

2011

Expanding Organizational Advocacy Capacity: Reflections From the Field

Annette Gardner

Philip R. Lee Institute for Health Policy Studies

Sara Geierstanger

Philip R. Lee Institute for Health Policy Studies

Lori Miller Nascimento

The California Endowment

Claire Brindis

Philip R. Lee Institute for Health Policy Studies

Follow this and additional works at: <https://scholarworks.gvsu.edu/tfr>

 Part of the [Nonprofit Administration and Management Commons](#), and the [Public Affairs, Public Policy and Public Administration Commons](#)

Recommended Citation

Gardner, Annette; Geierstanger, Sara; Miller Nascimento, Lori; and Brindis, Claire (2011) "Expanding Organizational Advocacy Capacity: Reflections From the Field," *The Foundation Review*: Vol. 3: Iss. 1, Article 4.

<https://doi.org/10.4087/FOUNDATIONREVIEW-D-10-00038>

Available at: <https://scholarworks.gvsu.edu/tfr/vol3/iss1/4>

This Open Access is brought to you for free and open access by ScholarWorks@GVSU. It has been accepted for inclusion in The Foundation Review by an authorized editor of ScholarWorks@GVSU. For more information, please contact scholarworks@gvsu.edu.

Expanding Organizational Advocacy Capacity: Reflections From the Field

Annette Gardner, Ph.D., and Sara Geierstanger, M.P.H., Philip R. Lee Institute for Health Policy Studies; Lori Miller Nascimento, M.P.H., The California Endowment; and Claire Brindis, Dr.P.H., Philip R. Lee Institute for Health Policy Studies

Introduction

Private foundations are increasingly willing to fund individuals and organizations to advocate for policy changes that benefit vulnerable populations. For example, The California Endowment, the Annie E. Casey Foundation, the Atlantic Philanthropies, and the W.K. Kellogg Foundation provide grant support to help organizations advocate for policies that increase access to health care and improve food systems. They also provide funding to advocates to create lasting change in their communities through activities including community organizing, targeted issue advocacy, and outreach campaigns (Harvard Family Research Project, 2007).

As part of its commitment to increasing access to high-quality, affordable health care for underserved Californians, The California Endowment provided nine years of funding for the Clinic Consortia Policy and Advocacy Program. In 2001, 15 California local and regional community clinic associations and four statewide clinic organizations received \$10 million in funding over three years to strengthen their capacity to support the policy and operational needs of community clinics. In 2004 and 2007, The Endowment renewed funding, granting \$18 million over three years to 18 grantees to start or continue similar activities.¹ Clinic consortia are nonprofit statewide, regional, and local associations of primary-care clinics that

Key Points

- Organizational advocacy capacity is an increasingly important area of inquiry, raising questions about the opportunities (and limits) for achieving and sustaining policy change.
- The California Endowment implemented the Clinic Consortia Policy and Advocacy Program to expand grantee advocacy capacity to support the policy and operational needs of California's community clinics.
- In-person meetings with decision-makers and developing working relationships were among the key advocacy activities undertaken by 19 grantees. Grantees secured several policy wins through a variety of strategies, including mobilizing member clinics to be potent advocates.
- The "return on investment analysis" indicates that grantees secured policymaker support for clinic programs and services that brought member clinics a total of \$1.63 billion from 2001 to 2009 to increase access to care.
- Longer-term outcomes achieved by grantee policy and program initiatives included a strengthened health care safety net and increased access to health care for medically underserved Californians.
- Funders of advocacy and policy change initiatives are encouraged to consider the resources needed to build and sustain advocacy capacity, including grantee technical expertise, partnerships with stakeholders, and time required to expand advocacy capacity.

undertake activities that individual clinics may not be able to do on their own (See Table 1.)

¹ One grantee was not funded in 2004 and 2007, bringing the total number of grantees to 18.

TABLE 1

Grantees or Clinic Consortia
Alameda Health Consortium (AHC)
Alliance for Rural Community Health (ARCH)
California Family Health Council (CFHC)
California Planned Parenthood Education Fund (CPPEF)
California Primary Care Association (CPCA)
California Rural Indian Health Board (CRIHB)
Capitol Community Health Network (CCHN)
Central Valley Health Network (CVHN)
Coalition of Orange County Community Clinics (COCCC)
Community Clinic Association of Los Angeles County (CCALAC)
Community Clinic Consortium Serving Contra Costa and Solano Counties (3C)
Community Health Partnership, Inc. (CHP)
Council of Community Clinics (CCC)
North Coast Clinics Network (NCCN)
Northern Sierra Rural Health Network (NSRHN)
Redwood Community Health Coalition (RCHC)
San Francisco Community Clinic Consortium (SFCCC)
Shasta Consortium of Community Health Centers (SCCHC)

In addition to providing funding, The California Endowment developed individual and cross-grantee objectives for each round of funding. It used a six-month interim-report template and final-report template to monitor individual grantee progress. The Endowment was also a key evaluation partner, assisting in the development of evaluation measures, identifying key areas for further inquiry, and co-hosting the annual evaluation convenings. It was also important to The Endowment that grantees learned from one another. The annual convenings and case studies provided grantees with lessons learned and gave them an opportunity to discuss their work and its implications. Last, a significant number of foundation staff were involved throughout the nine-year period to learn how the program could serve as a model for other multisite, multilevel policy initiatives and advocacy investments.

The evaluation began in 2002 and collected data for the entire grant period of 2001 through 2009. It focused on how The California Endowment’s grant supported grantees in responding to the challenges of the shifting health care and politi-

cal environments, such as budget shortfalls and changes to the Medicaid program.²

California is unique in having upwards of 18 community clinic consortia; the oldest consortium, the California Rural Indian Health Board (CRIHB), was launched in 1969. Five grantees were launched in the 1970s and two grantees were launched in the 1980s. Ten grantees were launched in the early 1990s to help clinics transition to Medicaid managed care.

Consortia vary in size and membership, staffing, scope of services, geographic focus, and age. Clinic needs vary; smaller, rural clinics need different types of support compared to large, multisite corporations. Although clinic consortia are diverse in their membership focus and areas of expertise, they all help individual clinics meet the needs of their patient populations. They provide a unified voice calling for increased services to the uninsured, offer economies of scale for business

² Additional analyses from the evaluation can be found at http://ihps.medschool.ucsf.edu/News/california_endowment.aspx

and program shared services, and allow clinics to work in partnership on local health improvement programs to benefit clients.

Collectively and individually, the grantees used this funding to educate policymakers and target clinic policy issues, establishing themselves as a voice at the federal, state, and county levels for the 951 primary-care clinics in California that serve 4.8 million low-income and uninsured Californians (Office of Statewide Health Planning and Development, 2009).³ Program funding supported advocacy activities to sustain needed health care services for vulnerable populations, including convening forums, publishing educational materials, conducting media advocacy, and providing advocacy technical assistance to increase the collective influence of clinics.⁴

Background

Collective political action by groups of all types is an important means for inclusion of voices that otherwise might be silent in U.S. politics and policymaking (Richardson, 1993; Baumgartner & Leech, 1998). These groups are referred to by many names, including political groups, special interest groups, and voluntary associations, and there is a large body of work detailing their specific tactics. For example, Schlozman and Tierney (1986) found that 14 of the 27 influential activities that were employed by advocacy organizations were used by 80 percent or more of the groups surveyed, ranging from testifying at hearings to grassroots lobbying efforts. In their review of six surveys of interest groups activities, Baumgartner and Leech (1998) had similar findings – namely, that although groups tend not to specialize and employ a particular strategy, they are often strategic in their deployment of specific tactics. A more recent study found that advocates use particular strategies based on available resources, the lobbying target, the particular policy issue, and the legislative context (Victor, 2007).

