OREGON SOCIETY OF HEALTHCARE EXECUTIVES

OSHE Graduate Student Case Competition
Spring 2019

Guidelines

- **One team** consisting of three to four graduate students will represent each school; please contact the advisor listed below for your school for further information Student teams may not exceed 4 members
- Teams may draw on outside resources, with the exception of program faculty.
- Teams will prepare a **Strategic Management Plan and Presentation.**
  - Teams' written materials are due on **Thursday, April 25, 2019** prior to the competition. These materials, must include a 12-page, double-spaced strategic plan consisting of:
    - A 2-page executive summary; and,
    - 10-page narrative, inclusive of all tables/figures.
    - Page limits do not include cover or references and must be presented in APA format.
- **Teams will present** their Strategic Management Plans to the panel of OSHE judges and members at the Spring Meeting on May 2, 2019.
  - Each team should bring a flash drive containing their presentation;
  - A presentation of no more than 20 minutes, followed by a 10 minute Q & A.
  - At least 3 students must actively participate in the presentation.
  - **Cash prizes** will be awarded to the top three competing schools First prize $1,500, second prize: $1,000, third prize: $500
  - Teams are free to decide how participation/prize money is distributed.
- An impressive **panel of judges** from the Oregon Society of Healthcare Executives membership will be evaluating the strategic management plan and presentation.
- Please note that permissions have been purchased from Harvard Business School Publishing by OSHE for this educational purpose. The case information may not be shared or posted outside of teams.

Kennedy School of Government
Case Program C16-06-1852.0

HKS342

Health Care & the Isolated Poor in the Lower Rio Grande Valley: The Quest to Make a Lasting Change

Introduction

In April 2005, five administrators from the nation's largest domestic health philanthropy, the Robert Wood Johnson Foundation, traveled from Princeton, New Jersey to the Texas-Mexico border to visit one of their grant recipients. RWJF had awarded a $3.8 million startup grant in December 2001 to "IHOS" (Integrated Health Outreach System), a program designed to improve health care access for thousands of residents living in impoverished, isolated settlements just north of the border in the Lower Rio Grande Valley. The grant was due to expire in November 2005—a once-distant precipice grown perilously close.

The leaders of the IHOS project had struggled through four difficult years, getting the program up and running. They now wanted to keep it going—albeit with a slightly different structure and a new approach that blended direct services with community organizing and planning. The biggest immediate problem was funding. RWJF, like many of its philanthropic counterparts, had traditionally provided the seed money to start new programs, but rarely the ongoing funds to sustain them over time; after all, no foundation wanted a static portfolio. What's more, during the four-year term of the IHOS grant, the Robert Wood Johnson Foundation had undergone a strategic reorganization that had significantly altered its approach to charitable giving. Under its previous approach, RWJF had given grant awards to a broad array of small "safety net" programs—like IHOS—that provided direct services to people who fell through gaps in the existing health care system. Now the Foundation was moving away from such projects in favor of broader, systemic, collaborative efforts to address the root causes of poor health in vulnerable populations. In other words, IHOS was no longer a good "fit" for RWJF. The IHOS project managers saw little hope of receiving another grant from the Foundation.

This case was written by Pamela Varley, case writer at the John F. Kennedy School of Government, Harvard University. It was sponsored by Christine Letts, Associate Dean for Executive Education and Rita E. Hauser Lecturer in the Practice of Philanthropy and Nonprofit Leadership. It was funded by a grant from the Robert Wood Johnson Foundation. The John F. Kennedy School of Government takes sole responsibility for the content of this case. (1106)

The RWJF visitors arrived with a more complicated outlook, however. It was true that the Foundation was moving away from funding programs like IHOS. At the same time, the RWJF administrators recognized that the plight of the IHOS clients was extreme and knew that resources on the border were scarce. They did not want to see IHOS go out of business; too many social service projects on the border popped up, struggled for a few years, then disappeared without a trace. They also did not want to fund IHOS indefinitely. So RWJF made a proposal: the Foundation would extend IHOS' funding for another three years—with a caveat. IHOS would have to use part of the grant to make a major, determined effort to ensure its own financial "sustainability."

This was an ambitious mandate for an organization that had struggled just to provide basic program services. Could IHOS administrators find a way to meet the new RWJF demand and also take the program in the direction they favored—one aimed at empowering *colonia* residents to advocate effectively for safer, healthier living conditions and better health care access? If they managed it, what would the "new improved IHOS" look like?[1]

The 'Wild and Vivid' Lower Rio Grande Valley

The Rio Grande River marks the southern border of Texas and—after a northward detour at Big Bend—plunges with steady determination southeast from the Amistad Reservoir to the Gulf of Mexico. At the southernmost end of the state's distinctive South Texas "v" is a 4,200 square mile, four-county area called the Lower Rio Grande Valley (see Exhibit 1).[2] At once an amalgam of north Mexico and South Texas cultures, yet unmoored to either one, the Valley was, in 2000, home to about a million residents—73 percent of Mexican descent and 14 percent Hispanic with roots elsewhere in Latin America. Census data showed that 28 percent of Valley residents were foreign-born in 2000 (compared to 14 percent statewide) and 36 percent were living below the poverty line in 1999 (compared with 15 percent statewide). These figures were high by any standard, but many border experts suspected that even so they underestimated both the number of immigrants and the extent of poverty in the area.

In the early 2000s, nonprofit health and social service providers in the Valley were also poor, struggling, and existed in what Jim Burdine, grant administrator for the IHOS program, describes as a "culture of organizational poverty." A telling dynamic in the Valley was the fierce competition among community clinics and other medical providers for Medicaid patients. Elsewhere in the country, many providers avoided treating Medicaid patients because, compared to private insurance, Medicaid reimbursement rates were low. But in the Valley, where so many

---

1 For a glossary of the key organizations named in this case, see Exhibit 2.

2 The region is not, in fact, a valley; it is a delta or, arguably, a flood plane. It was named the Lower Rio Grande Valley in error or, perhaps, in a minor act of deception, on the theory that the name made it sound more inviting. (Wikipedia.org, August 9, 2006.)

people were indigent, uninsured, and Medicaid-ineligible, Medicaid patients were actually viewed as a "cash cow." Some service providers reportedly even paid "kickbacks" for referrals of Medicaid patients.

On the other hand, not all parts of the Lower Rio Grande Valley were poor. By the early 2000s, frontier ranching had given way to a service-based economy in the Valley. Within a few miles of some of the most unsafe, marginal living conditions anywhere in the United States were thriving commercial areas, like the main drag in McAllen, with its built-overnight, boomtown spirit.[3] Further complicating the economics of the region were the off-the-books infusions of cash that came from the illegal drug trade, a major part of the South Texas economy. Perhaps owing to the combination of poverty, drug money, and money-laundering, the Valley was susceptible to a particularly brazen kind of lawlessness and "an infamous tradition of political chicanery," in the words of one newspaper report.[4] Locals were always interested (yet unsurprised) to hear the latest news of investigations, arrests, and indictments. In a single article in March 2004, the Houston Chronicle summarized a recent spate of incidents in the Valley—a list that included a judge indicted for embezzlement, police officers brought up on drug trafficking charges, a jail administrator accused of sexual assault, and a high school history teacher arrested for privately dealing in Israeli-made military assault rifles.[5]

The Valley was, in other words, a little larger than life—"a wild and vivid land," according to historian William H. Goetzmann. It was also a difficult place for an outsider, even one with the best of intentions, to navigate without the risk of stepping wrong.

The *Colonias*[6]

The ramshackle housing settlements known as *colonias*, located just north of the Mexican border, began to spring up in the 1950s in all the border states, but by the early 2000s they were, by a good margin, most prevalent in Texas. According to official estimates, a half million Texans lived in *colonias*—and some scholars argued that the true number was much higher. Three quarters of the *colonias* in Texas were located in the Lower Rio Grande Valley (see Exhibit 3). These settlements of homemade houses (in various stages of completion) were occupied primarily by Mexican farm workers and other immigrants or their descendants. Individual *colonias* ranged dramatically in size,

---

3 In 2005, McAllen's MSA, or metropolitan statistical area, would be listed as the country's fifth fastest growing.

4 "Valley struck by long wave of corruption; Public officials, teachers among those convicted," by James Pinkerton, *The Houston Chronicle*, March 1, 2004.

