at the end of year four,[38] as was a technical assistance (TA) contract or $200,000 to the Human Services Coalition (a participating agency in CVM).

Year Five (July 2002 to June 2003)

The focus of the fifth year was on finalizing and publicizing the MAP and in particular advocating for one of its objectives, improving the governance of publicly funded health care, and on monitoring the progress of the six capacity-building grantees.

After getting input from multiple stakeholders about the MAP, the CVM project team worked with a public relations firm to finalize it. Two versions, both in color and in English, were produced: the full version, which was an 8-inch square, 30-page, spiral-bound report, and a summary version, which was an 8-inch square, tri-fold brochure. A press conference was held in October 2002 at a luncheon of CVM participants and other community stakeholders to celebrate the final release of the MAP and to announce the lead entities that had been identified for specific key actions. The event was attended by more than 75 people and had local television and press coverage. With its announcement at such a public event, the completed MAP served as both a written product from the project and a way to reinvigorate CVM and raise its profile in the community.

While the overall MAP remained central to MAC meeting discussions, Pérez, in her role as chair, began to discuss the specific objective of changing the governance structure for indigent health care (i.e., of creating an independent body from the PHT). This idea had been originally considered in the CVM proposal but was not pursued due to the inflammatory nature of the issue in 1998. Discussions about governance went on for some time with

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[37] See http://www.comunityvoicesmiami.org/programs/capacity_building.htm.
[38] The grants were one-year planning grants, with the possibility of a second year of funding for four coalitions.

individuals on the MAC and OT, and the project team subsequently had many conversations and presentations about including governance as a policy target. It seemed that the Mayor's Health Care Initiative and Task Force had created additional momentum to address the issue of governance.

The CVM principal investigator and project director were very involved in the activities of the mayor's task force throughout year five of the project. Pérez was invited to present the MAP to the task force. Pérez and Greer participated on the governance committee, as did several other CVM participants. CVM requested that RAND research and write a report on good governance principles applied to the PHT. The findings of that study, including established principles of governance, were shared with the task force governance committee, and these principles and the language used to describe them were ultimately used by the mayor and the task force co-chairs. In working with a separate advisory group on school-based health, CVM was able to elevate this topic to policy-level discussion as well.

Concurrent with the work on the mayor's task force, United Way continued its oversight of the six capacity-building grantees. The technical assistance provider, the Human Services Coalition (HSC), played a lead role in assessing grantees' progress. Areas assessed included (1) coalition development, including membership characteristics, process and structure, communication, and purpose (the Wilder Factors Collaboration Inventory was used as a self-diagnostic process); (2) partnerships and collaboration with safety-net providers; (3) health care access focus (what issue the coalition is working on) and the challenges faced; (4) actions toward sustainability; (5) how technical assistance from HSC has facilitated or hindered areas 1—3 above; and (6) anecdotal evidence of effectiveness (stories). Coalition building dominated the first year's efforts as grantees began to build bridges between providers and residents. It was expected that the actual addressing of health care access issues would occur in year two. The six grantees were invited to re-apply for a second year of funding in May 2003. Five grantees made such applications, and four were funded for a second year in June 2003. some of the second-year developments of the four grantees are discussed in the epilogue to this report.

4. EVALUATION APPROACH

This chapter describes our evaluation approach. First, we present and describe the conceptual framework that we developed in collaboration with project partners. Second, we identify our principal evaluation questions. Third, we describe our evaluation design, a single-case study, and how we strengthened this design by using multiple sources of information. Finally, we discuss these multiple sources, which include three waves of stakeholder interviews, document review, on-going project documentation, a mail survey of CVM participants, and multiple site visits.

Conceptual Framework for CVM

There was no formal relationship between the cross-site evaluation performed by the national evaluator (first the Lewin Group, then Abt Associates) and the individual, site-specific evaluations. The cross-site and site-specific evaluators and teams communicated periodically to share their approaches, and there was some sharing of de-identified data (primarily from interviews) through summary reports. However, since Abt Associates' final evaluation report was being written concurrently with this report, it was not possible to use data from their evaluation to compare with our evaluation of CVM. Moreover, because the cross-site evaluation methodology changed radically after Abt Associates replaced the Lewin Group, the cross-site methodology had little influence on our approach. Instead, we worked closely with CVM project partners to develop a theory of action (Patton 1997) for the Miami initiative--that is, we specified the underlying assumptions about how CVM activities were to lead to improved access to care. As noted by Sofaer et al. (2003), although the majority of innovative programs do not clearly specify a theory of action, articulating one can be critical when evaluating complex initiatives that seek sustained system change.

The general theory behind CVM, according to project partners and leaders, was that mobilizing community stakeholders (health care providers, neighborhood residents or consumers, and community leaders) around issues of access to health care for the uninsured would produce a groundswell of support sufficient to compel policymakers to introduce policies and/or programs that would improve access to health care for this population. Indeed, CVM's activities were consistent with the theory. However, rather than proceed in a

linear fashion through the activities, allowing one activity to build upon another, CVM used a three-pronged approach, implemented on parallel tracks. Specifically, CVM tried to engender support by promoting collaboration through the MAC, influencing local policy through commissioned reports and participating in local health policy efforts, and building community capacity through community engagement and capacity-building efforts. There was some crossover among these three efforts, but for the most part, they remained separate activities, often involving different actors.

We next describe briefly each of these activities and how they were expected to lead to the desired outcomes. Figure 4.1 illustrates how CVM envisioned that promoting collaboration would improve access to health care. As shown, promoting collaboration includes an on-going cycle of convening stakeholders, facilitating dialogue, building relationships, developing common ground and goals, and developing action plans or recommendations for action. Collaboration, it was thought, would lead to concrete actions such as programs for the underserved (often requiring new or additional funding) and changes in public policy (requiring political will), and these, in turn, would result in improvements in access to health care. All of this was to take place within the Miami-Dade County environment, with its history of collaborative efforts and failures, a contentious local policy environment, and other complicating external factors such as a depressed economy.
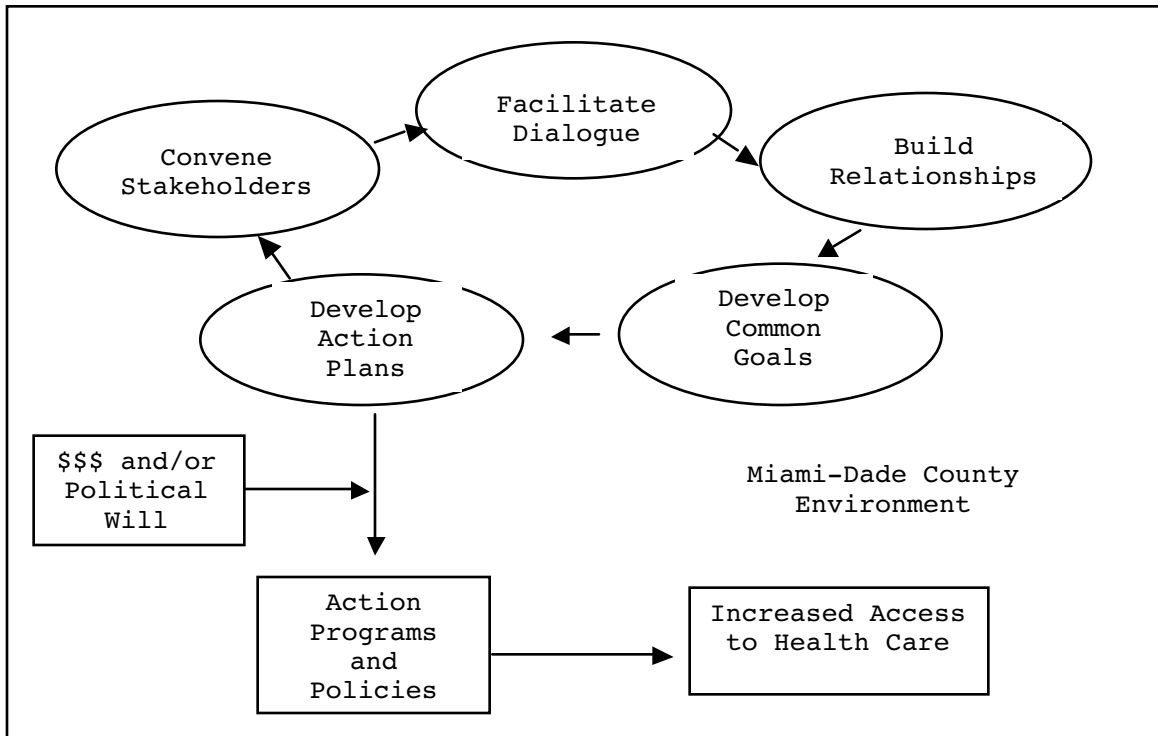
Figure 4.1. How Collaboration Could Lead to Improved Access to Care

Figure 4.2 illustrates another way that CVM tried to affect access to care, i.e., by informing policymakers about health care needs, barriers to care, and health-related policy issues (e.g., uncompensated care, access to care for the uninsured, and governance of public funds for health care). The CVM team felt that informing and influencing policymakers would engender more support for addressing issues of access to care for the uninsured (i.e., actual policy change). The majority of this work included disseminating CVM-commissioned reports,[39] participating in local health policy activities, and behind-the-scenes influence on the mayor.
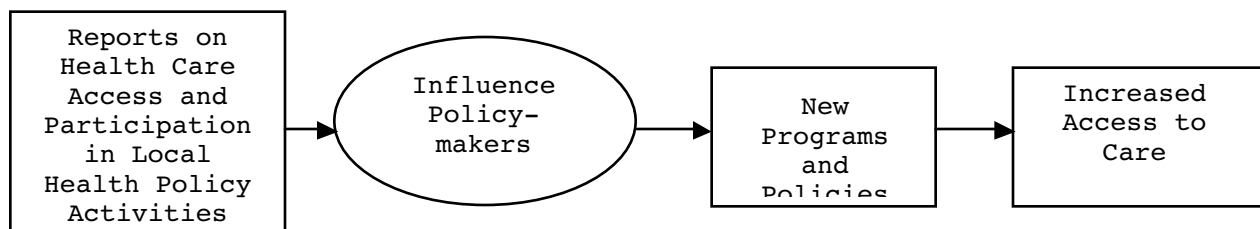
Figure 4.2. How Informing Policymakers Could Lead to Improved Access to Care

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[39]These included _Community Dialogues About Health and Health Care_, _Hospital Care for the Uninsured in Miami-Dade County_ (Jackson et al., 2002) and _Governance for Whom and for What_ (Jackson et al., 2003).

Figure 4.3 depicts a third way that CVM tried to affect access to care, i.e., by building community capacity. This community outreach, engagement, and funding effort was spearheaded by United Way. It culminated in a series of CVM-United Way capacity-building grants for neighborhood coalitions to develop innovative approaches to improving health care access.[40] The grants were intended to generate neighborhood-driven solutions by facilitating interagency and community-agency collaboration and enhancing community capacity to address needs through programs and advocacy (Perlmutter and Negron, 2003).
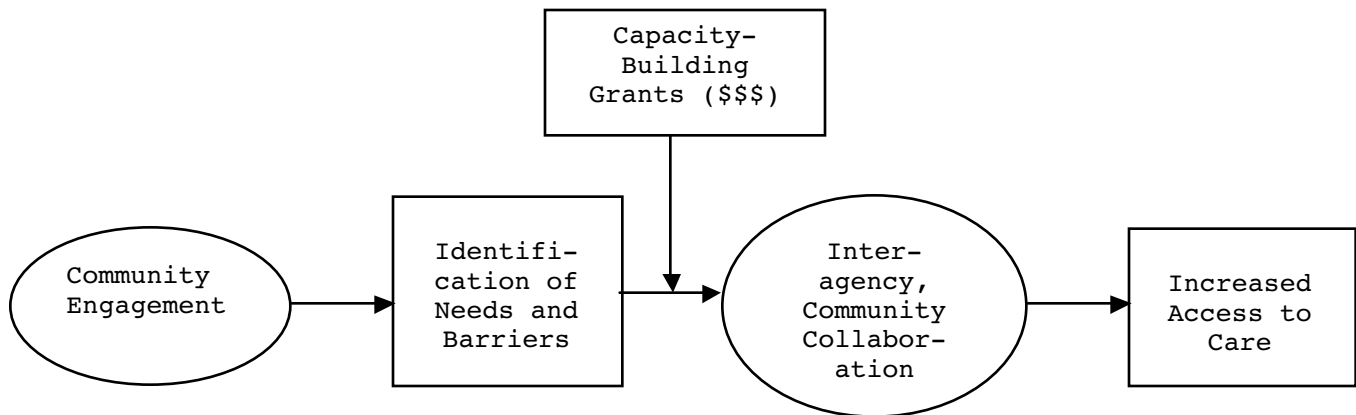
Figure 4.3. How Building Community Capacity Could Lead to Improved Access to Care

Evaluation Questions

Our evaluation focused on the first two categories of activities, promoting collaboration and informing policymakers. Our rationale for focusing on these activities was that (1) CVM spent most of its time and resources on promoting collaboration (sponsoring and attending meetings) and influencing policymakers through commissioned reports, and (2) the capacity-building grants had their own evaluations, and we did not want to duplicate these efforts. In addition, the capacity-building grants were made in the fifth year of CVM and extended beyond the term of the grant, leaving

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[40] Six neighborhood coalitions received one-year planning grants ($30,000—$75,000) in June 2002; four of these coalitions were funded for a second year in June 2003 ($30,000 each).

relatively little time for RAND to evaluate their effects. Because of their importance for CVM's overall vision, however, we do discuss recent developments in these efforts in the epilogue to this report.

The general questions guiding our evaluation were (1) What has CVM done? (2) How has CVM done it? (3) What have been the "effects" or outcomes of CVM's activities? We address these questions with the structure of our conceptual framework of collaboration and informing policymakers leading to improved access to care. To assess CVM's progress toward its stated goals of improving access to health care and establishing an evaluation system to monitor care, we focused on intermediate outcomes:

1. What has CVM done to promote collaboration (e.g., convene stakeholders, facilitate dialogue, build relationships, develop common goals, develop action plans)? (See Chapter 5.)

2. How well does CVM perform on the factors that facilitate collaboration? (See Chapter 6.)

3. How have CVM reports and participation in the Mayor's Health Care Initiative and Task Force on Health Care Access affected local policymaking regarding health care access, especially for the uninsured and underserved? (See Chapter 7.)

In addition to reports from those closest to the project (the project team, partners, active MAC and OT members, etc.), we sought external information and opinions regarding CVM's performance. Our rationale was that if CVM was to effect change, its actions would be recognized by the community participants and results would be linked to these actions.

