

The Robert Wood Johnson Foundation's Safety Net Programs



Robert Wood Johnson
Foundation

BY JAMES BORNEMEIER

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Editors' Introduction

The term *safety net*, which entered the health care vernacular during the Reagan administration, means different things to different people. To some, it is code for an alternative—and unsatisfactory—approach to caring for the poor: a parallel system of health services in lieu of a universal health insurance system. To others, it refers to providers of health care for people who live in low-income urban or remote rural locations where mainstream providers often do not locate. In the latter sense, an effective safety net will still be needed even when low-income, vulnerable populations have insurance coverage.

This chapter flows naturally from the previous chapter on the Robert Wood Johnson Foundation's efforts to expand health insurance coverage. For even as the Foundation has worked to expand such coverage, it has also funded initiatives to bring services to needy people—safety net services.

Successful safety net programs can undermine the case for universal health insurance. Because of this, plus the difficulty reaching agreement on exactly what the safety net consists of and the strong partisan feelings the term engenders, it is not surprising that the chapter's author, James Bornemeier, a freelance writer specializing in health and social policy issues, finds that the Foundation's approach to the safety net, though serious, has been inconsistent. Nonetheless, in examining Foundation-funded programs to maintain the safety net, Bornemeier highlights a number of interesting and worthwhile initiatives that have provided services to people who otherwise would not have received them. And even though the Foundation has never specified maintaining the safety net as a priority, it is striving, within its current impact framework, to improve the care given to vulnerable populations and to reduce the disparity in the quality of health care received by racial and ethnic minorities.

In the United States, the term *safety net* has come to mean the patchwork of health care providers and social service agencies—public hospitals, community health centers, local clinics, and some primary care physicians—that offers a combination of medical care and other services, such as language translation and transportation, to uninsured and vulnerable citizens. A recent report of the Institute of Medicine observed, “The safety net is the default system of care for many of the forty-four million low-income Americans with no or limited health insurance, as well as many Medicaid beneficiaries and people with special needs.”¹ In the absence of universal insurance coverage, it seems likely that the nation will continue to rely on safety net providers to care for its most disadvantaged populations. For the Robert Wood Johnson Foundation, this fact of life has provided the backdrop for a number of programs that have sought to strengthen this often overwhelmed segment of the health care system.

Yet the Foundation’s diverse safety net efforts, for all their ingenuity and earnestness, have never been consistently coordinated under a grand strategy (and certainly never anointed with an eponymous portfolio), and over the Foundation’s existence, engagement with safety net issues has taken place episodically and some would say erratically.

To understand why, it’s instructive to return to the Foundation’s earliest years and recall a political consensus that by today’s starkly divided electorate seems nearly unimaginable. In 1972, legislation to establish national health insurance was wending its way through Congress. Massachusetts Senator Edward Kennedy, chairman of the Health Subcommittee, was pushing the bill forward in the Senate, while Representative Wilbur Mills of Arkansas, chairman of the Ways and Means Committee, was shepherding it through the House. President Richard Nixon supported the concept. Though passage of the legislation was by no means certain, some form of national health insurance seemed likely.

“The notion of extending health insurance to the entire population didn’t seem as farfetched as it does now,” recalls Paul Jellinek, a former Foundation vice president. “The Foundation believed that health insurance was right around the corner, and the real challenge was to have a supply of doctors who could actually deliver the care. What good would it do for everyone to have an insurance card if there were no doctors to take it to?”

Access to care was a growing issue, and the Foundation’s board, anticipating the historic adoption of universal coverage, was poised to assist in the flowering of this new health care paradigm. “They wanted to get behind something that the average American would understand and approve of,” Jellinek says.

The legislative moment was lost. Mills began flaunting his enthusiasm for an Argentine ecdysiast, and his career derailed. Nixon had become embroiled in the Watergate scandal, leaving him little time to worry about health care. By the time of Nixon’s resignation, in 1974, the momentum for national health insurance had passed.

Larger forces were also at work. A more conservative strain of Republican national leader, exemplified by California’s Governor Ronald Reagan, was on the rise—one who took a sharply different view

of the role of the federal government. Robert Blendon, a Foundation vice president from 1971 to 1986, recalls, “Reagan thought that Nixon was nuts and that Republicans should not be for these large government systems. He thought we should turn it over to the states and get the federal government out of trying to fix these problems.”

