The Access Project: National Access to Care Initiative

An RWJF national program

SUMMARY

From 1997 to 2003, the Robert Wood Johnson Foundation (RWJF) funded a national program called The Access Project: National Access to Care Initiative. Its primary focus was to help more community organizations become involved in effective policy advocacy around access to care.

The program was affiliated with Brandeis University's Heller Graduate School for Advanced Studies in Boston. RWJF's Board of Trustees authorized $9.75 million for the program beginning in July 1997.

Key Results

According to program staff, the most important accomplishment of The Access Project has been the creation of a national resource center for local organizations working in health care. Among the key results, The Access Project:

- Convened and trained more than 1,600 people in topics such as gathering and using data, health care access for immigrants, community benefits (i.e., services or goods that a health care institution provides without charge to the public to improve the health of the community), and participating in the public policy process.

- Worked in 57 cities and towns in 29 states, providing about $3 million in contractual assistance to organizations. Program staff provided assistance to organizations to devise ways to ensure that tobacco-settlement funds were used for improving health, and in other areas, such as monitoring local hospitals' adherence to providing free care to people without insurance.

- Conducted a community-based survey of more than 10,000 people who were uninsured in 24 communities across 19 states. Groups used survey findings to persuade hospitals to reduce the debt owed by patients without health insurance and add language translation services.
THE PROBLEM
By 1996, ambitious efforts to provide health insurance for all were no longer under active consideration by federal legislators. Congress had turned to more incremental ways of addressing ills in the health care system, such as a patient's bill of rights. The problem of people without insurance or access to health care had not gone away, however. The number of people without health insurance hovered around 40 million. Because people seek care at their local hospital and health clinic, communities bore much of the responsibility for providing care to people without insurance.

RWJF STRATEGY
In 1996, RWJF provided partial support to the Health Resource and Services Administration, U.S. Department of Health and Human Services for a national competition to identify and showcase innovative projects for delivering primary health care to underserved and vulnerable populations in local communities (ID# 029385). One of the winners of that competition was the Hillsborough County Health Care Plan, a community-wide effort in Hillsborough County, Fla., that resulted in a program that raised the local sales tax to finance a managed-care plan for 27,000 uninsured people. RWJF used the Hillsborough program as a model for its national program, Communities in Charge: Financing and Delivering Health Care to the Uninsured, in which communities replicate the Hillsborough program in an effort to encourage more efficient services for low-income, uninsured individuals. While the Hillsborough approach was promising, RWJF staff wanted to learn if other local efforts that were improving access to health care could serve as models for other communities.

Local groups had few resources to help them in their efforts. National organizations tended to focus on assisting state-level groups in improving health access. RWJF had funded a number of state-level programs to address the problem of the uninsured and access to health care, but it had not funded a national program directed at assisting local organizations in improving access to health care.

As a first step, in 1996, RWJF funded a private, nonprofit organization, the Massachusetts Health Research Institute, to establish a plan for a National Access to Care Resource Center (ID# 030634). The project director was Catherine Dunham, who later became the national program office director for The Access Project. The purpose of the six-month planning grant was to help the RWJF staff conceptualize and design a resource center that could become a national program.

During the planning grant, staff surveyed leaders, academics, local funders and providers who were addressing community needs. Several common themes emerged from the survey:

- Local initiatives are underfunded and undercapitalized—which is a major problem.
• The small organizations that generally lead these initiatives often lack the capacity to plan effectively and develop stable funding, according to the project directors.

• Often heavily dependent on one or two highly motivated individuals, these organizations place a heavy demand on their leaders who typically lack the opportunity to develop and learn new information or skills.

• Community-based advocates often lack access to data or information on the uninsured, developments in the areas of community benefits, public/private partnerships, or national market and political initiatives that may affect them for better or worse.

The project's findings and plan laid the groundwork for RWJF’s decision to fund a three-year national program called *The Access Project*.

**PROGRAM DESIGN**

Another RWJF-funded national program, *Join Together*, provided the model for *The Access Project*. Developed in the early 1990s, *Join Together* uses training seminars, technical assistance, policy forums and enhanced communications to help local substance abuse coalitions connect with each other and overcome such barriers as leadership burnout, data deficiencies and poor policy.

*The Access Project* also developed a model of change that assumed that public and private policy changes at the local, state and national levels will yield expanded access to health care.

The model also assumes that policy changes are improved when communities are involved in making them. Therefore, *The Access Project*’s primary focus was to help more community organizations become involved in effective policy advocacy around access to care.

To accomplish this, program staff worked to increase the standing, influence, expertise and leadership of individuals and groups working at the local level.

Specifically, staff at *The Access Project* provided a range of technical assistance that varied in intensity (the financial and staff resources required to interact with a community organization) and reach (number of community organizations served by a given activity).

The most intense work done by the program staff was providing financial support and direct consultation and assistance in designing and implementing community-based surveys of people without insurance. Program staff also held workshops and conferences, provided information and referrals and produced and disseminated publications.
The two major components of the program were:

- **Documenting and Assessing Community Efforts.** According to former RWJF Vice President Paul Jellinek, Ph.D., RWJF staff felt that it was important to document the extent of local activities to solve access to care problems faced by people with no health insurance. Staff also wanted the project to identify policy barriers to local action, such as state and federal regulations. RWJF staff hoped that the project would identify more counties like Hillsborough County, Fla., that could potentially serve as models for other community efforts. In addition, Jellinek hoped that the program would identify new leaders in this area that could rise to national prominence, much as the Ford Foundation identified civil rights leaders in its work in the 1950s.

