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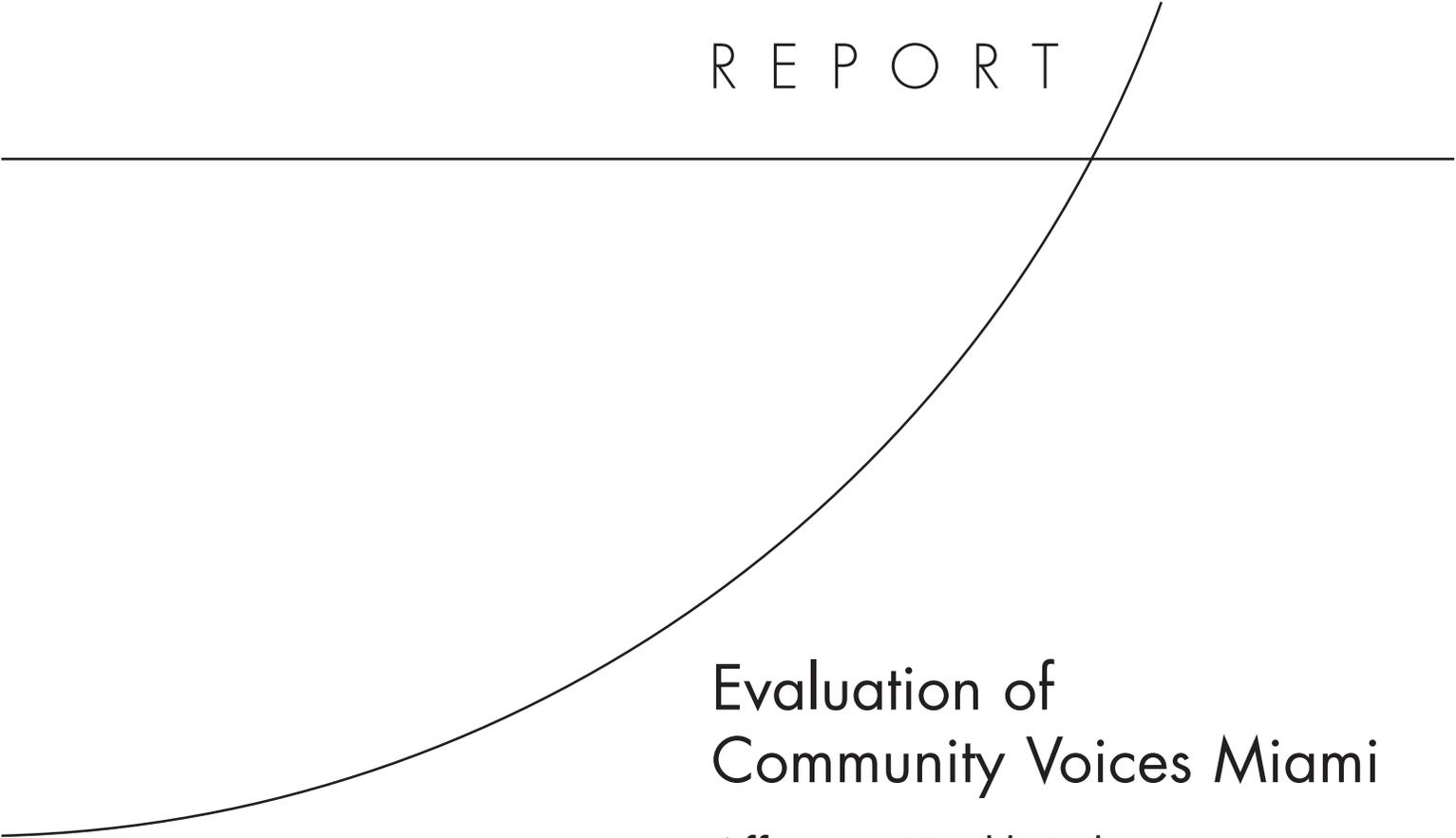
Evaluation of Community Voices Miami

Affecting Health Policy for the Uninsured

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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.