“We were quite affected by the shift in the national mood,” says Blendon, now a professor at the Harvard School of Public Health and the John F. Kennedy School of Government. “The country was faced with a lot of problems but Reagan believed it wasn’t the federal government’s responsibility to solve them. We at the Foundation thought we were going to be involved in numerous programs and partnerships, but quite quickly all these possibilities left the scene.”

“The Foundation found itself all dressed up with no place to go,” Jellinek says, “and it was confused about what it should do.”

“Access to care was the focus,” Blendon says. “We wanted to put together systems that tried to improve access for people who were having really difficult problems.” But the term *safety net* was not invoked.

As the prospect of national health insurance faded from view and the role of government diminished, the Foundation had to readjust its relationship with the safety net. “They struggled for seven or eight years to figure out what they wanted to do,” says John Billings, a Foundation grantee and director of the Center for Health and Public Service Research at New York University and professor of health policy at the Robert F. Wagner Graduate School of Public Service. “They couldn’t decide if the safety net providers were part of the problem or part of the answer. A lot of people thought that the safety net providers hadn’t been performing very well and that they had to be really shaken up. Therefore, doing any program directed at the current players didn’t make much sense. That sort of paralyzed them for a while.” The result? “They never developed a very clear, explicit, or coherent approach to what they wanted to do about improving the performance of the safety net,” Billings says.

Along with concerns about the performance of safety net providers, the Foundation’s approach to the safety net was complicated by a conundrum: Improving the quality and the delivery of safety net care gives comfort to those who argue against universal coverage. “We have a goal of increasing access to care, and we believe across the Foundation that the single strongest, most powerful tool toward access is health insurance,” says Pamela Dickson, a Foundation senior program officer. “We also recognize that in the short term it’s an impractical notion to assume that we are going to be able to get everybody covered by health insurance.”

“From a practical point of view, we want to be helpful to efforts that provide services to people who are not going to have health insurance or aren’t eligible for it,” Dickson continued. “But when you support safety net efforts, you can become vulnerable to the argument that you don’t need universal health insurance because the safety net is an adequate substitute. As a whole, the Foundation does not want to support that. That is one reason that the efforts to support safety nets may seem kind of sporadic.”

Dickson's colleague, Anne Weiss, also a senior program officer at the Robert Wood Johnson Foundation, echoes these thoughts:

When we first started thinking about safety net projects, we thought of them as related to the goal of access to health care: A lot of people get access to health care through the safety net, so let's see how we can make it supply more and better access. At some point in the late 1990s, our board and our leadership coalesced around the idea of coverage—covering the uninsured. That positioned these safety net programs somewhat separately. We didn't want to suggest they were the solutions. To a certain extent, we wanted to suggest to people that these safety net programs demonstrated the inadequacy of local solutions and the need for a national solution. The Foundation shifted from being proactive, "Here's something we're doing and we hope more people will do it," to "Here's something we're doing to take a very tough look at the limitations of these strategies." That made safety net programs kind of an orphan for a while.

Despite the notion that successful safety net programs can potentially undermine the justification for universal health insurance, from the 1970s through much of the 1990s, the Foundation put forth an impressive array of initiatives that attacked nagging problems of inadequate, poor-quality, or inefficient health care for the nation's most vulnerable individuals. During those years, the Foundation developed national programs aimed at strengthening health care centers, improving access to care for the rural poor, assisting large cities in providing municipal health services, helping low-income people get proper dental care, and providing housing and health care to the homeless.

In 1999, the Foundation reorganized into teams, and safety net programs fell loosely under the auspices of the Priority Populations team, whose mission was to reduce nonfinancial barriers to health care. "We didn't call ourselves the safety net team," Dickson says, "but in a way we were looking at the barriers that, in addition to lack of coverage, block poor people from getting the health care they needed. 'Safety net' was there under the surface, but we didn't use it directly to describe our work."