Evaluation Design

The overall design of our evaluation is best described as a single-case study. This design was the most appropriate given the nature of CVM (a project with an evolving agenda and a multi-pronged approach) and the fact that we did not have access to data about other sites or programs for comparison. As with most evaluations of broad-based community initiatives, it is difficult to establish the counterfactual, i.e., what would have happened in the absence of the initiative (Hollister and Hill 1995). To strengthen our ability to make conclusions about CVM and its effectiveness, we triangulated data from multiple sources to develop *converging lines of inquiry*. As noted by Yin, "Any finding or conclusion in a case study is likely to be much more convincing and accurate if it is based on several different sources of information, following a corroboratory mode" (Yin, 1994). Therefore, we

triangulated data from our interviews to arrive at the facts about CVM and the context in which it worked. We also triangulated data from interviews with data derived from document review, project activity logs, and other more objective sources to corroborate and validate the interview data. In sum, we followed the principles established by 30 years of evaluation research: Use theory as a guide, mix methods, seek patterns that corroborate each other, and creatively combine designs (Granger, 1998).

Data Sources

Table 4.1 outlines our principal data sources: three waves of stakeholder interviews, document review (*The Miami Herald*, *The Watchdog Report*), extensive project documentation (meeting agendas and minutes, staff activity and communication logs), a mail survey of CVM participants, and multiple site visits.

Stakeholder interviews were conducted with CVM project staff, partners, participants, and other community leaders throughout the CVM project. Our first group of stakeholder interviews (21 total, 1.5 to 2 hours each) were conducted in December 1999, the majority taking place at respondent offices (3 were done by telephone). These interviews explored expectations of CVM, process issues, the context of CVM, and accomplishments to date. Our second set of interviews (22 total, 30 to 45 minutes each) were conducted by telephone in December 2001. These interviews explored perceptions of the MAP. Our final set of interviews (25 total, 45 to 90 minutes each) were conducted by telephone in April and May 2003. These interviews explored CVM's accomplishments and shortcomings and the context and process of CVM activities. Over the course of the project, we conducted a total of 68 interviews with 53 stakeholders; 13 stakeholders, or about 25 percent, were interviewed more than once.

In order to keep abreast of the sociopolitical context of CVM, we reviewed *The Miami Herald* regularly for articles related to public health, immigration and immigrants, social policy, local politics, and critical current events. We wrote monthly summaries of the articles we reviewed to inform our evaluation and to share with the CVM project team. We also monitored local politics through *The Watchdog Report*, a weekly summary of local public meetings distributed via e-mail.

We collected and reviewed extensive project documentation, including all documentation associated with CVM meetings (membership lists, faxes and

letters, attendance lists, agendas, minutes, etc.). We also asked CVM project team members to keep phone logs to identify persons with whom they were communicating outside of CVM meetings. Finally, during the final three years of the project, we asked staff to provide biweekly reports on their principal activities (to ensure that we tracked important information along the way).

To evaluate CVM's collaborative efforts specifically, we conducted a mail survey of CVM participants in spring 2002. The survey instrument was based on the Wilder Collaboration Factors Inventory, a tool used to help groups assess where they stand on factors needed for a successful collaboration (Mattessich et al., 2001). (For more on the mail survey, see Chapter 6.)

Finally, we conducted site visits throughout the project to observe CVM meetings and events, interview stakeholders, and interact with the project team and CVM participants. RAND evaluators made 11 site visits over the five years of CVM (additional visits were made by RAND staff in charge of technical assistance). RAND staff participated in meetings that they did not attend in person via conference call.

Table 4.1

Data Sources Used in CVM Evaluation

Method of Data Collection	When Collected	Sample Description	Domains Explored
Stakeholder interviews (in-person, 1 to 2 hours each)	December 1999	21 CVM participants (project staff, partners, OT members, MAC members)	Expectations of CVM; project leadership, structures, and interactions; context of CVM (especially health care policy issues); community engagement; Kellogg's role; CVM accomplishments to date
Document review	June 1999—March 2003	*Miami Herald* articles about health and health care issues, sociopolitical issues; *Watchdog Report* (local e-mail newsletter)	Impact of CVM on current events and issues of public interest; impact of context on CVM
Project documentation	Throughout project	CVM meeting documentation and CVM project team activity and communication logs	Meeting attendance; networking between staff and others; process
Stakeholder interviews (telephone, 30 to 45 min. each)	December 2001	22 CVM participants (project staff, partners, MAC members)	Perceptions of MAP (goals, process, and expectations)
Mail survey	March—June 2002	60 CVM participants (OT members, MAC members)	Collaboration; participation in CVM
Stakeholder interviews (telephone, 40 to 90 minutes each)	April—May 2003	25 individuals (project staff, partners, OT members, MAC members, other community leaders)	CVM accomplishments, shortcomings, and lessons learned; context of CVM
Observations	Throughout project: 4 site visits in 1999, 4 site visits in 2000, and 3 site visits in 2002.	MAC meetings, OT meetings, Mayor's Health Care Summit, other community events	Participation level, salient issues raised, process

5. CVM EFFORTS TO PROMOTE COLLABORATION

In this chapter, we discuss the first prong of CVM's activities, i.e., efforts to promote collaboration through its Multi-Agency Consortium (MAC). The MAC was arguably the single most important collaborative working body of the CVM project. We start with a discussion of why we are interested in collaboration, then we offer a definition of collaboration and discuss what participants and stakeholders thought about collaboration in Miami-Dade in general and CVM specifically. Throughout, we draw on observations and insights revealed to us through interviews of CVM participants and community stakeholders.

We next use a conceptual model of collaboration to examine the phases of collaboration and how these developed in the MAC, and we analyze attendance data to determine who did and who did not participate in CVM. These findings are discussed in the context of the MAC as a collaborative effort. We close the chapter with a summary assessment of CVM as a collaborative effort and a discussion of how collaboration contributed to CVM's overall efforts.

Why the Interest in Collaboration and What Is It?

Promoting collaboration among organizations has become a popular strategy for improving community health, the premise being that in today's environment, rarely can a single organization improve community health by itself (Annison and Winford, 1998). A multi-sectoral approach involving diverse stakeholders is needed to appropriately address the complex health care needs of any community. However, building effective collaborative partnerships can be difficult, as it requires changes in relationships, procedures, and structures, as well as substantial investments of time and organizational resources (Lasaker, Weiss, and Miller, 2001).

Mattessich et al. (2001), who note that the term "collaboration" has been used in many ways and can mean different things to different people, suggest the following working definition:

> Collaboration is a mutually beneficial and well-defined relationship entered into by two or more organizations to achieve common goals. The relationship includes a commitment to mutual relationships and goals; a jointly developed structure and shared responsibility; mutual authority and accountability for success; and sharing of resources and rewards.

This definition provides benchmarks we can use to evaluate CVM's efforts.

Collaboration in Miami-Dade

We asked CVM participants to define collaboration during our final interviews in spring 2003. Many used the adjectives "common" and "mutual"--common mission, goals and agenda; mutual trust, respect, and risk--to describe collaboration. Others also mentioned transparency, openness, and willingness to share and to look beyond differences. A few respondents emphasized that collaboration required a leader or facilitator who encourages participation; others spoke about clearly defined roles, responsibilities, objectives, and time frame. CVM interviewees did not emphasize accountability or sharing resources, two factors included in the above definition. However, other evidence from the interviews suggested that the interviewees realized the relevance of both of these aspects.

We then asked interviewees whether they thought Miami-Dade had a history of collaboration within the health care sector and whether this had changed over the five years during which CVM operated. There was general consensus that Miami-Dade does not have a history of collaboration. Some respondents spoke about attempts at collaboration, but they stressed that certain organizations (e.g., the public hospital and community health centers) historically have not worked together, mainly because of the power differentials among them and disagreements about whether and how resources should be shared.

There was greater disagreement about whether there had been a change in collaboration. Several who believed that change had occurred

attributed this to CVM's efforts to discourage competition among providers or interest groups, encourage involvement and participation, and increase awareness of the needs of the uninsured (and therefore of the need to collaborate). Some of these interviewees cited examples of collaboration, including increased involvement by primary care centers, school-based health efforts, the MAC, and the CVM luncheon at which the MAP was formally presented. Others attributed the change to external circumstances, e.g., the fact that there are fewer resources available than there were in the past, making collaboration more necessary.

It is significant to note that when defining collaboration, not one interviewee discussed financial resources, but when discussing Miami-Dade's collaborative history, several spoke about collaborative failures due to lack of funding. One of the few collaborative successes mentioned was the recently funded Community Access Program (CAP) grant from the Bureau of Primary Health Care (Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services). This program funds the coordination of safety-net services by building on existing models of service integration.[41] CVM played an important role in convening the Miami-Dade organizations to apply for this grant,[42] enabling collaboration between health care providers who had previously seen each other as adversaries. Furthermore, CVM (through a United Way staff person) successfully advocated for the Alliance for Human Services to allocate the outreach dollars from the CAP grant instead of having PHT/JHS do it. Some stakeholders we interviewed felt that this was important because it made a more impartial organization responsible for decisionmaking. The Miami CAP grant, which was ultimately awarded to a coalition led by the PHT/JHS, brought approximately $2 million to Miami—Dade between 2001 and 2003; these funds were distributed among various collaborating organizations.

Furthermore, as part of the CAP effort, the PHT began Trust Care, a pilot health insurance program for uninsured residents. The pilot project was conducted in South Dade, an area that has a high

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[41] See http://bphc.hrsa.gov for more information about CAP.

[42] The organizations had to be convened twice because HRSA rejected the first proposal. Initially, the Miami organizations submitted two competing proposals, and HRSA wanted the community to work together.

concentration of uninsured persons. Within South Dade, the PHT focused

on two areas, Homestead and the cluster of zip codes representing

Richmond Heights, Perrine, and Cutler Ridge, where nearly half of the

estimated 67,000 uninsured in the area reside.[43] Trust Care initially

had an enrollment cap of 1,467 enrollees, but this cap was raised to

2,000 after the first year.[44] The PHT reportedly committed $5 million

per year for two years to support the pilot program[45] and additional

funds were provided from the CAP grant.

These experiences with the CAP grant suggest that access to funding

is necessary for successful collaboration around health care issues in

Miami-Dade County.

Phases of Collaboration and the MAC

The literature on community coalitions and collaborative efforts

has identified seven stages of coalition development: initial

mobilization, establishing organizational structure, building capacity

for action, planning for action, implementation, refinement, and

institutionalization (Florin et al., 1993). However, the literature

provides little information about the timing of these phases or about

the amount of time needed for a coalition to effect recognizable change.

Furthermore, the stages and the tasks involved in the development of

collaborative efforts do not necessarily occur sequentially, in a linear

manner. Across coalitions, there is considerable variation in the

developmental process. Nonetheless, the stages provide a useful way to

assess progress. A review of MAC activities over the five years

suggests the presence of at least the first four stages, albeit with

quite a bit of overlap among them.

Initial Mobilization

In the initial mobilization stage, community coalitions need to

recruit a critical mass of active participants and engage stakeholders

from a variety of sectors (Florin et al., 1993). For CVM, this phase

occurred between July 1998 and June 1999 and consisted of identifying

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[43] Rogers J, Plan for Pilot Health Insurance Program--South Miami-
Dade County, presentation made to the Public Health Trust Program
Planning Committee, January 26, 2001.

[44] S. Boisette, personal communication, 2003.

[45] J. Rogers, personal communication,2002.

MAC members, holding the first meeting, and establishing direction and purpose.

A significant and time-consuming activity during this phase was that of identifying potential MAC members. Instead of opening CVM up to anyone in the health policy, advocacy, consumer, and provider communities, the CVM principal investigator decided to initially target umbrella groups (e.g., Health Choice Network, a network of community health centers that share administrative resources, rather than individual community health centers; and the South Florida Hospital and Healthcare Association, rather than representatives from each of the hospitals in the county). But because not all organizations had an umbrella group or association, CVM also extended many individual invitations. For the first MAC meeting, in April 1999, the CVM project team sent out 70 invitations and made follow-up phone calls and visits to answer questions about project goals and agenda and to encourage meeting attendance. Approximately 30 individuals attended this first meeting.

Establishing the direction and purpose of CVM was also part of this phase. CVM purposely held the first meeting in a conference room across from the mayor's office to send a strong signal that the project had support at the highest level of county government. In introducing CVM at the meeting, CVM project director Pérez highlighted two of the project's objectives directly related to the MAC: "to have committed and accountable stakeholders (community leaders, consumers, providers and policymakers) create feasible health policy for service delivery and on-going mechanisms for community input"; and "to have a model or models in place through which health care is delivered in a more efficient and cost-effective manner."[46] Co-chair Sergio González, Chief of Staff for Mayor Penelas, additionally stated that the MAC would serve as a reality check for the project team and the collaborative by assessing the needs of Miami-Dade's communities. At the close of the meeting, the group expressed enthusiasm and support for this agenda. However, there was no discussion of specific strategies to address the stated goals.

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[46] MAC meeting minutes, April 29, 1999.

Establishing Organizational Structure

In the organizational stage, a structure and operations are established to produce a collaborative group that is cohesive and task-focused (Florin et al., 1993). For CVM, this occurred roughly during the second and third years (July 1999 to June 2001) and involved expanding MAC membership and forming subcommittees and task forces.

Defining the organizational structure of CVM--project team, partners, MAC, OT--provided the opportunity for the team to think through how CVM might expect to affect local policy. Ultimately, the project team chose to make the MAC more open and invited all stakeholders from the community. Inclusiveness notwithstanding, the project team also realized that the hands-on work would need to be done by a smaller group, and the MAC Subcommittee on Health Care Model Development (discussed later in this chapter) was formed for this purpose. The inclusion of a wide range of participants, some of whom had previously taken seemingly adversarial positions, was important to gain consensus.

Building Capacity for Action

The capacity of coalition members for action is built through changes in knowledge, attitudes, and skills, and by establishing linkages with various community organizations (Florin et al., 1993). In CVM, this phase occurred during the second, third, and fourth years (February 2000 to February 2002) and involved MAC meetings as well as parallel efforts led by United Way (the community engagement process) and by RAND (the analysis of uncompensated care and patient travel patterns). The engagement process included 18 community dialogue meetings that were co-sponsored by community partner agencies and held in various community locations to discuss residents' health care issues. In addition, the CVM project team held meetings with community-based organizations to discuss CVM and its goals. In this way, capacity for action was built both by being informed about the community and by informing the community about CVM.