Additionally, the universe of advocacy activi-

³ These 951 primary-care clinics are not all members of the 18 consortia grantees.

⁴ Please note that lobbying activities were not funded under this program and are assumed to be funded by other funding sources.

ties and groups has expanded due in large part to greater government involvement in new and existing areas, including the health care arena – which experienced a sizeable increase in the number of interest groups during the early 1990s when national health care reform efforts mobilized stakeholders from all sectors (Wiessert & Wiessert, 1996). Within the Medicaid program, for example, is a plethora of interests represented by influential groups, including providers, the elderly, people with disabilities, children in low-income families, and low-income adults (Kronebusch, 1997).

It is exceedingly difficult to assess the actual influence of these groups on policymaking, such as decision-maker support for a specific policy. There is evidence that interest groups strive to be influential – e.g., political action committees make large financial contributions to members of Congress – but their actual effectiveness varies greatly.

It is exceedingly difficult, however, to assess the actual influence of these groups on policymaking, such as decision-maker support for a specific policy. There is evidence that interest groups strive to be influential – e.g., political action committees make large financial contributions to members of Congress – but their actual effectiveness varies greatly (Baumgartner & Leech, 1998). Additionally, some advocacy tactics may be more influential than others. For example, Kelleher and Yackee (2006) found that interest groups that spent time with bureaucrats were more likely to influence state-agency rulemaking than those that did not. Collecting, analyzing, and disseminating information on key policy issues may be more important than other advocacy activities to secure access to

TABLE 2



decision makers (Kersh, 2007; Salisbury, Johnson, Heinz, Laumann, & Nelson, 1989). Advocacy success also may be highly contingent on specific conditions, such as restrictions on lobbying (Lowery & Gray, 2004). However, the recent development of advocacy-capacity and decision-maker support evaluation measures is expanding our ability to identify and assess advocacy strategies and account for contextual factors.⁵

Evaluation Methodology

In 2002, the University of California, San Francisco (UCSF) evaluation team began a multiyear evaluation to assess the outcomes and effectiveness of The California Endowment’s Clinic Consortia Policy and Advocacy Program. As described in the “program logic model” developed by The Endowment (see Table 2), the program is based on the theory that staffing and resources dedicated to policy advocacy and technical assistance will increase the collective influence of clinics and strengthen a broad base for long-term support of clinic policy issues. These activities are anticipated to contribute to improved health outcomes for target communities. The model provided the basis for identifying indicators and measures for the external evaluation, as well as for monitoring individual grantee progress in achieving their respective outcomes.

UCSF used a three-part approach to create a learning, participatory process whereby the evaluation findings met the needs of all stakeholders:

1. Creation of a mixed-method evaluation toolkit that combined rigor with reflection. UCSF used an outcomes framework to assess the program outcomes and qualitative methods to characterize grantee and program accomplishments.
2. Provision of evaluation technical assistance or creating a learning environment to strengthen grantee evaluation activities. During the first two rounds of the grant (2001-2006), UCSF worked with grantees to develop and use individual logic models and to communicate evaluation findings.
3. Communications or creating an information feedback loop. An important feature of the design was sharing evaluation results with grantees and the funder through hosting annual grantee meetings in which evaluation results were reviewed, and developing useful documents that could be shared more broadly. These efforts were used as a quality-improvement loop and assisted grantees in their planning efforts.

Assessing group influence can greatly benefit from the use of policy-change stage models that describe the policymaking process. Such mod-

⁵ The California Endowment, the Alliance for Justice and others have developed or compiled research and evaluation measures for use by researchers, advocates, and funders.

TABLE 3

Stages of Policymaking Process and Potential Advocacy Activities
Stage 1. Policy-issue recognition: Advocacy efforts are focused on educating and encouraging appointed and elected officials to recognize the compelling nature of the policy issue, increasing their motivation to act (e.g., policy forums, in-person meetings, media advocacy).
Stage 2. Agenda setting: Determining which issues will occupy the attention of decision-makers (e.g., securing media coverage, influencing public opinion).
Stage 3. Policy prioritization: The policy issue is formally adopted and key decision-makers actively advocate on its behalf in order to achieve the remaining stages (e.g., providing information on policy impacts on target populations).
Stage 4. Policy implementation: Legislative action, new legislation, and/or protocols are implemented (e.g., working with agencies to draft rules and regulations).
Stage 5. Policy maintenance: Advocates, interest groups, politicians, and other stakeholders work to sustain public interest and attention, with hopes for ongoing support of the implemented policies (e.g., partnerships with advocacy allies, educating new policymakers).

(Theodoulou, 1995; Lowery & Brasher, 2004)

els include clear points where advocates can intervene before, during, and after the legislative process. In the UCSF evaluation design, we worked with a modified stage model to organize the nonlobbying activities undertaken by grantees that were profiled in the three evaluation policy case studies (See Table 3.)

Data Collection Methods

Because the evaluation began during the first round of funding (2001-2003), UCSF used a combination of quantitative longitudinal measures; stakeholder, media and policymaker surveys; and qualitative case studies to both capture the early experience with the program and monitor progress⁶ (See Table 4.) As the evaluation progressed, we replaced interim measure, such as the Advocacy Activities Worksheet, with other approaches to assess the longer-term outcomes, such as case studies, as well as deepen our inquiry in the areas of partnerships and media coverage. A few approaches, specifically the Funding Secured Worksheet and Annual Grantee Interviews, spanned the entire grant period of 2001 through 2009.

To assess the role of the grant in increasing grantee capacity in policy advocacy, the first program outcome, a collection of quantitative and qualitative tools were administered. First, the

Advocacy Activities Worksheet assessed grant-funded policy-advocacy activities from 2002 to 2006, including the level (federal, state, local) at which they targeted these activities, the perceived effectiveness of these activities, and whether these activities contributed to three desired annual objectives: increased clinic funding, increased policymaker awareness, and achieved a policy change.⁷ Second, Annual Grantee Interviews documented their progress since the previous year and contextual information, such as facilitating factors and barriers to success. Third, the Implementation and Sustainability Survey assessed the initial impact of Round 1 of the program (2001-2003) on grantee capacity to engage in advocacy and plans for sustainability.

To assess the role of the grant in increasing decision-maker familiarity with consortia, clinic activities, and clinic policy issues, the Policymaker and Community Leaders Awareness Survey was completed by 86 policymakers and community leaders well-known to consortia in 2003. In 2004, the Stakeholder Awareness Survey was completed by 43 state and local policymakers and community leaders whom grantees perceived to be less familiar with consortia but who were nonetheless considered important stakeholders in California's health care safety net.

⁶ We are not including all of the evaluation-data collection activities in this article; specifically, our assessment of grantee media advocacy activities and partnership activities are reported elsewhere.

⁷ The number of advocacy activities increased by one or two activities annually during the course of the grant, for a total of 16 activity types. However, in the longitudinal analysis, we assessed a subset of these activities (13) and grantees (15) that remained the same from 2002 to 2006.

