Creating a Healthier Future for Our Children: A Prevention-Oriented Child Health System

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We are raising a generation of children who, for the first time in our history, are likely to be less healthy than their parents and may even have a shorter life expectancy (Olshansky et al. 2005). Chronic diseases remain the number one factor in poor health outcomes, many of which have their origins in childhood (Perrin et al. 2007). Over the last three decades, the number of overweight children has more than tripled, and one in every five children has a mental health problem (Ogden et al. 2006; Kataoka et al. 2002). It is a tragedy in the making, and one that is all the more disheartening because these health threats are largely preventable.

From the moment they are born until they become young adults, children interact with multiple systems – health care, early care and education, education, youth development (such as parks and recreation, community organizations) and for some, child welfare and juvenile justice. Each of these systems has the opportunity to shape the lives of children by providing or connecting them to needed services. Often, however, the systems operate in "silos" that do not communicate with each other or coordinate services for children. As a result, there can be a complex pathway for families to navigate when they need support, and this can result in children not getting the help they need when they need it.

Our nation requires a child health system designed to reach children wherever they live, learn, and play – in schools, early care and education, primary care, and community-based settings. Our definition of child health should be broader than medical care – we need to address present-day health threats and focus on prevention and promoting overall health and development. An approach that addresses the health and well-being of the whole child is a critical need at this time. The systems that care for children must proactively support children's physical, emotional, and environmental needs over time in order to address the social determinants of health, defined by the World Health Organization as the circumstances in which people are born, grow up, live, work, and age. A prevention-oriented child health system should have at least the following three core elements: 1) a population-based framework that is outcome driven; 2) a policy and practice change agenda that achieves sustainable results[1]; and 3) a network of strategic partnerships that works across sectors in all the places where children live, learn, and play (Chang et al. 2010; Nemours Health and Prevention Services and The California Endowment 2008).

What is at stake is not just the health of children today, but the health of America tomorrow. The modern epidemics we face have lifelong consequences and present significant costs to the economy. Our failure to ensure that children reach their full health potential may jeopardize our children's ability to function effectively as adults and our ability as a nation to remain strong and competitive in our global society.

Fortunately, we are living in a time of tremendous opportunities to help communities support the health and well-being of children. The Patient Protection and Affordable Care Act of 2010 (ACA) offers a

[1] For strategy design purposes, "policy" is defined as a principle or course of action chosen to guide decisionmaking, and a "practice" is defined as a habit, custom, or method of doing something; actual performance or use, such as to put knowledge into practice. A fundamental assumption of Nemours work is that policy and practice are linked and are, in fact, drivers of each other.

number of new opportunities to support local and state prevention programs and ensure high-quality medical and primary care for children (Koh and Sebelius 2010; Kocher et al. 2010). The new law, for example, provides funding for communities to implement innovative prevention programs in multiple sectors, expands health care coverage for children and coordinated care through "medical homes," and provides for pilot programs that integrate public health and clinical care. A set of provisions could be designed and implemented together to make a difference in the health and well-being of children and bring about system changes that we need (Bruner et al. 2010). In addition, the harsh reality of the obesity crisis has resulted in renewed focus on social determinants – factors such as social circumstances, environmental exposures, and behavior patterns – that contribute to more than 60 percent of morbidity and mortality in this country (McGinnis et al. 2002).

In leveraging these opportunities, communities can make sustainable and long-lasting changes for children. The private sector and nonprofit sector, including foundations, have a significant role to play in developing and implementing prevention-oriented child health systems at multiple levels. This paper provides one path for creating a healthier future for our children. It describes a set of strategies for achieving positive child health outcomes and changing the systems that nurture and care for children. Lessons learned are presented based on the experience of one foundation – Nemours – working with partners at the local and state levels to transform the system, and then bringing successful strategies to the national level to influence widespread change.

A Statewide Strategy: Making Delaware's Children the Healthiest in the Nation

Nemours, a foundation with more than 30 operating entities in four states, promotes child health and wellness in Delaware using a multisector approach that integrates population health and medical care. Nemours works with more than 200 partners, including those in early care and education, schools, primary care, and community-based organizations, to implement health-promoting policies and practices for children. This effort creates 360 degrees of child health promotion at the population level – influencing virtually all the waking hours of a child's day. Nemours is currently using this "surround sound" strategy to foster healthy eating and physical activity in child-serving systems and thereby reduce the prevalence of childhood overweight and obesity in Delaware.