Planning for Action

Planning for action includes identifying community needs, crystallizing goals and objectives, selecting a program or strategy to

achieve objectives, and developing a plan to implement the strategy or strategies (including timelines, budgets, and evaluation activities) (Florin et al., 1993). In CVM, this phase occurred in the third, fourth, and fifth years, when CVM developed the MAP and began to advocate for change in the governance of publicly funded health care. This stage also included several spin-off efforts from the MAC, such as the CAP grant (discussed earlier) and the Miami-Coalition on School-Based Health. The latter was formed as a working group after the MAP was presented (October 2002) because stakeholders agreed that there seemed to be convergence of interests and efforts around school-based health. Several groups in the community, including the Miami-Dade County Public Schools, the University of Miami School of Nursing, and the Miami-Dade County Department of Health, were working on this, but they needed help organizing these efforts, so CVM agreed to seek funding and staff the meetings.

Membership, Participation, and Frequency

Organizations and individuals participated in CVM primarily by attending MAC meetings. Meetings were held during regular work hours (9 to 5, Monday through Friday), initially in the conference room across from the Miami-Dade County mayor's office, and later at United Way. The general format of the meetings included presentations by project partners on work they were doing (e.g., the community dialogues, the patient travel patterns analysis), updates by other community partners, and discussion of next steps. The meetings usually lasted between 1.5 and 2 hours.

By the end of 1999, CVM had established a list of 60 MAC members;[47] by February 2002, the number had grown to 93. As discussed below, a small core group of individuals participated in the MAC consistently, and many individuals participated infrequently or rarely. RAND compiled

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[47] Whether individuals or organizations were members was not always clear. Some individuals who changed organizations still participated in the MAC (suggesting that membership was tied to the individual). Other individuals who changed organizations stopped participating in the MAC, and some were replaced by another person from the same organization (suggesting that membership was tied to the organization). Regardless, many of the MAC members did not have the authority to commit their organizations to particular policy positions or actions.

a database[48] of approximately 140 individuals who had attended one or more MAC meetings by April 2003. These attendees represented more than 70 organizations.

As shown in Table 5.1, CVM hosted a total of 13 MAC meetings, excluding MAC subcommittee meetings, between April 1999 and March 2003. From its inception, it was anticipated that the MAC would meet quarterly. There were no set meeting dates; instead, the project team convened a meeting when it felt that one was needed, usually with a month's notice. Members received information about subsequent meetings at the meetings they attended and/or received notices via e-mail, fax, mail, and courier. Across the five years of CVM, the project team convened two to four meetings per year. CVM held only two meetings during 2001, probably because the MAC subcommittee and task force work intensified over this period. Since core MAC members were involved, scheduling more frequent MAC meetings might have been an additional drain on these individuals' time. In addition, the logistics of convening a full MAC meeting could have further strained project team resources. The increased activity in 2002 reflects the work that was done on the MAP and the efforts of the project team to have it vetted by the MAC.

Table 5.1

Number of MAC Meetings Convened by CVM Each Year

Year	1999	2000	2001	2002	2003[a]	Total
Number of meetings	3	3	2	4	1	13

[a] Attendance data available for analysis represented only January—March, 2003.

On average, there were about 23 attendees representing 19 organizations at every meeting. Although the number of attendees remained relatively stable throughout the project, frequency and

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[48] Our attendance analysis is based on information compiled for the database. This database was developed using sign-in sheets and/or minutes of all MAC meetings. If individuals failed to sign in, we may not have record of all those who attended MAC meetings.

consistency of individual and organizational attendance varied greatly. As shown in Table 5.2, a small core of organizations sent representatives to meetings consistently, attending at least half (six) of the MAC meetings.[49] A total of 13 organizations were represented at six or more meetings, and 59 organizations were represented at five or fewer meetings; 37 organizations sent representatives only once or twice. Individual member attendance was less consistent: only seven individuals attended six or more meetings, and 111 individuals attended once or twice.

Table 5.2

MAC Core Group of Consistent Attendees

Total Number of MAC Meetings Attended	Number of Organizations Represented	Number of Individuals Attending
10+	2	0
6-9	11	7
3-5	22	30
1-2	37	111
Total	72	147

The core group of 13 organizations varied in their organizational focus and mission.[50] Figure 5.1 shows the sector distribution of the "highest-attendance" organizations (those that attended six or more meetings) in the MAC. Twenty-four percent of these were advocacy organizations, 23 percent each were health care providers[51] and social

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[49] Organization attendance was calculated by summing the number of meetings attended by any individual from one organization. For example, if three people from one organization attended the same meeting, that organization would be classified as having attended one meeting.

[50] Organizations were categorized as advocacy, health care providers (includes community health center or clinic and hospital or health system), planning and policy (includes government and non-government), social service agency (includes government and non-government), managed-care organization or health insurer, and other (e.g., education, research, or foundation).

[51] The majority of organizations in this group were community health centers or clinics.

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service agencies, 15 percent were planning and policy agencies, and 15
percent were other types of organizations (education, research,
foundations). The core group also held divergent views concerning
solutions to improving access to care for the uninsured. Indeed, both
public and private sector organizations were involved during the
formative period when the MAC developed its recommendations.

Other
15%

Advocacy
24%

Planning
and policy
agency
15%

Health Care
provider
23%

Social
Service
agency
23%
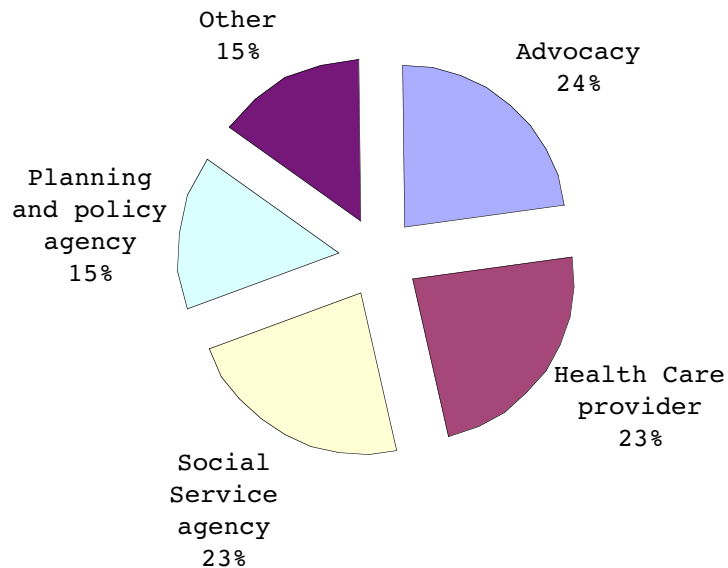
**Figure 5.1. Organizations Comprising the Majority of the MAC's Core
Members**

Interpretation of these attendance patterns depends on what type of
group CVM was trying to create--a large body with fluid membership and
less consistency or a smaller body with committed membership. It
appears that the MAC was a hybrid. The core group of 13 organizations[52]
represented a variety of constituencies in Miami-Dade and was arguably
the most important component. However, the large number of
organizations attending only once or sporadically suggests that the
majority of them were not committed to CVM. It is possible that this

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[52] These organizations included Abriendo Puertas, Alliance for
Aging, Alliance for Human Services, Borinquen Health Center, Department
of Children and Families, Health Foundation of South Florida, Health
Policy Authority, Human Services Coalition, Miami-Dade Homeless Trust,
Public Health Trust/Jackson Health Systems, South Florida Hospital and
Healthcare Association, Stanley Myers Community Health Center, and the
University of Miami School of Nursing.

fluidity hindered action by the core group, since its members were never
certain who would be attending and contributing to the discussion at a
given MAC meeting or who their collaborative partners would be in the
longer-term. Alternatively, the core group, through their shared
history, might have marginalized some members, discouraging more active
participation. In this sense, the MAC did not really have a developed
structure or mutual authority and accountability for success, although
many participants were committed to common goals. However, having a
small core group may have facilitated progress on the development of a
policy plan. Representatives from these organizations could more
quickly reach consensus and present well-developed plans to the full
cadre of MAC members.

In our final interviews, several stakeholders commented on a
perceived decline in the activity of the MAC after the subcommittee's
recommendations were presented (i.e., in late 2000 to 2001). Project
minutes and activity logs indicated that it was during this time that
the project team wrestled with wanting to move the MAC from broad
recommendations to something more specific, a process that ultimately
produced the MAP.

The CVM press conference and the Mayor's Health Care Initiative in
February 2002 were widely cited by CVM participants as a turning point
for the MAC and the project is a whole. These events marked a shift in
CVM's focus from bringing people together to advocacy. The MAC was no
longer neutral but was seen in the context of a project that advocated
for increased governance and transparency and changes to the PHT. This
new focus was consistent with the types of recommendations that Greer
had originally wanted from the MAC.

Shortly after the CVM press conference and the Mayor's Health Care
Initiative, MAC Chair Sergio González resigned as MAC chair. He had
recently left the mayor's office to join the administration of the
University of Miami, and he felt that his new position presented a
potential conflict of interest to continuing as MAC Chair.[53] Several
other MAC members were asked by the project team to serve as co-chairs,
but they declined on the grounds that their current positions also

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[53] The PHT contracts with the University of Miami Medical School
for physician services at its facilities.

presented potential conflicts of interest (in particular, given CVM's focus on changing the governance of publicly funded health care). Therefore, CVM project director Leda Pérez was proposed as interim chair and was approved by the MAC.

Despite the clear advocacy agenda (governance), discussion at MAC meetings declined. From early 2002 through March 2003, the MAC became more of a forum for reporting on project activities and developments than one for exchanging ideas. For the duration of the year, MAC meetings consisted of updates on the MAP, discussion about lead entities, and reports on implementing various components of the MAP. Additionally, the MAC meetings were used to discuss activities related to the capacity-building grants and to hear updates from grantees.

Underrepresented Stakeholders in CVM's Collaborative Efforts

When evaluating collaborative initiatives, it is important not only to look at participants (as was done above), but also to identify stakeholders who were absent but could have brought important perspectives to the collaboration.

When those interviewed in the first wave (December 1999) were asked what types of stakeholders were missing, some responded that the MAC was too heavily weighted to social services agencies rather than health care providers, that it lacked individual clinics and doctors providing low-cost care, and that it did not have enough private sector participation (e.g., Dade County Medical Association, private hospitals). One respondent felt that the agencies and providers involved were too content with the status quo and hence were not strong advocates for change. Another commented that while no one was turned away from a MAC meeting, there had been too little effort to involve community members and consumers who might have an interest in the issues the MAC was addressing. For example, apart from the community dialogues facilitated by United Way, there were few informational community meetings at which additional participants could have been recruited. The project team worked through local agencies to recruit consumers and members of the public to participate in the MAC, but in our first wave of stakeholder interviews, few beyond the project team, United Way, and RAND were aware of these efforts.

When we compared observations from the first wave of interviews (December 1999) with those from the third wave (April 2003), we found some similar observations about the composition of MAC membership. Again, respondents emphasized the lack of private sector health care providers (e.g., the South Florida Hospital and Healthcare Association was represented, but individual private hospitals were not), but in the latter interviews, many also mentioned the absence of the broader business community, e.g., the local chamber of commerce and labor organizations. The call for such representation might have been a result of the general acknowledgment that employers needed to become more involved in the issue of health insurance for workers.

As in December 1999, there was also mention of the need for more advocacy and other types of organizations that mobilize consumers or more general community members. One observer pointed out the absence of community mental health centers, federally qualified health centers, and direct providers. This interviewee explained the absence of these organizations as a function of the time when CVM held its meetings; meetings during working hours could not be attended by individuals employed in health centers or clinics.

Comparing these impressions with our attendance information, we found some inconsistencies. First, of the 13 organizations attending six or more meetings, those in the advocacy sector were represented consistently throughout all three phases of the project. Perhaps the organizations present were not considered the key organizations or were less vocal at CVM meetings. Second, as mentioned above, community health centers participated throughout the course of the project. Two community health centers or clinics attended six or more MAC meetings, and five individuals from centers or clinics attended three or more meetings in the two latter phases of the project. Thus, compared with other types of organizations, the community health centers had fairly consistent representation. However, given their important role in serving the uninsured, it may be that others wished more such centers had been involved and/or had been more active at meetings (i.e., attendance may not have equaled involvement).

At the same time, we did find examples of interviewee perceptions matching the attendance data. Private sector hospitals, represented

only by the South Florida Hospital and Healthcare Association, and the non—health-care-oriented private sector had little representation. Other sectors with little representation included community mental health centers, managed-care organizations, health insurers, the business community, and organized labor.

It is also important to note that the only hospital system that participated consistently on the MAC was the PHT/JHS. This county-run system serves a large portion of the uninsured in Miami-Dade County. PHT/JHS representatives participated heavily during the middle years of the project, in particular, during the MAC subcommittee's work. However, some PHT/JHS representatives ceased participation at the end of 2000, and all representatives discontinued participation by early 2002, when the project began to focus on governance of the PHT. Some stakeholders noted that the PHT/JHS's influence and power in the community made its representatives less likely to compromise, and thus, collaborating with the PHT/JHS may have been a challenge. However, the engagement of PHT/JHS was cited by other stakeholders as one of CVM's earlier accomplishments, and they regretted its absence during the latter phases.

How the MAC Contributed to CVM's Overall Efforts

The MAC was created to be an advisory body that would develop recommendations to improve access to health care. Some of those who participated in our final wave of stakeholder interviews felt that the MAC had accomplished this through the MAP. However, most characterized the MAC as a convening body, a forum for discussing policy options, or a place for health and social service providers to come together and exchange ideas. Some saw the MAC as providing community input or as getting the community invested in the project. Finally, others simply saw the MAC as a body that provided information to various stakeholders.

While community residents and groups (as opposed to health and social service providers, planners, etc.) did not have a significant presence in the MAC until December 2002, when capacity-building grantees were invited to participate, engagement was achieved, in part, through the community dialogues between February and July 2000. Interviewees stated that having the United Way community outreach director report regularly to the MAC was useful in informing the MAC subcommittee about

community needs. However, the community component was not significantly revisited in the MAC until 2002, when a replacement community outreach director was hired and re-engaged community involvement through the capacity-building grants.

Several interviewees in the final wave observed that the focus of the MAC changed substantially when the capacity-building grantees began participating. Because little policy-related discussion took place, some stakeholders expressed confusion about the purpose of the MAC, while others were not sure whether it was indeed still the MAC meeting or some new body, given the dramatic shift in focus. The introduction of the capacity-building grantees in the last year of the project was met with a variety of reactions from CVM participants. Many criticized the MAC for not incorporating enough community input or for doing so too late in the process, while others felt that inviting capacity-building grantees reinvigorated the MAC, despite the timing.

CVM spent much of its first three years mobilizing and establishing its organizational structure and the final two years building capacity for action. That the MAC did not reach the stages of implementation, refinement, and institutionalization, at least in the first five years, is not atypical among coalitions (Goodman et al., 1996). In fact, research has shown that many coalitions falter before they reach the institutionalization stage (Florin et al., 1993). The transition to implementation requires not only substantial time investments by institutions and/or individuals but also funding. That the MAC continued to meet throughout the five years is a credit to the persistence of the CVM project team and several key community partners.