TABLE 4 Evaluation Data Collection Instruments, 2001-2010

Year	Data Collection Activity	Focus
2003	Grantee Interviews (n=19)	Changes in activities and relationship with media
	Advocacy Activities Worksheet (n=15)	Effectiveness of advocacy activities
	Policymaker and Community Leader Awareness Survey (n=86 leaders targeted through program activities)	Perceptions of consortia advocacy activities
2004	Grantee Interviews (n=18)	Changes in activities and relationship with media
	Advocacy Activities Worksheet (n=15)	Effectiveness of advocacy activities
	Funding Secured Worksheet (n=18)	Funding secured by grantees that can be attributed to grant
	Grantee Implementation and Sustainability Survey (n=19)	Advocacy-capacity gains and resources required to support these activities
	Clinic Focus Groups (n=11)	Perceptions of consortia advocacy activities and benefits
	Stakeholder Awareness Survey (n=43 leaders less familiar with consortia)	Perceptions of consortia advocacy activities
2005	Policies Outcome Worksheet (n=17)	Federal, state, and local policies targeted by grantees
	Grantee Interviews (n=17)	Changes in activities and relationship with media
	Advocacy Activities Worksheet (n=15)	Effectiveness of advocacy activities
	Funding Secured Worksheet (n=15)	Funding secured by grantees that can be attributed to grant
2006	Policies Outcome Worksheet (n=17)	Federal, state, and local policies targeted by grantees
	Grantee Interviews (n=18)	Changes in activities and relationship with media
	Advocacy Activities Worksheet (n=15)	Effectiveness of media advocacy activities
	Funding Secured Worksheet (n=18)	Funding secured by grantees that can be attributed to grant
	Policies Outcome Worksheet (n=18)	Federal, state, and local policies targeted by grantees
2007-2010	Clinic Focus Groups (n=9)	Perceptions of consortia advocacy activities and impacts on clinics and their communities
	Policy Advocacy Case Studies (3)	3 policies targeted by a subset of grantees
	Grantee Interviews (n=18)	Changes in activities and relationship with media
2009-2010	Funding Secured Worksheet (n=18)	Funding secured by grantees that can be attributed to grant
	Policies Outcomes Worksheet (n=18)	Federal, state, and local policies targeted by grantees
2009-2010	Individual Grantee Case Studies (n = 16)	Detailed case studies of 16 policy and program initiatives undertaken during the grant period (2001-2009) that demonstrated achievement of the program longer-term outcomes

To assess success in increasing policymaker support for clinic funding, a Policies Worksheet was completed by grantees from 2004 to 2009 detailing information on their targeted federal, state, and local policies as well as the objectives achieved, including passage of legislation and funding secured. Second, a Funding Secured Worksheet provided information on the sources and amount of funding secured by all grantees on behalf of clinics and consortia from 2001 to 2009 that could be attributed to program-funded activities, as well as the allocation of these funds to clinics and consortia.

To assess the impact of grantee advocacy and policy change on strengthened clinic operations, UCSF conducted two Focus Groups of 11 and nine clinic executive directors in 2004 and 2006, respectively. UCSF asked participants to identify clinic capacity gains supported under the grant, as well as perceived benefits of grantee policy advocacy to clinics and their communities. Clinic staff were also interviewed for the 17 Individual Grantee Case Studies described below, and were asked to describe the impact of a policy or program on clinic operations and services and patient utilization of clinic services.

UCSF assessed the latter two outcomes, increased services for the underserved and uninsured and improved health outcomes for targeted communities and populations, by developing Policy Case Studies in 2006 and 2007 focusing on three successful policies at the state and local levels aimed at securing funding to integrate mental health and primary care services under the state Mental Health Services Act (Proposition 63), successful implementation of the state Medi-Cal Prospective Payment System, and passage and implementation of Measure A in Alameda County. UCSF also developed 17 Individual Grantee Case Studies of policy or program initiatives that demonstrated achievement of one or both outcomes, e.g., quantitative data on increased enrollment in Medi-Cal, the state's Medicaid program. UCSF conducted open-ended interviews in 2009-10 with grantee staff, decision makers, clinic staff, and partner organizations that were involved with the initiative. Informants were asked to describe their level of

involvement, the stakeholders involved, challenges encountered, and benefits to clinics and their target populations. Informants were also asked to provide quantitative evidence of achievement for program outcomes, such as the number of uninsured Californians enrolled in public or private insurance or in coordinated services.

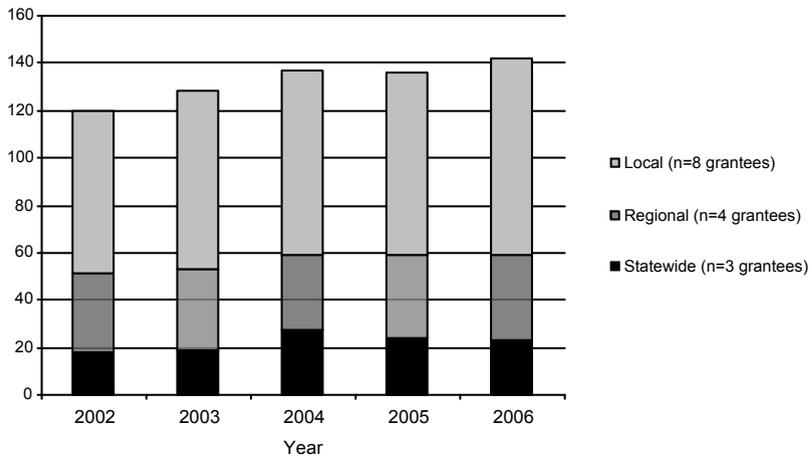
Analyses

All the qualitative and quantitative data were entered into Microsoft Office Excel to organize and analyze the data. Quantitative data, particularly the effectiveness data – such as grantee perception of usefulness of media advocacy – were tabulated in Filemaker Pro, a relational database software program. Qualitative data were categorized, coded, and tabulated to identify the most frequently mentioned responses. Since legislation can be pending for up to two years, UCSF clustered federal and state bills targeted by grantees by the three rounds of funding. Because the grantee population is small, in some cases we present the number of grantees that provided a specific response rather than the percentage. To strengthen the trend analysis of the Advocacy Activities Worksheet data, we adjusted all the years and eliminated the activities and grantees that did not stay constant for the five-year period. Additionally, the funding secured by grantees on behalf of clinics and consortia that could be attributed to grant-funded activities was determined by using a percentage estimate of grantee staffing devoted to activities funded under the grant. UCSF provided a metric that grantees used to calculate their percentage of involvement. Actual funding secured – federal, state, local, and private – was calculated using this metric. Input from the focus groups was transcribed and analyzed for common themes and benefits to clinics. Last, the Policy Case Studies were analyzed for crosscutting strategies and factors for success.

Findings

From 2001 to 2009, grantees used Endowment resources to develop their internal capacity (e.g., hiring an experienced policy director, learning how to secure media coverage) to undertake diverse advocacy activities at the federal, state, and local levels. Overall, the findings suggest

FIGURE 1 Number of Grantee Advocacy Activities, by Level of Membership Focus, 2002-2006



these capacity gains resulted in tangible benefits to clinics and their target populations, such as the strengthening of California’s health care safety net and improved health status of key clinic target populations. In this section, we report the findings by program outcome.

Outcome 1: Increased Grantee Capacity in Policy Advocacy

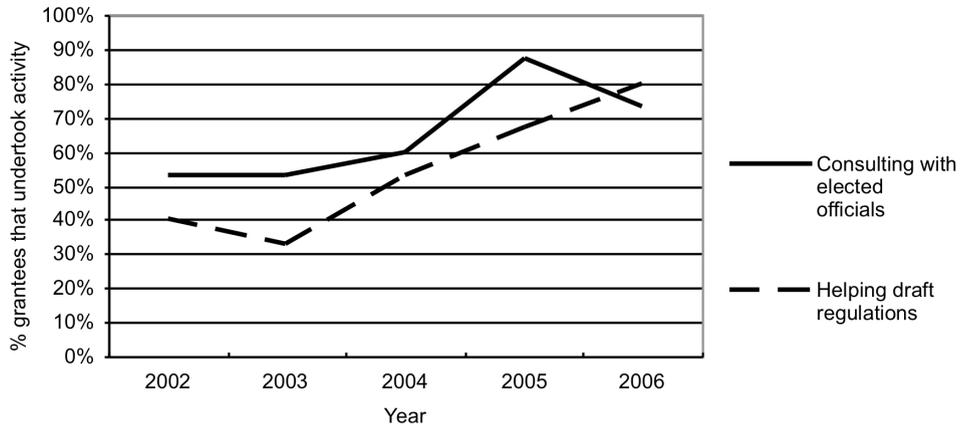
Overall, there was an annual increase in advocacy activities undertaken by grantees, from 120 activities in 2002 (72.7 percent of surveyed activities) to 142 activities in 2006 (86.1 percent). Local grantees experienced a modest increase in their activities, while statewide and regional grantees stayed relatively constant. Grantee involvement – the percentage of grantees that undertook a specific activity “more,” “less,” or “same” – stayed constant for most activities from 2002 to 2006. The level of focus of these advocacy activities – federal, state, or local – did not vary that much, either. (See Figure 1). However, grantees increased their involvement in activities specific to the policy-making process, particularly “helping draft rules, regulations, and guidelines” and “consulting with elected officials to plan policymaking strategies.” (See Figure 2).