5 Ibid.

6 The Kennedy School Case Program has also published a three-part case study about a housing initiative in the *colonias*. The case is called "Self-Help" Housing on the Texas-Mexico Border." Part A is subtitled, "The Complications of Good Fortune for a Small Nonprofit Organization" (1478.0). Part B, "The Frustrations of a State-Nonprofit Partnership" (1479.0). Part C, "Tackling Big Problems with Federal Dollars and Small Nonprofits" (1480.0). As a companion piece to Parts A and B, the Case Program has also published a 7-page background note about housing issues in the *colonias* (1478.3 or 1479.3).

from small settlements of just 10 to 20 lots to large ones of several thousand. Typically, the settlements were isolated from the mainstream border towns and lacked such basic residential infrastructure as water, sewer, electricity, and paved roads.

Beginning in the 1990s, federal, state and local governments began bringing water, sewer and other residential infrastructure to some of the more established *colonias*, transforming them by degrees into lower middle class subdivisions. But by the early 2000s, many older *colonias* were still without such services. What's more, new *colonias* were steadily appearing along the border, and the newest among them were often enclaves of extreme poverty. *Colonia* residents typically installed homemade septic systems—often leaky. In addition, many families made do without running water, refrigerators, or stoves. Without such basics, it was virtually impossible to maintain healthy levels of hygiene or nutrition. (See Appendix 1 for more detail on the *colonia* phenomenon.)

The Health Problems of the Colonias. Not surprisingly, public health studies of *colonia* residents showed a poor health profile, with disproportionately high rates of hypertension, high cholesterol, arthritis, cervical cancer, stomach cancer, pancreatic cancer, Hepatitis A and tuberculosis. A Centers for Disease Control (CDC) study estimated that as many as 30 percent of *colonia* residents had diabetes—and that perhaps a third of these cases were undiagnosed.

The number of uninsured residents was also disproportionately high in the Valley. A study of Hidalgo and Starr Counties calculated the uninsured rate at 41 percent, compared to 15 percent nationwide. Before 2001, *colonia* residents had often returned to Mexico for free medical care. With the increased border security after the September 11, 2001, terror attacks, however, undocumented residents no longer dared go to Mexico for fear of being unable to return.

A few clinics and ad hoc health initiatives in the area could, on a small scale, provide outpatient care to *colonia* residents, but in the words of one study, these were "an often confusing combination of state and federal programs, many of which come and go depending on the political and economic climate."[7] *Colonia* residents tended to go untreated or went to local hospital emergency rooms which could not legally turn them away. Hospital administrators in the Lower Rio Grande Valley watched in frustration as their expensive emergency departments served some patients who needed only routine clinical care, and others whose health was past repair because they had not received simple preventive care in the past. In fact, mortality rates for diabetes and heart disease in the Valley were twice the national average. The mortality rate for cervical cancer in the Valley was the worst in the nation. Daniel McLean, chief executive for the South Texas Health System, which owned the McAllen Medical Center, told a researcher, "I have people come in here everyday—pregnant women who wait in the parking lot until their babies are crowning

[7] "Building Capacity for Population Health Improvement in *Colonias* Using a Community Health Development Approach," a grant application prepared by Texas A&M's Center for Community Health Development, in the School of Rural Public Health, 2004, p. 5.

and then come into the emergency room, diabetics who need amputations, people who weigh 300 pounds and have severe hypertension and a history of heart attacks—and they all say, 'Fix me.'"[8]

Early Efforts

The Robert Wood Johnson Foundation took an interest in sponsoring a program to bring primary and preventive health care to *colonias* in the Lower Rio Grande Valley as early as 1998, when a North Carolina-based organization[9] first proposed such a project. Ill will soon developed between this group and potential "partner" organizations on the ground in Hidalgo County, however, and RWJF reluctantly backed away from the project. But Texas health care advocates—in particular, Frank Cantu, the border health field representative for the federal Health Resources and Services Administration and Ciro Sumaya, the incoming dean of the Texas A&M School of Rural Public Health—appealed to the Foundation not to give up, altogether, on the idea of a border health project in Hidalgo County. The Foundation therefore agreed to give special consideration to a new proposal, under development by a group of health care providers in the Valley, but this group soon came to loggerheads over how to divide program funds and responsibilities.

Concerned not to lose the opportunity, Sumaya enlisted the help of Jim Burdine, an incoming faculty member at the School of Rural Public Health, in crafting the proposal. Burdine had worked for many years as a Pennsylvania-based community health development consultant of national stature. He was slated to join the SRPH in July 2001 as associate professor and director of the newly-created Center for Community Health Development,[10] intended to provide a bridge between the academic interests of the school and the pressing needs of the community health service providers in the region. Sumaya persuaded him to parachute into the Lower Rio Grande Valley a few months before his arrival in an effort to rescue the border health project.

Burdine's Assessment

As a partner in Felix & Burdine Associates, Burdine had refined and championed a community health development strategy called the "partnership approach," which put a premium on involving all the actors in the fragmented health care sector in a given community—providers and clients; politicians and bureaucrats; civic leaders, nonprofits, educators, and businesses. Thus,

---

[8] "Filling a Health Void in Texas," by Christopher Conte, Robert Wood Johnson Foundation web site, www.RWJF.org/newsroom.

[9] The organization, Andean Rural Health Care (later renamed Cureamericas), worked to increase health care access in developing countries, and had proposed the border health project at the suggestion of a Texas board member.

[10] The new entity was called the Community Health Development Program from 2001 to 2004. Its aim was to provide direct services to the providers—training, consulting, technical assistance, program evaluation, etc.—and to sponsor academic research to inform and support community health efforts. In 2004, the Centers for Disease Control (CDC) would designate the program one of 33 national Prevention Research Centers and the program would be re-named the Center for Community Health Development. To avoid confusion, the name Center for Community Health Development is used throughout this case.

in approaching the border health project, Burdine's impulse—had he been given a blank slate—would have been to cast a wide net, talking to dozens of people in the area and prioritizing health care needs in the *colonias* before designing a project. But Burdine was stepping into a work-in-progress: "People were involved and a plan was in motion."

The IHOS Concept. By this point, local Hidalgo County service providers had conceived IHOS as the marriage of three interrelated initiatives (see Exhibit 4):

1. the project would provide a primary care team, led by a doctor or nurse practitioner, to each of two existing "community resource centers" located near the colonias (project leaders would select which colonias to serve, however);

2. IHOS would supply a 15-passenger van to each community resource center to ferry residents back and forth from their homes to the primary care providers in the center and, when necessary, to other clinics or acute care facilities in the area;

3. the project would deploy a group of about 18 community-based health outreach workers, called promotoras,[11] to walk door-to-door in the targeted colonias.

The Promotoras. This last aspect of the program was, perhaps, the most important. As a rule, *colonia* residents were leery of strangers. For one thing, an uncertain—but substantial—proportion of adults in the *colonias* lacked the immigration documents required to live legally in the United States; they lived in dread of being rousted by the US Immigration and Naturalization Service. They knew they were viewed with disapproval by some of the Valley's mainstream residents, and thus tended to keep to themselves to the extent possible. By language, geography, and culture, they were isolated from reliable, informal networks of information about the mainstream culture and poorly positioned to assess the intentions or credibility of a stranger.

If, however, a fellow *colonia* resident came to the door, speaking a familiar Spanish dialect—or if such a person accompanied a stranger into the *colonia*—the residents were far more likely to be receptive. Thus, as a practical matter, the *promotoras* had become a necessary asset for any outsider who wanted to work in the *colonias*. "Everyone wants a *promotora*," says Marlynn May, a sociologist at the Texas A&M School of Rural Public Health. "You have all kinds of agencies and organizations wanting to hire them." Over time, the *promotoras* had been sent out to *colonias* all along the border representing a host of different initiatives: breast cancer screening, diabetes education, teen pregnancy education, vaccination drives, and voter registration drives. Sometimes, their job was simply to provide entrée for census workers or academic researchers.

[11] In the Spanish language, a male outreach worker was a *"promotor"* and a female outreach worker, a *"promotora."* Along the border, generally (and in the IHOS program, in particular), the overwhelming majority of outreach workers were women, so the feminine form is used in this case study.