Because the MAC evolved into a forum for networking and exchanging ideas rather than a coalition intent on implementing a specific program or policy, it may be that the latter stages of coalition development are not appropriate benchmarks for CVM. In a sense, the MAC functioned as an incubator: Stakeholders came together, which allowed ideas for collaborative efforts to develop and germinate, and this in turn generated spin-off efforts that supported more narrow aspects of improved access. For example, the CAP grant application was initially facilitated through the MAC and led to concrete funding for disease management, eligibility screening, and other coordination efforts among

safety-net providers. Likewise, the Miami Coalition for School-Based
Health got started through the MAC and ultimately received funding from
the Health Foundation of South Florida for school-based programs.
Generally, these spin-off efforts reflected one or more MAP objectives,
which linked them to the broader CVM agenda.

6.   COLLABORATION SURVEY OF CVM PARTICIPANTS

Empirical evidence of the effectiveness of collaborative partnerships on community-level health outcomes is somewhat limited (Roussos and Fawcett, 2000). Nevertheless, many practitioners, community organizers, researchers, and funding organizations see an intrinsic value in coalition building (Kreuter et al., 2000). Understanding how and how well collaborative partnerships function is therefore an important step in evaluating such strategies.

To explore issues of collaboration in CVM, we conducted a mail survey of CVM participants. We administered the survey during the fourth year of the five-year initiative because the first three years focused primarily on building the MAC and getting it to function as a collaborative group. Also, the MAP had recently been completed, and we wanted to gauge participants' evaluations of CVM before this extensive planning document was implemented. We chose to do a mail survey rather than telephone or in-person interviews because we wanted to include all participants.

In this chapter, we first describe the collaboration survey instrument, including the questions on collaboration and how they were scored, as well as other questions related to participant involvement and demographics. Then we discuss how we administered the survey, including how we identified potential respondents and how we dealt with non-response while still maintaining anonymity. Finally, we present survey results and discuss what they might mean for CVM.

Methods

Survey Instrument and Scoring

Although adapted slightly to include issues germane to CVM, our questionnaire consisted primarily of the Wilder Collaboration Factors Inventory, a tool used to assess the elements of effective collaboration.[54] We chose this inventory because it has a clear

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[54] The inventory and the guide to interpreting it are found in Mattessich et al., 2001. See also www.Wilder.org/pubs/inventory/collaboration.HTML.

evidentiary base (i.e., its development was rooted in the research literature) yet is still concise and simple to use. Furthermore, the survey instrument was designed to be a diagnostic tool for collaborative groups, to be used throughout a project's lifespan. We preferred the assessment approach of identifying strengths and weaknesses with respect to the factors that influence collaborative success, since this type of information is more useful as feedback than is an overall score of collaborative success or potential for success.

The inventory's authors identified 20 factors that contribute to the success of collaboration. These factors were developed through a systematic review[55] of empirical studies of collaboration and were grouped into six categories: environment, membership characteristics, process and structure, communication, purpose, and resources. Each factor corresponds to from one to three survey items.

For our survey, we added three additional items that make up two factors addressing specific aspects of CVM. One item related to the effectiveness of CVM in convening people and organizations to address issues of health care access. Participants in earlier stakeholder interviews consistently described both the importance of convening, given the history of indigent health care policy in Miami-Dade County, and the role that CVM had played as convener. We labeled this factor "convening." The other two items related to the anticipated success of CVM, so we labeled this factor "future." Again, these items were developed from earlier stakeholder interviews that emphasized the importance of CVM having a positive effect and improving access to care in the county.

Each item in the inventory was given as a statement, and respondents were asked to respond using a five-point scale: strongly disagree (1), disagree (2), are neutral or have no opinion (3), agree (4), or strongly agree (5). We scored the factors according to Wilder Inventory guidelines, which recommended averaging across all ratings for items within a given factor.[56] We interpreted factor scores as suggested by the authors of the inventory: scores of 4.0 or higher show

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[55] See Mattessich et al., 2001, for a description of the systematic review and the development of the inventory.

[56] For more on scoring surveys, see Mattessich et al., 2001, p. 41.

strength and probably do not need special attention; scores between 3.0 and 3.9 are borderline and may require attention; and scores of 2.9 or lower indicate concern and should be addressed.

In addition to the items on collaboration, we used closed-ended questions to collect information about participants' demographic characteristics (age, gender, race or ethnicity), organizational affiliations, and involvement in CVM, including duration and level of involvement, number of meetings attended in the past year, type of involvement (job-related or other), and satisfaction.

Survey Administration

We surveyed individuals who attended CVM-sponsored meetings between October 1998 and December 2001, excluding members of the CVM project team and the contracted affiliates, United Way of Miami-Dade and RAND. These individuals and organizations had, in a sense, created the collaboration or coalition, and we felt that they might therefore be less able to objectively evaluate it. In addition, because these organizations received financial compensation for their participation, they had a different kind of relationship to CVM than did the other participants, who were volunteers. We compared the information in our attendance database with current CVM participant lists (MAC, OT, and various subcommittees and task forces). Our attendance list was more comprehensive than project participant lists were, because it included some people who were no longer participating in CVM. We included those who had stopped participating because we thought it important to get their perspectives as well.

We mailed questionnaires, along with a cover letter from the RAND researcher leading the evaluation and postage-paid return envelopes and response cards to 139 CVM participants on March 25, 2002. To maximize candor about potentially sensitive topics, we made the survey anonymous; survey recipients were asked to return the questionnaires and the enclosed postcards (which contained the recipient's name and address) separately. The postcards notified us when a recipient had returned the questionnaire, but there was no way to link respondents' names to questionnaires.

We conducted follow-up with non-respondents primarily via telephone (a minimum of two calls) and, as a final reminder, via fax or e-mail. Between April and June 2002, we made 260 follow-up calls, sent 21 e-mail reminders, and sent 51 fax reminders. Based on responses from the follow-up, we re-sent 79 questionnaires to individuals for whom we had incorrect addresses or who requested another survey to replace the original that had been lost or was never received.

Results and Discussion

Participant Characteristics

We determined through follow-up that 24 of the 139 individuals surveyed were no longer employed at their listed organizations, and we were not able to obtain current contact information for them. Of the remaining 115, 60 (52.2 percent) returned a questionnaire. The characteristics of these respondents (whom we call "collaboration survey participants") are shown in Table 6.1.[57]

The majority of participants were between 30 and 49 years of age (61 percent), female (65 percent), and white, non-Hispanic (56 percent). Nearly one-third were Hispanic. The organizational affiliation of survey participants varied, with the majority categorizing their affiliation as "other" (including non-profits, planning agencies, funders and foundations, and trade associations) and one-quarter of respondents choosing "advocacy." Fewer survey respondents (14 percent) were associated with health care providers (community health centers or clinics, hospitals, or health systems). An overwhelming majority (87 percent) were involved in CVM as part of their jobs.

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[57] All descriptive statistics are self-reported.

Table 6.1

Characteristics of Collaboration Survey Participants

Participant Characteristic	% (N = 60)
Age	
< 30 years	---
30—49 years	61.1
50—64 years	37.0
65+ years	1.9
Gender	
Female	64.8
Male	35.2
Race or ethnicity	
African-American or black	11.1
Hispanic or Latino	31.5
White, non-Hispanic	55.5
Other	1.9
Organizational affiliation	
Advocacy	27.3
Government	18.2
Health care provider	14.5
Other	40.0
Involved as part of job	87.3
Length of involvement	
< 6 months	6.8
6 months to 1 year	15.2
1 to 2 years	28.8
2+ years	49.2
Level of involvement	
Extremely involved	11.7
Very involved	21.7
Somewhat involved	56.6
Not involved at all	10.0
Number of meetings attended in 2001	
0 meetings	6.7
1 to 2 meetings	36.7
3 to 5 meetings	23.3
6 to 9 meetings	13.3
10+ meetings	10.0
How satisfied with involvement	
Completely satisfied	31.6
Mostly satisfied	36.8
Somewhat satisfied	17.5
Not satisfied at all	14.0
Still involved?	
Yes	74.6
No	25.4

The duration and level of involvement also varied among participants. Nearly 50 percent became involved in the first or second year of the project, and nearly 30 percent became involved in the second or third year. More than 50 percent of respondents considered themselves "somewhat" involved, while 22 and 12 percent, respectively, considered themselves ""very"" or ""extremely"" involved.

Not surprisingly, there was a correlation between respondents' perceptions of their level of involvement and the number of CVM meetings they attended in 2001. That year, approximately 13 meetings were held (two MAC, five OT, two MAC subcommittee, four task force). However, not all participants were expected to attend all meetings. For example, there was little overlap of the OT and MAC membership, and not all MAC members were invited to participate in the MAC subcommittee. We could not interpret attending one or two meetings as poor attendance if the respondent was solely a MAC member and not on the subcommittee or either task force. Although it is difficult to identify unambiguously low involvement, we can interpret attendance at more than six meetings (nearly half) as a high level of involvement. Of those who characterized themselves as somewhat involved, more than half had been to two or fewer meetings. Of those attending six or more meetings, 80 percent considered themselves very or extremely involved. Therefore, survey measures of involvement (number of meetings attended) were fairly consistent with participants' self-characterization of intensity of involvement.

Survey participants also expressed diversity in their levels of satisfaction with their involvement. Approximately one-third were completely satisfied, one-third were mostly satisfied, and another third were somewhat or not at all satisfied. Satisfaction did not differ greatly between those who are still involved with CVM (75 percent) and those who are no longer involved (25 percent).[58] However, satisfaction did differ according to intensity of involvement. We found a positive correlation between respondents' satisfaction with their involvement and

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[58] See Table 6.1 for information on current involvement.

their self-assessed level of involvement. All respondents considering themselves extremely involved were either completely or mostly satisfied. Nearly 70 percent of those who considered themselves very or somewhat involved were completely or mostly satisfied, whereas 50 percent of those who considered themselves not involved were not satisfied with their involvement. Similarly, whereas over 80 percent of the respondents who reported having attended six or more meetings were completely or mostly satisfied with their involvement, less than 60 percent of those attending fewer than six meetings were completely or mostly satisfied.

Collaboration Factor Scores

Table 6.2 presents the scores for each factor examined and the corresponding reliability (Cronbach's alpha) for factors consisting of multiple items.[59] Most factors fell within the 3.0—3.9, or borderline, range, and a few fell in the strength and concern ranges. According to Wilder guidelines, this indicates that there are a few factors that do not need attention, a few on which the collaboration should focus heavily, and many about which the collaboration may want to reflect and re-evaluate. However, we had many factors in the borderline range, so we divided these further into those approaching strength (3.5—3.9) and those approaching concern (3.0—3.4).

Key areas of strength identified by survey participants were:

1.   CVM is in a favorable political and social climate, and

2.   CVM has convened key organizations and people around issues of health care access.

Primary areas of concern or low scores were found for "sufficient funds, staff, materials and time" and "history of collaboration or cooperation in the community." Our results as categorized by the Wilder Inventory, along with our subcategories for the "borderline" scores, are described and analyzed below.

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[59] The alpha measures the reliability of the scale, i.e., how much a respondent's ratings on these items were correlated.

Table 6.2

**Wilder Collaboration Factors Inventory Scores for Collaboration Survey
of CVM Participants**

Factor Group	Factor (Number of Questions or Items)	Score	Scale Reliability (alpha)
Convening[a]	Convened necessary organizations and people (1)	4.0	N/A
Environment	History of collaboration or cooperation in the community (2)	2.7	0.85
	Collaborative group seen as a legitimate leader in the community (2)	3.4	0.59
	Favorable political and social climate (2)	4.1	0.81
Membership characteristics	Mutual respect, understanding, and trust (2)	3.3	0.52
	Appropriate cross-section of members (2)	3.5	0.72
	Members see collaboration as in their self-interest (1)	3.8	N/A
	Ability to compromise (1)	3.3	N/A
Process and structure	Members share a stake in both process and outcome (3)	3.6	0.71
	Multiple layers of participation (2)	3.3	0.52
	Flexibility (2)	3.7	0.90
	Development of clear roles and policy guidelines (2)	3.5	0.92
	Adaptability (2)	3.5	0.81
	Appropriate pace of development (2)	3.6	0.63
Communication	Open and frequent communication (3)	3.6	0.82
	Established informal relationships and communication links (2)	3.6	0.73
Purpose	Concrete, attainable objectives (3)	3.8	0.93
	Shared vision (2)	3.8	0.75
	Unique purpose (2)	3.9	0.59
Resources	Sufficient funds, staff, materials, and time (2)	2.9	0.50
	Skilled leadership (1)	3.9	N/A
Future[a]	Positive effects and improved access (2)	3.9	0.92

[a] These factors were added to the Wilder Factors Inventory by RAND researchers.

Environment

Environmental characteristics describe how effectively groups have worked together in the past, the current political and social climate in which groups work, and the community's perception of the legitimacy of the collaboration's leadership (Mattessich et al., 2001, p. 14). According to CVM participants, past collaborative ability is cause for concern (the factor score for "history of collaboration or cooperation in the community" was 2.7), but the current environment was perceived as having a lot of potential (the factor score for "favorable political and social climate" was 4.1).

To put these findings into context, the survey was fielded shortly after CVM released the MAP and the two commissioned reports, United Way's *Community Dialogues about Health and Health Care*[60] and RAND's *Hospital Care for the Uninsured in Miami-Dade County: Hospital Finance and Patient Travel Patterns* (Jackson et al., 2002). All three reports were highlighted in local media coverage and raised the visibility of CVM and its mission. In addition, the Mayor's Health Care Initiative, where several themes emphasized by CVM received high priority, had just been held.

An additional environmental characteristic is the collaboration's leadership ability. Being seen as a legitimate community leader is critical to making comprehensive changes and working with and influencing a variety of groups. CVM leadership scored 3.4 on this factor, at the lower end of "borderline." It should be noted, however, that the reliability of this scale (0.59) was lower than that of the other two scales in this factor group, indicating divergence of the respondents' answers to the two items in the scale. For example, nearly half of the respondents (49 percent) agreed or strongly agreed that others outside of CVM would say that the right organizations were involved, whereas only 38 percent agreed or strongly agreed that leaders not involved in CVM seem hopeful about what CVM can accomplish.

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[60] http://www.camillushouse.org/cv_reports.htm

<u>Membership Characteristics</u>

Membership characteristics relate to perceptions and attributes of collaborative group members, ability of members to compromise, and members' level of self-interest and investment in the group.