We identified the key advocacy capacity gains that grantees might not have been able to do without

the first round of program funding (2001-2003):

1. increased capacity to monitor the policy environment (89 percent);
2. increased advocacy technical assistance to clinics (84 percent);
3. provision of written briefs and other materials to others, e.g., “action alerts” (79 percent);
4. increased staffing (74 percent); and
5. expanded level of focus, e.g., county and state policy arenas (68 percent).

Interestingly, the grantee perceptions of the success of their advocacy activities in achieving the desired outcomes stayed fairly constant from 2002 to 2006 and ranged from 3.28 to 3.36, where 4 equaled “very effective” (N=15 grantees). “Helping draft rules, regulations and guidelines” experienced the greatest increase in effectiveness since 2002 (from 3.14 to 3.50). Two activities decreased in perceived effectiveness from 2002 to 2006: “media advocacy” (from 3.31 to 2.57) and “engaging in informal contacts with elected officials about general points of view” (from 3.58 to 3.00).

FIGURE 2 Grantee Involvement in Individual Advocacy Activities: 2002-2006

From 2002 through 2006, there were modest differences in advocacy activities by grantee age (pre-1990 and post-1990). By 2006, younger and older grantees engaged in the same percentage of activities (86 percent). However, older grantees were significantly more active at the federal level (70 percent vs. 49 percent) from 2002 to 2006. Additionally, early in the grant period, younger grantees were less likely to perceive their advocacy activities as achieving key program objectives. By 2006, however, there were limited differences in the perceptions of effectiveness of activities, with all consortia similarly perceiving their activities as resulting in “increased funding to clinics,” and “achieving a policy change.”

The analysis of three types of policies that resulted in financial gains to clinics – state Prospective Payment System (PPS) for Medi-Cal (SB 36), Measure A in Alameda County, and local Mental Health Services Act (Proposition 63) funding in two counties – afforded a detailed look at how grantee advocacy resulted in these policy “wins.” The impact of PPS on clinics was significant, securing a more beneficial payment methodology for clinic Medi-Cal services. Measure A provided new funding (approximately \$16.8 million over three years) to community clinics and strengthened the county’s safety net. The local Mental Health Services Act (MHSA) provided \$1 million a year for three years to clinics in Alameda County for integrated mental health and primary care programs, and \$5.6 million over two and a

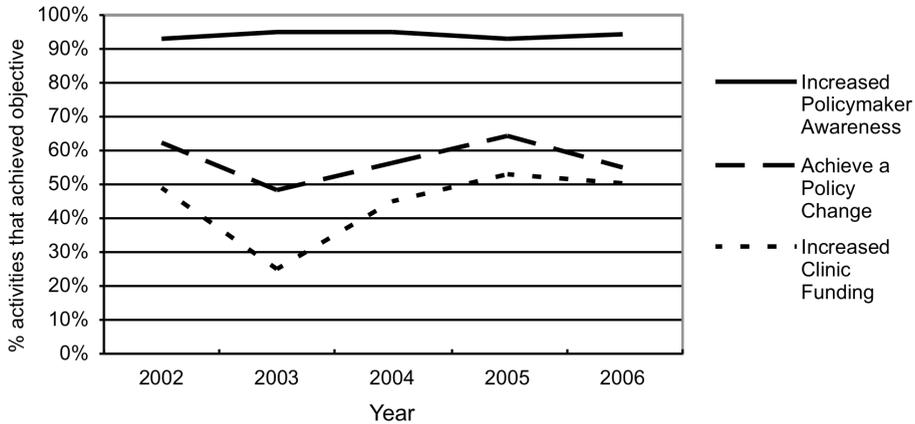
half years for San Diego County. Key factors that contributed to grantee success included “staff expertise and long-time relationships,” the ability to “participate early and often during the planning and implementation phases,” “business acumen” and “the ability to make financial projections,” the “ability to build coalitions and mobilize stakeholders,” and the “ability to leverage partnerships with member clinics.” For example, grantees facilitated partnerships among stakeholders early on and then applied their technical expertise in allocation methodologies (e.g., collecting and analyzing clinic financial and utilization data) later on in the implementation stage.

While consortia used similar advocacy strategies, there were some differences. For example, the media was used extensively in Alameda County to increase policymaker and community awareness about the role of clinics, while the media played less of a role in implementation of PPS and securing of local MHSA funding. PPS negotiations also included discussions with federal, state, and local decision-makers, while Measure A and MHSA funding were primarily local decisions.

Outcome 2: Increased Policymaker Awareness of Safety Net and Clinic Policy Issues

Grantees reported that nearly all advocacy activities consistently increased policymaker awareness. (See Figure 3). These perceptions were corroborated by our findings from surveys of two different cohorts of decision-makers. The

FIGURE 3 Percent of Activities Reported to Achieve 3 Program Objectives: 2002-2006



policy makers surveyed in 2003 were well known to consortia and reported high familiarity with clinic consortia (3.7 where 4 equaled “very familiar”), consortia activities (3.3), and clinic policy issues (3.6). They also felt that “consortia-sponsored policy events” (74 percent) and “consortia media activities” (60 percent) were “very effective.” Finally, 90 percent rated consortia as “very effective” in “meeting the needs of the uninsured.” In 2004, we surveyed state and local policy makers and community leaders whom grantees perceived to be less familiar with consortia or clinics, but who were nonetheless considered important stakeholders in California’s health care safety net. These stakeholders reported less familiarity with clinic consortia (2.7 where 4 equaled “very familiar”), but high familiarity with consortia activities (3.5), and clinic policy issues (3.4). A somewhat smaller percentage of the 2004 stakeholders than of the 2003 policy makers felt that “consortia-sponsored policy events” (61 percent) and “consortia media activities” (42 percent) were “very effective.” Finally, 71 percent of the stakeholders rated consortia as “very effective” in “meeting the needs of the uninsured.”

Outcome 3: Increased Policymaker Support for Clinic Funding

UCSF tabulation of state and federal legislation targeted by grantees indicates that grantees experienced an increase in federal legislation (from 5 to 10 bills) that was signed in to law, signaling a change in administration and new funding

opportunities. Passage of state legislation stayed somewhat constant (20 to 26 bills), despite an increasingly negative environment for policies requesting new funding. (See Figure 4.) In addition, grantees focused on existing programs like Family PACT, an 1115 Medicaid waiver focused on reproductive-health coverage, to expand the number of clients served. Last, policies that created cost-savings were emphasized, e.g., the Provider Enrollment Streamlining (AB 2307) legislation, which streamlines the enrollment of primary-care clinics as providers in California’s various public programs, thereby eliminating costly duplicative requirements.