- **Building Community Capacity to Improve Access to Care.** *The Access Project* was atypical of most RWJF national programs in that RWJF did not make grants to local organizations. Instead, through grants from RWJF the program provided assistance in the form of publications, meetings and on-site consultants to help local organizations and small amounts of funding (an average of $21,500) to assist these organizations in their work. Included in this work was the building links to state and federal policy-makers to work for long-lasting change in the health care access problem.

**THE PROGRAM**

The office of *The Access Project* was located in Boston and was affiliated with Brandeis University's Heller Graduate School for Advanced Studies in Social Welfare and the Collaborative for Community Health Development, which is a part of Boston-based Third Sector New England, an organization providing resources for nonprofit organizations.

The national program director was Catherine Dunham, who was also the director of the *Robert Wood Johnson Foundation Community Health Leaders Program*. Deputy director Mark Rukavina is a long-time community organizer. *The Access Project* also received $265,000 from the Annie E. Casey Foundation during the time RWJF supported it.

**The Planning Phase**

*The Access Project* office staff began by conducting regional meetings in Memphis, Tenn.; El Paso, Texas; Waltham, Mass.; and Portland, Ore., that altogether drew more than 700 participants from community organizations.

From the meetings, program staff learned about the work of these organizations and the types of assistance that they needed. On the basis of these initial meetings, staff created publications on common issues, and arranged specialized meetings and one-on-one consulting assistance for groups that requested more in-depth assistance.
When the program provided financial assistance to groups or organizations, the staff entered into contracts with specific deliverables for both parties.

*The Access Project* also conducted a survey of 5,000 local organizations to learn whether they were working on the issue of the uninsured and access. According to national polls, uninsured issues had fallen off the radar screen of both policy-makers and the American people. However, the survey found a great deal of activity around the issue at the local level.

**The Implementation Phase**

**Change in Approach**

As the program got underway, some of the initial assumptions and approaches changed. Program staff understood that local organizations needed data to persuade officials about the extent of the problems that people with no insurance faced in their communities.

But they had not realized how little experience these organizations had in collecting or interpreting data. *The Access Project* began focusing some of its efforts on holding training sessions and creating publications about data collection.

*The Access Project* staff also began involving community organizations in designing projects, including data collection. Staff initially planned to assist local organizations in collecting data about the uninsured through interviews of local health providers and others responsible for providing this care.

But representatives from local groups said they wanted to hear from the people who were uninsured. As a result, program started the Community Access Monitoring Survey in which local residents, many of whom were uninsured themselves, interviewed people without insurance who had tried to access care from hospitals. See Overall Program Results.

In 2000, *The Access Project* commissioned an internal evaluation by researchers from Brandeis University. This evaluation found that carefully selecting sites that had coalitions broadly focused on the uninsured and organizational goals and strategies geared to policy and program change, and making multiple investments in their capacity to operate through training, materials, small grants and shared community research, yielded better results than simply distributing materials and offering one-time training. As a result, the staff combined all training with follow-up assistance.

**EVALUATION**

In 2000, RWJF funded a four-month assessment (ID# 038525) in preparation for RWJF staff and Board of Trustees discussion about future funding of *The Access Project*. 
Carried out by Barker Bi-Coastal Health Consultants, the assessment was aimed at helping articulate the lessons learned and the problems faced by this program.

The evaluators visited five communities that received assistance from The Access Project:

- El Paso, Texas
- Lincoln County, Ore.
- Marion and Polk Counties, Ore.
- Portland, Ore.
- Washington

They also interviewed an additional eight by phone:

- Champaign County, Ill.
- Chicago
- Cincinnati
- Columbus, Ohio
- Franklin, La.
- Memphis, Tenn.
- New Orleans
- Norfolk, Neb.

**CHALLENGES**

The national program office ran into some challenges in its work.

- **The project failed to find new "Hillsboroughs" as hoped.** RWJF Vice President Paul Jellinek and the staff at The Access Project had different perspectives on this task. According to Jellinek, it was a disappointment that there did not appear to be any promising new models at the community level that The Access Project could identify. The Access Project staff, however, said that looking for such models was not their main task. They indicated that they did find smaller promising activities and leadership at the local level.

- **The project struggled with linking local organizations to state policy opportunities.** Program staff found this is difficult without an explicit strategy and dedicated resources to organized multiple local leaders within a state to take their wisdom and priorities into the state policy stream. In only one instance, the Texas
Health Access Project, did the program staff help local groups effectively work for a policy change at the state level (simplification of Medicaid applications).

- **The short time frame and the complexity of the undertaking was a challenge.** Program staff needed more time to develop relationships with local leaders, work out investments that honored local priorities and capacities, evaluate the results, and continue their efforts. In 2004, seven years after beginning the process, there are results from early investments, in terms of local access improvements and state policy change. At the end of the RWJF investment, those results were not possible.

- **Program staff learned that bringing in Boston-based consultants to communities did not always work.** Some local organizations resented the consultants who at times appeared to have the answers without understanding the nuances of the community they were supposed to help. "We were like Henry Ford. You can have any color car you want as long as it's black," said Mark Rukavina, deputy director of the program. "We didn't think we were doing it, but we were."

**Communications**

Program staff produced 61 reports including manuals, fact sheets and data guides and distributed about 30,000 copies. Program staff and consultants prepared local reports that addressed specific needs of communities, such as immigrant health access, numbers of uninsured and community health assessments. National reports addressed overarching issues about access as well as practical guides on collecting date and advocating for policy change.