Nemours' strategy for reducing the prevalence of childhood obesity is focused on social determinants. The goal is to change the culture and empower Delawareans to take more responsibility for their health and become active participants in the systems that care for, or affect, the health of children. As a pediatric health system heretofore focused primarily on treating illness, Nemours realized that it had a responsibility to help build health promotion capacity and mobilize Delaware communities to begin making the cultural shift toward child wellness, rather than sickness.

Lessons Learned at the Local and State Levels

The Nemours experience suggests that there are three key areas that require intensive focus to achieve the desired changes at the local and state levels: 1) a population-based framework that is outcome driven, 2) a policy and practice change agenda that achieves sustainable results, and 3) a network of strategic partnerships that works across sectors. The details of how each locality tackles these three areas may differ, but we have found that they are critical to ensuring that the systems that care for children work together. We have also begun to see that results do occur when communities implement these key building blocks. Early evaluation results of Nemours' work in Delaware demonstrate that the prevalence of overweight and obesity among the state's children ages 2 to 17 did not change between 2006 and 2008. As these rates had previously been increasing, this leveling-off is cause for optimism. Results also showed significant positive behavior changes at the population level in terms of fruit and vegetable consumption, screen time, and consumption of sugary beverages.

- ***Population Health Outcome Focus.*** The work in Delaware began with a specific population health outcome in mind – reducing the prevalence of overweight and obesity for all children in the state. This focus on the aggregate population required that we think differently about how to address the problem. To achieve the desired outcome, the initiative had to reach large groups of children. Strategic partnerships with the various child-serving systems (schools, child care, youth-serving organizations, primary care, etc.) are leading to the development of a cross-systems network and shared strategies to help reach the most children, using high-impact and sustainable policies and practices to promote healthy eating and physical activity. Over time, this network has succeeded in reaching a significant number of children in the state while also building a base of like-minded groups to advocate for legislative and regulatory changes.

- ***Sustainable Policy and Practice Changes in Multiple Sectors.*** Policy and practice changes in multiple sectors are essential to achieving population-level outcome changes. Four key sectors – schools, early care and education, community/youth-serving organizations, and primary care – were chosen as focus areas specifically because they are the places where children spend the majority of their time and where there are significant opportunities to impart health information and change behavior. By focusing on healthy eating and physical activity practices in a wide variety of community settings, Nemours increased the chance that a given child will be repeatedly exposed to the prevention initiative, strengthening its impact. This place-based, multisector approach is more likely to affect and sustain prevention outcomes over time than any single intervention.

  In order to sustain efforts, adopting policy change and increasing community capacity to implement practice change are vital. Policy change transforms local best practices into those with large-scale influence that can be sustained over time. For example, in Delaware, the child care licensing regulation that improves the nutritional quality of foods and requires physical activity has the potential to affect 54,000 children statewide compared to a pilot reaching 200 children in a single child care center. This policy has remained in effect under a new governor, demonstrating the sustainability of policy efforts.

  Community capacity is important for ensuring that there is a training and skill-building infrastructure in place for those who care for children to implement new policies through practice changes. By providing partners with the training and information they need to implement best practices and spread the *5-2-1-Almost None*[2] prescription for a healthy lifestyle, Nemours was able to build capacity in the community, change environments, and help children/families change their behaviors. Nemours shared data and developed tools grounded in the best evidence available, and then put them in the hands of the practitioners who could best influence children's behaviors. An efficient platform of training and technical assistance was also created, including in-person consultations and web-based support, to enable and motivate practitioners. Nemours enhanced the support provided to partners by building learning communities among practitioners in the each sector, including early care and education, schools, and primary care. These collaboratives allowed practitioners to learn and support each other in the change process over multiple sessions timed to allow skill practice and positive reinforcement. To further sustain the effort, Nemours helped establish ongoing infrastructure in the community to continue these learning collaboratives. For example, Nemours worked with the University of Delaware's Institute for Excellence in Early Childhood to continue the spread of promising child care policies and practices in child care centers through learning collaboratives and training programs on an ongoing basis.

  Another fundamental aspect of community capacity building is the use of coalitions to keep community leaders focused on the value of social change. Nemours made health promotion a

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[2] 5-2-1-Almost None consists of eating at least five servings of fruits and vegetables a day, limiting screen time to no more than two hours a day, getting at least one hour of physical activity a day, and drinking almost no sugary beverages.

priority and continued to disseminate information to leaders throughout the state. This was particularly needed to counteract the institutional bias that favors a "system" that addresses the sick, rather than one that promotes the health and development of children overtime. This has helped with maintaining long-term commitment and trust – the root of success in the community – as well as accountability at all levels.