What distinguished the design of the IHOS project from that of many other service programs on the border was the level of responsibility assigned to the *promotoras*. Many projects employed *promotoras* to perform a single function—for instance, rounding up children for a vaccination program, or encouraging residents to participate in a breast cancer screening event. IHOS *promotoras*, by contrast, were to receive special training that would prepare them to go door to door in the targeted *colonias*, make inquiries about the health status of each household, identify unmet health care needs, and record basic surveillance data. The *promotoras* were to provide health education and, when necessary, refer residents to the most appropriate clinic. If the residents lacked transportation, the *promotoras* were to arrange van transportation for them. They were also to assist eligible residents to enroll in Medicaid. Thus, IHOS would rely on *promotoras* to be well-informed about health care resources, to be adept at eliciting delicate information from *colonia* residents, to be persuasive, persistent, and well-organized.[12]

Service Delivery by Partnership. Instead of creating a new organization to run the IHOS program, the providers had conceived a service partnership—that is, IHOS services would be supplied by existing service providers in the Valley. Two local leaders had taken lead roles in developing the plan: (1) the founder of El Milagro, a private community clinic in McAllen, and (2) the director of South Texas office of the Center for Housing and Urban Development (CHUD). CHUD, a project of the Texas A&M College of Architecture, had worked with local jurisdictions to build (and in many cases, manage) a group of community resource centers at strategic locations along the border, in order to provide facilities near the *colonias* for service providers that wanted to assist *colonia* residents. The other three organizations in the planning group were Nuestra Clínica del Valle, Hidalgo County's "Federally Qualified Health Center"[13]; Planned Parenthood Association of Hidalgo County, which provided reproductive health care and already did some work in the *colonias*; and Migrant Health Promotion, which specialized in *promotora* training.

They envisioned a $5 million, four-year demonstration project, funded 3:1 by the Robert Wood Johnson Foundation and HRSA's Bureau of Primary Health Care.

Burdine's "Fix"

Burdine quickly ascertained that the five potential IHOS partners had reached an impasse over how grant funds and responsibilities would be divided among them. To some degree, he says, this was unremarkable: "Every United Way, every Federally Qualified Health Center, every Planned Parenthood in every community is competing for resources, so there's some degree of adversarial-ness" among service providers almost everywhere. But the rivalries had a more

---

[12] IHOS was not the first or only border project to assign such case management responsibilities to *promotoras* but numbered among the programs that chose to give *promotoras* a particularly ambitious role.

[13] A Federally Qualified Health Center, or FQHC, was a federally designated clinic, eligible for special funding in return for a commitment to provide clinical care to indigent, Medicaid-ineligible residents in a given jurisdiction—in this case, Hidalgo County.

personal flavor in the Lower Rio Grande Valley, he adds: "As the saying goes, in the Valley, everybody is related to everybody else, so there're whole family structures that influence what's going on." As a consequence, "what I see more in South Texas is undercutting and backbiting." For example, El Milagro's leadership—arguing that private clinics were the best vehicle for serving the indigent—had actively opposed Nuestra Clínica's efforts to secure funding in the past; the two were therefore in conflict from the start.

Burdine focused his attention on the two most intractable disagreements among the partners: (1) which organization would manage the grant and (2) which organization would run the primary care facilities. El Milagro was pushing to manage the grant, and CHUD, which already ran several community resource centers in the area, to manage the primary care operations inside the centers. Under Burdine's proposal, the HRSA and RWJF grants would be separated. The four-year $1.2 million Bureau of Primary Health Care grant would go to Nuestra Clínica (which already ran nine satellite clinics elsewhere in the county) to fund the operation of the two primary care facilities. The four-year $3.8 million RWJF grant would be managed by his own Center for Community Health Development, and Burdine would serve as principal investigator. Each of the five partners would receive a share of the RWJF grant, on a reimbursement basis, for supplying services to the program (see Exhibit 5). CHUD would supply the van service; Migrant Health Promotion, the *promotora* training; and El Milagro, dedicated clinical service. Nuestro Clínica, CHUD, Planned Parenthood (and later El Milagro) would each provide *promotora* service. The amount of *promotora* service provided by any of the partners in a given month was flexible, but collectively the Partnership was expected to supply IHOS with a cohort of 18 *promotoras.*

To ensure coordination and accountability, IHOS would employ a simple management structure (see Exhibit 6):

- Burdine and the Center for Community Health Development, in the School of Rural Public Health (located several hundred miles away in College Station, Texas), would manage the grant, reimbursing each partner for services provided. They would also hire a management consultant and project director to administer and coordinate the project in the Valley, working out of the SRPH's South Texas Center in McAllen. They would hire several members of the SRPH faculty to conduct a program evaluation.

- The IHOS Partnership, made up of executive-level representatives from each of the five IHOS service partners, would initially meet monthly (and later as needed) to make major decisions. These meetings would be facilitated by the management consultant retained by Burdine, and staffed by the IHOS project director.

Neither El Milagro's founder nor CHUD's regional director were happy about the attenuated roles their organizations would play under Burdine's proposal, but they recognized that

Burdine had RWJF's confidence. In order to secure the RWJF funds for the project, the five IHOS partners signed on. On December 13, 2001, the RWJF and HRSA awards were announced in a large, triumphal press conference. "When we risk losing funding, everyone pulls together and puts their issues aside," observes Aurelio Martinez, then Nuestra Clínica's outreach director. But, he adds, this apparent unified front was "just lip service"; once the press conference was over and the money was in hand, the spirit of cooperation rapidly vanished.

A Rocky Start

Before the IHOS project could begin in earnest, the partnership had to make a series of important decisions—choices as basic as which *colonias* to target. Burdine hired his former consulting partner, Michael Felix, a community health development specialist, to facilitate the partnership meetings and to provide strategic support for the project.

Felix had worked in the Valley before, and had no illusions that this would be easy. But, at early meetings of the IHOS Partnership, he was dismayed to find that some of the partners simply refused to speak to one another at all. Thus, one partner might direct a question to Felix that was intended for another partner, sitting right across the table, and Felix would have to turn and ask it again. To Felix, this state of affairs was not only awkward and time-consuming, it was alarming in a project that assumed—and counted on—good cooperation among the parties: "I am a practical problem-solver, and I realized that what they said they were going to do was nearly impossible, because of how much they didn't like each other."

As a result, Felix continues, he and Burdine decided early on that they needed to act quickly to figure out who was who, and why relations were so difficult. The two met privately with each of the IHOS partners, but Felix also met with some 200 local leaders in education, politics, health care, government, business, and religion "to better understand the Valley's leadership infrastructure as well as the local issues, trends and themes."

From these interviews, the pair acquired important local intelligence: that the leaders of El Milagro and CHUD's South Texas office were controversial local figures, with allies and enemies of longstanding. More broadly, Burdine and Felix learned that previous efforts at collaboration among service providers in the Valley had consistently fared badly "due to jealousies, lack of collaborative experience among the agencies and the fight over money," says Felix. Within the mainstream border towns, there was also a sharp divide between Mexican Americans and undocumented Mexican immigrants, and a strong vein of community opposition to programs designed to help anyone who had crossed the border illegally.

None of this news boded well for IHOS, but it gave Burdine and Felix a better grasp of the challenges before them. They took several steps to improve relations among the IHOS partners early on. For one, Felix persuaded the five IHOS partners to divert many of the smaller, day-to-day

decisions to a "working committee" made up of mid-level staff and *promotoras* from each partner organization. These meetings, led by then-Nuestra Clínica Outreach Director Martinez, were more constructive, Felix says. In addition, Burdine and Felix quietly tried to persuade the El Milagro and CHUD leaders to step back personally from the partnership and send other administrators in their stead. The maneuver succeeded, but perhaps at a cost; Burdine and Felix found themselves vilified in a local newspaper article. But the change of personalities did ease tensions within the IHOS Partnership meetings. Gradually, the partners were able to make the key decisions necessary to get the project off the ground.

Almost immediately, though, a new problem surfaced. Three (eventually four) of the IHOS service partners were supposed to provide *promotora* service to IHOS—but each organization was accustomed to hiring and managing its *promotoras* in a very different way, which made it difficult to create a cohesive IHOS *promotora* outreach effort.