During the project, it became clear that immigrants were having a difficult time accessing health care. To address this, The Access Project partnered with the National Health Law program to develop a manual and training curriculum on the issue of immigrant access to health care.

The National Health Law Program is a Los Angeles-based public interest law firm that works to improve health care for working and unemployed poor, minorities, the elderly and people with disabilities.

In addition to the publications that The Access Project produced, staff held regional and national meetings for local organizations and created a website with many of the publications available for download. The site receives an average of 6,000 unique visits a month. See the Bibliography for details.

**OVERALL PROGRAM RESULTS**

According to program staff, the most important accomplishment of The Access Project has been the creation of a national resource center for local organizations working to improved access to health care. Such as center did not exist before. The program also
identified local groups that were working in this area and created a network of organizations that had not known about one another and now can draw on one another's expertise.

Key accomplishments include:

- **Program staff inventoried the existence and activities of more than 1,200 coalitions and organizations addressing health care access issues in more than 600 cities and towns across the country.** The project surveyed more than 5,000 organizations and created a database of the organizations working on health access issues. It is housed on its website. Among those organizations documented was a community task force in Lynn, Mass., which was described in *Action Where It Counts: Communities Responding to the Challenge of Health Care for the Uninsured*, produced by The Access Project.

  — *Lynn is a working-class community whose residents have difficulty obtaining health care. A large percentage of its population lacks health insurance and the city has high rates of substance abuse, preventable hospitalizations, teen pregnancy, and communicable disease transmissions. To address these issues, community members founded the Lynn Health Task Force in 1985. Volunteers run the task force and members include community activists and representatives of advocacy organizations, legal services, unions, a community health center, an organization addressing teen pregnancy issues, senior groups, the NAACP and the visiting nurse association. When the only hospital in Lynn was purchased by a large nonprofit health system, the Lynn Health Task Force succeeded in obtaining a $15-million capital commitment from the health system as a condition for transfer of the hospital's license to the health system. This commitment is funding a wide range of services, including a primary care clinic, school-based health centers, substance abuse treatment programs and transportation services to the hospital. The health system also agreed to diversify the hospital's board of directors to better reflect the ethnic composition of Lynn.*

- **Program staff convened and trained more than 1,600 people in topics such as gathering and using data, health care access for immigrants, community benefits and participating in the public policy process.** Many local organizations ran on shoestring budgets and were largely staffed by volunteers. While they might run successful free clinics, they could lack the background or training to work with hospital officials or local politicians to make institutional changes to ensure that residents received health care. For example, *The Access Project* provided training on community benefits. While no universal definition of community benefits exist, it generally means services or goods that a health care institution provides without charge to the public to improve the health of the community. (For more on community benefits, see Program Results Report on ID# 028634.) Community benefits not only include free care provided by health care institutions, but services such as translation services for non-English speakers or a youth recreation program to
help reduce youth violence. Local community organizers may have been unaware of the community benefits being provided by their local institutions. They also may have had an adversarial relationship with the local hospital or health maintenance organization (HMO). The Access Project trainings included sessions on the benefits of working together with hospital and HMO administrators and examples of successful collaborations.

- **Program staff worked in 57 cities and towns in 29 states. The project forged a contractual relationship for intensive technical assistance and/or financial support with specific deliverables from both parties in these communities.** The project provided about $3 million in contractual assistance to organizations. This included, for example, helping organizations to devise ways to ensure that tobacco-settlement funds were used for improving health. Several sites monitored their local hospital's adherence to providing free care to people without insurance and worked to include citizen participation on hospital boards.

  - *The Oregon Health Action Campaign* worked with program staff to collect data and conduct surveys at four major nonprofit hospitals in Marion County (site of the state capital, Salem) and neighboring Polk County. The surveys revealed several barriers to health care for the uninsured including different free care policies at each hospital, poorly communicated policies, complicated application forms for free care and little or no access to translation services. As a result of the data, the four hospitals made a commitment to adopting a uniform free-care policy and creating simplified application procedures. The hospitals also made a commitment to better inform the community of their policies for free care and to improve their translation services.

  - *In Texas,* The Access Project staff and consultants gave financial and consulting support to three statewide policy and advocacy groups and 10 local coalitions working on access expansion. The local groups worked with state organizations in finding policy solutions to problems they faced. One of those problems was that people did not have time to apply for Medicaid. The application was complicated and lengthy, discouraging many eligible Texans from applying for the program. According to program staff, the work by the Austin-based Texas Health Access Project (one of three contract sites in the state) helped educate lawmakers on the importance of simplifying the Medicaid application process. The Texas Legislature approved a simplified application during the 2001 session. (See Appendix 2 for a listing of the consulting projects.)

- **Program staff conducted a community-based survey of more than 10,000 people who were uninsured in 24 communities across 19 states.** In 2000, The Access Project undertook the Community Access Monitoring Survey (CAMS) initiative with partners in 24 communities. The goal of the project was to document the experiences of the uninsured people who received care at health care institutions in the community. The local partners worked with Access Project research staff and consultants to create the face-to-face survey. Staff at community organizations
recruited and trained residents to conduct the interviews, which ranged in number from 150 to 190 per facility (either a safety-net hospital or community clinic). In all, participants completed more than 10,000 surveys. Each site received a customized report that outlined the survey results for its community. Groups used CAMS to persuade hospitals to reduce the debt owed by patients without health insurance, add translation services and publicize free care policies. Among the groups that participated was the We Care Network, which provides free specialty care in Tallahassee, Fla., whose work was summarized in the report Data + Organization = Change: Community-Based Participatory Research as a Strategy for Changing Health Care Policy.