In January 2003, Risa Lavizzo-Mourey became the president and chief executive officer of the Robert Wood Johnson Foundation. She quickly reorganized the Foundation into issue portfolios by employing an "impact framework" to heighten the emphasis on goals and results. Lavizzo-Mourey says:

The safety net plays out in several different ways in the impact framework. First, in the Vulnerable Populations portfolio, which is focused on providing innovative programs for the most vulnerable in our society. That's the same population that the safety net institutions typically serve. Second, in our Disparities team, which has as an objective to define evidence-based ways to reduce the disparities in health care based on race and ethnicity. Many of the ways in which the safety net institutions have been leaders is in providing care that addresses the disparities that people have both before and after they get health insurance. Last, and more significant for the overall economic viability of the safety net, we're continuing to push very hard to ensure that everyone has health insurance. Those three approaches to the kinds of populations and challenges that the safety net institutions address are the ways that we are demonstrating our strong commitment.

Lavizzo-Mourey notes that the new arrangement offers a more comprehensive strategy. "Before, there was a group of individuals [the Priority Populations team] that focused on some safety net issues, and there were very strong programs geared toward individual issues within the safety net, but there

wasn't any multipronged approach that looked at the various challenges that safety net institutions have—financing, delivering high-quality care to an ethnically diverse population, and being located near and serving the most vulnerable people. The difference now is that we are looking at issues of the safety net from a multipronged approach.”

Notable Safety Net Programs

Writ large, the Foundation's safety net grantmaking has been aimed at expanding health care services for people who are poor or uninsured or who have difficulty gaining access to the system—minorities, people with serious mental illnesses, immigrants, and individuals living in inner cities or rural areas or having a disease such as AIDS. In this macro sense, virtually all the Foundation's programs could qualify as safety net programs.

But a tighter focus can be used: those programs aimed at providing or expanding medical services to individuals having difficulty getting adequate care because they are poor or uninsured or live in areas where physicians are in short supply. Even using this tighter focus, there is a rich lode of grantmaking initiatives. Here, grouped under the general categories of expanding ambulatory care, strengthening volunteerism, and improving services for homeless people, are sketches of some notable initiatives.

Expanding Ambulatory Care

Municipal Health Services Program (1977–1984, \$15 million)

The Municipal Health Services Program was designed to respond to the increasing need for general medical care in urban communities, where municipal health departments and hospitals are the principal institutional resources available. The country's fifty largest cities were invited to apply for funding, and five—Baltimore, Cincinnati, Milwaukee, San Jose, and St. Louis—were selected to participate. The goal was to assist the cities in their efforts to provide basic health care services to families living in underserved urban neighborhoods. A key feature of the program was helping municipalities develop those services by consolidating and building upon existing services offered by public health departments, hospitals, and other local health agencies, with a limited investment in new funds by the municipality. It was developed in cooperation with the American Medical Association and the U.S. Conference of Mayors.²

One of the central questions Municipal Health Services sought to answer was this: Can the program improve access to care while containing costs to the Medicaid program? (The federal Health Care Financing Administration authorized waivers so that people could use primary care centers rather than more expensive hospital-based sources of care.) According to evaluators, the program had mixed success. In terms of access, the Municipal Health Services Program was able to provide certain targeted groups with sources of care, which were generally more convenient than those they had been using. But the program did not provide care at a lower cost than that received by people who went to other public facilities. “Costs overall were not significantly different for the Municipal Health Services Program and public facility users,” the evaluators concluded, “[but] we are relatively certain that MHSP did not cost more.”³

Program to Strengthen Primary Care Health Centers (1985–1994, \$3.4 million)

In the early 1980s, a trend toward the privatization of health care led to a reduction in funding available to community health centers (which were called “primary care health centers” under the program), which had originated in the antipoverty programs of the 1960s as places where financially, medically, and geographically disadvantaged people could go for care. In response to this retrenchment, the Foundation developed the Program to Strengthen Primary Care Health Centers—specifically to help them become more entrepreneurial and less dependent on public funds. The program aimed at helping health centers find new sources of revenue and become more financially efficient. More precisely, it provided grants and technical assistance aimed at improving the operational, financial planning, and managerial capacities of health centers and reducing their dependence on federal support.