Given the overall goal to reach the most children in the shortest amount of time with the greatest impact, designing a portfolio of policy and practice changes that optimize the available resources requires consideration of spread, intensity/impact, and sustainability. All three aspects are integral to maintaining a strong strategy of policy and practice change in the areas where children live, learn, and play. With a greater emphasis placed on strengthening the link between policy and practice change and desired behaviors and outcomes, the following questions were asked:

- Does this policy/practice change goal create **spread** of healthy behaviors that will lead to healthy outcomes?
- Does this policy/practice change goal provide the necessary **intensity and impact** to deliver the desired change?
- Does this policy/practice change goal create **sustainable** systems or other changes that will continue to exist beyond the length of the partnership?

↗ ***Strategic Partnerships across Multiple Sectors***. Nemours elected to use strategic partnerships, including alliances with targeted state and regional organizations and community coalitions and networks, as the organizing structures to advance population-level change in health outcomes. These partnerships, formed across disciplines and the public and private sectors, mobilized organizations to advocate for and make priority policy and practice changes, and to leverage their resources.

Nemours forged alliances with the organizations having the greatest potential for impact, including state and local governments, nonprofit organizations such as the YMCA, child care centers, and school districts. In order to be cost effective and efficient in its use of resources to affect population-level outcomes, Nemours worked collaboratively with partners that could reach the largest numbers of children at the state or regional level, use their clout or authority to make the priority policy and practice changes, impact multiple priorities, and leverage resources.

The role of the coalitions/networks is to bring together all segments of the communities in which they are located to implement the priority policy and practice changes, integrate child health promotion efforts across the sectors, advocate for those priorities in their communities, collaborate on efforts to spread child health promotion messages, provide training and technical assistance, and leverage resources for sustainability. They play an important role in generating the momentum in a community to affect the culture shift needed to value and promote child health. Nemours has supported the development of coalitions/networks to create this permanent and sustainable capacity for child health promotion in the major political jurisdictions in Delaware. These coalitions/networks now work to serve and support the wide range of partners needed to efficiently bring about change in the community.

Translating Regional Innovation into National Action

Locally, communities and states need support to innovate, design, and evaluate prevention-oriented child health systems. Helping community leaders take advantage of current funding opportunities is a critical first step, as is a focus on sustainability and spread. To take full advantage of the prevention climate and the funding available right now, those currently working in the field could be doing more to collaborate and share knowledge, with their sights set on helping communities be successful long-term. As our experience in Delaware showed, strategic partnerships and information sharing are essential components to empowering communities. We need to be working on both fronts – locally to mobilize communities, and nationally to focus on the spread and sustainability of system changes that

further support and enhance community efforts.

Like most mission-driven organizations, Nemours is focused on achieving outcomes. In our case, we are striving to influence children's health and well-being. The focus on a prevention-oriented child health system expanded our service population from the 55,100 patients who come through our clinical doors to all 207,000 children living in Delaware (Chang et al. 2007). In 2008 Nemours expanded further, with the goal of leveraging our experience to help improve child health and wellness nationally. The Office of Policy and Prevention based in Washington was established, with dedicated staff and resources, to work nationally toward a specific policy and practice change agenda with the potential to positively affect millions of children beyond those who receive care at Nemours. The organization found that the knowledge gained working locally and at the state level better informs national efforts in terms of spread, scaling up, and sustainability. Local/state efforts benefit from the national experience – that is, the knowledge and experiences of others working with a national focus. The office sets its agenda based on where the work of Nemours has been a model, filled a void, or had the potential to move the field of child health promotion and health care, not the specific business interests of Nemours.

Having a dedicated national staff and resources provides Nemours with the opportunity to leverage lessons learned from its prevention work in Delaware. For example, Nemours advocated for the Healthy, Hunger-free Kids Act, legislation reauthorizing critical child nutrition programs, to improve the nutritional quality of foods in the Child and Adult Care Food Program. These efforts were grounded in the organization's success working with strategic partners to change child care licensing regulations in Delaware and to provide training and technical assistance to early care and education providers. Nemours' experience in Delaware provided a model that informed federal legislation, providing the opportunity to spread its child care model nationally to more than 3.2 million children who participate in the Child and Adult Care Food Program. Nemours advocated for passage of this legislation through intense education, including coalition work, briefings for key members/staff and administration officials, letters to Congress, sign-on letters with coalitions, press releases, opinion editorials, and targeted advertising and lobbying.