— In Tallahassee, Fla., community advocates had unsuccessfully lobbied the county commissioners for years to pay for needed primary health care services. The two primary care clinics were operating beyond capacity and could not take on more patients. The area had a large number of people with incomes below the federal poverty guidelines. It also had high incidences of breast cancer, cervical cancer and infant mortality. The We Care Network had taken the lead in advocating for better access to primary care for the poor. Advocates for We Care argued that when people do not have access to primary care, they inappropriately use the emergency room (ER), driving up health costs for everyone. But until the Community Access Monitoring Access Survey, they did not have data to back up their claims.

"CAMS gave us information on how patients inappropriately access care at emergency rooms when they don't have emergency room needs," said Robin McDougall, program coordinator at the We Care Network. "That crowded our ERs so that people with true emergencies have to wait for care. The survey helped us develop the case that we needed for increased funding for primary care."

The county commissioners later passed a $1.4-million increase in property taxes that allowed the two primary care clinics to expand. The CAMS survey added legitimacy to the claims that advocates had been making for years, McDougall said.

"We achieved a landmark change. This is one of the tools that we used to create momentum for that change," she said. "The county commissioners had never acknowledged fiscal responsibility for primary care before. That shift was very dramatic for our community."

**EVALUATION FINDINGS**

The evaluator concluded that The Access Project had provided valuable technical assistance to many local organizations. The evaluator also found that the program did not focus enough on helping organizations sustain their efforts and make long-lasting policy changes.
The Access Project had helped these communities but they [Access Project staff] were lacking in several key areas that would ensure that these efforts would be sustained. Their technical assistance had been valuable to these tiny projects. The problem was that it hadn't raised itself above just working with these small projects. It hadn't developed itself into a way to sustain and expand these groups outward to affect policy for the long term as well as figure out a way for the whole project to provide more technical assistance to more groups—Dianne Barker, evaluator.

The evaluators reported the following key findings:

- **All community groups, regardless of policy sophistication, organizational maturity, national exposure or funding source, benefited from technical assistance provided by The Access Project.**

- **A centralized resource with national perspective, experience and networks is highly valued by local community groups seeking exposure to other approaches and solutions to the uninsured problem.** Publications, training sessions and direct consultation have been well received. The efficiency of "one-stop" shopping saves considerable time and energy for these often short-staffed community groups. There is some evidence that the predominantly Boston-based staff and consultant roster had limited experience in extensive on-site consulting, which occasionally hampered their interactions with the community groups.

- **Evaluators found some indication that local community groups can contribute to state and local policy processes to help improve health care access for the uninsured. The Access Project has been instrumental in helping several groups become recognized players in policy discussions and in providing tools and resources to affect local policy decisions.** Of the 13 projects interviewed, however, only two appear to have achieved the ultimate outcome in The Access Project model, a tangible policy change affecting health care access: Health Care Now (D.C.), which contributed to the retention of the Greater Southeast Hospital; and the Oregon Health Action Campaign, which has influenced the free-care policies of four hospitals. (The Austin-based Texas Health Access Project discussed above—which helped educate lawmakers on the importance of simplifying the Medicaid application process—was not one of the 13 sites the evaluator interviewed during the assessment.)

- **Sustainability issues must be addressed.** At the time of the evaluation, in June 2000, the national program office had yet to engage most contractees in long-term planning to assure their stakeholder position remains in place, to use other resources, including those available locally, to maintain policy gains they had achieved and to use their new tools to achieve local policy change. More recent experience showed that, despite the challenges of the recession, participation in The Access Project did assist these groups in maintaining their presence in the policy discussions and elevating their standing through the introduction of research evidence that they helped gather through the Community Access Monitoring Study.
LESSONS LEARNED

1. **A planning and developmental phase is necessary for any new start-up organization.** As indicated by program staff, a center may need two-to-three years to become fully operational and meet its objectives. The planning phase for this program (ID# 030634) was only six months long. "Having a planning phase…would have helped them think through how they were going to give technical assistance to a lot of groups or even a small number of groups and figure out different models for technical assistance that they could expand outward," said the evaluator, Dianne Barker. (Evaluator)

2. **A manageable number of clients appropriate to staff size should be determined prior to marketing services.** Providing customized technical assistance to many sites spread the staff thin. When the staff worked with sites, they figured out what types of assistance the organizations needed and provided these services rather than offering a limited number of types of assistance. (Evaluator)

3. **Audiences should be made fully aware of all technical assistance services available and should be provided with a menu of options for self-selection.** A restrictive list of services, at least initially, may serve to direct staff resources more efficiently. Having a limited menu of services also gives local organizations a choice, which many sites said that they would like. (Evaluator)

4. **A national center, because of its broad overview of local, state and national agendas, should be proactive in matching clients with existing services in their area.** In this case, *The Access Project* staff could have brokered relationships between the community organizations it was assisting and other RWJF grantees in the same state or community that also were working on access issues, such as local universities, hospitals and professional organizations. Each of these groups could have benefited from working with each other but probably needed Access Project staff to bring them together. (Evaluator)

5. **When national technical assistance centers begin working with community organizations, they should begin by making sure that both parties understand their goals and then map the steps to reaching those goals.** It is important to include short-term goals so that community organizations can celebrate successes while working toward longer-term change. (Evaluator)