The activities initiated by the health centers focused on five major objectives:

- Increasing patient service revenues
- Serving more patients
- Promoting the stability of center operations
- Expanding the kinds of services provided at the centers
- Enhancing nonpatient revenues

According to the program’s evaluation, those centers receiving Foundation support improved their financial stability. Most striking, one comparison center went bankrupt during the study period, but none of the participating centers met that fate.⁴

Hospital-based Rural Health Care Program (1986–1992, \$16.5 million)

A significant number of the 2,700 rural hospitals in the United States experience financial distress. Although closing may be appropriate for some, a large number are a vital part of their local communities. Rural hospitals are often a major capital investment, a large local employer, and an important provider of care for the poor and the elderly, and are necessary to recruiting and retaining physicians.⁵

The underlying assumption of the Foundation in this demonstration project was that local hospitals and their managers are a key leadership force in improving rural health care, and that small rural hospitals can accomplish more by working together with other hospitals than they can in isolation. In 1988, the Foundation initiated the Hospital-based Rural Health Care Program to improve the access, quality, and cost-efficiency of health services for rural populations by supporting consortia of hospitals to implement several strategies:

- Improve organizational arrangements by forming linkages among hospitals and other providers.
- Promote cost-efficiency through improved management by sharing data and billing systems, management teams, the purchase of supplies and new technology, and the recruitment and employment of physicians and specialized staff.
- Expand new revenue bases by diversifying into new health and health-related services, developing joint ventures, and expanding the use of existing systems.

The response to the announcement of the program was overwhelming—some 180 applications were received. The program provided grants for up to four years, averaging about \$625,000 a year to thirteen consortia of hospitals in rural areas. Examples of innovative consortia programs included efforts to provide a network of geriatric care providers in the western part of North Carolina; a hospital conversion from medical-surgical to psychiatric inpatient services in northeastern New York; and the cooperative recruitment of physicians by twelve hospitals in western New York and twenty hospitals in Wisconsin.

An evaluation by the University of Minnesota's Institute for Health Services Research found that nearly 40 percent of the networks had ceased to function within one year after the grant funding of the Robert Wood Johnson Foundation had ended, in 1991. The evaluators found that lack of funds was the precipitating factor in the demise of two-thirds of the networks. One out of five networks singled out competitive factors in explaining why they disbanded, for example, their fear of sharing information or resources with hospitals viewed as competitors for patients or outside funding. This suggested to the evaluators that "the rural hospital network is a relatively unstable organizational form."

Communities in Charge (1997–2005, \$15.5 million)

In 1996, the Robert Wood Johnson Foundation provided partial support to the federal Health Resources and Services Administration for a national competition to identify and showcase innovative projects for delivering primary health care to underserved and vulnerable populations in local communities. One of the winners of that competition was the Hillsborough County Health Care Plan, a community-wide effort in Hillsborough County, Florida (which includes Tampa and surrounding communities), that resulted in a program that raised the local sales tax to finance a managed-care plan for 30,000 uninsured people. The Hillsborough model, which won an Innovations in Government award in 1995, was particularly interesting not only for its tax mechanism but also because it was a rare county-based approach whose scale seemed transferable elsewhere.

The Hillsborough County Health Care Plan inspired the Robert Wood Johnson Foundation to develop a new initiative that would encourage other communities to develop innovative programs for improving access and quality of care for their uninsured residents. Called Communities in Charge, the initiative was a competitive grants program that challenged local communities to rethink how funds and services are organized for the uninsured. It also provided funding and technical assistance to help communities design and implement new, or significantly expand existing, community-based approaches to the problem.⁶

Twenty communities received organizational and planning grants beginning in January 2000. Grants for development and implementation matching grants were awarded in January 2001 to fourteen communities. During the course of the program, the focus of Communities in Charge shifted, in part because of the economic downturn, surging state budget deficits, and increases in the number of uninsured, and in part because of the recognition that Hillsborough County's coverage program was an anomaly—an almost perfect meshing of state, county, and community political will—and that communities cannot solve the coverage problem without significant assistance from state and federal governments. The program was able to recommend smaller-bore strategies that had a better chance

of being replicated (health policy forums, shared clinical records, state-federal partnership coverage programs) and strategies to be avoided (such as models requiring small businesses to buy insurance for their employees).

