

## ESSAY

## Faith In Action: Building Capacity For Interfaith Volunteer Caregiving

*How the largest program in the Robert Wood Johnson Foundation's history came to be.*

by Paul Jellinek

OVER THE PAST DECADE, as the effects of devolutionary policies at the federal and state levels have spread across the country, local leaders have become increasingly interested in finding ways to make better use of resources to address their communities' most pressing health and social needs. In recent years there has been a particular interest in expanding the role of faith-based organizations, which often enjoy high credibility and support among local residents.

The Robert Wood Johnson Foundation (RWJF) is currently supporting a major national program that helps communities to meet the needs of the growing number of persons who are homebound as the result of a chronic illness, disability, or infirmity. Entitled Faith in Action, it is the largest program in the foundation's history. Since the program's initial launch in 1993, the RWJF has awarded 1,091 Faith in Action grants, and in July 2000 the foundation launched a second phase in which it expects to award up to 2,000 additional grants over seven years.<sup>1</sup>

This essay briefly describes the program model, its history to date, and the reasons behind the foundation's unprecedented commitment to the Faith in Action program. It concludes with some observations about implications for public policy.

■ **The model.** Data from the 1994–1995 National Health Interview Survey on Disability indicate that more than ten million Ameri-

cans with long-term care needs live in the community. Approximately 8.5 million require assistance with instrumental activities of daily living (IADLs)—such as preparing meals, shopping, and doing light housework—and this number is expected to increase as the nation's population ages.<sup>2</sup> While family members can and do provide much assistance in this area, additional help is often necessary, especially for chronically ill and disabled persons who live alone. One important source of such assistance is the nation's faith congregations.

Recognizing this, Faith in Action supports the establishment of local interfaith coalitions of volunteer caregivers. These consist of diverse religious congregations, as well as health, social service, and civic organizations, which have come together to provide informal care and support to the community's homebound chronically ill and disabled residents.<sup>3</sup> Administrative data from current grantees indicate that many of the persons served are elderly (40 percent age 75 and older and 24 percent ages 65–74), but younger persons, including those with chronic conditions such as dementia, physical disability, mental illness, substance abuse, and human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS), also receive services.<sup>4</sup>

Services are provided by volunteers recruited primarily from the participating congregations (57 percent) and from the community at large (34 percent) and include such

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activities as friendly visiting and telephone reassurance (22 percent), transportation (14 percent), meal preparation and delivery (11 percent), shopping (8 percent), linkage to community services (8 percent), minor chores and household repairs (5 percent), and respite for family caregivers (5 percent).<sup>5</sup> Services do not include any care for which licensure is required and are intended to supplement, rather than substitute for, services already available to the care recipients. If the need for additional services is identified, the coalition staff initiates appropriate referrals. The relationship with other service providers is reciprocal: 42 percent of referrals to the coalitions during the first twelve months come from health and social service providers.<sup>6</sup> Religious proselytizing is strictly prohibited.

A key to the model is the presence of a paid coalition director, usually full time. The director, who reports to a volunteer board of local religious and civic leaders, organizes and staffs the coalition, by recruiting congregations and other organizations into its ranks and helping the participating congregations to enlist, train, and supervise volunteers. Faith in Action grants are intended primarily to provide start-up support for this position.

### **History Of The RWJF's Efforts**

The viability of this model was first tested in 1983 by the RWJF through a national demonstration entitled the Interfaith Volunteer Caregivers Program. The foundation provided, on a competitive basis, three-year grants of up to \$150,000 to establish coalitions in twenty-five communities across the nation. This initial demonstration program explored whether congregations of different faiths and denominations could work together in an effort of this kind; whether enough congregations and volunteers would come forward to justify the expense; and whether the model could be sustained by local funding sources once RWJF funding had ended.

The results were encouraging. All but one of the grantees established a viable interfaith coalition. As these coalitions matured, they typically grew to include more than twenty

congregations and served hundreds of people. Twenty of the original twenty-five coalitions are still operational today, fifteen years after their RWJF funding ended, with support now coming from participating congregations, local United Way chapters, hospitals, public programs, and other sources.

At the conclusion of the Interfaith Volunteer Caregivers Program, its national director, Kenneth Johnson, and the chairman of its national advisory committee, Arthur Fleming, persuaded the RWJF to support the establishment of a new national organization, the National Federation of Interfaith Volunteer Caregivers (since renamed the Interfaith Caregivers Alliance), which could advocate and seek support for the development of new caregiver coalitions. Although small, the federation attracted support from others, including the Pew Charitable Trusts, the Commonwealth Fund, the Public Welfare Foundation, and an anonymous donor.