6. **Contracts with local community groups need to be specific but simple.** Local community groups may need help preparing budgets and may need to receive the funds at the beginning of a project to pay for new staff and other expenses. These organizations are on tight budgets and often do not have the cash to carry expenses associated with new projects. (Evaluator)

7. **National projects such as these need to make sure that they do not become so focused on short-term issues that they lose sight of ensuring long-term gains and successes.** According to the evaluator, program staff became so involved in the day-
to-day work of helping community groups address immediate issues that they did not step back to look at how these groups would build an infrastructure and sustain it after the consultants left. (Evaluator)

8. **When providing technical assistance, it is not a good idea to try and create new community groups.** In one case, a group the program's staff helped create in Washington was resented by other local organizations and activities as being outsiders and not understanding the problems they faced. It made more sense, Access Project staff concluded, to work with established groups that already had credibility in the community. (*The Access Project Staff*)

**AFTERWARD**

RWJF staff decided not to seek reauthorization for *The Access Project* in part because, according to Program Officer Pamela Dickson, it was unclear whether the work was helping local efforts take root or making a difference in the broader RWJF goal of increasing the number of Americans who had access to health insurance. The RWJF-commissioned assessment also found that the impact of *The Access Project* was isolated in the select communities.

At the same time, RWJF was changing its priorities in funding. Among RWJF’s current priorities in the area of access to health care are reducing racial and ethnic disparities in health care and raising public awareness to ensure coverage for all Americans. Instead, RWJF granted the project a follow-up grant (ID# 042407) to complete pending projects and to further disseminate the project's findings.

As RWJF funding came to a close, *The Access Project* received another $535,600 in funding from foundations, medical centers and government. See Appendix 1 for list of other funders and contractors. The bulk of this funding is a three-year $500,000 grant from the U.S. Department of Health and Human Services, Health Resources Services Administration (HRSA). Through that grant, staff is collaborating on a federal effort to expand the number of community health centers. Staff works with communities around the country that are considering developing a proposal for funding a health center. Staff help them determine whether it makes sense to submit a proposal, and if so, provides assistance in preparing a proposal. With the same grant, staff also are helping communities submit proposals for another HRSA project called the Community Access Program, which provides funding for communities to set up integrated delivery systems to coordinate care for the uninsured and underserved populations.

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**Prepared by: Susan G. Parker**

**Reviewed by: Robert Crum and Molly McKaughan**

**Program Officers: Paul Jellinek and Pamela Dickson**
APPENDIX 1

Additional Funding

(Current as of the time of the grant; provided by the grantee organization; not verified by RWJF.)

Grants

- Annie E. Casey Foundation, $265,500
- Commonwealth Fund, $31,798
- Health Resource and Service, Administration's Bureau of Primary Health Care, U.S. Department of Health and Human Services, $500,000
- Health Resource and Service Administration, $130,656
- Quantum Foundation, $154,342
- Public Welfare Foundation, $50,000
- Rhode Island Foundation, $20,000
- UMass Medical Center/Worcester, $93,333

Contracts

- Abt Associates, $2,800
- Betah Associates, $14,000
- Blue Cross Blue Shield Foundation of Massachusetts, $7,251
- Medical Foundation, $10,351
- Quantum Foundation, $21,069
APPENDIX 2

(Current as of the time of the grant; provided by the grantee organization; not verified by RWJF.)

The Access Project - Site Contracts and Collaboration Descriptions

Arizona

Healthy Arizona Initiative
1240 N. 3rd Ave.
Tucson, AZ 85705-7472
(520) 792-9867
Mark Osterloh
The Access Project provided the Healthy Arizona Initiative with consultative support and assistance from experts in the public policy-making process, the tobacco settlement, tobacco prevention, and health care policy and financing. Staff assisted them in developing an action plan to support public education and dialogue on use of the tobacco funds for the purposes of improving health-related programs including tobacco control and access to health care.

University of Arizona Rural Health Organization
888 N. Euclid
Tucson, AZ 85721-0158
(520) 626-7862
Cindy Resnik
The University of Arizona-Rural Health Organization worked closely with The Access Project and The Healthy Arizona Coalition to conduct policy and regulatory analysis and prepare a case study of the coalition's work.

Arkansas

Partnership for a Healthy Community
200 S. University Ave., Suite 310
Little Rock, AR 72209
(501) 663-6080
Adrienne Nimmer
The Access Project collaborated with the Partnership for a Healthy Community to conduct an inventory of community organizations and programs.
California

Asian Health Services
818 Webster St.
Oakland, CA 94607
(510) 986-6837
Sherry Hirota

The Access Project and Asian Health Services in Oakland are developing an affordable health care package for the working poor and immigrant communities in Alameda County.

Domestic Workers Home Care Center
610 Gateway Center Way, Suite K
San Diego, CA 92102
(619) 263-7254
Fahari Jeffers, Esq.

The Access Project provided consultative support to the Domestic Workers Home Care Center to research and design models for providing insurance in low-wage industries.

District of Columbia

D.C. Community Health Advocacy Initiative
Center for Community Change
1000 Wisconsin Ave. NW
Washington, DC 20007
(202) 342-0594
Howard Croft

Working through the D.C. Community Health Advocacy Initiative, a project of the Center for Community Change, the project worked to galvanize and strengthen a consumer-led effort to participate in health policy and service delivery in the District.