The Complexities of the *Promotora* Program

Despite universal acknowledgment that *promotoras* were essential for anyone attempting to work in the *colonias*, the *promotora* profession all along the border had traditionally been unstable. Most *promotoras* worked at or below minimum wage, without benefits and with little training, on short-term projects. Like "piece workers," the *promotoras* "worked for a project for a period of time, then jumped to another organization or another grant for another little piece of work," says CHUD's Marlynn May. "There was always a lot of juggling behind the scenes. Grants would run out, they would fire everyone, then three months later, they'd get a new grant and hire everybody back." A number of organizations obtained *promotora* "volunteers" under the AmeriCorps/VISTA program, which paid only a modest stipend and provided no benefits. This program was not intended to provide local residents with low wage jobs. But, feeling they had few options, local *promotoras* learned the "system": they signed up as AmeriCorps/VISTA volunteers, lived off the stipends as best they could, and, when a stint at one organization expired, they signed up to volunteer at another.

Promotora Policies of the IHOS Partners. Only one IHOS partner—Nuestra Clínica—hired a permanent crew of full-time *promotoras*. Planned Parenthood hired *promotoras* on a shorter term, part-time basis. CHUD's *promotoras* were AmeriCorps/VISTA volunteers. At El Milagro, which did not begin to hire *promotoras* until the third year of the project, there was high turnover "due to the agency's funding issues and other priorities," Felix says.

In addition, CHUD and Planned Parenthood managed *promotoras* as a flexible, interchangeable resource—outreach workers who could be mixed, matched and relocated—assigned to whatever project most needed them on any given day. The CHUD *promotoras* were, in fact, frequently moved from one community resource center to another within the CHUD system,

depending where they were needed most. They were viewed as "community property," Martinez recalls:

> The *promotoras* would be told, "Okay, today you're going to work on this project. And oh, by the way, we need two of you to go to an RWJ[14] training—report there from 8 to 5 Monday through Wednesday. So—do that—and then the next day, you're going to be doing prenatal referrals, or running a presentation on diabetes."

The idea, Martinez continues, was that the *promotoras* would be cross-trained, so that they could easily shift from one project to another. But the relatively complicated role IHOS had devised for the *promotoras* required extensive training. The project administrators had envisioned an ongoing training model, with each session building on the lessons of the last. Without a stable crew of *promotoras*, however, this model rapidly fell apart. The IHOS trainers found themselves addressing a largely new set of faces at each training session. Some *promotoras* missed one session, others missed the next, and it was impossible to make sure all the *promotoras* had received the training they needed. Adding to the difficulty, the trainers themselves were not always sophisticated facilitators, Felix says. As a result, he adds, the "training sessions" sometimes devolved into gripe sessions, as frustrated *promotoras* complained about the program.

The lack of a stable group of IHOS *promotoras* also led to problems of accountability. The initial grant had allowed flexibility, but had called for the service partners collectively to supply "approximately 18" *promotoras* to the project at any given time. With the IHOS project director in a coordinating role, the partners were expected to divide up this responsibility among themselves; each partner would then bill IHOS for the amount of *promotora* service it had provided in a given period. Because some of the *promotoras* were working part-time, and some were working on more than one project at once, it was hard for the project director or Burdine's financial staff to be certain how much *promotora* time each partner was actually contributing to the project. Looking back, Felix estimates that, collectively, the partners were probably contributing "seven or eight" *promotoras* to the project at any given time, rather than the full 18.

Coping with the Chaos. With help from Felix, Martinez—who headed up the IHOS working committee and in April 2004 became IHOS project director—tried to cultivate a more consistent, reliable *promotora* program in several ways. One was to create a schedule indicating which *promotoras* would team up and go to which *colonias* at which times. But in practice, the schedule often conflicted with what a *promotora*'s immediate supervisor told her to do on a given day. "In some cases, *promotoras* ended up doing the work they were told to do by their boss, and then working extra hours without pay for IHOS, to try to keep everybody happy," Martinez says.

---

[14] Among its participants, IHOS was commonly referred to as "the RWJ project."

When they discovered what the *promotoras* were doing, Felix and Burdine were appalled. "They felt very strongly that the last thing they wanted to be doing was exploiting the *promotoras*," Martinez recalls. "We heard from the *promotoras* that they were supposed to be working 15 hours a week, but they were really working 40. Michael [Felix] would say, 'We can't allow that. If you're working, you must get paid.' But the [IHOS] partner would say, 'No! Don't work more than 15 hours.'" Martinez tried to resolve this issue through the IHOS working committee, but, says Felix, "unfortunately, these folks didn't have the authority to agree on any resolution."

The *promotoras* grew increasingly frustrated at being caught between the demands of the IHOS project managers and their own employers, and in IHOS' third year, Martinez began to hold monthly problem-solving meetings for the IHOS *promotoras*. These were separate from either the *promotora* training sessions or the IHOS working committee meetings and became important in several respects. For one thing, Felix and Martinez encouraged the *promotoras* to speak freely at the meetings—a professional first for many of them. Several *promotoras*, in particular, developed from frustrated (but quiet) workers to confident and assertive spokespersons.

In fact, Burdine and Felix began to see in the IHOS *promotoras* the potential to play an even more ambitious role in the *colonias*: organizing the residents to voice their greatest needs and concerns with respect to community health and safety. Thus, Felix and Martinez began to train the *promotoras* in the art of community organizing. The *promotoras* already knew how to rally *colonia* residents and persuade them to attend a meeting. Felix and Martinez began to train them in other aspects of community organizing—for example, how to lead and facilitate a group discussion, how to think strategically, how to problem-solve, collaborate, and develop a plan of action.[15]

As the role of the IHOS *promotoras* evolved, however, it became increasingly urgent to Felix and Martinez that each IHOS partner assign a stable cohort of *promotoras* to the project. "What we ended up doing is that we went back to the partners, and we said to them, we must have a commitment from all partners that we know who are the assigned *promotoras*, so we can rely on them for continuity—and also, [so the program would be] more credible with the target population," says Martinez. This was a hard sell for Planned Parenthood and CHUD, as it departed radically from their model of a flexible cohort of *promotoras* that could be moved from project to project. What's more, IHOS was moving in a direction at odds with the Texas Department of State Health Services, which was trying to create a *promotora* profession, with a standardized curriculum and certification; the Health Services vision of a *promotora* did not include community organizing skills.

---

[15] In April 2005, IHOS would sponsor large community meetings in each of its two *colonias* communities—Alton and San Carlos. Residents discussed community health issues, broadly defined, and developed committees in each location that were to develop three strategic plans, addressing problems of health, environment, and transportation, respectively.

Burdine and Felix argued that it was in the best interests of both the *promotoras* and the *colonia* residents for the *promotoras* to step up a level and learn how to organize the residents. Eventually, Planned Parenthood's leadership came around on this point and assigned a stable group of *promotoras* to IHOS. For CHUD, however, the shift was more difficult, because the CHUD community resource centers shared and traded *promotoras* back and forth; any change of policy would have to be made by the central office—and CHUD was, at this juncture, going through a major organizational upheaval. A new dean with new priorities at the Texas A&M School of Architecture had led to downsizing, an administrative shakeup and talk of financial irregularities. Both the CHUD director in College Station and the South Texas regional director departed the organization during this period. In the midst of this upheaval, CHUD did not take up the question of its *promotora* policy.

The IHOS Group Takes Stock

At the end of the 2004 calendar year, Burdine, Martinez, and Felix recognized that it was time to take stock. IHOS had one remaining year of funding. Burdine believed it likely that the federal Bureau for Primary Health Care would continue to fund the operation of the satellite clinics, but less likely that RWJF would continue to fund the *promotora* program and van service. If IHOS was to continue these parts of the program, the partners and administrators would have to think hard about a funding strategy. At this juncture, too, it was appropriate to think about whether to make any changes in the IHOS model.

Successes on the Ground. After three years, Burdine, Felix and Martinez agreed that IHOS had struggled its way to some significant accomplishments. Despite a daunting array of logistical difficulties, the *promotoras* had visited more than 6,000 households in the *colonias,* and had made an average of five health care referrals per visit. (There was little information about whether the *colonia* residents had followed up on these referrals, however. Nor did the program have ready information about the number of *colonia* residents transported to clinic appointments via the IHOS vans.) Anecdotally, some of the *promotoras* recounted cases in which they had made a crucial medical intervention. Perhaps most dramatic, a team of IHOS *promotoras* found one woman with an undiagnosed case of cervical cancer and, after persistent effort, brought her into the medical system, where she eventually received intensive treatment.