The support from the Public Welfare Foundation is especially noteworthy in terms of the subsequent dissemination of the model. In contrast to the \$150,000 grants provided through the RWJF's initial demonstration, the Public Welfare Foundation offered one-year seed grants of \$20,000 to coalitions, together with support for technical assistance to be provided by the federation, for establishment of up to sixty new coalitions. In a sense, this was a test of whether the relatively costly prototype could be replicated at a considerably lower start-up cost. The success of most of the coalitions funded through Public Welfare's replication helped to set the stage for the Faith in Action program.

### **Faith In Action: Phase One**

Following these initial activities, the RWJF did not expect to continue funding in this area. In the late 1980s the foundation tended to limit its role in the service delivery arena to the development and testing of innovative new models through demonstration programs. The results of these demonstrations were communicated to policymakers, institutional leaders, and other interested parties,

often through the professional literature, and decisions about wider replication and adoption of the models were left in their hands.

However, when Steven Schroeder became president of the RWJF in 1990, several things happened that led the foundation to reconsider its position with respect to interfaith volunteer caregiving. Shortly after Schroeder arrived at the foundation, he received a letter from Judith Miller Jones, director of the National Health Policy Forum in Washington, D.C., urging that the foundation resume its support of the National Federation of Interfaith Volunteer Caregivers. She explained that she and her husband, Stanley Jones, also a respected health policy expert, had become involved in interfaith volunteer caregiving in their own community and had become increasingly impressed by the potential of the model. However, without RWJF support, she warned, the federation might soon be forced to cease its leadership and technical assistance role, placing future dissemination of the model in jeopardy. Soon thereafter the foundation did resume its support.

At the same time, the RWJF reassessed its funding priorities and identified the improvement of care for persons with chronic health conditions as one of its three primary goals.<sup>7</sup> While the foundation had supported numerous programs in the past to improve services for the chronically ill and disabled, these programs had generally focused on specific categorical populations, such as persons with AIDS. By taking a noncategorical approach, the foundation shifted its attention to issues common to all of the populations, including the need for informal care and support.

Also, by the early 1990s, it was becoming increasingly apparent that the days of expansionary federal spending for new health and social programs were numbered. Simply demonstrating the effectiveness of a new service delivery model might no longer be sufficient to ensure its widespread replication by the federal government. Schroeder challenged the staff to be creative in exploring alternative strategies for achieving nationwide impact.

As the staff began to consider how the

foundation might address its new chronic care goal in an environment of increasingly constrained federal spending, the appeal of the interfaith volunteer caregiver model became apparent. Not only did the model address one of the most fundamental and pervasive needs of persons with chronic health conditions, but the success of the Public Welfare Foundation's seed-grant approach suggested that with a funding commitment on a par with some of the RWJF's larger demonstration programs, the RWJF could itself support the establishment of hundreds of new coalitions throughout the nation. It was these considerations that prompted the development of the Faith in Action program.

Faith in Action was initially authorized by the RWJF in July 1992 at \$23 million over a four-year period, enough to fund 920 interfaith coalitions with eighteen-month start-up grants of \$25,000. The authorization was later increased to expand the number of coalitions to 1,091, and supplemental grants of \$10,000 have been made available to help coalitions develop stable long-term funding.

In this first phase, under the direction of Kenneth Johnson, Faith in Action established coalitions in all fifty states, the District of Columbia, Puerto Rico, and the Virgin Islands. More than 9,000 individual congregations representing a wide range of faiths were part of the funded coalitions at the time of their application, yielding an average of between eight and nine congregations per coalition, and that number has most likely increased as the coalitions have matured and expanded.<sup>8</sup> At the same time, however, it is estimated that 229 of the 1,091 coalitions (21 percent) will not continue beyond the period of their RWJF grants, primarily because of difficulties in securing continuing funding.<sup>9</sup>

Twelve-month reports from the coalitions indicate that in the first year of their grants, they recruited 59,142 active volunteers and served 80,680 individuals. The average volunteer served 3.17 hours per week.<sup>10</sup> Applying a mid-range hourly valuation of \$8.18 for informal caregiving (based on 1996 data from the Bureau of Labor Statistics), the estimated dol-

lar value of volunteer services during the coalitions' first year of operation alone would approach \$80 million.<sup>11</sup> This figure would be expected to increase as the coalitions add more congregations and volunteers.