The first factor addresses mutual trust and understanding, key components of collaboration. Stakeholders who feel that others are willing to compromise and deem others' efforts to be genuine will be more likely to commit to the goals of the collaboration and to support their implementation. Survey respondents rated mutual respect, understanding, and trust on the low end of borderline, approaching concern (a score of 3.3). The two components of this factor--mutual trust and respect for others involved--scored very differently, with mutual respect rated higher than trust, as reflected in the relatively low reliability of this scale (0.52). More than 82 percent of respondents agreed or strongly agreed with the statement, "I have a lot of respect for the other people involved in CVM," whereas only 16 percent agreed or strongly agreed that "people involved in CVM always trust one another." Thus, those involved in CVM held mutual respect for one another but had not yet established trust.

Having an appropriate cross-section of members is important for collaboration, so the membership should include people who have a stake in the outcomes (stakeholders). With a score of 3.5, CVM is approaching strength in having the right stakeholders, according the survey respondents.

Respondents demonstrated a fairly high level of self-interest in the collaboration (with a score of 3.8, approaching strength). This component is important to collaboration because individuals and organizations with a vested interest in the process are likely to stay consistently involved and be willing to compromise on important decisions.

In rating others' willingness to compromise on important aspects of the project, respondents provided slightly less favorable ratings (a score of 3.3). Thus, while CVM scored well in terms of building blocks to collaboration--for example, having the right organizations involved-- it had not achieved trust and faith in fellow participants' willingness to compromise.

Process and Structure

Process and structure factors include layers of participation and decisionmaking, tools for developing consensus, adaptability, and pace. All of these factors were rated borderline (3.3—3.7). The highest-ranking of these factors was flexibility in decisionmaking and the groups' willingness to discuss different approaches (3.7, approaching strength). Flexibility is important in the collaborative process not only because it provides members with an incentive to join and remain committed to the group, but also because codified structures and behaviors can stifle new attempts at problem solving and outreach to new members (Mattessich et al., 2001, pp. 20—21).

Participants also provided positive ratings (a score of 3.6, approaching strength) of members' time commitment and commitment to project success. Organizations investing the right amount of time in the project was rated lower than participants wanting the project to succeed. This implies that the commitment of participants to the project's goals and objectives was perhaps higher than that of the organizations they represented. Participants' responses indicated that the collaboration assumed the right amount of work at the right pace and that the project team was able to keep up with all coordinating aspects of the project (a score of 3.6, approaching strength).

The process and structure factor receiving the least favorable score (3.3) was participation, that is, sufficient time allotted for participants to confer with colleagues about decisions related to CVM and participants being able to speak for their entire organization. Allowing enough time for participants to consult members of their organizations encourages broader engagement in the collaborative process (Mattessich et al., 2001, pp. 19—20). Individuals not attending meetings may have information pertinent to the efforts of the collaboration; a lack of sufficient time to reflect and engage others reduces the overall effectiveness of the process. Additionally, by giving participants time to discuss major decisions with colleagues, the collaboration demonstrates that input from participants is essential to the collaborative process. Again, there was divergence in how respondents answered the two items in this factor (alpha = 0.52). Half (50 percent) agreed or strongly agreed that there was enough time to

confer with colleagues for CVM decisions, whereas only one-third (33 percent) agreed or strongly agreed that CVM participants could speak for their entire organization.

Also critical to decisionmaking is members' understanding of their roles and responsibilities and the collaboration's decisionmaking procedures. Members who are not familiar with their roles, rights, and responsibilities may be less likely to be engaged in important decisions. CVM scored in the middle range of borderline (3.5, approaching strength) on this factor. Mattessich et al. suggest making member responsibilities explicit, e.g., by asking participants to sign letters of agreement (Mattessich et al., 2001, p. 20).

Adaptability, defined as the collaboration's capacity for maintaining focus and momentum in the face of major changes (Mattessich et al., 2001, p. 21), received a score of 3.5, approaching strength. In theory, the collaboration should be sustained as community needs, trends, and environment shift. One element critical to sustainability is periodic re-evaluation of the collaboration's mission, goals, and objectives. If appropriate, the collaboration may need to redefine its agenda.

Communication

Communication is essential to effective collaboration; group efforts require open exchange of ideas between leadership and members and among members. Mattessich et al. recommend establishing open communication, with clearly defined member responsibilities, and they caution against selected distribution of project ideas and documents, which can fragment the group (Mattessich et al., 2001, p. 23). The focus of the communication factors is on inter-participant communication, information dissemination by leadership, and leadership-participant communication. Here, CVM received a factor score of 3.6 (approaching strength).

To achieve effective collaboration, the leadership must consistently inform participants about project developments and meetings and must encourage participants to work together, inside and outside the structured framework of scheduled meetings. Informal communication leads to increased trust, greater commitment to the collaboration, and greater potential for future collaboration. In the areas of within-group

and informal communication, CVM received a score of 3.6, approaching strength.

Purpose

Having articulated goals that are understood and formulated by collaboration members and commitment to the collaboration itself as a means of attaining goals contribute to fulfilling the collaboration's purpose. Members will devote time and effort to the collaboration only if they are convinced that the goals are reasonable and concrete and that other members share them. Moreover, they must be committed to the general goal of creating the collaboration, understanding that its purpose is to achieve what no organization could achieve alone. A vision for the collaboration that is shared by its members, whether it is developed inside or outside the collaboration, will motivate participants to realize that vision (Mattessich et al., 2001, p. 26).

Having a mission, vision, and goals that are unique to the collaboration also support the collaboration's purpose. A participant who feels that the collaboration's goals are identical to those of his or her own organization may be less likely to collaborate, questioning the collaboration's purpose and perhaps sensing that the collaboration is redundant (Mattessich et al., 2001, p. 26). CVM received factor scores of 3.8 (approaching strength) for goals and shared vision. The factor score for unique purpose also approached strength (3.9). However, the somewhat low reliability of this scale (0.59) means that the two items are not completely correlated. For example, 89 percent of the respondents agreed or strongly agreed that "what we are trying to accomplish with CVM would be difficult for any single organization to accomplish by itself." But only 48 percent agreed or strongly agreed that "no other organization in the community is trying to do exactly what CVM is trying to do."

Resources

Resources consist not only of funding sources and physical capital, but also human capital, people power, and networking skills. To be sure, a dedicated funding source is necessary for an on-going collaboration such as CVM. However, in-kind support and staff skills can be even more important than financial resources in building and sustaining the collaboration. The CVM scores for funds and staffing

fell within the area of concern (2.9). The reliability of this scale is
somewhat low (0.50), since respondents were generally more positive
about CVM having sufficient human resources (30 percent agreed or
strongly agreed) than about having sufficient funds to accomplish its
goals (11 percent agreed or strongly agreed). This is typical of
voluntary efforts, which often have more human capital than fiscal
resources.

CVM received higher marks when participants were asked to evaluate
whether CVM leaders were skilled at working with people and
organizations, that is, whether they had experience in the subject area,
were able to minimize power struggles and turf issues, and were able to
create a balance between group process and task activities (Mattessich
et al., 2001, p. 28). For this factor, CVM received a score of 3.9, at
the higher end of borderline (approaching strength).

<u>Future</u>

CVM participants were asked to predict how the collaboration would
fare, both generally and in improving access to care for the uninsured.
Participants' projections will determine how much they are willing to
invest in the collaboration and how hard they will work to contribute to
its success. If participants think there is good potential, they will
be motivated to make the collaboration work. The CVM score for this
factor approaches strength (3.9).

Survey Limitations

The primary limitation of our survey was the response rate (52
percent). Response rates for mail surveys vary widely and are generally
improved by (1) having a respondent-friendly questionnaire, (2) multiple
contacts, (3) proving return envelopes with first-class postage, (4)
personalization of correspondence, and (5) token prepaid financial
incentives (Dillman, 2000). We used all but the fifth element. In their
review of 14 mail surveys by nonprofit organizations, Hager et al.
(2003) found a mean response rate of 42 percent (with a range of 10
percent to 89 percent). Florin et al. (1993) conducted a mail survey of
task force members of community coalitions and received responses from
47 percent of current members and 44 percent of former members. Thus,
our response rate was higher than that of some mail surveys targeted to
similar populations, but our findings still may not generalize to all

CVM participants. For example, the response rate from health care providers was low--only 14 percent of the respondents were involved in health care--whereas 47 percent of non-respondents were health care providers or otherwise involved in health care. In addition, it is conceivable that non-respondents were more negative about CVM performance, which would mean that we overestimated CVM's scores on the collaboration factors inventory.

Conclusions and Recommendations

Overall, survey respondents seemed fairly hopeful about CVM. Although the majority of the factor scores were in the borderline category, according to the instructions in the Wilder Factor Inventory, they were at the high end of the category (3.5-3.9, approaching strength). One factor, having a favorable political and social climate, was clearly rated strong ($\geq$4.0), although the degree to which this factor relates to CVM's activities and relationships versus other conditions in the community is unclear. In addition, participants favored CVM's convening ability, its unique purpose as a collaborative (in particular, that "what we are trying to accomplish with CVM would be difficult for any single organization to accomplish by itself"), and the leadership's good interpersonal skills, and they expressed the belief that CVM will have positive effects and improve access to care.

There were fewer issues of concern (two factors) or approaching concern (four factors), but these are important to consider when evaluating CVM overall. The perception that there was little history of collaboration or cooperation in the community and that CVM lacked sufficient funds, staff, materials, and time to accomplish its goals posed challenges. Likewise, the perceived lack of trust, reluctance to compromise, and low levels of participation among partners reflect process issues that affected how CVM operated and made decisions. Nevertheless, since CVM continues to be engaged with the community and various organizations to move toward improving access to health care services, there are opportunities to address these issues.

7. CVM EFFORTS TO INFLUENCE LOCAL POLICY

In this chapter, we examine the policy aspect of CVM's work. First, we discuss several issues regarding care of the uninsured that were present in the local policy context and that set the stage for CVM's work. In particular, we examine the push for an independent body for planning and evaluation of health programs and services and the concern about geographic access barriers for the uninsured that live in the more remote parts of the county. Second, we examine how CVM tried to influence local policy, in particular, through production of commissioned reports and staff participation in local policy efforts such as the Mayor's Health Care Initiative and Mayor's Health Care Access Task Force. Finally, we assess CVM's role in developments concerning indigent health care policy in the county.

The Policy Context

As noted in Chapter 2, considerable controversy has surrounded the original intent of the health care surtax in Miami-Dade County and, in particular, its governance. Community advocates assert that (1) the administration, planning, and evaluation of the surtax funds' use should be accomplished by an independent board, i.e., one that is not connected to a provider of services, such as PHT/JMH, and (2) many uninsured persons live substantial distances from JMH but feel compelled to travel to it for their hospital care, bypassing numerous other hospitals. We elaborate on these assertions and the ensuing public debate about the appropriate use of the surtax funds, because these were important factors affecting CVM's path.

An Independent Body for Planning and Evaluation

The push for an independent body for planning and evaluation of the use of public funds for indigent care began prior to CVM and continued throughout its five years. An initial approach to this in the community involved efforts to revise the ordinance of the Health Policy Authority (HPA), to make it a fully independent entity from the Public Health Trust (PHT), accountable to the Board of County Commissioners

(BCC). Commissioner Barreiro proposed a revision that would make the HPA report directly to the BCC and would reconfigure its board to make it more independent of the PHT (Hoo-You, 2000). In addition to changing the reporting mechanism for the HPA, Barreiro's proposal would have formally created a dialogue between the HPA and the PHT as separate entities regarding health care planning in the county. However, this ordinance revision effort was not successful, and it never came to a vote at the BCC. A second approach was offered through the Mayor's Health Care Access Task Force, discussed later in this chapter.

Concerns About Geographic Access to Care

The surtax funds are allocated to the PHT, which has its major hospital facility in the northeastern, more urban area of Miami-Dade County. Most of the other hospitals in the county are also located in the densely populated northeast, leaving the western and southern areas with fewer facilities to care for the population generally and the uninsured specifically. Only recently was this situation addressed, when the PHT purchased Deering Hospital and renamed it Jackson South Community Hospital. The centralization of publicly funded hospital facilities had led to disparities between the geographic access to hospital care of the uninsured and that of the insured and is an issue of continuing concern among activists and policymakers.

Public Debate About the Use of the Surtax Funds

Public pressure on the PHT to be accountable for the expenditure of surtax funds began to build in the second year of CVM. *The Miami Herald* reported that JMH had substantial cash reserves, reported to be as much as $470 million (Balmaseda, 1999). PHT officials contended that referring to all of these funds as reserves is misleading, since substantial amounts are legally restricted by bond issue terms, have been committed to construction programs by approved contracts, support employee benefit programs, or have been escrowed for self-insurance

liabilities based on actuarial reports.[61] PHT representatives estimated
that the unrestricted funds in reserve equaled $300 million.[62]

In the midst of these community debates about JMH's cash reserves,
the Florida state government attempted to address the concerns of access
to health care for the uninsured in Miami-Dade County through the Lacasa
Bill (HB 71, 2000), which proposed to divert up to 25 percent of the
county's current maintenance-of-effort funds from the PHT to a special
fund. This fund was to be administered by an independent board from
that which runs the county public hospital (i.e., the PHT) and was to
provide some level of reimbursement to all eligible hospitals within the
county that provide health care services to the indigent. The amendment
would have transformed the Miami-Dade County system into one where
dollars followed the patient. Although the Florida State Legislature
passed the bill, Miami-Dade BCC determined that it violated their home
rule law. The court agreed and ruled the Lacasa bill unconstitutional.

How CVM Tried to Influence Local Policy

Policy efforts evolved over time, as CVM matured and refined its
policy agenda and as it helped create and capitalized on opportunities
in the external environment. These efforts focused primarily on raising
awareness about the problem of the uninsured, proposing solutions, and
refining policy targets. We elaborate on these efforts below.

Raising Awareness About the Problem

To foster a better understanding of health care access problems,
particularly those of the uninsured, CVM conducted two simultaneous
activities. The first, led by United Way, consisted of a series of
community dialogues to discuss barriers to care and overall experiences
with the health care system. A total of 18 dialogues in which more than
700 persons participated were held in different neighborhoods around the
county, with the cooperation of some 60 community partner agencies. The
results of these dialogues were presented at meetings of the MAC and the
OT, the Florida Governor's Summit on Health Care for the Uninsured, the

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[61] Conchita Ruiz-Topinka, Public Health Trust, personal
communication, October 12, 2001.

[62] Public Health Trust Executive Committee meeting minutes,
September 27, 1999.

Public Health Trust strategic planning committee, and elsewhere.
Ultimately, the results were published as a CVM report, *Community
Dialogues About Health and Health Care*,[63] which was officially released
at a press conference (discussed below).