The financial gains from many of these policies were significant. In total, grantees reported securing more than \$5.27 billion between 2001 and 2009, with \$1.63 billion (31 percent) of that financing attributable to support from The California Endowment.⁸ Total funding secured by grantees that was attributable to their advocacy and fund-development activities increased from \$104 million in 2001 to \$364 million in 2009. (See Figure 5.) Most of these funds (about 90 percent annually) were directed to clinics and the remainder went to consortia. Much of this funding (64

⁸ By “attributable to support from The California Endowment,” we mean that program funding paid for staff time that was used to secure this funding. The remaining 70 percent of funding secured by grantees was supported by other means, such as core-support grants from other foundations, lobbying or other organizations that played a lead role in securing the funding that was not supported by this grant.

FIGURE 4 Federal and State Legislation Targeted by Grantees, by Round

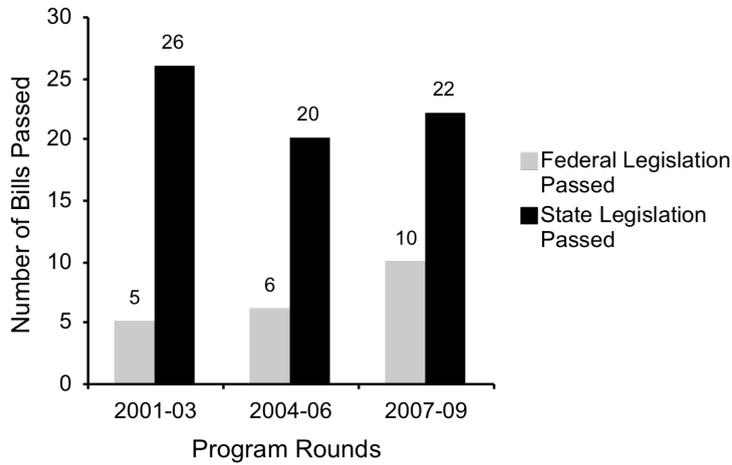
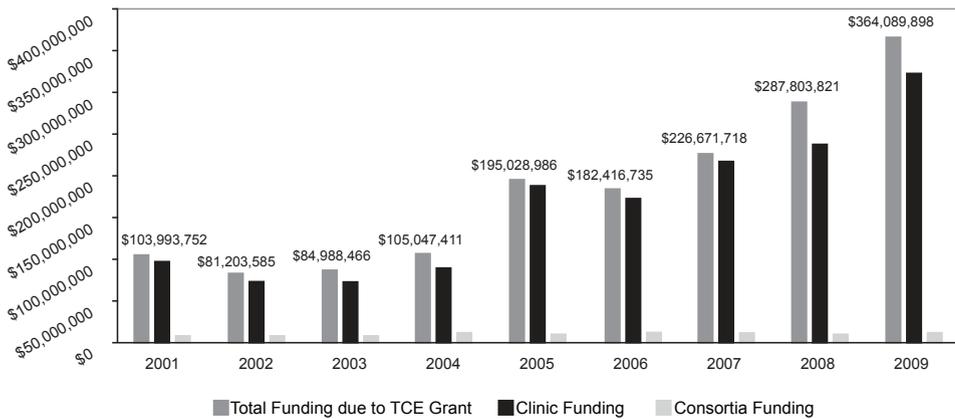


FIGURE 5 Total Funds Attributed to Endowment Policy and Advocacy Program Activities



percent) was maintained funding (versus new funding), such as clinic Medi-Cal funding.

Upon closer examination, the change in funding over time by source of funding reveals a changing policy environment, with varying funding levels by source. Local funding increased throughout the grant period, becoming the largest source of funding (36 percent), due in large part to county contracts for clinics. Federal funding was stable and was the second-largest public funding source (34 percent), particularly clinic funding directed to Federally Qualified Health Centers and funding under the American Recovery and Reinvestment Act of 2009. State funding was the

third-largest source (25 percent) and experienced a significant decline in 2009 due to the elimination of Medi-Cal optional benefits (such as adult dental) and Traditional Clinic Programs, such as the state-funded Expanded Access to Primary Care program. Private funding, such as foundation support, remained stable (5 percent) during the grant period.

Additionally, the 17 individual grantee case studies illustrate the linkages between grantee education activities that contribute to increased policymaker awareness of the role of community clinics and support for policies or programs that increase access to care for clinic target popula-

TABLE 5 Funding Secured by Individual Grantees (Partial List), by Level

Federal funding secured:
<ul style="list-style-type: none"> Title X funding for reproductive health services was increased by 3% in 2008 and 2009 (CFHC). Tribal Health Programs received a 13% increase in funding in the 2010 HIS budget (CRIHB).
State funding secured:
<ul style="list-style-type: none"> SB 94 was passed, for an increase in Medi-Cal provider reimbursement rates for family-planning services (CPPEF). \$40 million was allocated to 146 community clinics under the Community Clinic Grant Program of 2005 (CPCA).
County funding secured:
<ul style="list-style-type: none"> Four clinics will receive \$2.3 million in MHSA funding in Alameda County (AHC). Mendocino Board of Supervisors provided \$240,000 in general fund support for Healthy Kids Mendocino (ARCH). Los Angeles County expanded the Public Private Partnership Program by \$46 million in 2010, benefiting 18 clinics (CCALAC). Contra Costa County paid 45 clinics \$1.5 million to provide services to upwards of 5,000 uninsured undocumented immigrants (3C). San Diego County awarded the Council of Community Clinics \$1.8 million for 3 years to administer MHSA funding for 9 clinics (CCC).

tions. Most grantees (13) were able to secure some form of monetary support from either local, state, or federal decision-makers. Seven were successful at either maintaining existing funding or receiving new funding, e.g., for expanded Medi-Cal provider reimbursement rates. Four grantees secured county contracts for member clinics and two grantees received county in-kind support, such as staff time, office space, or training. Policymaker support can also be nonmonetary; four grantees received letters of support for their policy position or help in convening stakeholders. (See Table 5.)

Outcome 4: Strengthened Clinic Operations

The evaluation findings demonstrate a variety of areas in which the grant strengthened clinic operations. First, most of the funds secured by grantees – 90 percent – were directed to clinics and their target populations, including funding for patient services, clinic facilities, technical assistance, and programmatic expansions, such as information technology. The 2004 and 2006 clinic focus group participants also described funding gains that consortia had helped them achieve, such as mobilizing clinics to apply for clinic 330 and 330 look-alike status to secure federal funding.

Second, the focus group participants said that consortia had increased their representation in a variety of state and local policy initiatives, such

as securing local contracts. Clinics have come to rely on the consortia, indicating that it is extremely helpful to have someone whose job it is to digest information, analyze the impact of upcoming legislation, develop strategies, and engage clinic staff, and sometimes patients/consumers, in policy advocacy. There was overwhelming consensus among focus group participants that consortia had increased the ability of clinics to influence policy. As one participant put it: “We are a force to be reckoned with.”