Improved Relations Among the Partners. In addition, Burdine, Felix, and Martinez report that relations within the IHOS Partnership gradually improved over the course of the first three years. In IHOS' second year, for example, the IHOS working committee developed a common intake form, to be used by all IHOS *promotoras*. This success cemented the bond among the partners, and yielded more benefits as time went on. For example, two IHOS partners would later collaborate on a grant proposal. In addition, some of the partner organizations began to refer patients back and forth.

Invested, Enthusiastic Promotoras. Best of all, Burdine, Felix and Martinez were heartened at the evidence of growing leadership capacity within the IHOS *promotora* team. According to a 2004 summary report, prepared by Burdine and his staff, the *promotoras* showed increasing "empowerment, professionalism and collegiality.... As a result, when partners began to bicker internally, the *promotoras* began to assert themselves as meaningful participants in the process of improving access to care for *colonia* residents."[16]

Re-thinking the Structure

At the same time, Burdine, Felix and Martinez had come to the conclusion that the IHOS partnership structure itself was continuing to generate an inordinate number of problems, especially for the *promotora* outreach effort. Thus, at a meeting of the IHOS partners, they made the case that a single organization ought to run the whole outreach and transportation program. They next asked whether any of the IHOS partners would be interested in taking on this role. To do so would mean inheriting the IHOS operating funds and all the IHOS staff for the remainder of the RWJF grant, but would also entail taking on the responsibility for finding the funds to continue the project.

The partners were not receptive to the idea, according to Martinez and Felix. For reasons unrelated to IHOS per se, several of the partner agencies happened to be facing major organizational challenges at this juncture. All across Texas, for example, Planned Parenthood chapters were reeling from a dramatic reduction in federal and state funding. CHUD was in the midst of its own organizational upheaval. Nuestra Clínica was struggling to cope with a sudden shortage of doctors in Hidalgo County, stemming from a federal determination that the county no longer qualified as medically "underserved." Although not in crisis, El Milagro was a small operation with limited capacity compared to the other partners.

For each partner organization, therefore, the idea of losing IHOS funds was a blow but the idea of taking over the IHOS program was overwhelming. "I think they felt it was such a big challenge—a humongous task to undertake," says Martinez. It was easier to assume that, at least as far as they were concerned, the project and the funding were about to end, he continues: "Historically, what happens with partners here is that everyone panics during the last year. They start 'phasing out' mode: 'it's going to end, so we need to start *phasing out*.'" In the absence of a successor organization, this meant phasing out the *promotoras* themselves. Six to nine months before the November 2005 end of the grant funding, Martinez recalls, "The *promotoras* were calling me and Michael [Felix] and saying, 'Should I start looking for a job? Should I start panicking?'" At the human level, Martinez and Felix wanted to be able to offer the *promotoras* reassurance. In

---

[16] "Building Capacity for Population Health Improvement in *Colonias* Using a Community Health Development Approach," a grant application prepared by Texas A&M's Center for Community Health Development in the School of Rural Public Health, 2004, p. 6.

addition, they did not want their fragile cohort of dedicated *promotoras* to scatter, leaving them to start over from scratch. But they were not in a position to offer any guarantees, "because, remember, it's not us who's phasing them out," says Martinez. "We're not their bosses."

The RWJ Foundation Weighs In

In the midst of this uncertainty, in April 2005, the RWJ Foundation sent five emissaries led by James Marks, senior vice president in charge of RWJF's Health Group, to IHOS to discuss the future of the program. The delegation brought to IHOS a new set of considerations, based on recent changes in the Foundation's approach to charitable giving.

Under the leadership of RWJF CEO Risa Lavizzo-Mourey, the Foundation's executive team had concluded that its prior approach—funding a wide array of initiatives under 35 broad topic areas—was not allowing RWJF to have enough national impact in any particular area. Thus, the Foundation had decided to focus more tightly on a set of four portfolios. One of the four was "Vulnerable Populations"—that is, groups with complex social problems inextricably entwined with badly substandard health indicators. These populations included low-income children and their families, frail older adults, adults with disabilities, the homeless, those with HIV/AIDS, immigrants and refugees, and those with severe mental illness. The *colonia* residents certainly qualified as the kind of population RWJF wanted to assist.

But the Foundation was no longer trying to assist these groups via "safety net" projects like IHOS, and was instead moving toward broader, collaborative "interventions that cut across multiple service systems and result in lasting changes in the health of vulnerable people." For example, the Foundation took the position that the health of chronically homeless people was unlikely to improve meaningfully until their fundamental problem—homelessness—was addressed. Similarly, the health of the *colonias* residents was unlikely to improve meaningfully as long as the *colonias* remained isolated, substandard housing settlements without even minimal residential infrastructure.

At the same time, the RWJF group recognized that the health care needs in the *colonias* were extreme, that resources on the border were very limited, and that there was no large-scale effort on the horizon to improve conditions there. The team also appreciated the recent efforts of Felix, Martinez and the *promotoras* to try to mobilize the *colonia* residents and help them find a productive way to engage with the mainstream border communities about unhealthy conditions in the *colonia* settlements. If a withdrawal of Foundation support would simply result in the collapse of IHOS—which seemed likely—then RWJF was reluctant to pull out. Thus, the Foundation proposed a compromise: three years of continued funding for IHOS—with a caveat.

Financial Sustainability. RWJF made it clear that the Foundation would not fund IHOS in perpetuity; to do so would limit RWJF's ability to invest in other programs over time. Nor did the

Foundation want to provide three more years of funding to a program that was going to fold up and die as soon as the RWJF funding cycle ended. Thus, in its new grant, RWJF would include the funds—and the requirement—that IHOS administrators take aggressive action to persuade local institutions, whether in business, politics, government or the health care sector, that the IHOS program was important to the health of the community, and to secure ongoing local funding for it.

In other words, the Foundation wanted IHOS to think more entrepreneurially, as if it were the recipient of "venture capital" rather than a social service grant, according to Debra Perez, program officer for research and evaluation at the Foundation, and a member of the visiting group. IHOS administrators must develop a "business case" for the program—for example, conducting a study which showed that under IHOS more *colonia* residents were getting routine health care from local clinics, thereby taking pressure off local hospital emergency departments. Armed with such a study, IHOS administrators could then approach local hospitals to help pay for the program. A similar case might be made to show that, with increased primary care, *colonia* residents lost fewer days of work to illness and their children missed fewer days of school. If presented with such data, the RWJF visitors suggested, businesses that employed *colonia* residents and local school districts might be persuaded to chip in as well.

A Community Health Development Approach? The Foundation's sustainability goals were daunting—especially in a community so ambivalent about the presence of undocumented immigrants and the programs that served them. But Burdine and Felix thought that their community health development approach—combining community organizing in the *colonias* with an ongoing push to increase communication, understanding, and mutual assistance among all the fragmented actors involved in health care in the Valley—might, in fact, work to build the support IHOS needed to sustain itself after the RWJF grant expired. But how should IHOS integrate these new high-flown goals and responsibilities with IHOS' original mission? At a more rudimentary level, how should IHOS, a badly teetering service partnership, solve the crucial question of who should run the program?