The community dialogues report was significant in at least three
ways. First, it was the first local report derived directly from
community input that summarized the concerns of residents in low income,
at-risk neighborhoods. These were the communities for which CVM was
designed, and these were the voices that needed to be heard to develop
policies that addressed their concerns. Common among the themes
mentioned were:

- Health care is not affordable: Insurance premiums and co-
  payments and encounter fees are too high, and pre-existing
  conditions limit insurance availability.
- Services are difficult to obtain: Lack of neighborhood health
  care providers and poor public transportation make accessing
  services difficult.
- The health care system is difficult to navigate.

The community dialogues report was also significant because it raised
several issues that could be directly addressed by JHS, the major
safety-net provider in Miami-Dade. A representative from JHS attended
many of the dialogue sessions at the invitation of the CVM project team.
While at times this representative was a lightning rod for discussion
(e.g., he was put on the spot about problems of accessing care at JHS),
he also served as a conduit for direct communication about community
concerns, particularly those related to the publicly funded health care
system. Finally, the report was significant because it was published
without attribution to United Way or any authors. Because the impact of
CVM was still uncertain, one could surmise that the absence of
attribution was intended to distance the United Way from any political
fallout and maintain its donor base.

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[63] *Community Dialogues about Health and Health Care*, Community
Voices Miami, 2002.

A second way that CVM tried to promote understanding of the health care access issues of the uninsured was by examining the financing of health care for this population. At the request of the MAC, RAND researchers examined publicly available hospital finance and discharge data to explore the distribution of uncompensated care in the county and potential disparities in geographic access for the uninsured. RAND presented results of their analyses to the MAC and OT multiple times, each time getting feedback that led to additional analyses and/or refinement. Ultimately, the results were published in *Hospital Care for the Uninsured in Miami-Dade County: Hospital Finance and Patient Travel Patterns* (Jackson et al., 2002), which was also released at a press conference, along with the community dialogues report.

The RAND report was very different from the United Way report in that it did not reflect community perspectives; rather, its principal source was administrative data reported from the county's hospitals (to the Florida Agency for Health Care Administration). Thus, while the RAND study did not have the human interest of the dialogues report, it documented the travel patterns of hospital patients in the county by insurance status and residence (a measure of geographic access). Travel patterns were based on the distance between the center of the zip code in which the patient lived and the hospitals in the county, with hospitals ranked from closest to furthest. The report showed that in the county as a whole, there were few disparities in geographic access by insurance status. This probably reflected the fact that most hospitals and most of the population are concentrated in the northern part of the county. However, when subgroups, such as patients living in South Dade and Western Dade, were analyzed, there were substantial disparities. For example, while 50 percent of insured adult and pediatric patients went to the first or second closest hospital to their home, 30 to 40 percent of uninsured adult and pediatric patients went to hospitals further away (the ninth hospital, or even further). Between 30 and 40 percent of adult and pediatric uninsured emergency admissions were at non-South Dade hospitals. Large differences were found among payer groups, with a larger proportion of Medicaid and uninsured traveling beyond numerous hospitals.

The recommendations from the RAND report included the following:

- Reduce the number of uninsured in the county.
- Revisit the financing of health care for the indigent.
- Consider the role of community benefits[64] in the county and their impact on the provision of indigent care.
- Monitor the dynamics of hospital care provision in the county and publicize any changes.

Interestingly, while the report included considerable statistical analysis, perhaps its most significant contribution to the discussion of improving access to health care for the uninsured was its recounting of the history of the half-penny surtax. Prior to this report, many believed that the surtax was allocated specifically to health care for the indigent. After the report was published, the community had to readjust its perception of the surtax, understanding that the funds were dedicated to JMH for improvement of services generally.

The community dialogues and RAND reports were both released at a press conference timed to coincide with the Miami-Dade County Mayor's Health Care Initiative (as noted earlier and discussed below). At the press conference, Greer and Pérez spoke about CVM and its activities, Jessica Perlmutter of United Way spoke about the community dialogues report, Catherine Jackson spoke about the RAND report, and Katy Sorenson, a member of the Miami-Dade County Board of Commissioners, spoke in support of CVM and its activities. A common theme of both reports was that many uninsured persons in the county faced geographic access barriers as a result of the centralized PHT system and the county's poor transportation system. The press conference resulted in front-page articles in both the Metro Miami section of *The Miami Herald* and *El Nuevo Herald* on the issues raised, particularly the allocation of the surtax (Driscoll, 2002). Furthermore, the release of the reports and the press coverage of the Mayor's Health Care Initiative prompted a

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[64] Community benefits are free or low-cost services provided by nonprofit hospitals to community members in moral exchange for the hospitals' tax-exempt status. To our knowledge, no state requires this exchange, and few require hospitals to report their donated services.

series of op-ed pieces in *The Miami Herald* debating the use of the surtax dollars.[65]

Proposing Solutions

As CVM moved into the stage of identifying and advocating solutions, it published another report and intensified its participation in local policy efforts. The Miami Action Plan (MAP) for Access to Health Care, a planning document that outlined goals, objectives, indicators, and lead entities, was based on the work of the MAC Subcommittee on Health Care Model Development. The MAP became a centerpiece of CVM's work during the latter half of the project, and project leadership offered it to the Mayor's Health Care Access Task Force as a blueprint for change.

The MAP was released in draft form at the February 2002 press conference and in final form at a community luncheon in October 2002. The MAP is a "product of over three years of research, planning and consensus building by health care consumers, providers, community-based organizations, advocates, educators, business leaders, and researchers" and "is meant to serve as a roadmap for improving access to health care for the uninsured and underserved in Miami-Dade County."[66] The idea and structure for the MAP was influenced by the work of another CV site, Ingham County, Michigan, which produced a similar action plan. The MAP was written by the CVM project team after they reviewed project documents related to the MAC and the MAC subcommittee. Considerable community outreach was done by project team members and by United Way to gain "buy-in" and "sign-on" from community organizations and other agencies, including those involved with the MAC. This back-and-forth activity between the MAC and community organizations and agencies meant that the MAP went through many revisions before its final form. Even so, the organizations of some MAC members did not endorse the MAP.

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[65] See, for example, Balmaseda, 2002a, 2002b, 2002c; *The Miami Herald*, editorial, 2002; Hertz, 2002; Abrams, 2002; Bieley, 2002; Greer, 2002; Weiss, 2002; Cowden, 2002; Pérez, 2002; Lanham, 2002; Rose, 2002; Horstmyer, 2002.

[66] See inside cover of The Miami Action Plan (MAP) for Access to Health Care, available from http://www.communityvoicesmiami.org/cv_map.htm.

The MAP has four general goals: (1) health insurance coverage for all; (2) elimination of non-insurance barriers; (3) training, education, and outreach; and (4) policy planning and sustainability. For each goal, there are objectives and key actions with lead entities (each key action can have more than one lead entity). Organizations already engaged in or with a mission related to the key action were listed as a formal recognition of their work. In addition, the CVM project presented all organizations that agreed to sign on as leads with written descriptions of what it meant to be a lead entity (i.e., a definition and roles and responsibilities). However, our stakeholder interviews revealed that not all organizations listed as leads had agreed to be lead entities.

The reception of the MAP by CVM participants and the broader community was mixed. Some praised its comprehensive view of how Miami-Dade's access for its underserved populations could be improved and the participatory process used to develop it. But others felt that the plan had appeared mysteriously, was too broad to be useful, and was redundant with other planning documents. Still others felt that it provided good benchmarks against which progress could be measured, although they acknowledged that the tasks were largely not funded and no clear sources of available funds had been identified.

While CVM was developing the MAP, its leaders began to make use of their connection to Miami-Dade County Mayor Alex Penelas. Several members of the OT (including the mayor's chief of staff, Sergio González) met with the mayor in August 2000 to encourage him to take a leadership role on the issue of health care access for the uninsured. In the summer of 2001, the mayor started planning for a one-day health care initiative for community leaders that would focus on children's access to health care. CVM project team members participated actively in the planning for this initiative. The project team members and the principal investigator put pressure on the mayor to include all age groups, since access to health care for children is already largely addressed through a plethora of publicly funded programs. Because of CVM's insistence, along with that of other advocates in the community,

the mayor conceded and opened the initiative to addressing health care access for all residents of the county.

The Mayor's Health Care Initiative was held on February 15, 2002. It was attended by more than 150 people representing health care organizations and advocacy groups, as well as other community members interested in health care for the uninsured. Some of the attendees were involved in CVM and were familiar with the CVM reports released the day before. The program consisted of presentations by a number of experts on issues of the uninsured, including the characteristics of the uninsured and the impact of the uninsured on business. After the presentations, attendees met in small groups to discuss one of the proposed topics for action: (1) expanding eligibility, (2) outreach and education, and (3) public/private partnerships to engage the business community. In the plenary discussion after the small groups, the issue of the governance of the public funds for indigent care allocated to the PHT was raised. Both Pedro José Greer and Amadeo Lopez-Castro, the chairman of the PHT and a member of the OT, debated the importance of governance in their turns at the open microphone. Given the very public debate, governance was added to the topic list. Participants were then asked to prioritize activities within the four action topics, and the activity that received the most support was "pay private providers that give indigent care" (96 votes).[67]

In his closing remarks, Mayor Penelas mentioned the RAND report on the uninsured, noting how it had raised the issue of access and the challenges associated with a centralized local publicly funded system such as the PHT. He announced the creation of the Mayor's Health Care Access Task Force to address the issue of access to care for the uninsured and the specific issues discussed at the initiative meeting. To engender broad support for the effort, the mayor appointed a tripartite chairmanship with well-known individuals representing the medical, business, and foundation communities. In addition to these

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[67] For a summary of the initiative, see "Mayor's Health Care Initiative Outcomes Report," The Health Council of South Florida, Inc., 2002 (available from http://www.co-miami-dade.fl.us/healthcare2002/library/mayor_int.pdf).

private sector representatives, four elected representatives from
federal, state, and local government were invited to join future
discussions. Before the first task force meeting, the mayor's office
sent invitations to individuals in the county who were interested in
developing health care policy for the uninsured and to stakeholders of
various interested organizations.[68] Both Greer and Leda Pérez of CVM
were invited to participate. By the time of the first meeting, the task
force had a total of 54 members, including the mayor and three co-
chairs.

Refining Policy Targets

As CVM moved into the final year of its first five years, it began
to hone in on one of its key policy targets, creating an independent
body for health care planning and evaluation (i.e., changing
governance). This had been a theme of CVM since its inception and was
one of the MAP objectives. The CVM principal investigator in particular
felt that improving governance was key to effecting any other changes in
health care policy for the uninsured. The efforts to change governance
included op-ed pieces, letters to the editor, participation in the
mayor's task force, and another CVM report.

A month after the Mayor's Health Care Initiative, Greer wrote an
op-ed piece in *The Miami Herald* supporting the mayor's task force and
raising the issue of the PHT's governance (Greer, 2002). In particular,
he wanted to highlight the fact that many voters thought the half-penny
sales tax was supposed to pay for indigent care, but "then we came to
find out that the money was not for the patient, but for an
institution." Greer stressed that the governing body (the PHT or
another body) should be in charge of indigent care for the entire
county, not in charge of an institution. Several weeks after Greer's
op-ed piece, *The Miami Herald* published a letter to the editor from

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[68] The categories of invited members included: business
representatives, educational, Miami-Dade Board of County Commissioners,
health care association/private hospital, health care services delivery
system, pharmaceutical, advocacy, faith-based organizations,
government/elected officials, health care planning, senior economists,
legal, and health care consumers (see http://www.co.miami-
dade.fl.us/healthcare2002/taskforce_members.asp).

Pérez that contained a similar message.   Pérez highlighted one of the
Health Care Initiative meeting recommendations, the call to re-evaluate
the governance of the half-penny sales tax by the PHT, and called for
better health care oversight, i.e., separating the PHT from oversight of
JHS (Pérez, 2002a).

At the first meeting of the task force, the co-chairs proposed an
ambitious work plan whereby a final set of recommendations would be
presented to the mayor in nine months, by March 2003. The full task
force met monthly, and separate committees met approximately biweekly or
as needed to address expanding coverage for the working uninsured;
improving existing delivery systems and resources; exploring coverage
alternatives; and governance planning and organization. Greer and Pérez
joined the governance committee, and Heather Harrison, one of CVM's
program managers, joined the expanding coverage committee.[69]

Project director Pérez also authored an op-ed article in *The Miami
Herald* describing the MAP and its implications for local policy change
(Pérez, 2002b) to ensure that the Miami-Dade community was aware that a
plan existed that made specific recommendations for improving access to
health care services. Moreover, it was hoped that the Mayor's Health
Care Access Task Force would adopt the MAP in its deliberations. Pérez
was later invited to present the MAP to the task force.

In a separate but complementary effort, the CVM project team and
close community partners asked the RAND team to research and write a
report on governance that could inform decisionmakers in Miami-Dade.
While seemingly a duplicative effort to the governance committee's work,
the RAND team and the task force committee took slightly different
approaches. The RAND approach reflected an orientation toward objective
analysis, and the research team spent considerable time reviewing
relevant literature and identifying useful examples of good governance.
The committee, in contrast, had the advantage of having witnessed the
governance and actions of the PHT over a long period of time, and it
included individuals from private health care providers, health planning
experts, and the chairman of the PHT, Michael Kosnitzky. For many, the

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[69] Although membership in the mayor's task force was by invitation
only, any community member could participate in the committees.

problematic governance issues had been identified much earlier; the
issue was how to resolve them in a politically charged environment.

Because RAND's governance report was being written while the task
force discussions were being held in Miami-Dade, material the RAND team
identified as being relevant was shared with Pérez and, ultimately, with
the governance committee. In addition, Catherine Jackson, the lead
author of RAND's governance report, attended a governance committee
meeting in late October 2002. Although she was there principally as an
observer, she was asked to participate in the discussion and share what
had been learned through RAND's research. As a consequence of that
discussion, RAND provided the committee with 64 principles of good
governance (Pointer and Orlikoff, 2002), which it used as a model in its
report.

Initially, there was some concern on the part of CVM project team
members and others that a report focusing exclusively on reforming the
governance structure of the PHT would be divisive and unproductive.
Therefore, RAND researchers, in collaboration with others, decided to
articulate principles of good governance and apply them to the situation
in Miami-Dade County, with the hope that this could provide input into
local discussions around these issues. While the governance committee
discussed and developed their own recommendations, Michael Kosnitzky,
the chairman of the PHT, was pushing for self-reflection and change in
the way the PHT conducted business.