Faith in Action represented the first attempt by the RWJF to replicate on a large scale a model that it had supported at the demonstration stage. Given its scale and the relatively modest size of the grants, there was some concern initially that the program might not achieve its goal of launching close to a thousand coalitions. And indeed the response in the first year of the program was well below expectations. Adjustments were made, however, in response to recommendations of a national advisory committee chaired by the late Congresswoman Barbara Jordan, including a decision to allow religious and secular health and social service organizations to apply on behalf of an interfaith coalition. The number of grants awarded rose from 39 in 1994 to 184, 254, 298, and 316 over the next four years (38 percent awarded to free-standing interfaith coalitions; 18 percent to religious organizations; and 44 percent to secular organizations, such as hospitals, AIDS agencies, hospices, and Area Agencies on Aging).<sup>12</sup> The decision to allow religious and secular organizations to apply on behalf of interfaith coalitions was prompted by the fact that many coalitions did not have the wherewithal to apply for tax-exempt status, which was needed in order to receive a grant.

## Faith In Action: Phase Two

As response to the program continued to grow, foundation staff began to explore the possibility of renewing the program for a second phase. The RWJF supported Debra Rog of the Vanderbilt Institute for Public Policy Studies to conduct a modest independent assessment of the viability and perceived value of the Faith in Action Phase I coalitions.<sup>13</sup> The foundation also supported a team, headed by Stanley Jones at the George Washington University, to investigate the potential "market" for additional Faith in Action grants.<sup>14</sup> Findings from both were encouraging. Rog re-

ported that "most of the services...appear to be directed to unmet needs in their communities." The Jones report noted that while thousands of faith congregations had participated in the first phase, there are some 330,000 faith congregations in this country, suggesting great potential for future growth. RWJF staff then met with a group of national religious leaders representing many of the nation's major faiths, who also encouraged the foundation to support a second, larger phase of Faith in Action. In particular, they emphasized the importance of the interfaith dimension of the program and urged the RWJF to give the program greater national visibility.

There were a number of reasons for the RWJF to consider an expanded second phase of Faith in Action. First, it was clear that as the nation's population ages and as deinstitutionalization of the chronically ill continues, the need to provide informal care and support for homebound persons is likely to increase.<sup>15</sup> While the health care system can provide certain kinds of home care and supportive services, the need is likely to exceed its capacity. Moreover, the kinds of friendly visiting and companionship that lie at the heart of interfaith volunteer caregiving are difficult to provide within the context of a professional health care delivery system. (This aspect of the program also holds promise as a means of reducing social isolation, shown by a growing number of studies to be an important health risk factor.)

Second, by further expanding the number of coalitions funded from approximately 1,000 to a cumulative total of approximately 3,000, Faith in Action could put a dent in the unmet need for informal care and support among the nation's homebound chronically ill and disabled populations. Experience to date suggested that approximately three out of four coalitions would succeed in obtaining ongoing support beyond their RWJF grants. Conservatively estimating that as they reached maturity over a period of about five years, they would serve an average of 200 persons per year, Faith in Action coalitions together could serve upwards of 400,000 persons per year.

Third, an expansion of the program could provide an opportunity to reach out more aggressively to low-income inner-city and rural areas that were underrepresented in the first phase. To accomplish this, somewhat greater flexibility might need to be built into the program, as well as additional resources added for outreach and technical assistance. Fourth, expanding Faith in Action could enable the foundation to provide support to many communities and organizations that rarely, if ever, have received RWJF funding.

Finally, and perhaps most important, with its emphasis on people helping people, the program reflected core altruistic values that are held by the RWJF and are fundamental to its work. By greatly expanding the program and including a substantial investment in communication, Faith in Action could help to reaffirm those values nationwide.

As with all major programs, the decision to proceed with an expanded second phase was debated by foundation staff. Among the issues raised was a concern that such a large and visible commitment to a volunteer program might suggest to some that volunteerism alone would be sufficient to address the nation's chronic care needs. Another concern was that the prominent role of faith congregations might be interpreted as excluding or discounting volunteers outside the faith community. It was agreed that the communications component would need to address these issues to try to reduce the risk of misperceptions.

The foundation's commitment to the second phase of Faith in Action is \$112 million over a seven-year period (2000–2006), including greatly increased commitments for technical assistance and communication. Special attention will be given to reaching underserved communities and to improving the coalitions' capacity to secure long-term funding. Individual grants will be for approximately \$35,000. The second phase of the program is directed by Burton Reifler at Wake Forest University. Technical assistance is being provided by the Interfaith Caregivers Alliance; communications support is provided by Porter Novelli.

## Policy Implications

It is unusual for a private foundation to support the national dissemination of a program model at the level that the RWJF is funding Faith in Action. Foundations typically limit their role to demonstration and evaluation, in the hope that if the model is found to be effective, other funding sources—in particular, the federal government—will support its dissemination. Yet while Faith in Action is a large program by foundation standards, by itself it is not large enough to address the total national need for informal care and support. The National Health Interview Survey on Disability data cited above suggest that, over time, Faith in Action may be able to serve approximately one in twenty Americans who live in the community and need help with IADLs.