Exhibit 1
(Map showing location of the Lower Rio Grande Valley)

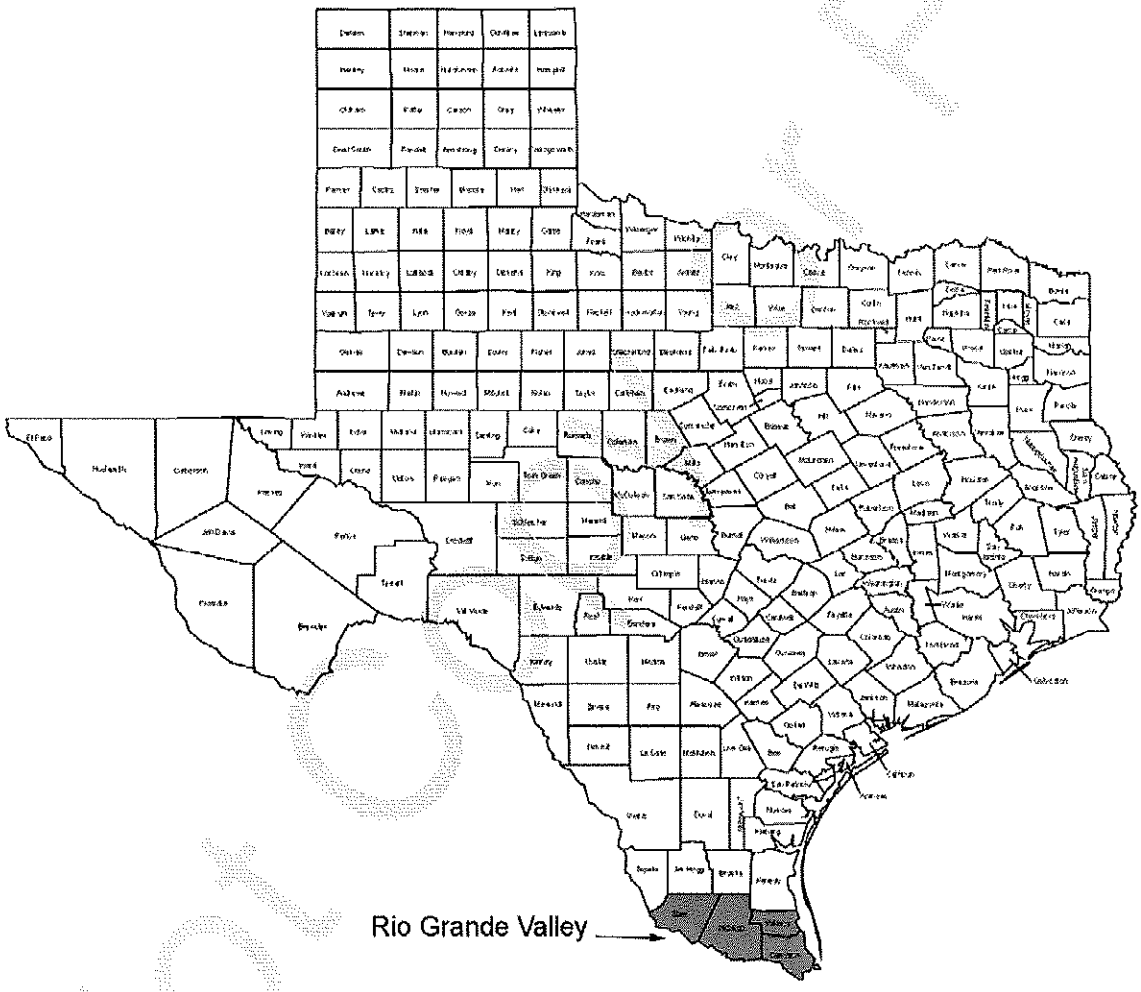


Exhibit 2
Glossary of Organizations

The Funders

- **Robert Wood Johnson Foundation (RWJF)**—the nation's largest domestic health-related philanthropy; provided a $3.8 million startup grant to IHOS to fund four years of outreach, referral and transportation service.

- **Bureau of Primary Health Care (BPHC)**—division of the federal Health Resources and Services Administration, responsible for providing clinical care to indigent, uninsured patients; provided a $1.2 million grant to fund operation of Nuestra Clínica del Valle's two satellite clinics for four years under the IHOS program.

    - **Health Resources and Services Administration (HRSA)**—an agency of the US Department of Health and Human Services and the primary federal agency for improving access to health care services for people who are uninsured, isolated or medically vulnerable.

The IHOS Program

- **IHOS (Integrated Health Outreach System)**—two-part program created to improve health care access for thousands of residents living in near the Mexican border in two *colonia* clusters in Texas' Lower Rio Grande Valley; one part provided outreach, referral, and transportation service; the other part provided for the operation of two small satellite clinics.

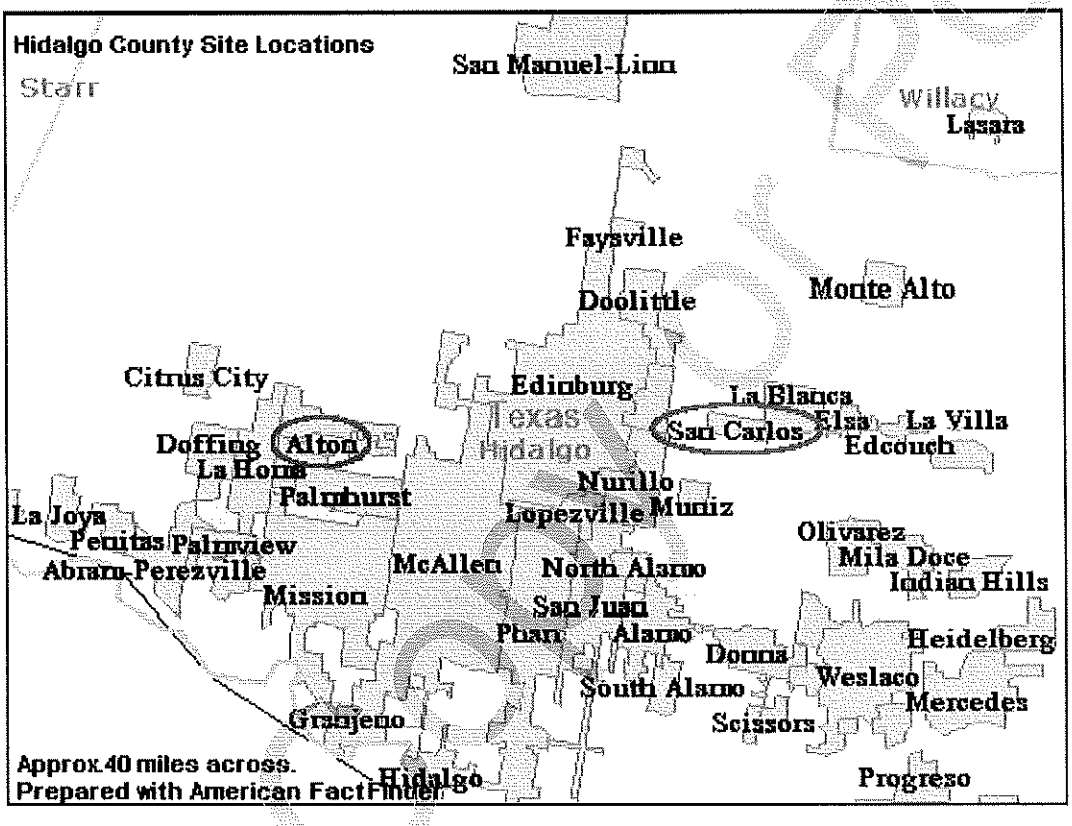
- **Center for Community Health Development (Community Health Development Program)**—division of Texas A&M's School of Rural Public Health; responsible for administering RWJF's startup grant to IHOS, and for hiring the day-to-day administrative staff for the program—principally, the IHOS project director and program consultant; created in 2001 under the name Community Health Development Program and renamed in 2004, when it was designated a Prevention Research Center by the Centers for Disease Control (CDC).

    - **School of Rural Public Health**—one of several graduate schools and research institutes in the Texas A&M University System Health Sciences Center; operates a South Texas Center in McAllen, Texas.

- **IHOS partners**—the five organizations that provided services under the initial RWJF grant. They were Nuestra Clínica del Valle, CHUD (Center for Housing and Urban Development), El Milagro, Planned Parenthood, Migrant Health Promotion.
    - **Nuestra Clínica del Valle**—Hidalgo County's "Federally Qualified Health Center," a designation from the federal Health Resources and Services Administration (see above) that qualified the clinic for certain federal funds in return for a commitment to provide clinical care to indigent county residents with neither private insurance nor Medicare/Medicaid eligibility; one of the five IHOS partners, responsible for operating two satellite clinics and providing *promotora* outreach services; recipient of a separate $1.2 million grant from HRSA's Bureau of Primary Health Care to operate the satellite clinics.
    - **CHUD (Center for Housing and Urban Development)**—center within the Texas A&M School of Architecture that, by the early 2000s, had built (and in many cases, continued to manage) some 18 community resource centers near large *colonia* settlements in Texas; one of the five IHOS partners, responsible for providing *promotora* outreach service and van transportation service.
    - **El Milagro**—a small community clinic in McAllen, Texas; one of the five IHOS partners, responsible for providing clinic services.
    - **Planned Parenthood Association of Hidalgo County**—Hidalgo County affiliate of Planned Parenthood, providing reproductive health care and sexual health information to county residents; one of the five IHOS partners, responsible for providing *promotora* outreach service and clinic services.
    - **Migrant Health Promotion**—Texas office of a Michigan-based organization that supports migrant farm workers; one of the five IHOS partners, responsible for training *promotoras* to do IHOS outreach and case management work.