The RAND report on governance was presented to the community in
draft form in March 2003, just prior to the Board of County
Commissioners' Workshop on Healthcare Governance (March 25, 2003) at
which the task force's findings were discussed, and in final form at a
press conference in May 2003 (the end of year five)(Jackson, Derose, and
Beatty, 2003). In addition to discussing the principles of good
governance, the report listed specific recommendations for the mayor and
the BCC to consider. These included:

- Separate the functions--services operations and policy
  development and monitoring--currently under the governance of
  the PHT.
- Create a new countywide policy and planning agency.

- Strengthen the oversight activities of the BCC to improve accountability and transparency.
- Clarify the relationship between the PHT and the University of Miami and periodically audit the operating agreement to enhance accountability.
- Maintain funding for the PHT and find additional funds for the planning agency.
- Reform certain administrative practices of the PHT, e.g.:
  o Improve accessibility of meetings and information about the PHT and its role as the county's public provider of health care services.
  o Document and report board member attendance.
  o Report policy relevant statistics.
  o De-politicize the appointment and removal of trustees.

Jackson authored an op-ed article for *The Miami Herald* that summarized the points of RAND's governance report to support governance changes in the PHT. This op-ed was published the week following the formal release of the report (Jackson, 2003).

Results of Policy Efforts

The pace of policy development concerning the governance of public funds for health care was slower than expected. Indeed, even the mayor offered his views of the situation before his task force had made its recommendations. According to *The Miami Herald* (Karl Ross, 2/13/03),

> Penelas argued that the Trust's dual role of making healthcare policy and overseeing Jackson Memorial Hospital, the county's main public health facility, creates "an inherent conflict of interest." He recommended leaving Jackson in the hands of a board of directors, while having elected officials take the lead on setting the county's policy.

The task force committees submitted their reports to the larger task force in early 2003, and by March 11, 2003, the task force had

written its report.[70] Many of the recommendations paralleled those of
the MAP. The three principal recommendations were:

> 1. Establish a new health care policy office for the county,
> separating it from the PHT.
>
> 2. Maintain local public funding for the PHT but compel the PHT
> to be more accountable in its reporting.
>
> 3. Develop a county-sponsored health flex plan that would
> provide a limited set of benefits to those who are working and
> earning less than 200 percent of the federal poverty level,
> using a "third-share" model for premium payment (one-third paid
> by employer, one-third paid by employee, and one-third
> subsidized by the county, using drawdown dollars from the
> federal government).[71]

The task force also recommended increasing emphasis on school-
based health services and increasing funding for outreach to children
and families to enroll those eligible for existing state and federal
programs.

The BCC held a workshop on health care governance March 25, 2003,
to address the primary recommendation of the task force. The language
of the discussion echoed the materials that CVM provided to the
governance committee. Mayor Penelas stated that people who govern
themselves cannot be accountable. The task force co-chairs went
further, saying that when the funder and the provider (that is, the PHT
and its facility, the JHS) are the same, they cannot govern themselves.

Ultimately, two proposals were brought before the BCC, both of
which called for eliminating the HPA, which, as noted before, was not
allowed to operate independently from the PHT/JHS. Rather than
establish a fully independent policymaking body, the BCC established an
Office of Countywide Healthcare Planning that will report to the Miami-
Dade county manager. This new office will be somewhat removed from
political influence and is independent of particular service providers.

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[70] Available from
http://www.miamidade.gov/healthcare2002/healthcare_final_report_03-05-
10.asp.
[71] "Drawdown dollars" are federal dollars that are available as
matching funds for local and state funds.

Funding for the new office was increased about 50 percent from the HPA's funding level, from $300,000 to $450,000 for fiscal year 2003—2004.[72]

CVM's Role in Policy Developments

CVM's reports on health care access contributed to the growing public concern about the uninsured in Miami-Dade. The releases of these reports were strategically timed to coincide with high-profile community events, thereby increasing their impact: The community dialogue report (about barriers to health access) and the RAND report on hospital funding and geographic access were released the day before the Mayor's Health Care Initiative and therefore generated a good deal of press coverage, including front-page articles and subsequent op-ed pieces about related issues. Although the RAND report on governance did not receive as much press coverage, it was prepared in parallel with the mayor's task force work on governance, and there is some evidence that it contributed to local policy discussions.

The CVM principal investigator and the CVM project team were very involved in the activities initiated by the mayor to address access to health care for the uninsured. They played an important role in engaging the mayor to address the issue and to emphasize coverage for adults as well as children. CVM project team members participated in the planning of the Mayor's Health Care Initiative, and Greer played an important role in getting governance issues on the agenda. Pérez was invited to present the MAP to the task force, and some of the stakeholders we interviewed thought that the MAP had influenced the task force's recommendations. The CVM imprint was most visible on the discussion and recommendations concerning governance. CVM introduced established principles of governance to the task force committee on governance, and these principles and the language used to describe them were subsequently used by the mayor and the task force co-chairs. CVM also influenced the task force's other recommendations. Heather Harrison, working with a separate advisory group on school-based health, was able to elevate this topic to policy-level discussion as well.

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[72] M. Lucia, personal communication, 2003.

8. SUMMARY OF ACHIEVEMENTS, SHORTCOMINGS AND LESSONS LEARNED

In this chapter, we review the activities of CVM and the changes that occurred in health care policy in Miami-Dade. In retrospect, it is clear that CVM was involved in the many changes that occurred. It is difficult to conclude definitively whether or not the changes could be attributed primarily CVM or whether CVM served as the "tipping point" (Gladwell, 2000) of change. But at a minimum, CVM's efforts contributed to the synergy that ultimately led to concrete changes in policy.

Principal Accomplishments of CVM

Convening Role

The most frequently mentioned accomplishment of CVM, throughout the project, was its success in convening, i.e., getting divergent interests around the table and engaging people in constructive dialogue. CVM was credited with bringing together the JHS and federally qualified health centers, despite their previously strained relationships. CVM's strengths in convening seemed to come from both the high-profile persons and organizations involved with CVM and the consensus-building and facilitator skills of the CVM project team.

The move from convening to collaboration was not as easy. The MAC infrastructure that CVM developed to promote collaborative efforts had many members, but only a relatively small core group of persons and agencies participated consistently throughout the five years of the initiative. Moreover, the MAC not did entirely meet the working definition of collaboration suggested in Chapter 5,[73] primarily because there was little mutual authority and accountability for the success of the collaboration and no financial bond among organizations. This is

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[73] "Collaboration is a mutually beneficial and well-defined relationship entered into by two or more organizations to achieve common goals. The relationship includes a commitment to mutual relationships and goals; a jointly developed structure and shared responsibility; mutual authority and accountability for success; and sharing of resources and rewards" (Mattessich et al. 2001).

consistent with CVM's borderline ratings on many of the factors that are
thought to lead to successful collaborations.

Perhaps because of its strong convening role, however, CVM was able
to effect some degree of collaboration among other local safety-net
providers. The coalition of safety-net providers led by the JHS probably
would not have received a Community Access Program (CAP) grant without
CVM.[74] Although CVM did not have any operational role in Miami-Dade's
CAP programs (e.g., disease management, eligibility screening), CVM
project team members did remain active on CAP subcommittees and were
even asked during the second year to reach out to community mental
health centers that had traditionally been alienated from the JHS.
Therefore, although CVM's work through the MAC did not always represent
collaboration per se, the CVM project team became known in the community
as good facilitators, able to build bridges between organizations that
might not otherwise work together. By the end of CVM's first five years
(2003), CVM project team members had begun to staff meetings of
collaborative groups beyond the MAC, including the Miami Coalition for
School-Based Health (which CVM helped form) and the Partnership for a
Healthy Community spearheaded by the Human Services Coalition.

Efforts to Influence Local Health Policy

The second most frequently mentioned accomplishment of CVM was the
influence it had on local health policy. In general, CVM participants
felt that the project had raised awareness about the problem of health
care access for the uninsured and the inability of the current system
and funding to address the issue. For example, stakeholders described
the community dialogues conducted in various neighborhoods by United Way
as useful for bringing attention to community needs and significant in
that such dialogues are rarely conducted, publicized, and used in policy
development. Some respondents felt, however, that the dialogue results,
which represented approximately 700 people in a county of over 2
million, were not generalizable because of selection bias (i.e., those
who chose to participate were more likely to have issues with the health

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[74] CAP is a federally funded program designed to support
coordination of safety-net services. In Miami, CAP is led by the JHS.

care system). Nevertheless, CVM was seen as having described the existing system, including the way care was being delivered to the uninsured, and its stumbling blocks.

CVM also played a role in local policy developments associated with the Mayor's Health Care Initiative and the Mayor's Health Care Access Task Force. Although few beyond the project team and partners were aware of CVM's behind-the-scenes influence on the mayor, nearly all interviewees acknowledged that CVM played a lead role in stimulating the public debate about governance of the PHT. Some of them did not see the focus on governance as positive because it politicized the CVM agenda and made CVM less effective as a convener and collaborator. Others, however, felt that advocating for governance change was useful, as it challenged the status quo and forced a dramatic rethinking of the PHT.

Other Accomplishments

Another accomplishment cited by survey respondents, although one with some limitations, was CVM's community-building work. In our final interviews, several respondents mentioned the capacity-building grants provided by CVM through United Way as an important accomplishment because the grants put money back into communities and increased their capacity to advocate.[75] However, most felt that the grants occurred too late in the process (year five) and the period they covered (one year with possible extensions for a second year) was too short to really affect CVM's path. Furthermore, some CVM participants were not that aware of the capacity-building grants until the grantees were invited to participate in the MAC meetings.

A final accomplishment cited was that of affecting organizations' community work. In particular, respondents noted that United Way had not been very involved with health care issues previously and that its participation in CVM brought a new player into this arena. Moreover, United Way's community outreach efforts for CVM connected it to the community in a new way, through community engagement and through the oversight of the capacity-building grants to neighborhood coalitions.

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[75] The first-year planning grants ranged from $30,000 to $75,000 per coalition; the second-year funding averaged $30,000 per coalition.

Respondents also noted that CVM had affected the PHT, making it more
community-focused and getting it to put money on the table. CVM played a
major role in facilitating the development of the CAP grant, to which
JHS committed substantial in-kind contributions as the lead agency. And
by drawing attention to community needs, CVM had put pressure on the PHT
to be more responsive. For example, CVM may have led to more people
getting health insurance, since it pushed the PHT to subsidize new
programs such as Trust Care, a pilot project in South Dade that provided
health benefits for up to 2,000 people.[76]

CVM as Participant

Perhaps the most significant contribution CVM made to the policy
debate in Miami-Dade was the active participation of project team
members on various committees and task forces, including the Mayor's
Health Care Access Task Force (including the governance and working
uninsured subcommittees), the various CAP grant subcommittees, and the
Immigrant Health Access Task Force. As noted above, CVM project team
members also staffed two coalitions, the Miami Coalition for School-
Based Health and the Partnership for a Healthy Community. Finally,
project team members regularly attended PHT board meetings. Their
presence and leadership in these coalitions and committees accomplished
two things: First, being representatives of CVM, they contributed to
the discussion not only as professionals in the field but also with the
authority of knowledge of the "community voice." Second, because CVM
maintained connection to the community through MAC meetings and reports
from capacity-building grantees, its representatives acted as policy
watchdogs--the project team liked to say, "We hold the feet of
policymakers to the fire." Several of our interviewees also emphasized
that CVM project team members could express views that many other health
organizations were not able to express publicly because CVM's funding
was independent of the county and PHT. This became especially important

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[76] As noted in Chapter 5, Trust Care initially had an enrollment
cap of 1,467 enrollees, but enrollment was raised to 2,000 after the
first year (S. Boisette, personal communication, 2003).

as CVM took more of a leadership role on advocacy for changed governance of publicly funded health care.

Changes in Policy During CVM

The first five years of CVM saw numerous changes in policy. Arguably, the most significant came out of the Mayor's Health Care Access Task Force. However, even before the task force was convened, CVM participated in activities that led to changes in the health care system and health policy:

1. JHS created the position of community liaison, which was filled by the representative who attended CVM's community dialogues.
2. CVM clarified the purpose of the surtax, which is now well understood and a reasonably secure source of financial support for JHS.
3. JHS acquired Deering Hospital, located in South Dade, and added it to the publicly funded health system.
4. Through the CAP grant, disease management efforts were strengthened and coordination among safety-net providers was increased.
5. Through the CAP grant, a county-subsidized health insurance product (Trust Care) was tested in South Dade and the concept was included in the recommendations of the mayor's task force.

As noted in the previous chapter, the Mayor's Health Care Access Task Force opened the door for a number of policy changes, many of which are currently in process. A new Office of Countywide Healthcare Planning was proposed, to which many of the PHT's planning functions were transferred. This change signaled a shift of power away from the PHT to the BCC. Furthermore, the new office was given a larger budget than the HPA had had at its disposal. There was also talk of a county health flex plan to provide health coverage to up to 5,000 working uninsured residents and their families. This plan proposes to provide health insurance coverage for workers in small businesses, with the cost being split three ways between the employee, the employer, and the government (both federal and county combined).

Principal Limitations and Shortcomings of CVM

Like any project or endeavor, CVM had its limitations and shortcomings. It was not fully successful in its efforts at participation and outreach. The business and labor communities, which are key to effecting change in the availability and provision of health care coverage, were largely absent from CVM. Health care providers also did not participate extensively in CVM. Although several federally qualified health center and health department representatives attended MAC meetings, few private hospitals or physicians, many of whom provide care to the uninsured, participated. Moreover, some key portions of the community dropped out of CVM at different times during the process, and no concerted effort was made to re-engage them. Finally, CVM was seen by some survey respondents as lacking in political clout. Although the principal investigator had strong connections to the mayor, and one county commissioner (Katy Sorenson) served on the OT, respondents felt that CVM needed to develop stronger relationships with other political leaders, including other county commissioners and Florida legislative members, and that it had to become more politically savvy to accomplish its objectives.

CVM also had its shortcomings in leadership, goal-setting, and operational strategies. Participants in our three waves of stakeholder interviews perceived that CVM strategies for improving access to health care varied somewhat over time, producing confusion and misplaced expectations. One respondent noted that participants were sold "a fast, flashy sports car" and instead received "a more conventional, but reliable car." In other words, to solicit support from stakeholders at the beginning, CVM was presented as a radical approach to improving access to care (e.g., by getting the surtax funds to follow the patient), but in fact, it ended up promoting change incrementally. Some felt that the CVM leadership had overestimated what could be accomplished given the political realities in the county, i.e., that the existing structure was more entrenched than they realized. Other respondents felt that the CVM leadership was misguided and biased, seeking only to push a particular agenda (i.e., taking away the surtax revenues from the PHT, eliminating the PHT, etc.). Even respondents who

were generally supportive of CVM's approach felt that too much emphasis had been placed on the PHT and JHS, to the neglect of making measurable progress in improving access to care. One respondent said that if CVM had not focused so much on governance, it could have achieved more changes in the private sector. Another noted that CVM could have expanded its efforts more by leveraging other funds that would go directly to communities, as the capacity-building grants did. Finally, a number of respondents felt the OT's role and responsibilities were not clearly delineated and that it did not lead the project, ultimately compromising CVM's leadership, governance, and transparency.