More than ever before, private and public sectors need to collaborate in support of community action and making communities successful. Nemours has found it very productive to convene groups of like-minded individuals and organizations to explore different models and issues, and work together on areas of common interest. Being proactive and deliberate in identifying and convening groups and taking part in group learning have been key strategies. Best-bet policies and practices are being strategically disseminated to key stakeholders and policymakers so they can be spread to a wider population, all with the intent of informing and influencing change nationally. Similar to the model in Delaware, participants represent multiple sectors and address the themes of health and well-being of the whole child, public/private partnerships, and policy and practice changes to achieve sustainable results. A few examples of collaboration at the national level follow.

To support collaboration among experts in the obesity prevention and early care and education disciplines, the leadership of Nemours and the Centers for Disease Control and Prevention (CDC) formed the Healthy Kids, Healthy Future Steering Committee[3]. This expert group includes approximately 40 national and state leaders from the obesity prevention, and early care and education fields. Together these experts are working on a plan to reduce and prevent obesity in children five years of age and under. The three primary objectives are to:

- disseminate tools, technical assistance, and training to states and communities to accelerate the spread of promising policies and practices;
- prioritize policy opportunities for obesity prevention in early care and education; and
- assess the research and build the evidence base by identifying what other questions need to be

[3] http://healthykidshealthyfuture.com

answered and then by answering them.

In 2006 a collaboration of funders came together to create the Healthy Eating Active Living Convergence Partnership (CP)[4] with the shared goal of changing policies and environments to better achieve the vision of healthy people living in healthy places. The steering committee includes representatives from The California Endowment, Kaiser Permanente, Nemours, Robert Wood Johnson Foundation, and W.K. Kellogg Foundation. The CDC serves as technical advisors on the committee. The CP seeks to change policies, establish systems for engaging and connecting people, and transform places so they foster health, prosperity, and well-being for all residents. To accomplish this work, it became clear that silos must be made flexible and permeable – meaning that the multiple components of the health field are working together, and the fields of health, transportation, community development, and others are working cross-sectorally – to create environments that support health. The CP has achieved significant success, seizing on national policy opportunities with the Healthy Food Financing Initiative, reframing transportation as a health issue, and health reform. The CP has also sought to spark innovation and foster partnerships within the funding community by creating regional convergences and attracting new philanthropic investment in healthy people and healthy places.

Nemours also recognized that it would be helpful to convene teams of individuals who run innovative, place-based, multisector children's initiatives in order to identify and disseminate promising policies and practices and help inform national opportunities. In late 2009, Nemours, The California Endowment, and an anonymous donor established the Children's Outcomes Project (COP). The COP promotes the work of multisector, integrated place-based initiatives to improve the health and well-being of children. The COP learning community is comprised of state- and community-based teams plus a select group of national program, policy, and advocacy experts. The purposes of the COP are twofold:

- to help the multisector, place-based COP teams advance integrated prevention/promotion policies and practices for children in their communities and states, and
- to influence federal policy to better support multisector and integrated place-based initiatives focused on the health and well-being of children.

Conclusion

Nemours found that it could best support and accelerate prevention-oriented child health systems by being a catalyst and model locally while having a national strategy to expand on local strategies that have worked well. Our local and state experiences have underscored the importance of 1) a population-based framework that is outcome driven, 2) a policy and practice change agenda to achieve sustainable results for groups of children, and 3) a network of strategic partnerships that works across sectors. Our national experience has taught us that it is important to establish a national presence and a deliberate strategy focused on policy and practice change; to work in strategic partnership to move the field forward; and to share learning, with an eye toward informing change nationally. The time is ripe to catalyze community and state efforts to support a prevention orientation and to work nationally on sustainable policies and practices that help all children grow up healthy.

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[4] http://www.convergencepartnership.org

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Strengthening Communities through Micro-Lending: A Journey of Discovery from Mongu to St. Louis

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The Incarnate Word Foundation's journey to bring micro-lending to St. Louis began in Mongu, Zambia, an eight-hour bus ride through the bush from the capital of Lusaka. Several of our Mexican Sisters from the Congregation of the Sisters of the Incarnate Word were there working with mothers in an HIV/AIDS clinic, and we were coming to develop programs in micro-lending and early childhood development. Even though I had not done micro-lending, I was familiar with the concept. With the hubris I saw in the philanthropic world and in myself, I was confident that I could easily conduct a workshop on this topic. How hard could it possibly be? As it turned out, it was surprisingly easy – but not because of anything I did.