How might the remaining unmet need be addressed? One possibility, especially given the growing interest in public-sector support for faith-based programs, would be for the federal government to step in with a major program of its own. This option, however, would need to be exercised with great caution. While Faith in Action is a large program, every effort has been made to minimize bureaucratic requirements and constraints. This includes the use of simple application, budgeting, and reporting procedures and considerable local latitude in determining program priorities and design. Imposition of the kinds of bureaucratic demands often associated with government funding could inadvertently undermine the viability of this flexible grass-roots model. Moreover, the model is designed to strongly encourage a sense of local ownership, both through the establishment of broad-based local governance boards and through local funding partnerships to supplement and, over time, replace RWJF funding. A large new “top-down” federal program could jeopardize this, and with it, the prospects for broad community participation and long-term sustainability. Finally, a comprehensive, independent evaluation of the impact of the model on outcomes for recipients (and for volunteers) would probably be necessary before a major public funding commitment could be

considered.

A second, more gradual, but perhaps less risky approach would be to promote localized “word of mouth” replication in areas where Faith in Action coalitions have been established. Under this approach, as local clergy, hospital administrators, public officials, and others in nearby communities begin to hear positive reports about an existing coalition, supplemented by information obtained from a national communications campaign, they may initiate coalitions of their own, with start-up funding either from the national Faith in Action program (assuming that it is still active) or from local philanthropic and public sources. This kind of local ripple effect, already observed in a number of areas, could begin to transform the program into a kind of national movement. The federal government could help to support such a movement, especially by supplementing local funding in low-income communities, but the government would need to take a low-key approach that would preserve the grassroots character of the model.

Finally, Faith in Action, almost like a midwife, has helped to stimulate the growth and development of many local interfaith coalitions around the nation that are committed to addressing local needs. These coalitions represent a potentially useful addition to the social infrastructure of our communities. They provide a vehicle for congregations of different faiths and denominations to work together while avoiding religious proselytizing sometimes associated with single-faith efforts. However, there are clearly limits to how much of the nation’s unmet need for informal care and support can ultimately be met through this approach. Many communities may lack the necessary leadership, volunteer base, or financial resources to establish and sustain coalitions. Others may simply prefer alternative approaches or have other more pressing priorities.

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*The author thanks Ann Pomphrey for her assistance.*

## NOTES

1. Robert Wood Johnson Foundation, *Faith in Action Call for Proposals* (Princeton, N.J.: RWJF, June 2000).
2. H.L. Komisar and M. Niefeld, “Long-Term Care Needs, Care Arrangements, and Unmet Need among Community Adults: Findings from the National Health Interview Survey on Disability,” Working Paper no. IWWP-00-102 (Washington: Georgetown University, Institute for Health Care Research and Policy, December 2000); and University of California, San Francisco, Institute for Health and Aging, *Chronic Care in America: A Twenty-first Century Challenge* (Princeton, N.J.: RWJF, August 1996).
3. P. Jellinek, T.G. Appel, and T. Keenan, “Faith in Action,” in *To Improve Health and Health Care 1998–1999: The Robert Wood Johnson Foundation Anthology*, ed. S.L. Isaacs and J.R. Knickman (San Francisco: Jossey-Bass, 1998), 131–144.
4. Kingston Hospital, Health Services Research Center, *Summative Report, Faith in Action, Phase I* (Kingston, N.Y.: Faith in Action National Program Office, November 2000). The data for this report were obtained from grantees’ proposals and their six-month and twelve-month reports to the National Program Office.
5. *Ibid.*
6. *Ibid.*
7. The RWJF’s other two primary goals were to assure access to basic health services for all Americans and to reduce the harm caused by substance abuse.
8. Faiths/denominations represented in Faith in Action, as reported in the Kingston Hospital’s *Summative Report*, are: Methodist, 14 percent; Catholic, 13 percent; Baptist, 13 percent; Lutheran, 10 percent; Presbyterian, 8 percent; Episcopal, 6 percent; Jewish, 4 percent; AME, 1 percent; and other, 31 percent.
9. Kingston Hospital, *Summative Report*.
10. *Ibid.*
11. P.S. Arno, C. Levine, and M.M. Memmott, “The Economic Value of Informal Caregiving,” *Health Affairs* (Mar/Apr 1999): 182–187.
12. Kingston Hospital, *Summative Report*.
13. D.J. Rog, M. Brown, and C.S. Holupka, *Faith in Action: Assessment Report* (Washington: Vanderbilt Institute for Public Policy Studies, October 1997).
14. S.B. Jones et al., *Nurturing the Heart of America: Leadership Opportunities in Volunteer Caregiving* (Washington: George Washington University, December 1997).
15. Kingston Hospital, *Summative Report*.