Pipeline, Profession, and Practice: Community-based Dental Education (2001–2007, \$19 million)

Oral Health in America: A Report of the Surgeon General, released in May 2000, recognized impressive gains in oral health over the past fifty years for many Americans, but noted that only 35 percent of the people below the poverty line had visited a dentist in the previous year. It also noted that, sadly but not surprisingly, vulnerable populations—the poor, the medically disabled, the geographically isolated—suffered the worst oral health.⁷

The report cited several factors contributing to this disparity: public and voluntary dental clinics for low-income patients treat only seven million people a year of the tens of millions who are without adequate access to other care; the dental profession lacks the cultural and ethnic diversity necessary to enhance access to and utilization of oral health care by racial and ethnic minorities; and high tuition and the prospect of high student debt contribute to the decline in dental students from lower-income families.

The Pipeline, Profession, and Practice: Community-Based Dental Education program strives to increase access to dental care for underserved populations in urban and rural communities by expanding the number of underrepresented minority and low-income students studying dentistry. Specifically, the program is funding fifteen dental schools to, among other things, initiate programs to recruit, enroll, and graduate greater numbers of underrepresented minority and low-income students; change the standard curriculum to incorporate more public health dentistry training; raise awareness of sociocultural issues and sensitivity in the practice of dentistry; and advocate public policy changes at the national, state, and local levels. (The program is cofunded by the California Endowment, which supports participating dental schools in California.)

As an example, as part of the program at the University of North Carolina, dental students can do their required community training at sites that include prisons, nursing homes, psychiatric hospitals, veterans hospitals, mental institutions, and community health centers. As another example, the Temple School of Dentistry appointed an associate dean for institutional relations and community affairs to further develop and implement community-based programs. These programs now serve hundreds of underserved patients in Philadelphia and Tioga County, Pennsylvania. Community clinical rotations have become a requirement for graduation.

State Action for Oral Health Access (2001–2005, \$8.2 million)

This program supports demonstration projects testing innovative approaches to expanding access to dental care for low-income, minority, and disabled individuals served through Medicaid, the State Children's Health Insurance Program, and the public health system. In South Carolina, for example, the Department of Health and Environmental Control developed a collaboration with a district African Methodist Episcopal Church in which children attending church events are screened and, where appropriate, referred to dentists. In Oregon, the Department of Human Services and the

Oregon Dental Association developed a project whereby a coalition of public, volunteer, and professionals are working together to coordinate free or low-cost oral health services for low-income families.

Urgent Matters (2002–2007, \$6.4 million)

Dramatic increases in emergency room wait times plague many big cities, with implications for the health and health care of millions. In a 2002 national survey, 62 percent of all American hospitals reported being at or over operating capacity in their emergency departments, and the number rose to 79 percent for urban hospitals.⁸

This situation is troubling, given the unique role of emergency departments in the health care system. Emergency rooms are often the only open door in a community's health care system and the only provider of many essential services, such as burn and trauma care. In addition, the nation's ability to respond to bioterrorism or events involving mass catastrophes requires both robust and sustainable hospital and emergency room capacity.

To help address these nagging problems, the Foundation funded Urgent Matters, an initiative to help hospitals relieve emergency room crowding. The program provides resources to hospitals in ten communities to improve the timeliness and the availability of emergency care. The hospitals work as part of a learning network to develop and implement best practices to maximize patient flow and relieve emergency room crowding. Four of the hospitals also received \$250,000 for special demonstration projects to lessen emergency room crowding. All sites participate in a safety net assessment and community education process in conjunction with community partners. This helps raise awareness about the state of the local safety net.

Urgent Matters communicates program findings and lessons learned to a variety of local and national audiences. Beginning in February 2005, Urgent Matters embarked on its second phase, using seminars conducted over the Web, conferences, and a new learning network.

Strengthening Volunteerism

Reach Out (1993–1999, \$11 million)

Against the backdrop of the failed health care reform efforts during the first Clinton administration, the Foundation unveiled a program designed to encourage locally based groups of physicians to volunteer their time to serve people without health insurance. Its official name: Reach Out: Physicians' Initiative to Expand Care to Underserved Americans.⁹ Thirty-nine sites, ranging from entire states to inner cities to remote rural areas, received funds to increase access to care through a combination of physician leadership and community support. The two most common models—the free clinic and the referral network—accounted for two-thirds of the total number of projects.

As cited in the *Journal of the American Medical Society* in January 2000, approximately 11,000 physicians participated in Reach Out. Some 200,000 people received medical care through the program. Put differently, under Reach Out, approximately 2 percent of American physicians volunteered to treat 0.5 percent of the nation's uninsured. A significant number of these patients were provided

with ongoing medical homes throughout the three-year implementation phase of the program, while others received specialized care such as surgery or costly tests.