Additionally, clinic focus group participants said consortia had strengthened their institutional relationships and helped to forge new partnerships, such as with the county health department. They also reported that consortia brought new resources and expanded the provision of services, such as introducing clinics to new information technology systems. Grantee and clinic informants provided anecdotal information on expanded clinic operations, including outreach and enrollment, e.g., co-locating a certified application assister for on-site public health insurance enrollment; increased coordination of services, e.g., adoption of the medical home model; and expanded advocacy skills, e.g., patients trained by a clinic consortia to advocate for clinic policies. They also described benefits of these areas of expertise to the clinic, particularly expanded capacity to serve new patients, expanded reimbursement for uninsured patients, and reconfiguring of

TABLE 6 Evidence of Achievement of Longer-Term Program Outcomes

Increased insurance coverage:
<ul style="list-style-type: none"> • The number of uninsured children in Mendocino County was reduced from 16% to 8% from 2005 to 2007. • Certified Application Assistors in Sonoma County processed more than 83,000 applications since 1998 (25,000 per year). About 9,000 children were enrolled in public and private insurance in Sonoma County from 2005 to 2009.
Increased utilization of clinic services:
<ul style="list-style-type: none"> • There has been an increase of 70,000 clinic clients since the Medi-Cal provider reimbursement rate increase went into effect. • It is estimated that the \$40 million in clinic infrastructure funding under The Community Clinic Grant resulted in 700,000 visits. • The \$46 million in new funding for community clinics in Los Angeles County will provide an additional 401,163 encounters. • 5,000 undocumented immigrants retained access to primary-care services in Contra Costa County. • Securing HPSA designations resulted in 36,655 patient visits in rural Northern California. • The number of Medi-Cal clients served by community clinics in Orange County increased from 8% to 17%. • Community clinics in San Francisco serve as the medical home for 21,982 Healthy San Francisco participants (43%).

clinic services to better meet the needs of target populations, e.g., co-location of mental health and primary care services.

Outcome 5: Increased Services for the Underserved and Uninsured

Of the 17 grantee initiatives, seven grantee policy or program initiatives resulted in expanded clinic services and consequently an increase in utilization of services. For example, one grantee secured \$46 million in new funding for 18 community clinics in Los Angeles County that will be used to expand services for an additional 401,163 encounters. Additionally, two grantees reported expanded enrollment in insurance for children, as well as an increase in well-child prevention visits. In Sonoma County, approximately 9,000 children were enrolled in public and private insurance through a public-private partnership between the county health agency and a grantee from 2005 to 2009. In many cases, advocacy continues to be an important component to achieve program sustainability, protecting clinics from regulatory challenges as well as sustaining policymaker support. For example, one grantee is constantly monitoring potential changes in Health Professional Shortage Area regulations and engaging decision-makers to write letters of support when clinic interests are at risk. (See Table 6 for a list of specific initiatives and the number of actual and anticipated patient visits.)

Outcome 6: Improved Health Outcomes for Targeted Communities and Populations

While the most challenging outcome to assess, a “strengthened health care safety net” that better meets the needs of the community was seen in seven grantee initiatives. Of the 17 grantee initiatives, four grantee initiatives were able to strengthen the relationship between clinics and their patients through adoption of the patient-centered medical homes, and two grantees increased availability of mental health services in the clinic setting. Second, five initiatives demonstrated “improved health status for clinic target populations,” such as the reduction of unintended teen pregnancies. Last, a couple of initiatives demonstrated other communitywide outcomes, such as increased use of preventive services by newly insured children and decreased use of emergency room services. Decision-makers and partner organizations spoke positively of these countywide or system wide changes and the benefits to the community, including the preservation of clinic services in the face of state and local budget cuts, the increasingly important role of clinics in providing care for the uninsured, and the linking of people to the right place for care.⁹

Program Lessons for Funders

Clinic consortia were found to be an effective

⁹ The 17 four-page individual case studies can be found at http://ihps.medschool.ucsf.edu/News/california_endowment.aspx

voice for change on behalf of their member clinics, and their accomplishments in the policy realm have strengthened clinic operations as well as expanded clinic services of all types. The evaluation findings suggest that nearly all grantees made significant progress in achieving the first five program outcomes, resulting in a strengthened health care safety net and access to care for millions of Californians. In this section, we discuss the relevance of the findings for expanding advocacy capacity, including suggestions for parlaying these capacity gains into meaningful and lasting change.

The comparison among consortia that were formed before and after 1990 suggest advocacy-capacity gains take two or three years to secure. The capacity gains by younger grantees indicate the advocacy funding allowed them to hire an experienced advocate, as well as free up staff time to focus on advocacy, played an important role in quickly leveling the field among new and old grantee organizations.

Increased Capacity to Become an Effective Voice for Change

Our longitudinal research is one of the few efforts to document annual changes in advocacy group capacity and how long it takes to become an effective voice. The comparison among consortia that were formed before and after 1990 suggest advocacy-capacity gains take two or three years to secure. The capacity gains by younger grantees indicate the advocacy funding allowed them to hire an experienced advocate, as well as free up staff time to focus on advocacy, played an important

role in quickly leveling the field among new and old grantee organizations. Newer agencies, for example, can hire an experienced advocate as well as free up staff time to focus on advocacy.

Once resources were mobilized, grantees expanded their repertoire of advocacy activities from 2002 to 2006 in number, type, and in the effort devoted to these activities. Grantees were able to respond to opportunities at multiple levels, monitor emerging issues in diverse policy arenas, and apprise a broad target audience of key issues and their repercussions. For example, grantees expanded their venues and strategies for approaching, educating, and working with decision-makers, ranging from participation on committees during the early planning stages of policies to shaping rules and regulations post-passage at the local and state levels.

Staffing or hiring of a part- or full-time policy director may be the key factor here. Similar to an interest group entrepreneur, these individuals are responsible for collecting and disseminating information, monitoring and targeting key policy issues, acting as agents for the membership, and communicating with the media, public and public officials (Ainsworth, 2002). Grantee policy directors play an important role in strengthening the relationships among member clinics, as well as creating a policy agenda that reflects those of the membership.

Strategic Involvement in the Policymaking Process

Although earlier research has shown that some advocacy activities may be more effective than others, our data suggest the differences are modest. Except media advocacy, which declined in perceived effectiveness to 2.57, the difference between the highest- and lowest-rated activity rarely exceeded 0.5. Interestingly, the most effective activity varied somewhat from 2002 to 2006, with “helping to draft rules and regulations” being perceived as an increasingly effective strategy to pursue. This activity was also considered the most effective in “achieving a policy change” and “increased funding to clinics,” two program objectives. These findings suggest

grantees have leveraged their capacity gains and secured entrée into key policy arenas, where they can parlay their technical expertise. Moreover, these findings speak to the importance of being involved throughout the policymaking process as described in our stage model, and not focusing on only one or two stages. As described earlier, the policy-change stage model demonstrates the importance of engaging in different types of activities at numerous points in the process. Policy change is complex and thus, as Lowery and Brasher (2004) point out, advocacy activities must be used strategically and tailored to different stages of the process. However, ongoing participation in the decision-making process raises important questions about deploying limited resources and sustaining advocacy expertise over an extended period of time.

Gaining Access to and Establishing Partnerships With Decision-Makers

The findings on high policymaker and stakeholder awareness of consortia, the safety net, and clinic policy issues early on in the grant period (2003-04) speak to grantee success in targeting and educating decision-makers on important clinic issues, such as the increase in the number of uninsured. To those policymakers already familiar with clinic consortia, grantees are viewed as credible partners to whom policymakers can turn to for information and input on policy issues, creating the basis for an ongoing relationship. High policymaker familiarity with consortia activities and perceived high effectiveness with consortia media events were shown to bode well for influencing the clinic policy agenda.

The moderately high level of familiarity among stakeholders less known to consortia suggests grantees have made inroads in developing relationships beyond their usual allies. Since California has term limits, grantees are under increased pressure to maintain their relationship-building efforts, as well as broaden their efforts beyond the decision-makers who focus on their particular policy issues, such as Medicaid, as there is constant churning of decision-makers.

The most effective activity varied somewhat from 2002 to 2006, with “helping to draft rules and regulations” being perceived as an increasingly effective strategy to pursue. This activity was also considered the most effective in “achieving a policy change” and “increased funding to clinics,” two program objectives. These findings suggest grantees have leveraged their capacity gains and secured entrée into key policy arenas, where they can parlay their technical expertise. Moreover, these findings speak to the importance of being involved throughout the policymaking process.