Non-Profit Clinic Consortium
1100 17th St. NW, Suite 900
Washington, DC 20036
(202) 785-1894
Robert Cosby

The Access Project worked with the Non-Profit Clinic Consortium to enhance its capacity to conduct analysis and to disseminate current policy information to its membership.
Florida

Human Services Coalition of Dade County
260 N.E. 17th Terrace
Miami, FL 33132
(305) 576-5001
Daniella Levine
The Access Project worked in collaboration with the Human Services Coalition of Dade County on several projects. They included an evaluation of a telephone help line as an outreach tool for the coalition to serve as a clearinghouse for problems related to health access issues. The Access Project also prepared a report based on data from the Florida Health Insurance Study, which revealed uninsurance rates in Miami-Dade County exceed state averages for all income groups, all age groups and all work status categories.

Department of Health and Social Services
Tampa, FL 33602
(813) 272-5040
Cretta Johnson
The Access Project supported the Hillsborough County Health Care Plan in researching possibilities for expanding coverage to the working uninsured. The plan provides coverage to approximately 26,000 individuals living in households with incomes below the poverty level. (It also includes approximately 8,000 indigent inmates in the county's jails.)

Idaho

Idaho Community Action Network
1311 W. Jefferson St.
Boise, ID 83702
(208) 385-9146
Kevin Borden
The Idaho Community Action Network learned that Idaho is one of the few, if only, state in the country that attaches liens on the personal property of anyone who accesses the state's indigent care fund. With the assistance of The Access Project, the network mounted a statewide campaign to repeal the lien provision of Idaho's indigent care law and replace it with a free care law that would apply to all hospitals across the state.
Illinois

Campaign for Better Health Care
44 E. Main St., Suite 414
Champaign, IL 61820
(217) 352-5600
Jim Duffett
In Chicago, The Access Project worked with the Illinois Campaign for Better Health Care on a community benefits campaign targeted at two local hospitals. The group completed a free-care monitoring survey of the hospitals to determine how accessible charity care is for people who are uninsured.

Champaign County Health Care Consumers
44 E. Main St. Suite #208
Champaign, IL 61820
(217) 352-6533
Claudia Lennhoff
The Access Project collaborated with Champaign County Health Care Consumers on two projects. The first was to research, assess and document current hospital and clinic billing practices and their effect on access to health care for low-income individuals and families. The second project focused on a campaign to increase community benefits provided by local health care institutions.

Gilead Campaign of United Power for Action and Justice
4814 N. Winchester
Chicago, IL 60640
(773) 334-7281
Joshua Hoyt
The Access Project collaborated with the Gilead Campaign of United Power for Action and Justice on an effort to provide health care services to the citizens of Chicago who are uninsured. The Access Project provided support that enabled the Gilead Campaign to research, produce and disseminate reports describing the magnitude of the problem and solutions to address the needs of the uninsured.

Louisiana

Louisiana Health Care Campaign
P.O. Box 2228
Baton Rouge, LA 70821
The Access Project and the Louisiana Health Care Campaign worked with the Community Advisory Board members of Louisiana State University Hospital (formerly Charity Hospital) to increase the capacity of the community representatives on the board.

**Teche Action Clinic**
1115 Weber St.
Franklin, LA 70538
(318) 828-2426
*Carla Decuir*

The Access Project collaborated with the Teche Action Clinic to support the engagement of community members in a planning process and discussions on sustainability.

**Maine**

**Consumers for Affordable Healthcare**
P.O. Box 2490
Augusta, ME 04338-2490
(207) 622-7083
*Ann Woloson*

The Access Project supported the Maine Consumers for Affordable Health Care Foundation in an effort to survey small businesses about health insurance coverage.

**Massachusetts**

**Central Massachusetts Community Health Coalition**
360 W. Boylston St.
Worcester, MA 01583
(508) 852-5539

The Access Project collaborated with the Central Massachusetts Community Health Coalition to support the collection and analysis of data documenting access concerns.

**Lynn Health Task Force**
15 Trenton Terrace
Lynn, MA 01902
(781) 581-2665
*Leslie Greenberg*
With support from *The Access Project*, the Lynn Health Task Force conducted a strategic planning process to set program priorities for the next three years.

**Michigan**

**Michigan Organizing Project**
420 W. Summit Ave.
Muskegon, MI 49444
(616) 733-6198
*John Musick*


**Nebraska**

**Faith Regional Health Services**
1500 Koenigstein Ave.
Norfolk, NE 68701
(402) 644-7349
*Sally McKenzie*

*The Access Project* collaborated with Faith Regional Health Services in developing an action plan to support public education and dialogue on use of the tobacco funds for the purpose of improving health-related programs such as tobacco control and access to health care. The project also provided support for a public engagement process to involve multi-cultural populations in an effort to address issues raised through a community needs assessment survey.

**New Hampshire**

**New Hampshire Citizens Alliance**
4 Park St. Suite 403
Concord, NH 03301
(603) 225-2097
*Sam Mekrut*

*The Access Project* assisted the New Hampshire Citizens Alliance, a statewide, multi-issue group, in developing a written guide to help health care institutions and community groups better implement a new community benefits law passed late last year.
New Mexico

Valencia County Coalition for Families, Children and Communities
P.O. Box 2598, 1850 Main St.
Los Lunas, NM 87031
(505) 865-0345
Evangeline Pena-Jenks
The Access Project collaborated with the Valencia County Coalition for Families, Children and Communities on a community access monitoring pilot survey. The survey assessed the experience and perceptions of those without insurance regarding access to health care in their community.