Mongu

The heat and dust of Mongu in October was tempered by the beauty of the convent gardens and the hospitality of the Lotsi women who arrived for the workshop wrapped in colorful batik fabrics. Senana, a Lotsi princess educated in England, would serve as our translator and group leader for the newly formed Masupanzila Women's Empowerment Association. I began to pass out a powerpoint and that was when I realized that my approach was completely wrong. How could I tell these women how to organize their micro-lending program just because we were providing funds through Women's Global Connection, an international ministry of our Sisters? I had never walked their path. It turned out the powerpoint handouts made great scrap paper.

Instead, I posted a series of questions:

- What types of loans would be made?
- What activities were precluded from being funded?
- Who could borrow money?
- What was the interest rate?

Then I sat back and listened. The women quickly delineated how the program would work. Some were outspoken, others reserved, but all contributed their proverbial two-cents worth as Senana called on each to express her thoughts. They determined the interest rate by going around the table. The funds would be divided between a micro-lending program to start businesses, and money that could be tapped for the rice cooperative, children's school fees, emergency needs, and a funeral fund. They worked so quickly that we were able to spend time in the afternoon developing the beginnings of a business plan for their rice cooperative. When our time together concluded, they sang as they swayed and danced around the conference table. I was a long way from St. Louis, and I had re-learned some important principles:

- Building healthy communities is all about empowerment of the people themselves.
- Foundations can bring resources and knowledge, but these are tools not the solution.

St. Louis

My time in Africa was a period of deep learning, and I was determined when I returned to St. Louis to do micro-lending there. I began by tracking down an expert in the field who had served as faculty at a

leading university and was currently an international micro-lending consultant. His reaction was quite negative: micro-lending could never work in the United States if left to the hands of the people themselves; we have an entitlement culture, and the poor could not be trusted; the poor are uneducated and unmotivated. I explained that the groups that I was thinking of were personally known to me, and he responded that that would be even worse – that people would be even more likely to take advantage and abscond with the money. If I were to do this despite his counsel, he recommended working with immigrants because they would be more responsible and industrious. I thanked him for his advice and said I was going to do it anyway. He laughed and said it sounded like fun but would not work.

I began by inviting several agencies to a meeting to discuss the possibility of micro-lending. I told the agency directors that Incarnate Word Foundation would provide $5,000 in start-up funds as a grant, not to be repaid. I made the decision to make this a grant, not a loan, so that the agencies would not be compelled to run the lending program but would serve as conduits to community members who would form the micro-lending groups. There were no strings attached. If the groups failed, the agencies would not be liable for the funds.

Certain criteria were key in the agency selection:

- **History**: The agencies had a long history of working with Incarnate Word, and the agency directors were comfortable being honest and direct.
- **Relationship**: The community members were well-known to one another. In most cases, they saw each other almost on a daily basis. The community members also had significant personal relationships with the agency directors. These were not agency directors who treated people like clients – they were neighbors. The strength of relationships is probably the most important success factor.
- **Interest in Long-Term Systemic Change**: The agency directors were committed to long-term relationships with individuals to change circumstances and were not focused on providing services that merely enabled clients to survive.
- **Commitment to Community-Building**: Whether the community was a physical one, like the Forest Park Southeast neighborhood, or a virtual one, such as the support group at Let's Start, all of the micro-lending groups relied upon this sense of community to buttress their efforts.

We began with five groups. One, a domestic violence transitional housing agency, never was able to start a group because of the challenges abused women had in trusting others. That agency returned the funds after a few months of dialogue. A second agency offering transitional housing to homeless mothers began the program with micro-loans but, based on input from the women themselves, requested that the funds be shifted to an individual development account (IDA) matched savings program.

Three groups have thrived. These groups are sponsored by Let's Start, a support program for ex-offenders; East Side Heart and Home, a grassroots housing cooperative; and Midtown Catholic Community Services, a neighborhood revitalization agency. Of these, the Women's Helping Hands Bank at Midtown offered the best example of how micro-lending can be an essential tool for building healthy communities.