In the view of H. Denman Scott, the program's director, Reach Out's most important accomplishment was probably its documentation of physicians' capacity and willingness to lead community-wide efforts to provide care to the medically underserved. The program also demonstrated the ability of communities to develop and run programs that suit their local needs. In assessing the program's accomplishments, Scott remains cautious. He notes that in 1993, as Reach Out began, about thirty-seven million people were without medical insurance, and the number swelled to forty-five million in 2005.

Realistically, the program was designed only to point the way to possible solutions; it could at best make only a modest dent in the uninsured problem. "A major expansion of Reach Out would not solve the growing problem of access to health care," he said. "One thousand organized programs, performing as the Reach Out projects have on average, would provide care to about five million uninsured and underserved persons—a small fraction of the large national problem."

Faith in Action (1992–2007, \$86.5 million)

In 1992, the Foundation's board of trustees authorized the creation of its largest program to encourage volunteerism, Faith in Action. The program is designed to draw upon the spirit of helping others that is found in faith groups and to leverage it by providing funds to hire a full-time director at each site to organize and deploy volunteer services through an interfaith coalition. Local Faith in Action coalitions bring together volunteers from many faiths to work together to care for their neighbors with long-term chronic health needs.¹⁰

The volunteers, who come from churches, synagogues, mosques, and other houses of worship, provide services to their neighbors such as shopping for groceries, providing rides to doctors' appointments, cooking, and doing light housework. The most frequently provided services, in descending order, are friendly visitor–telephone reassurance (that is, keeping in touch with neighbors by phone, reminding them to take their medications, making sure that they have enough to eat, and simply checking in on them); transportation; meal preparation and delivery; linking people to community services; shopping; and respite for caregivers.

The majority of persons assisted by volunteers are old and very old women, homebound or unable to go out without help, poor or near poor, and living in isolation, with few social contacts. The Foundation reauthorized Faith in Action several times, but in 2005 decided not to renew it once its current funding ends, in 2007.

Improving Services for Homeless People

Health Care for the Homeless (1983–1990, \$18 million); Homeless Families Project (1989–1995, \$5 million)

During the 1980s, homelessness took center stage as a largely unexpected new social problem. Homeless people have been found in most times and places, of course, but the increasing appearance of homeless women and children, and even whole families, on the streets and in shelters made

the issue highly visible and compelling. Best estimates were that women and children totaled one-fifth to one-third of the homeless population. One heated debate at the time concerned the extent to which these families were homeless because of temporary economic dislocation or because of endemic poverty and other complicating factors.

The Foundation has made two large investments in national programs directed at alleviating problems facing homeless people in America. The first, Health Care for the Homeless, attempted to increase the availability of health care services for homeless people.¹¹ It became a model that was cited when the federal government passed the McKinney Act in 1987, providing federal dollars to improve access to health care for homeless people throughout the country.

The projects undertaken under the Health Care for the Homeless program, funded jointly with the Pew Charitable Trusts, were considered to be one of the single most effective networks of health care services developed for homeless people in the 1980s.¹² The creation of the program reflected the growth of the homeless problem and the fact that agencies that had historically been able to provide services to homeless people could no longer cope with their increasing numbers. Begun in 1983, the program was developed to provide cities—limited to the country's fifty largest—with an opportunity to make a significant impact on health care delivery to the homeless. Cosponsored by the U.S. Conference of Mayors, the program's guidelines required that cities forge a coalition of disparate groups of health care professionals and institutions, volunteer organizations, religious groups, public agencies, shelter providers, and members of the philanthropic community. These coalitions were charged with developing a program to meet the health care needs of the homeless, improving their access to other supportive services and entitlements, and conceiving a strategy for continuing the program services after the termination of foundation funding.

Nineteen cities participated in the program, each with a distinctly different approach based on its specific needs. In the early years of the program, service delivery methods included mobile vans outfitted as clinics, mobile teams going to existing programs that serve the homeless (particularly shelters and soup kitchens), and central clinics located in areas where homeless people could be found in substantial numbers.

After the Health Care for the Homeless program was completed, the Foundation funded a second program, the Homeless Families Program, which was more ambitious than its predecessor. It attempted to improve not only health care services for homeless families but also a range of other social services. The Foundation established a partnership with the U.S. Department of Housing and Urban Development, which made stable housing arrangements for families participating in the program.