New York

Long Island Coalition for a National Health Plan
P.O. Box 4227
Great Neck, NY 11023
(516) 483-1110
Donna Kass
The Access Project collaborated with the Long Island Coalition on a National Health Plan on a local assessment of access to care.

North Carolina

North Carolina Fair Share
530 N. Pearson St.
P.O. Box 12543
Raleigh, NC 27605
(919) 832-7130
Lynice Williams
The Access Project collaborated with North Carolina Fair Share on a community access monitoring pilot survey.

Ohio

Legal Aid Society of Greater Cincinnati
901 Elm St.
Cincinnati, OH 45202
(513) 241-9400
Trey Daly

*The Access Project* collaborated with the Legal Aid Society of Greater Cincinnati on several projects including a community access monitoring pilot survey. In addition, Legal Aid conducted a free care monitoring survey of five hospitals in Cincinnati to better understand to what extent those hospitals offer free care.

**Universal Health Care Action Network (UHCAN)**

1015 E. Main St., Room 302
Columbus, OH 43205
(614) 253-4340

*Cathy Levine*

*The Access Project* collaborated with UHCAN-Columbus on an effort to expand access to care for vulnerable constituencies, including linguistic minorities. Program staff trained community members about community benefits and helped them conduct a free care monitoring survey of hospitals to determine the current level and accessibility of free care.

**Oregon**

**Oregon Health Action Campaign**

3896 Beverly Ave. NE, #J6
Salem, OR 97305
(503) 581-6830

*Ellen Pinney*

*The Access Project* collaborated with the Oregon Health Action Campaign to evaluate access barriers for immigrant populations in Marion and Polk Counties.

**Pennsylvania**

**Consumer Health Coalition**

650 Smithfield St., Suite 2390
Pittsburgh, PA 15222
(412) 456-0973

*Geoff Webster*

*The Access Project* supported the efforts of the Consumer Health Coalition and a community-based organization in Pittsburgh called the Bloomfield Garfield Corporation to improve access to health care at local hospitals. Program staff provided an initial training on community benefits for the group.
Mon-Valley Unemployed Committee
120 Ninth Ave.
Homestead, PA 15120
(412) 462-9962
Paul Lodico
The Access Project provided the Mon-Valley Unemployed Committee with consultative support and assistance in developing an action plan to support public education and dialogue on use of the tobacco funds to improve health-related programs including tobacco control and access to health care.

Rhode Island

Ocean State Action Fund
99 Bald Hill Rd.
Providence, RI 02920
(401) 463-5368
Marti Rosenberg
The Access Project collaborated with the Ocean State Action Fund on two efforts. The first involves monitoring the state's effort to cut back the RItc Care Medicaid Managed Care Program. The second supported Ocean State Action's ongoing negotiations with several key hospitals and regulators to obtain commitments for community benefit programs, with an emphasis on charity care and interpreter services.

South Carolina

South Carolina Coalition of Black Church Leaders
P.O. Box 3076
Columbia, SC 29230
(803) 779-4528
Rev. Randall Jackson
The Access Project provided the South Carolina Coalition of Black Church Leaders with consultative support to assist them in developing an action plan to support public education and dialogue on use of the tobacco funds to improve health-related programs including tobacco control and access to health care.

Tennessee

Latino Memphis Conexion
69 N. Cleveland
Memphis, TN 38104
The Access Project worked with Latino-Memphis Conexion on a variety of mutually supportive efforts that have helped build the capacity of the organization overall, with particular emphasis on developing its capacity as a leader in health access expansion.

**Texas**

**Southeast Texas Health and Human Services Networking Group**
Lamar University  
Department of Nursing  
P.O. Box 10081  
Beaumont, TX 77710  
(409) 880-8820  
*Sherry Tutt*

*The Access Project* provided consulting services to a community coalition for an assessment of the indigent care and hospital community benefits provided to those without insurance.

**Project Bravo**
4838 Montana St.  
El Paso, TX 79903  
(915) 562-4100  
*David Morales*

*The Access Project* provided Project Bravo with consultative support and assistance to assist it in developing an action plan to support public education and dialogue on use of the tobacco funds to improve health-related programs including tobacco control and access to health care.

**Texas Health Access Project**

**ProTex**
1506 S. First St.  
Austin, TX 78704  
(512) 441-3003  
*Tricia Forbes*

*Center on Public Policy Priorities*
906 Lydia St.
Texas Alliance for Human Needs
1016 E. 12th St.
Austin, TX 78702-1056
Kerrin Lemieux
The Access Project gave financial support to these statewide groups to provide ongoing assistance to local groups (several of which received Access Project support as well) participating in the Texas Health Access Project. This support was intended to strengthen the connection between state policy and local needs. In particular, the statewide groups provided local groups with up-to-date information on the work of the state's Blue Ribbon Task Force on the uninsured; analysis of policy proposals being presented to and discussed by the task force; and assistance in presenting their findings to the Task Force, state legislators, and county officials within the context of the broader Texas policy environment. One priority of the of the project was to educate lawmakers on the importance of simplifying the Medicaid application process. In 2001, the Texas Legislature approved a simplified application.