Moreover, the depth and breadth of these relationships may be critical to advocacy success. As the grant progressed, grantees spoke increasingly of the importance of in-person meetings and establishing ongoing working relationships with decision-makers, such as participation on committees and work groups that include a representative from the county board of supervisors and regular presentations to decision-makers on the clinic role in addressing the health care needs of the uninsured. The grantee perceptions of the importance of the quality and frequency of their interactions with decision-makers are supported by the findings by Kelleher and Yackee (2006) that informal interactions are important to the policy outcome.

Achieving a Policy Change: Gains to Member Clinics and Their Target Populations

The increase in the number of federal and state policies targeted by grantees from 2001 to 2006 reflects the sustained capacity to influence decision-making in the face of increasingly limited opportunities for new funding. The findings from the policy case studies show how grantees successfully targeted policies that provide new funding, such as state and local tobacco settlement funds or county-level measures to fund the safety net. Grantees included a variety of policy-relevant strategies within their portfolio that they were able to apply to different and emerging policy issues, including pursuing passage of local measures, developing a coordinated approach to state-level policy change among multiple grantees, and partnering with county agencies to secure a local policy change. Clearly, being mindful to the policy context is important to determining how to deploy limited resources and determine a successful strategy (Victor, 2007).

local, and private funding emerges, as well as the role played by particular policies. Federal and local funding were important for compensating for the periodic shortfalls at the state level. Federal funding was fairly consistent from 2001 to 2009, reflecting bipartisan support for clinic services under both political administrations. Local funding, particularly county contracts for clinic services, increased during the grant period. In sum, grantee efforts are increasingly pitted against larger negative macro forces, such as the growing number of uninsured being served by clinics. Opportunities at the federal and local level have helped, but they do not necessarily provide an adequate safety net for all of California's community clinics. Opportunities within health care reform, including substantial funding for safety net providers, will require an even greater level of political astuteness by clinics and consortia to assure that they can continue to increase access to care for the newly insured and remaining uninsured populations,

Grantee efforts are increasingly pitted against larger negative macro forces, such as the growing number of uninsured being served by clinics. Opportunities at the federal and local level have helped, but they do not necessarily provide an adequate safety net for all of California's community clinics.

Partnering With Clinics to Expand Political Reach and Strengthen Clinic Operations

The findings from the 2004 and 2006 clinic focus groups suggest member clinics have come to see clinic consortia as advocacy allies and important voices working on their behalf in the policy and political arenas. In addition, the evaluation noted that clinic executive directors are potent political voices in their own right. Collaboration between consortia and member clinics on key policy issues is important for developing sound policy solutions and implementation guidelines. The literature on the benefits afforded to members by groups is extensive, such as social material gains and supporting a specific mission or agenda (Baumgartner & Leech, 1998). However, there are few studies that examine the ways in which advocates can mobilize their membership beyond grassroots advocacy. Our findings speak to an important synergy between member clinics and consortia staff that increases the likelihood of creating a workable solution for all concerned, as well as expanding the recognition of the "clinic voice," which traditionally has served to give voice to those clients whose voices are rarely heard in policymaker circles.

The funding secured by grantees speaks to their versatility and willingness to target traditional and new funding streams, as well as leverage a mix of advocacy tactics. We can also use these findings to tell a more robust story of the policy environment at the federal, state, and local levels. When we analyze individual funding streams, a detailed picture of the differences among federal, state,

Evaluating Advocacy Capacity and Policy Change: Approaches and Challenges

Considered a difficult-to-measure, “messy” area of inquiry, the evaluation of advocacy groups, their activities, and the outcomes of their campaigns pose many challenges (Coates & Rosalind, 2002). First, it is difficult to attribute a specific advocacy activity to a particular policy outcome, and less obvious activities may be more important in determining a policy outcome. Additionally, a policy change may produce outcomes well beyond the evaluation period. Advocacy evaluators are thus striving to focus on interim activities earlier in the policy process, such as developing relationships with decision-makers, strengthening advocacy alliances with other advocates, and developing internal expertise to work with the media.

Initially, the scope of the evaluation posed many challenges. While the design focused primarily on grantee achievements in the aggregate, grantees varied in membership, date of incorporation, size, and target populations, creating differences in advocacy capacity, such as limited advocacy allies in a policy arena. Second, we began the evaluation in the second year of the program (2002) and did not have baseline or pre-program data against which to compare subsequent changes. There were also some differences in program policy goals and individual grantee objectives by round. For example, grantees were asked to focus on cultivating partnerships with traditional allies in the health arena (e.g., clinics, other consortia) during Round 1. During Rounds 2 and 3, they were encouraged to expand their partnerships more broadly to nonhealth stakeholders, such as the business community. Additionally, we had to contend with a lack of existing evaluation models and measures to use in an evaluation of advocacy efforts, i.e., assessing the impact of a particular advocacy activity on a particular piece of legislation. Next, the long time horizon and resources required to measure some advocacy activities, such as the effectiveness of media advocacy in changing public awareness of the role of clinics, precluded ready assessment. Last, grantees were limited to engaging in nonlobbying activities under the program, such as educating decision-makers on issues more generally. Consequently,

we were unable to assess and compare the full compliment of advocacy tactics deployed at different stages of the policymaking process.

Another challenge was addressing the different information needs of the evaluation stakeholders. We learned that advocates themselves benefited more from detailed descriptions of particular policies and factors for success (or failure), while funders often looked for broader-stroke findings to guide future programmatic investments.

However, we were able to address nearly all of these issues and gain insights into evaluation strategies that might be useful in other situations. First, grantees had similar policy objectives during each round that lent themselves to development of cross-grantee, longitudinal measures, such as assessment of specific advocacy activities directed to a particular policy. Some measures, specifically funding secured and targeted policies, could be measured across all three rounds. Second, survey instruments developed by political scientists to characterize interest groups and their activities served as a good foundation for the development of new questionnaires and assessment tools. Annual adjustment of the evaluation framework allowed for necessary flexibility to focus on prioritized learning objectives, for example, sustainability efforts during an economic downturn. Triangulation of the findings from different data collection activities was critical to addressing methodological issues of bias and sampling, strengthening the findings. Third, the program’s long time horizon turned out to be very useful for assessing other advocacy capacity gains and their impacts, particularly the monitoring and analysis

of specific policy changes and their outcomes. We were also able to identify quick-to-assess interim or process measures, such as developing relationships with the media and annual content analysis of print coverage, where the time horizon was less of an issue. Last, while we were unable to assess and compare specific lobbying strategies, such as in-person meetings to present a position on a bill or measure, we addressed this issue in a couple of ways: 1) we conducted an analysis of legislation and local decisions since they are a useful indicator of capacity, while acknowledging that lobbying probably did play a role, although it was paid for by different sources of funding, and 2) we identified all the nonlobbying advocacy activities funded under the program, such as grantee media advocacy targeting broader health issues and convening annual policy forums to educate local decision-makers.

Systematically increasing and sustaining the organizational capacity to achieve a policy change is feasible, and attention needs to be paid to how this capacity is developed and sustained.

Another challenge was addressing the different information needs of the evaluation stakeholders. We learned that advocates themselves benefited more from detailed descriptions of particular policies and factors for success (or failure), while funders often looked for broader-stroke findings to guide future programmatic investments. On the other hand, the longitudinal measures on advocacy activities proved to be very helpful to the funder and the UCSF evaluation team in identifying potential areas for increased support, such as working with the media. The latter strategy provided legitimacy to the clinic voices and was a useful conduit for getting the clinic's messages to a far broader audience. We also developed different types of evaluation documents to address

the different information needs of the funder and grantees, such as the development of two-page, accessible "best practices" case studies that could be readily disseminated by grantees to a broad target audience.