The premise of the program was that both housing and social services (including health care) were needed to get many homeless families back into stable and independent lives. The Homeless Families Program exemplifies a range of national programs begun by the Foundation in the late 1980s and the start of the 1990s, which emphasized systems reform as a long-range solution to making social services more productive. The theory held that the problem with social services was not just that more were necessary but that existing resources needed to be better coordinated and better focused.

The Homeless Families Program was the first large-scale response to the problem of family homelessness. Started in nine cities across the nation, it had two complementary goals:

- To develop or restructure the systems of health, support services, and housing for families.
- To develop a model of “services-enriched” housing for families that have multiple, complex problems.

The ultimate goal of the program was to improve the residential stability of families, promote greater use of services, and increase steps toward self-sufficiency. Each of the nine sites received \$600,000 in grants over five years to develop systems to care for homeless families and demonstrate a model of services-enriched housing for a group of families.

Corporation for Supportive Housing (1991–2000, \$8 million);

Taking Health Care Home (2002–2006, \$6 million)

As much as 70 percent of the homeless population has health problems, mental and physical disabilities, and substance abuse problems. Supplying shelter to these individuals in the absence of health and supportive services is unlikely to result in their successful reintegration into society. Thus, the concept of “supportive housing” was born: permanent housing that combines health and social services for homeless people suffering from chronic health problems such as alcoholism, substance abuse, mental illness, and HIV/AIDS. Previous efforts to integrate access to health and social services with housing had been developed on a case-by-case basis, with no standard model for financing.

The Pew Charitable Trusts began this initiative with a feasibility study of a potential mechanism to promote the development of special-needs housing across the country. Pew brought together the Robert Wood Johnson Foundation’s experience in special-needs housing and the Ford Foundation’s experience in developing national financing for community-development programs to form a unique collaboration among three major philanthropic organizations that resulted in grants to create the Corporation for Supportive Housing.¹³

Early grants were used to select cities to test the feasibility of supportive housing, raise money to finance the housing from national, state, and local private and nonprivate sources, and provide technical assistance to community-based health and human services organizations and housing providers. Each community was required to match each dollar of the Corporation for Supportive Housing’s national funding with one dollar of local philanthropic funding. In addition, states and localities committed capital and service funds to finance supportive housing development at each program site.

In 1995, grants from the Robert Wood Johnson Foundation, the Pew Charitable Trusts, and the Ford Foundation allowed the Corporation for Supportive Housing to establish programs at eight sites: New York City, Chicago, Columbus, Ohio, and the states of California, Connecticut, Michigan, Minnesota, and New Jersey. Through 1999, the Corporation for Supportive Housing raised more than \$95 million from philanthropic and public funding sources. With this funding, it made grants and loans that backed the development of nearly 10,000 units of supportive housing, and leveraged more than \$169 million in corporate investments to produce 4,000 more units.

The Foundation renewed its support of the Corporation for Supportive Housing with a \$6 million, two-year program beginning in 2005 called Taking Health Care Home. Under the renewal, the existing eight supportive housing sites, plus two new ones, will receive funding, and a larger collaboration of foundations working to alleviate chronic homelessness will be established.

**The Foundation and the
Safety Net: An
Assessment**

For three decades, the Robert Wood Johnson Foundation and its leaders and staff have allocated hundreds of millions of dollars, countless hours of intellectual engagement, and incalculable well-intentioned effort into improving, stabilizing—or demonstrating the fragility of—the safety net. To hear past and present Foundation officers and grantees tell it, the Foundation deserves two cheers for its accomplishments.

“As far as doing work to make the safety net work better, they haven’t made much of a mark,” says John Billings, the NYU professor of health policy and a Foundation grantee. “They’re beginning to take it on in a more head-on way, but historically they haven’t.” The Foundation’s main downfall, Billings says, is its failure to recognize that an insurance card alone is not a panacea. “Of course coverage matters, and is the first and most important step,” he says. “But a large share of the gap between rich and poor and different minority groups is how the providers are performing. A lot more time needs to be spent talking to patients about how they make health care decisions and where things go wrong. We tend to develop interventions based on what the middle class thinks is the right way, rather than recognizing the particular needs of these more vulnerable populations.”