Exhibit 3[17]

(To come, map showing *colonia* clusters in Hidalgo County)



[17] Source: Center for Community Health Development, Texas A&M School of Rural Public Health.

Exhibit 4
IHOS Health Outreach Model

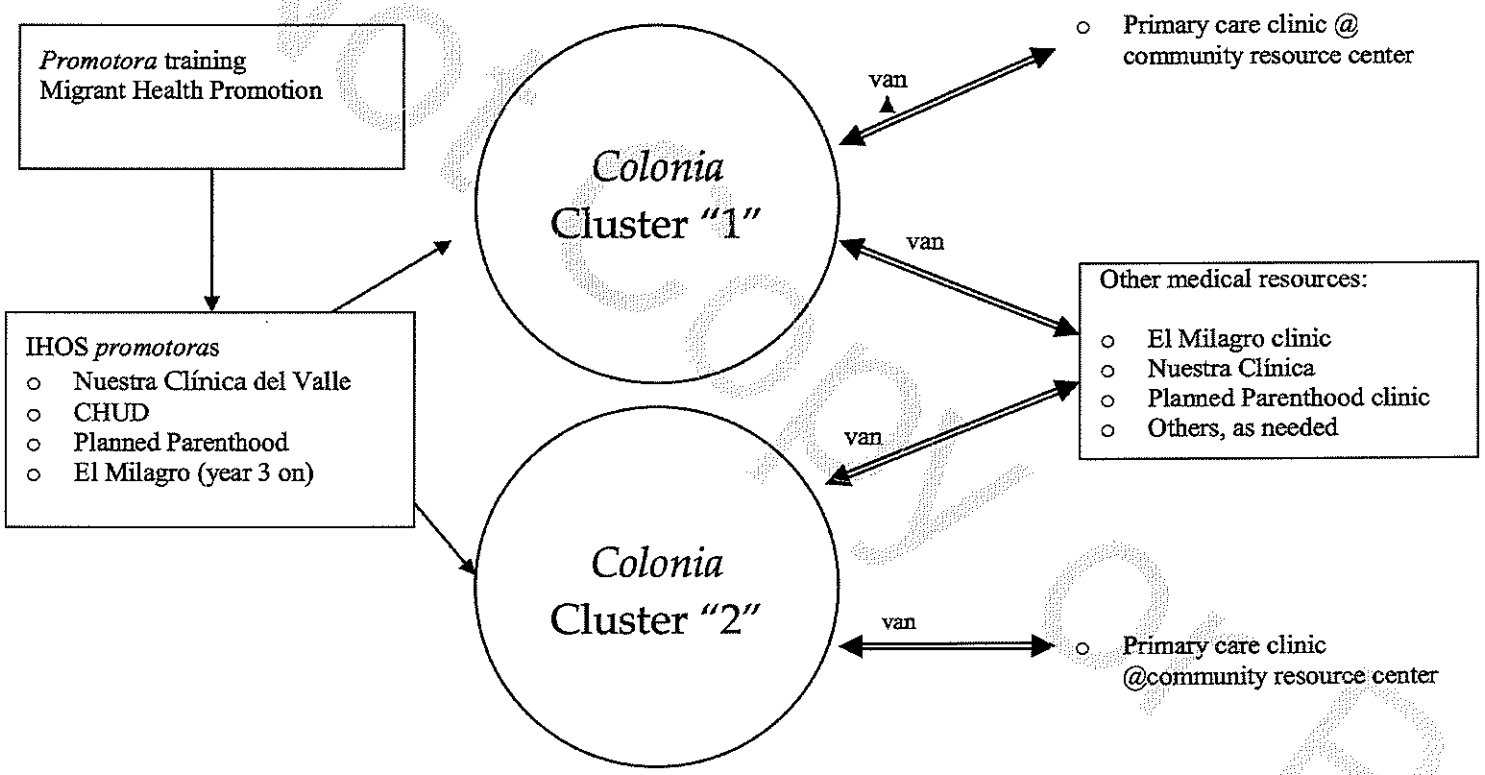


Exhibit 5
IHOS Funding and Responsibilities

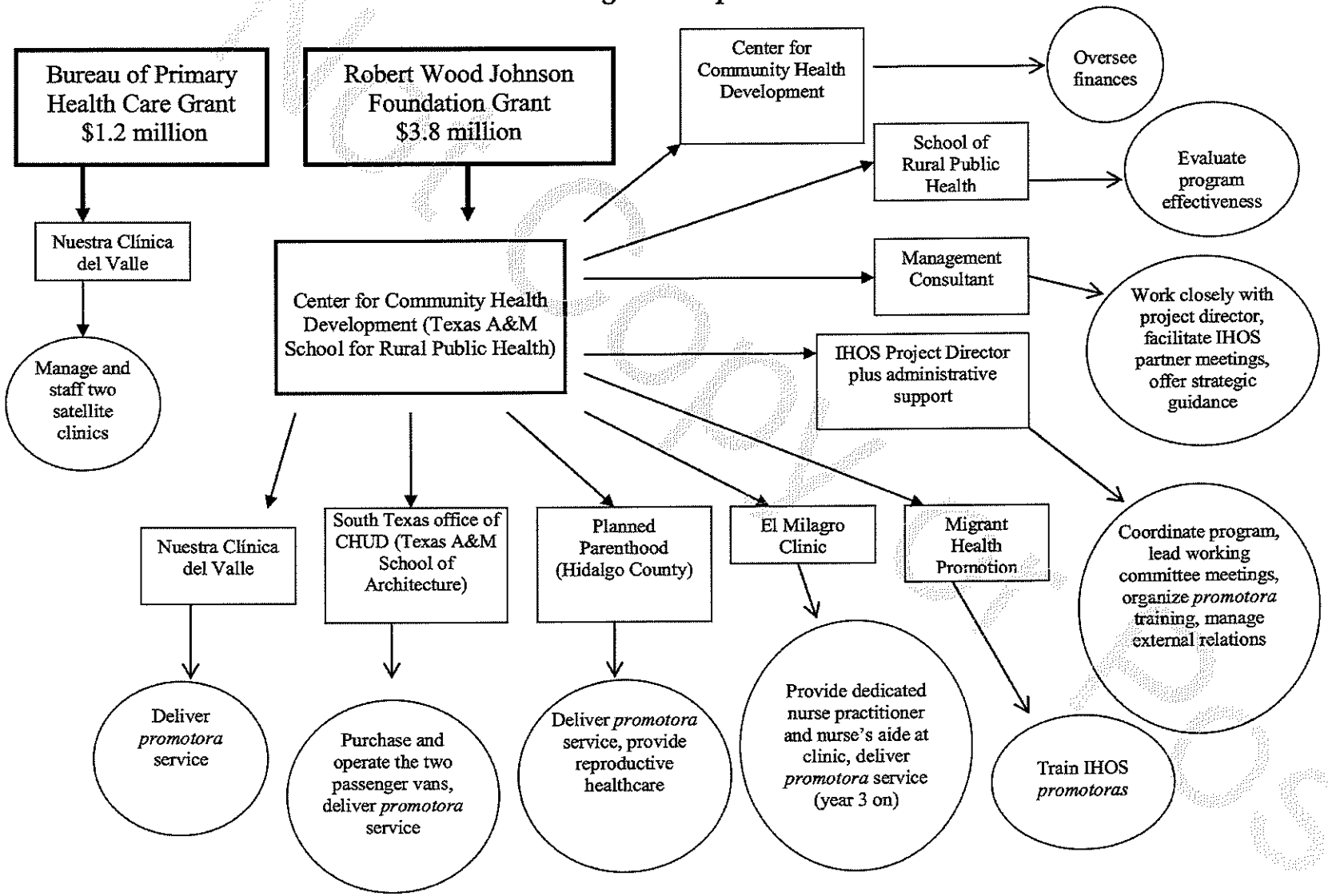
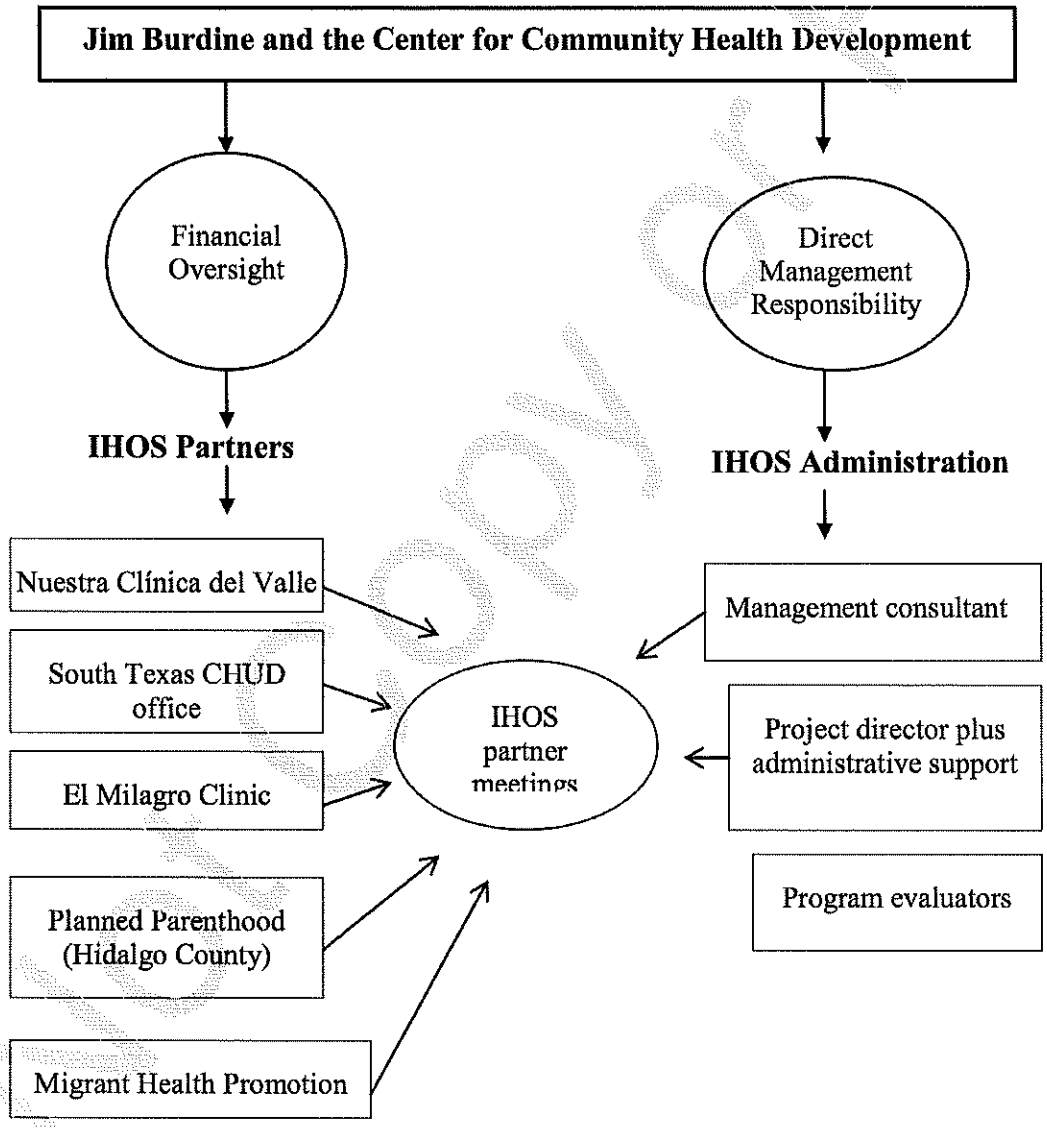


Exhibit 6
IHOS Management Structure



Appendix 1
Understanding the *Colonias*

Colonias began to appear just north of the US/Mexican border as early as the 1950s when landowners discovered that they could take otherwise unprofitable tracts of land (often those prone to flooding or erosion), divide them into small lots, and sell them off to Mexican farm workers and other immigrants, who were keen to buy land in the United States and unable to afford anything in the mainstream housing market. Individual *colonias* ranged dramatically in size, from small settlements of just 10 to 20 lots to large ones of several thousand. Typically, the settlements were isolated from the mainstream border towns and lacked such basic residential infrastructure as water, sewer, electricity, and roads. A family bought a lot over time and, in the meantime, camped out there in second hand trailers, old school buses, or makeshift shelters cobbled together from pallets, scrap wood, and cardboard, and began to build a house, often patched together from available materials.

Colonias existed in all the Border States—Texas, New Mexico, Arizona, and California—but over the years, most of these ad hoc communities had cropped up in Texas. By official estimate, the Texas *colonias* were home to a half million people—and some scholars believed the number to be significantly higher. Within Texas, the vast majority of the *colonias* were clustered in the Lower Rio Grande Valley.

Beginning in the 1990s, federal, state and local governments began bringing water, sewer and other residential infrastructure to some of the more established *colonias*, transforming them by degrees into lower middle class subdivisions. In fact, some border scholars caution against an overly negative view of the *colonias*. "To buy land in a *colonia* is to have a chance to build at one's own pace as finances allow," stated one report. "Thus defining *colonias* solely by their dire conditions misrepresents them and the residents. They are not places ruled by desperation and fatalism—the difficult socio-economic conditions therein must be understood within the context of community life in the *colonias*."[18]

