Annual Report
Community Advisory Committee
Missouri Foundation for Health
Approved, April 3, 2003

SUMMARY:

1. This report complies with the Community Advisory Committee's (CAC) obligation to advise the Board of Directors (BoD) of the efficacy of the Missouri Foundation for Health (MFH) programs at least annually.
2. In 2002 MFH matured from an organization-building phase into a full-fledged grant-making organization.
3. MFH has gone beyond pro forma compliance with its Sunshine Law obligations to actively involve public interest and input through a series of nine public forums around the state.
4. The BoD, CAC, and staff successfully model the ethnic diversity of the State.
5. Much talent, dedication, and time have been exhibited and invested by the volunteer members of the BoD and CAC. The staff has shown itself to be talented, professional, and hard-working.
6. The BoD showed collegiality and maturity through a difficult change in leadership and the incorporation of new board members who replaced resigned or expired members.
7. Policies adopted for grant-making were thoughtful and resulted from both planning and adjustment instructed by the experience of processing and making grants.
8. MFH is owed high praise for its progress, openness, accountability, and evolution, but a number of problems/challenges confront it.
    - Regarding its mission to improve health services to underserved people it is still feeling its way. Its advocacy role is not fully developed.
    - Despite its policy to not replace lost government funds, it is inevitably drawn into that arena and should adhere to its policy more closely.
    - How to get proportional and meaningful input and participation from underserved populations in addition to that of the sophisticated grant-making community is a special challenge for MFH because of its mission.
    - Public input (from forums and other sources) is valuable but can also be self-interested or peripheral to MFH's mission. It should be evaluated against the MFH mission before being incorporated into programs or publications.
    - "Core grant" requests should be reviewed more closely to ensure that they actually increase health care services to underserved people.
    - A next major challenge, once grants have been awarded and implemented, will be evaluating their effectiveness in relation to MFH's mission.
    - In 2002 the BoD rejected CAC nominations to the BoD as three candidates per vacant slot. Instead it chose to accept the nominations as a block. This

decision discounted the careful decision-making of CAC and showed the potential for strain between the two entities.

- CAC members are appointed by the Attorney General. There have been four vacancies for several months which should be filled quickly.

I. General Observations:

> *"The Community Advisory Committee shall be responsible for advising the Board on no less than an annual basis as to the efficacy of the Foundation's programs from the communities' perspectives as well as the communities' priorities for future efforts of the foundation…"* (Section 5.1.5, MFH Bylaws)

In 2002 the Missouri Foundation for Health (MFH) matured from an organization-building phase into a fully-staffed, functioning foundation. It is led by a talented, competent, and dedicated Board of Directors (BoD) and impressive staff. It awarded grants for the first time in 2002 worth $9.7 million to 78 private nonprofit health organizations in its service area (84 counties and the City of St. Louis).

The BoD has invested many hours of voluntary, uncompensated time managing the complex affairs of MFH. It showed collegiality and depth through a difficult change of leadership which was accomplished without rancor. The integration of new board members resulting from resignation or expiration of terms has been accomplished smoothly.

By design MFH is subject to the sunshine laws of the state, and has welcomed the public to all meetings that do not involve sensitive subjects like personnel and finance. It has gone beyond mere compliance with the sunshine laws by reaching out to invite public input through a series of nine successful public forums held throughout the state in conjunction with the Community Advisory Committee. As a result of those forums it issued a report to the public entitled *"Community Voices"* outlining regional community health concerns. At each of the nine public forums held throughout the service area there were from 50-100 people attending and media coverage as well that extended MFH's visibility beyond the meeting place. These meetings increased public knowledge and the number of proposals received.

II. Grant Making

The public face of the Missouri Foundation for Health (MFH) is the grant process and awards. It is critical for public confidence that this process is and appears to be fair, targeted toward improving health care of underserved populations, and proportionately distributed, geographically and ethnically.

There is a three-step process for handling grant proposals.

1) MFH staff receives and reviews proposals, asks grant applicants clarifying questions, and writes a summary of the grant with the staff's recommendations for approval or rejection.

2) The grant and staff recommendation are assigned to a committee of the Board of Directors (BoD), the Programs and Grants Committee (P&GC). The PG&C (consisting of BoD and Citizens Advisory Committee [CAC] members) makes a judgment that may or may not agree with staff and forwards its recommendations to the BoD. Upon approval, P&GC also votes to prioritize its recommendations so that the highest priority proposals receive funding.

3) BoD subsequently approves or modifies the recommendations of the P&GC.

Meetings of the P&GC and BoD are subject to the Sunshine law and are open to the public. Members of P&GC, BoD, and staff are subject to MFH ethics policy and are required to recuse themselves from discussion or decision-making on grant applicants with whom they have business or personal relationships.

Thus, structures, policies, transparency, and checks-and-balances are in place that seems to ensure that the process is indeed fair.

There have been several grant applications that were brought directly to the BoD -- a Robert Woods Johnson Foundation request to partner in a universal health care promotion and a request from the University of Missouri Medical Center Trauma Unit. The Board properly referred both of these back to the P&GC (which recommended one but not the other).

A test of public confidence is the number of grant applications received and the numbers who showed up at public forums throughout the state. 527 proposals, were received in 2002, a number which strained the processing capacity of the staff and P&GC.

Applications in 2002 requested a total of $161.9 million. 239 were processed, and 78 projects were approved with a total value of $9.7 million. That left a backlog of 299 carried over to 2003.

Although staff spent several hours per proposal, the large number allowed P&GC only a few minutes of discussion per proposal. We note that MFH has taken steps to make the process more orderly by considering policy changes that would streamline the handling of grants, especially those with particularly lower amounts of funding.