Steven Schroeder, former Foundation president and CEO, is equally blunt. “I don’t think we have a very good feel for that,” he says of safety net programs. “We came at these programs in different ways—by supporting workforce programs and by increasing Medicaid coverage for children, for example—but in terms of directly operating with safety net institutions, making grants accessible to them, I don’t think we took it on frontally. I don’t think we can look back and say that we directly helped the safety net institutions much, but I think we had a lot of programs that influenced them.”

As Schroeder sees it, the Foundation could not agree on a clearly defined plan of attack. “I don’t think we ever got a coherent strategy to bring to the board,” he says. “The board was not the obstacle. You can frame it in one of two ways: We were not smart enough, or the task was too daunting for the resources we had. I suspect it was a mixture of both.”

Paul Jellinek, who as a Foundation vice president played a key role in the shaping and implementing of several major safety net initiatives, takes a long view of the Foundation’s safety net efforts. “The good news is that these programs were able to serve a fair number of people,” he says. “The Foundation did make some headway in strengthening the financial viability of some community health centers; we did set up physician volunteer programs; Faith in Action set up hundreds of coalitions all over the country. But the bottom line is that we have forty-five million uninsured, and access to care is a huge problem for a lot of people. The argument is made that if we hadn’t done what we did, the problem would be even worse. I’m not so sure about that.”

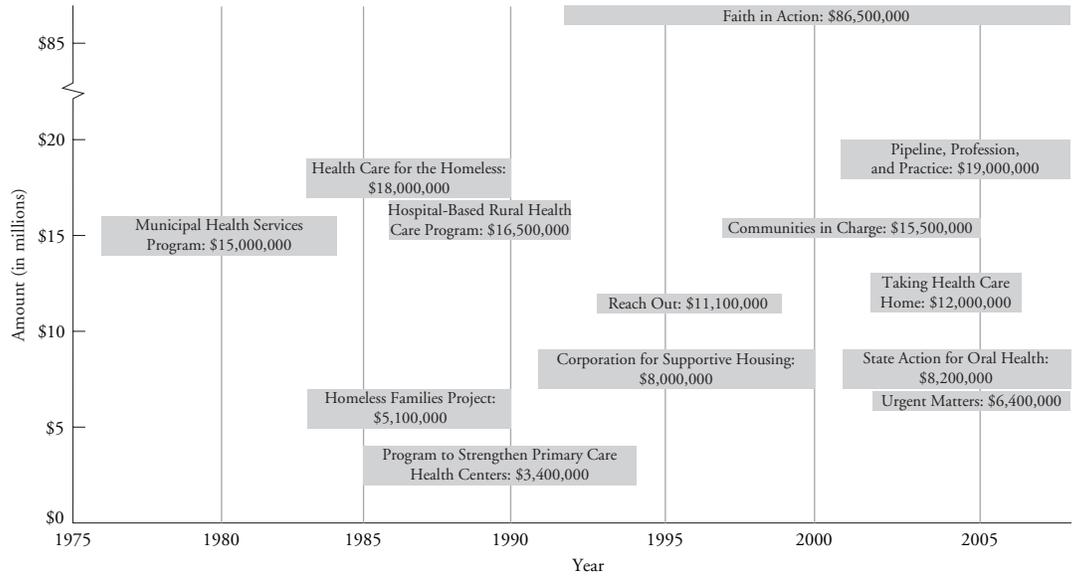
Perhaps the last word belongs to the current Foundation president and CEO, Risa Lavizzo-Mourey. Calling the safety net “very much a priority,” Lavizzo-Mourey says that the strategy going forward will focus on specific issues within vulnerable populations rather than on a generalized commitment to continue investing in the safety net.

Safety net is a term that is not universally defined in the same way. Some people mean hospitals, some people mean hospitals and clinics. Some people mean federally qualified health centers, others place faith-based institutions in there—so it’s a term that is difficult to get universal agreement on. However, many more people can agree on the populations, from a health care perspective, that are most vulnerable, most in need, most likely to have adverse outcomes or not realize their full health potential. So we look at it from that vantage point: who are the people in our society for whom the Robert Wood Johnson Foundation can make a difference? And how can we best go about doing so?

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Appendix. Safety Net Programs



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