Lessons Learned

Our findings indicate grantees supported by the Clinic Consortia Policy and Advocacy Program have experienced notable achievements at all stages of the program logic model. First, they significantly expanded their advocacy capacity and repertoire of activities, using these skills to secure a place at the policy table. Once there, they were successful in increasing policymaker awareness and navigating difficult policy terrains, such as negotiating complex clinic reimbursement rates and maintaining Medi-Cal funding during state budget shortfalls. Next, they leveraged policymaker support and partnerships with member clinics to guide implementation of policies and programs that benefit clinics and their target populations, achieving the fourth and fifth program outcomes. Last, nearly of all the grant-supported initiative described in the individual case studies are or will result in meaningful communitywide change, such as a strengthened safety net that will facilitate adoption of national health care reform.

The findings speak to the ability of consortia to branch out and be agents for systems change, creating lasting improvements to their local health care delivery systems. They also suggest continued growth in some key areas, namely strengthened clinic advocacy, developing expertise in new policy arenas, and partnering with allies within and outside the health care arena. The challenge is to leverage these gains and seek new opportunities, such as implementing health care reform, as well as serving populations that are not being covered under traditional channels of health care insurance and health care.

The implications of the findings for funders and evaluators of advocacy and policy change are three-fold. First, systematically increasing and sustaining the organizational capacity to achieve a policy change is feasible, and attention needs to be paid to how this capacity is developed

and sustained. Creating a potent voice in the policymaking and political arenas benefits from directing funding to a designated policy director and planning for a two- to three-year period to achieve capacity expansion. Planning for sustainability is also key, particularly when funders no longer provide the financial resources. Second, a multifaceted evaluation approach for examining organizations engaged in advocacy expands our understanding of factors that contribute to advocacy success, including involvement in all facets of a policy or program initiative; maintenance of partnerships, particularly with member clinics; and technical expertise to launch and maintain an initiative. Third, process measures, such as “expanded advocacy capacity” and “educating policymakers,” have practical utility for grantees and funders, providing information for targeting resources, such as training in media advocacy and grassroots mobilization. These insights and lessons learned point to the importance of investing in advocacy capacity building, while also striving to achieve sustainability of these efforts over the long run.

Acknowledgements

We acknowledge the assistance of Coline McConnell, Beth Newell, Nell Marshall, Nadine Chabrier, and Joe Funk. Additionally, we would like to acknowledge The California Endowment for its funding and support of the program and its evaluation, and the 19 grantees, as well as the decision-makers, partner organizations, and clinic staff who participated in the evaluation.

References

- AINSWORTH, S. (2002). *Analyzing interest groups*. New York: Norton.
- BAUMGARTNER, F. R., & LEECH, B. L. (1998). *Basic interests: The importance of groups in politics and in political science*. Princeton, NJ: Princeton University Press.
- CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY. Office of Statewide Health Planning and Development. 2009 Primary Care Clinic Utilization Data. http://www.oshpd.ca.gov/hid/Products/Hospitals/Utilization/PC_SC_Utilization.html.
- CIGLER, A. J., & LOOMIS, B. A. (EDS.). (2007). *Interest group politics* (7th ed.). Washington, DC: Congressional Quarterly Press.
- COATES, B., & ROSALIND, D. (2002). Learning for change: The art of assessing the impact of advocacy work. *Development in Practice*, 12(3&4), 530-541.
- DEARING, J., & ROGERS, E. (1996). *Agenda-setting*. Thousand Oaks, CA: Sage Publications.
- GRABER, D. (2006). *Mass media and American politics* (7th ed.). Washington, DC: Congressional Quarterly Press.
- GRAY, V., & LOWERY, D. (1995). Interest representation and democratic gridlock. *Legislative Studies Quarterly*, 20(4), 531-552.
- HARVARD FAMILY RESEARCH PROJECT. (2007). Pioneers in the field: Four foundations on advocacy evaluation. *Evaluation Exchange*, 13(1), 12-15.
- KELLEHER, C. A., & YACKEE, S. W. (2006). Who's whispering in your ear? The influence of third parties over state agency decisions. *Political Research Quarterly*, 59(4), 629-643.
- KERSH, R. (2007). The well-informed lobbyist: Information and interest group lobbying. In A. J. Cigler & B. A. Loomis (Eds.), *Interest group politics* (7th ed.), 389-411, Washington, DC: Congressional Quarterly Press.
- KRONEBUSCH, K. (1997). Medicaid and the politics of groups: Recipients, providers and policy making. *Journal of Health Politics, Policy and Law*, 22(3), 839-878.
- LOWERY, D., & BRASHER, H. (2004). *Organized interests and American government*. New York: McGraw-Hill.
- LOWERY, D., & GRAY, V. (2004). A neopluralist perspective on research on organized interests. *Political Research Quarterly*, 57(1), 164-175.
- RICHARDSON, J. J. (ED.). (1993). *Pressure groups*. New York: Oxford University Press.
- SALISBURY, R. H., JOHNSON, P., HEINZ, J. P., LAUMANN, E. O., & NELSON, R. L. (1989). Who you know versus what you know: The uses of government experience for Washington lobbyists. *American Journal of Political Science*, 33(1), 175-195.
- SCHLOZMAN, K. L., & TIERNEY, J. T. (1986). *Organized interests and American democracy*. New York: Harper & Row.
- THEODOULOU, S. (1995). *Public policy: The essential readings*. Upper Saddle River, NJ: Prentice Hall.
- VICTOR, J. N. (2007). Strategic lobbying: Demonstrating how legislative context affects interest groups' lobbying tactics. *American Politics Research*, 35(6), 826-845.

- WALKER, J. L. (1983). The origins and maintenance of interest groups in America. *The American Political Science Review*, 77(2), 390-406.
- WALLACK, L., DORFMAN, L., JERNIGAN, D., & THEMBA-NIXON, M. (1993). *Media advocacy and public health: Power for prevention*. Thousand Oaks, CA: Sage Publications.
- WIESSERT, C. & WIESSERT, W. (1996). *Governing health*. Baltimore: Johns Hopkins University.
- WILSON, G. (1990). *Interest groups*. Oxford, England: Basil Blackwell.

Annette Gardner, Ph.D., is an assistant professor in the Department of Social and Behavioral Sciences and academic specialist with the Philip R. Lee Institute for Health Policy Studies at the University of California, San Francisco. A political scientist, her current research focuses on access to care for uninsured Californians, including strengthening the safety net through increased involvement in the policy process. She is also the principal investigator of a multiyear evaluation to evaluate The California Endowment's Clinic Consortia Policy and Advocacy Program. Correspondence concerning this article should be addressed to Annette Gardner, University of California, San Francisco, 3333 California Street, Suite 265, San Francisco, CA 94118 (email: annette.gardner@ucsf.edu).

Sara Geierstanger, M.P.H., is a senior evaluation analyst with the Philip R. Lee Institute for Health Policy Studies, University of California, San Francisco. She has evaluated numerous school health and adolescent pregnancy prevention programs, including policy advocacy efforts by community and statewide nonprofit organizations and youth researchers.

Lori Miller Nascimento, M.P.H., an evaluation manager at The California Endowment, is a trained public health researcher and evaluator who focuses on health access issues and community learning around various public health issues. She has three years experience in philanthropy and 20 years in public health, with a primary focus on evaluation and community health.

Claire Brindis, Dr.P.H., is the director of the Philip R. Lee Institute for Health Policy Studies at the University of California, San Francisco and professor of pediatrics and health policy at UCSF. She is an expert in quantitative and qualitative evaluation methods and the translation of research into policy. Her primary areas of research are adolescent health; population health, for example, in the area of asthma; and reproductive health.