Still, by the early 2000s, many older *colonias* were still without basic water, sewer and electricity. What's more, new *colonias* were steadily appearing along the border, and the newest among them were enclaves of extreme poverty.

"If you travel in [Hidalgo] County, you'll see these humongous tanks in tiny yards and you wonder, 'What the heck is that? That can't be a… swimming pool?' But it's the sewer system," says Aurelio Martinez, who would become IHOS' project director in April 2004. Lacking access to

[18] "Community as Context: The Study's Geographic, Social, Economic and Cultural Base," expanded draft of the first chapter of *Mujer y Corazon: Community Health Workers and Their Organizations in Colonias on the US-Mexico Border, An Exploratory Study*, by Marlynn L. May, Ricardo B. Contreras, Linda Callejas, Elvia Ledezma, of the Southwest Rural Health Research Center of the Texas A&M School of Rural Public Health, August 2004, p. 12.

public sewer systems (or unable to afford the cost of hooking up to an existing sewer system), the *colonia* residents typically installed homemade septic systems. "It's maybe six feet in height and six-by-four, and it's just four walls with no ceiling. That's the system," says Martinez. Often such systems leaked, so that sewage steadily seeped out into the yard, creating severe sanitation hazards in addition to unpleasant living conditions.

In addition, many families made do without running water, refrigerators, or stoves. Without such basics, it was virtually impossible to maintain healthy levels of hygiene or nutrition. "I can tell you that as recently as a couple weeks ago, I went to a home where a family of five little kids live in this little shack with no water, no heating, no electricity," says Martinez.

> And everyday they walk to the local [convenience] store and buy what they're going to eat for that particular meal. They can't save food—it'll spoil. They probably feed the kids donuts and a glass of milk and treat them to a small candy bar—and that's breakfast. And lunch will be some other type of bread that fills their stomachs. And for supper, maybe they'll eat a cold sandwich that's been there for months.

If they cooked food at all, he continues, it was generally over an open pit fire, sometimes with a makeshift grill. "You know what I've seen—the rim of a bicycle tire—the spokes—that's their 'grill,'" Martinez says. For bathroom and water needs, "they have to walk to the local gas station." Thus, for some households, simply managing basic needs required hours and hours of walking with small children in tow. "It's a daily thing," Martinez says. "If they don't have transportation, they walk—I've seen that. … I can tell you, when I first got here [to the Lower Rio Grande Valley], I didn't believe it."