Conclusion and Lessons Learned

CVM was conceived in a contentious environment in which safety-net providers were fairly polarized and efforts to address the barriers to care for the uninsured, at least on a countywide basis, had been thwarted by political opposition. Originally, CVM appeared to take the approach of rallying the community together to change the allocation of the half-penny surtax revenues from a centralized system, where all the revenues went to the public hospital, to a decentralized system, where the funds would follow the patient. At the same time, CVM project staff went to great lengths to involve representatives of the PHT and the JHS, which played a primary role in caring for the uninsured of Miami-Dade County, in the MAC and OT. In some ways, the acknowledgement of CVM by the PHT and JHS confirmed CVM's growing visibility in the community. However, the involvement of PHT/JHS representatives came with a cost, as it alienated or at least disappointed some members who had hoped for more radical change.

CVM project team members spent much of their time trying to develop and maintain a broad-based partnership. As described in Chapter 5, the list of MAC members was very large (nearly 100), but only approximately 20 percent of the organizations attended more than half of the meetings. As noted by Shortell et al. (2002), community health partnerships often require a certain size and heterogeneity to gain credibility. However, this diversity also raises management challenges (e.g., in coordination, communication, and conflict management) and may

not serve initiatives that have extremely broad agendas, as it can make selecting targets for action and actually taking action more difficult (Hasnain-Wynia et al., 2003). As Green (2000) observes, multi-agency coalitions involve opportunity costs (for example, individual agencies must sacrifice taking separate action to maintain the coalition) and sometimes neutralize community action, protect the status quo, intimidate or co-opt smaller agencies, or contribute to burnout.

As CVM project leadership came to realize that changing the allocation of the half-penny surtax was not easy, given the ballot referendum language,[77] it turned its focus to governance of the PHT. Governance issues had been of concern since the Indigent Health Care Task Force in the early 1990s. However, previous attempts to substantially change the governance structure by separating PHT's service provision and policy and oversight roles had been unsuccessful. It appears that the momentum built up by CVM and other organizations, along with the Mayor's Health Care Initiative and the task force, made change a real possibility.

By the time CVM began to focus on governance of the PHT in year four, most of the PHT/JHS representatives were no longer participating actively in CVM. On the basis of the information available to us, we suggest that this is probably due as much to the fact that, up to that point, CVM had not produced any operational programs to improve access to care as it was to the perception of such a focus as an attack on their institution. Some of the stakeholders we interviewed were aware of programs that other Community Voices sites were implementing and had expected CVM to create similar programs. Relatively few of the stakeholders interviewed knew much about what the capacity-building grantees were doing. In many ways, the focus on governance issues was a turning point, with CVM no longer perceived as neutral. However, this focus provided a specific policy target, the establishment of a truly independent body for health care planning countywide, which was

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[77] The language specifically earmarked the proceeds of the surtax for "the operation, maintenance and administration of Jackson Memorial Hospital."

reinforced by the mayor's task force subcommittee on governance and eventually acted upon by the BCC.

Through CVM's involvement in the mayor's task force, many of the issues that it had been trying to raise during its first four years were immediately raised to a policy-level discussion. CVM project team members and participants were actively involved in planning for the Mayor's Health Care Initiative and in participating in the task force and its subcommittees. CVM was asked to present its MAP to the task force, and some of our interviewees felt that the MAP had informed the task force's final recommendations. It was clear that the 2003 proposals brought before the BCC to establish a fully independent health policymaking body, something that CVM advocated in its MAP, would not have appeared as quickly had the mayor's task force not been convened. However, some stakeholders noted that CVM became involved with the mayor's task force when it had concluded its long planning phase and was poised to work for the implementation of the MAP. The minutes of MAC meetings in 2002 indicated that CVM project team members thought implementation of the MAP would be a major focus of the final year of the project, with working groups making measured progress on key actions. The year-long process of the task force required many of its members (a number of whom had participated in CVM) to repeat the process of studying the problem and proposing recommendations, ultimately delaying any progress that CVM and its partners might have made in implementing MAP objectives and key actions.

In many ways, it is too early to determine whether CVM has been effective in improving access to health care for the uninsured and underserved of Miami-Dade County. This is the nature of efforts to affect and effect policy change. Certainly, CVM and its partners set the stage for change by affecting intermediate outcomes, e.g., raising awareness of issues, getting safety-net providers to collaborate on specific programs, nurturing neighborhood-based solutions, and advocating for the establishment of an independent health care planning body. However, the measurement of ultimate outcomes of improved access remains for a future study.

9. EPILOGUE

Since the completion of the formal evaluation, CVM has continued its efforts to build community capacity and effect local policy change. This epilogue discusses some of the activities that continue and the changes that have been made.

Continuing Activities

In June 2003, CVM moved from Camillus House to the Collins Center for Public Policy. The move was facilitated by continued funding from the W. K. Kellogg Foundation for an additional four years. Pérez, in describing this move, said that as CVM matures, it needs a base to further develop local policy. The Collins Center has contacts in Miami and Tallahassee, and this should facilitate further progress. Moreover, CVM will have the opportunity to work with other projects within the Collins Center to capitalize on prior experiences and new opportunities to affect local policy.

The CVM project team has continued convening the MAC to discuss CVM's work plan, which includes establishing policy targets and community outcomes for the second phase of the CVM initiative (e.g., better informed stakeholders, policy briefs), possible action items and recommendations for the newly established Office of Countywide Healthcare Planning, and further development of the Miami Coalition for School-Based Health.

The project team has also begun a more concerted effort to improve access to oral health care. In March 2004, CVM co-sponsored a community forum on oral health with the Health Care Committee of the League of Women Voters of Miami-Dade County and the Human Services Coalition of Dade County.

Finally, United Way has continued its community capacity-building efforts. Of the six neighborhood coalitions originally funded, four received an additional year of funding to continue grass-roots efforts to educate and to improve access to health care services. The four coalitions reflect the ethnic diversity of Miami-Dade, as well as organizational diversity. In North Beach, the coalition has worked with

the local safety-net clinic to institute an on-going consumer satisfaction survey to identify problems and track improvements in service and created an "Adopt a Family" program to encourage dentists to provide free care to the uninsured. In Perrine, the coalition reached out to various community clinics in the area and reestablished a school-based clinic by engaging a nurse practitioner from the University of Miami School of Nursing. The West Dade coalition worked with the local clinic, Families R Us, to expand hours, change from a flat fee to a sliding-scale fee structure, and institute customer satisfaction surveys. Finally, the coalition in Little Haiti has brought various community members together to provide education about health literacy and to encourage use of health care services.

 Common threads among the continuing coalitions funded by CVM through United Way are efforts to:

- Bring community members together to work toward a common objective.
- Build on-going communication links between community residents and local health care providers.
- Help local health care providers better understand the needs of the community (especially through door-to-door surveys).
- Encourage the use of customer satisfaction surveys as a way to identify health care delivery problems and track improvements.

CVM also hopes to build on the work of these coalitions to enhance community participation in the health policy process. During the first five years of CVM (1998–2003), neighborhood-based perspectives were gathered through CVM's work in the community and were then shared with policymakers through reports and testimonies. In the second phase, CVM aims to enable neighborhood residents (through the coalitions) to participate more directly in the health policy process.

Local Policy Changes

 Two events directly affected local policy regarding health care for the uninsured in Miami-Dade County. The first was the resignation of the president of JHS. The second was the Mayor's Health Care Initiative. CVM's actions as a catalyst for change arguably influenced

both of these events, and as an active voice in the policy debate, CVM has helped frame the future direction.

The president of JHS resigned under pressure from the chairman of the PHT, Michael Kosnitzky. Although Kosnitzky stepped down before a new president was hired, he began a process whereby the trustees carefully considered what qualifications a new president would need to take the PHT to the next level. The PHT developed a job description and contracted with a recruiting firm that launched a nationwide search. Marvin O'Quinn was hired, and he came into the organization aware that the board was seeking leadership through a time of change. Since becoming president in July 2003, he has brought transparency and accountability to the position. He has instituted the presentation of the JHS Quarterly Report, which discusses in detail the financial status of the hospital and operational issues. He also communicates straightforwardly with the PHT. However, he is also testing the limits of his managerial authority and that of the PHT. Recently, he recommended engaging in a $12 million, three-year contract to improve Medicaid enrollment without going through a competitive bidding process. While he initially received PHT approval to waive the competitive bidding process, the approval was rescinded. The contract, however, was pushed through an expedited process to minimize the amount of revenue that would be lost due to non-enrollment.[78] From a governance perspective, clarifying the role and authority of management distinct from the responsibilities of the board is an important step in the process of reform.

Another important step is the PHT's decision to conduct internal and external audits. One issue that has been of concern is the amount of publicly funded care being delivered to non-residents of Miami-Dade County. In December 2003, the PHT completed an internal audit of their active accounts for uninsured non-resident admissions and found that more than $25 million of uncompensated care had been provided in the preceding five years. But the Office of Inspector General recently completed an audit of both the active and inactive accounts for all non-

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[78] *The Watch Dog*, Vol. 4, No. 43, April 4, 2004.

resident admissions and found $85 million in uncompensated care. This discrepancy was discussed publicly in the media, providing an opportunity for the PHT to clarify the hospital's accounting procedures. In part, the discrepancy resulted from different audit methodologies: The internal audit found that much of the uncompensated care was provided to patients presenting to the emergency room, who, by law, must be treated. Nonetheless, the public scrutiny encouraged the PHT to create more restrictive policies regarding the treatment of foreign, non-resident patients to reduce its exposure to continued bad debt.

At the start of 2004, five trustee positions were up for reappointment or renewal, and 43 people, including several current trustees, applied for the positions. Four previous members were re-elected, and the fifth member, new to the PHT, is the first Haitian-American on the board. Two very vocal and former PHT chairmen, Amadeo Lopez-Castro and Michael Kosnitzky, were not reappointed. Both had been on the board during the turbulent times of board governance reform.

In February 2004, the PHT met in the BCC chambers, and the session was televised. Televised meetings had been required by regulation, but the requirement had been ignored for many years and was only resurrected late in 2003 under pressure from the BCC. In addition, the BCC requested that the PHT hold its meetings in BCC chambers from time to time. Significantly, the location underscores which body has the ultimate authority over the PHT. Improving PHT accessibility to the public and reinforcing accountability were recommendations made by CVM in an earlier RAND report (Jackson et al., 2003).

In his State of the County address in February 2004, Mayor Penelas mentioned the restructuring of the county's health care governance to create the Office of Countywide Healthcare Planning, which will foster better relationships between the public and private sectors. In addition, he introduced the County Health Flex Plan, which will provide health insurance to up to 5,000 working uninsured county residents and their families, with the premiums being split three ways between employee, employer, and the government.

State Policy Changes

The year following the conclusion of CVM's first phase was a busy one at the state health policy level as well. Following Miami's example, the governor formed a task force on access to affordable health insurance.[79] However, the governor's task force was much smaller than the mayor's task force in Miami and had a more compressed time frame. Marvin O'Quinn of the JHS and Fleur Sack of the Florida Academy of Family Physicians were the Miami representatives on the 15-member governor's task force, which met seven times between September 2003 and February 2004 (monthly except for December, when it met twice), each time in a different region of the state and inviting public input. The December 17, 2003, meeting was held in Miami, and among the public input noted, Danielle Levine of the Human Services Coalition made an oral and written presentation (no other CVM participants are listed as having provided public input).[80]

Shortly after convening the governor's task force, the Florida Agency for Health Care Administration (AHCA) received a state planning grant of $975,000 from the U.S. Department of Health and Human Services' Health Resources and Services Administration (HSRA) and its Office of Special Programs. Florida was one of seven states to receive a one-year grant, which will be used to support its efforts to develop options to increase health insurance coverage.

The governor's task force presented its final report on February 15, 2004, recommending that the state develop pooled purchasing for small businesses, health flex plan pilot programs (including one in Miami-Dade), local initiatives using local taxing authorities, Medicaid re-structuring using Health Insurance Flexibility and Accountability waivers, mechanisms to track the success of efforts to reduce the percentage of uninsured (a 2004 update to the Florida Health Insurance Study is planned), and expansion of the KidCare program.[82]

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[79] Executive Order No. 03-160; see http://www.fdhc.state.fl.us/affordable_health_insurance/executive_order.shtml

[80] For more information, see the Task Force's Final Report at http://www.fdhc.state.fl.us/affordable_health_insurance/PDFs/task_force_report_021504_final.pdf

Summary

While CVM is rarely acknowledged externally as a driving force in the changes that are occurring in Miami-Dade County and at the state level, its efforts can be seen in many of those changes, particularly at the local level. The Office of Countywide Healthcare Planning is testament to the success of CVM's efforts to separate the governance of healthcare planning and services provision that had been traditionally housed within the PHT. CVM and other advocates believed that this separation was key to improving governance of the health care system in Miami-Dade County and, ultimately, access to health care.

The County Health Flex Plan is the next step in providing affordable health insurance. While the work of the MAC subcommittee did not progress to the point of a program design, CVM's efforts to assist Miami-Dade to get the HRSA CAP grant provided the opportunity for the PHT to launch a demonstration of Trust Care, a subsidized health insurance product. These efforts, along with the work of the mayor's task force and the participation of the private sector, produced the health flex plan concept. In March, the BCC approved the hiring of a private consultant to design the plan and seek federal funding. The expectation of saving county money in the future by subsidizing health insurance premiums motivated this next step toward improving access to health care for the uninsured. With developments at the state level progressing around many of the same issues, it would seem that CVM's move to the Collins Center positions it well to have an even broader impact, facilitating concrete policies and programs to improve access for the uninsured throughout Florida.

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APPENDIX

NINE CORE ELEMENTS OF THE COMMUNITY VOICES INITIATIVE

1. A plan and capacity for informing the public and marketplace policy.

2. A plan and strategy for development and/or refinement of a cost-effective delivery system.

3. Linkages to public health.

4. Community involvement that includes all the key members of the community.

5. 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.

6. Explicit responsiveness to the community's culture and environment for creating health and wellness.

7. Effective use of resources to attain systems change.

8. Demonstrated readiness of the organization(s) that will spearhead the project.

9. The capacity to function and serve as a laboratory for systems change in which new approaches can be tested and through which others can learn.