Policy-making has been part of the grant-making process from the beginning and has continued to evolve. The BoD approved three initiative areas that it would consider for awards: 1) Prevention and services improvement for diabetes and cardiovascular disease; 2) "Strengthening the Core" which assist agencies with equipment and other capacity building assets; and 3) Services Improvement which allow an agency to improve or expand the services it currently provides. MFH remained open to a fourth undefined area, 4) Unsolicited grants.

Table 1: Types of grants approved

	Approved Projects			
Types of requests	#	% all	$million	% all
Strengthen Core	58	74	7	72
Service Improvement	15	19	1.9	20
Cardio/diabetes	5	6	0.8	8
Unsolicited	0	0	0	0
TOTAL	78	100	9.7	100

As noted in the Summary above, Core grants were the most popular submissions and most likely to be funded. Nonetheless they pose a challenge for MFH. It is surely understandable that hard-pressed nonprofits are grateful for this new opportunity to upgrade their assets and capacity, and the Core grants gave MFH an opportunity to jump-start its grant-making. But it is MFH's duty to ensure that its grants actually improve and extend health services for underserved people. While some of the Core grants surely do, it is not clear that all do.

The difference between "Core" and "Service Improvement" grants is not clear. There appears to be overlap between the two categories.

Other policies differentiate social services related to health care from social services peripheral to health care. (A complete list of policy enactments appears in a document entitled *"2002 Activity Summary"*, January 2003, prepared by staff as source information for this report.)

MFH has approached policy-making sensibly from both a planning and experiential perspective. The policies adopted seem appropriate to the mission of serving underserved populations and making the process fair and transparent.

III. Other problems and challenges

1) Role Definition : MFH's role in advancing health care for uninsured and underinsured people has not yet been clearly defined. Its granting practices to

date have typically provided additional funding for worthy efforts in a troubled and inefficient health care system.

2) Health Policy Reform: While MFH has decided that it must move into the policy arena – the only area with the potential for gaining wide coverage for underserved populations -- it is still feeling its way forward. It has, however, helped fund a Robert Woods Johnson initiative to increase public understanding of the growing number of uninsured persons and just recently recommended funding for a state budget policy initiative.

3) Replacing Public Funding: Despite its policy of not replacing lost government funds it is inevitably drawn to funding painful retreats by state and federal governments. While it is not clear how much of the $9.7 awards went to slashed government programs, some certainly did because the human cost of not funding them was too high. However, no foundation has the funds to supplant lost government health programs and any MFH rescue can only be short term. An alternative to funding slashed government programs is an effective advocacy program which could strive to increase or at least maintain current funding.

4) Role of Public Input: The input one gets from the public through forums or the grant proposals themselves are often valuable and deserve thoughtful attention, but they mostly come from established service agencies, and there is always a degree of self-promotion. Testimony often originates from those most aggressive and skillful at grant writing. While such agencies deserve a respectful hearing, they are nonetheless components of a seriously flawed health care delivery system. Such input should be evaluated and prioritized against the broader MFH mission before it is incorporated into its program activities or its publications.

   Reaching, hearing, and responding to needy populations which are not part of the grant seeking establishment is a special duty of MFH.

   How to incorporate validated public input into the grant making process is still not clear. Presumably all members of the BoD, P&GC, and staff read and absorbed the report *"Community Voices"* but nonetheless how much the input does or should shape actions is not clear. *"Community Voices"* tended to list the input from community forums in an attractive format rather than evaluate and prioritize the input against other sources of information

5) Evaluation: A next major challenge to MFH will be evaluating the programs it has funded in 2002. It will require a new set of policies, practices, and special skills. In particular, a set of indicators should be developed to allow MFH to determine whether positive changes are occurring over time in response to the

programs funded. It will be especially important for the evaluation process to be objective and independent of the grant-making process.

6) Role of the CAC: The CAC is an unusual entity whose role has not yet fully evolved. Its clearest function is screening and nominating members of the BoD and it has carried out this role three times upon the expiration of terms or resignation of directors (who serve overlapping three year terms). Another more complex duty is to provide community input and critical oversight.

   A disagreement between CAC and the BoD in 2002 was whether BoD would accept nominations to the board in the format of three nominees per vacancy or only accept nominees as a group for the BoD to select from. Despite an appeal from the Attorney General's office, BoD chose to accept the nominees only as a block and to reject the slotting of nominees. By doing so it discounted the efforts and decisions of the CAC and hampered its fundamental role of ensuring the geographic and demographic representation on the MFH board that preserves the public's confidence in, and integrity of the grant-making process . Even though CAC chose not to contest the BoD decision, it may nonetheless slot future nominees and expect the BoD to honor its decision.

   Four CAC vacancies have persisted for several months, thus increasing the work load of the remaining volunteer members. Both the unusual nature of its task and the persistent vacancies has restrained the evolution of the CAC.

7) Expanding Health Care Delivery: Reaching, hearing, and responding to needy populations which are not part of the grant-seeking establishment is a special duty of MFH. It must constantly ask "What health care needs of our target population are not being met by the existing system, and what we can do to directly meet those needs."

<u>Conclusion</u>: Given the complexity of its task and the context of the political , social and economic environment in Missouri and the country, MFH has done an excellent job establishing itself organizationally, building public confidence, getting grants to carefully selected nonprofit organizations, and moving the vision of better health care for underserved people forward. The CAC observes considerable good will, intention, and action on the part of BoD and staff to address real problems and regularly improve MFH's performance.