Wisconsin

Community Advocates
4906 W. Fond DuLac Ave.
Milwaukee, WI 53216
(414) 449-4777
Ken Germanson
The Access Project collaborated with Community Advocates in the development of a Health Advocacy Certificate Program. The program is designed to engage and further educate adults (particularly parents) in moving forward community change agendas to improve access to, or quality of, health care in a particular local institution or mobilize a community base to effect change in the health care system through legislation and policy.
Other work of The Access Project around the country:

*The Access Project* has contracted with other sites around the county to work on specific projects. They include:

**Community Access Monitoring Survey**
Campaign for Better Healthcare
1325 S. Wabash
Chicago, IL 60605
(312) 913-9449
*Anthony Lowary*

**Capital Medical Society**
1204 Miccosukee Rd.
Tallahassee, FL 32308
(850) 877-9018
*Cheryl Phoenix*

**Central CA Legal Services**
2014 Tulare St., Suite 600
Fresno, CA 93721
(559) 441-1611, ext. 113
*Manuel Romero*

**Legal Aid Society of Cincinnati**
901 Elm St.
Cincinnati, OH 45202
(513) 241-9400
*Trey Daly*

**HealthCare Centers in Schools**
6650 Cedar Grove Dr.
Baton Rouge, LA 70812
(225) 355-9759
*Geraldine Brewer*

**House Next Door**
804 N. Woodland Blvd.
DeLand, FL 32720
(904) 734-7571
*Nita Schmellick*

**Human Services of Dade County**
1920 Biscayne Blvd.
Miami, FL 33132
(305) 576-5001
*Terry Coble*

**Idaho Primary Care Association**
4948 Kootenai St.
Boise, ID 83705
(208) 345-2335
*Becky Robinson*

**Lake Cumberland District Health Department**
500 Bourne Ave.
Somerset, KY 42501
(606) 679-4466
*June Burton*

**LifeLong Medical Care**
P.O. Box 11247
Berkeley, CA 94712
(510) 704-6010
*Linda Collins*

**Memphis Latino Conexion**
2770 Madison Ave. #6
Memphis, TN 38111
(901) 327-3915
*Kelly Duke*

**North Berkshire Community Coalition**
85 Main St., Suite 332
North Adams, MA 01247
(413) 663-7588
*Al Bashevkin*

**North Carolina Fair Share**
2350 Grant Ave.
Raleigh, NC 27608
(919) 834-1704
*Claudia Egelhoff*

**NW Bronx Community & Clergy Coalition**
103 E. 196th St.
Bronx, NY 10468
(718) 655-1054
*Mitchell Andrews*

**Oregon Health Action Campaign**
3896 Beverly Ave. NE #36
Salem, OR 97305
(503) 581-6830
*Ellen Pinney*
Immigrant Health Access

The *Access Project* supported efforts by organizations/coalitions in Miami and southeast Texas to increase their capacity to improve access to health care in local immigrant communities.

**Florida**

**Dade County Human Services Coalition**
260 N.E. 17th Terrace
Miami, FL 33132
(305) 576-5001
Terry Coble

**Florida Immigrant Advocacy Coalition**
3000 Biscayne Blvd., Suite 400
Miami, FL 33137
(305) 573-1106 x1430
Tom Zamorano

**Haitian Youth of Tomorrow**
1348 N.E. 147th St.
Miami, FL 33161
(305) 949-8239
Caroline Paul

**Texas**

**Casa de Proyecto Libertad**
113 N. First St.
Harlingen, TX 78550
(956) 425-9552
Rogelio Nunez
The Access Project contracted with the Massachusetts Immigrant Refugee Advocacy Coalition and two of their partner organizations in New Jersey and Illinois to conduct local symposia. The goal of these symposia was to bring together staff in immigrant community-based organizations, staff at public agencies serving immigrants, and staff from health care provider agencies to improve immigrant access to health care in their states. The symposia focused on disseminating information about federal regulations and health care services for which immigrant populations are eligible. The following agencies were involved in the project:

**Texas Rural Legal Aid**
316 S. Closner
Edinburg, TX 78539-4561
(956) 383-5673
Renee Trevino

**Illinois Coalition for Immigrant and Refugee Rights**
36 S. Wabash Ave., Suite 1425
Chicago, IL 60603
(312) 332-7044
Eric Hillebrand

**Massachusetts Immigrant Refugee Advocacy Coalition**
105 Chauncy St.
Boston, MA 02111
(617) 350-5487
Tyler Moran

**New Jersey Immigration Policy Network**
976 Broad St.
Newark, NJ 07102
(973) 622-6448
Helene Tobin
BIBLIOGRAPHY

(Current as of date of the report; as provided by the grantee organization; not verified by RWJF; items not available from RWJF.)

Reports

Note: All of these reports also appear online.


**Survey Instruments**

The Access Project, *Community Access Monitoring Survey.* Somerton, AZ; Fresno, CA; Berkeley, CA; Tallahassee, FL; DeLand, FL; Miami; Albany, GA; Boise, ID; Chicago; Somerset, KY; Baton Rouge, LA; North Adams, MA; Raleigh, NC; Las Vegas; Bronx, NY; Cincinnati; Cleveland; Yachats, OR; Memphis, TN; Houston; Austin, TX; Alexandria, VA; and Huntington, WV, fielded May–August 2000.

**Sponsored Workshops**


"Getting and Using Data for Improving Health Care Access (Advanced)," July 1, 1999, Chicago. 50 people attended.


"The Texas Health Access Project (THAP) Initiative Networking Forum," December 5–6, 2000, Austin, TX. 30 people attended.


**Grantee Websites**

[www.accessproject.org](http://www.accessproject.org) includes information about The Access Project, publications that can be downloaded and links to other resources. Boston: The Access Project.