The Women's Helping Hands Bank began with 11 women. They worked together to develop the outline for their program. It is driven by the women themselves – not by agency staff. At first, the women were hesitant to even try to develop a micro-lending program. They doubted their own abilities and were skeptical. As they came to the realization that they really were in charge, however, they quickly created their own unique program. Unlike micro-lending in the developing world, the Women's Helping Hands Bank focuses its program on providing loans for daily living – car repairs, appliance purchases, school tuition, and back bill repayment. This enables members to avoid rent-to-own stores, payday

loan offices, and other predatory lending that is rampant in the urban core.

The women give applicants points based on their participation in the bank, attendance at meetings, and volunteer work. Most of the women have incomes of less than $12,000 per year. The repayment rate for the loans has been about 94 percent. One of their first loans was to the group itself. They lent themselves $400 to host a fish fry and doubled their money. The bank then had an annual membership meeting at a local Italian restaurant – nothing fancy, but for many these women, one of the few times they were able to go out.

More importantly, the Women's Helping Hands Bank has expanded its reach into several other areas. They created the Urban Greens Market, a membership farmers market that provides access to produce from local farmers in what was once a food desert. Fees from the sliding scale memberships subsidize the costs of fresh produce and eggs. The market also provides health screenings and cooking lessons. The women's latest venture is their own version of a matched savings program for neighborhood youth, similar to an IDA program.

I purposely did not meet with any of the groups when they were in the formation stage. I wanted to avoid having the group dynamic shift from what the group actually thought would work to how do we please the funder and do what the funder would do. After two years, however, I invited the women from the Women's Helping Hands Bank to meet with the foundation's advocacy committee to request $1,000 for the youth-matched savings program. These women had become empowered, articulate advocates for the community, and the foundation's board members had no hesitation in providing more funds. Since then, I have been invited to sit with the women in dialogue as they work to develop skills that will enable them to begin a housing corporation. And it all started with $5,000.

Micro-lending in St. Louis requires:

- addressing cultural biases that erroneously regard the culture of the urban core as an entitlement culture that lacks fiscal responsibility and integrity;
- avoiding hierarchical models and challenging participants to recognize that they have valuable knowledge and skills, and can develop the program themselves, not rely on outsiders with more education and resources to impose a program upon them;
- building upon the strong relational skills and networks among women in communities;
- creating joint decisionmaking within the group and a shared sense of responsibility; and
- stressing the ability of each woman to explore her own dreams and determine her own destiny.

Final Reflections

The story of our micro-lending program that I carry with me involves a mother who needed $1,000 to keep her daughter in a Catholic high school as opposed to the alternative – a poorly performing public high school in an unaccredited district. She had a garage sale and that, in addition to money from family and friends, yielded $500. Still $500 short, she went to the micro-lending group and borrowed the $500 dollars, which she has since repaid. Her daughter graduated two years later and is in college today.

This story always leads me to the road not taken. What would have happened to that girl? Would she have still graduated – gone to college? And what would have happened to her relationship with and belief in her mother? And finally, how would the mother have felt about herself, her abilities, and her capacity to provide for her daughter? What would the mother's life have been? Because of $500, we will never ever know what would have happened on that other path.

The micro-lending program began with $25,000 that was left over from the annual grant budget – it was an experiment born out of personal experience. There was no strategic planning or needs assessment, and the best practices were limited to a cursory reading of Muhammad Yunus' book, *Banker to the Poor*, on the plane ride to Mongu. Actually, the only expert consulted said to not go forward. And

yet, whenever I speak about the Incarnate Word Foundation, it is the program that most engages the imagination. It is the program that most reflects the spirituality of our Sisters, their belief in the divine presence within all of us. The micro-lending program is a tangible manifestation of the possibility within people to realize their own potential if they have the tools to do so. The path to creating health communities is within the people themselves.

From Soda Pop to Creating a Healthier Future for Children and Families

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Speaking at a TEDxChange in New York in the fall of 2010, Melinda Gates, co-chairperson of the Bill and Melinda Gates Foundation, focused on what nonprofits working in the developing world can learn from Coca-Cola.[1] For many years, Coca-Cola has ranked as the most valuable brand in the world. With a distribution system that reaches into the most remote areas of the third world, it is a brand recognized by 94 percent of the world's population. So it should not be surprising that Mrs. Gates, who is concerned about encouraging development, relieving poverty, and improving health in the developing world, would look to Coke for lessons for success. However, we too at The David and Lucile Packard Foundation have seen the three elements of Coke's success that Mrs. Gates highlights working in our children's health insurance grantmaking. The three elements are:

- Use aspirational messages.
- Rely on entrepreneurship on the ground.
- Make decisions based on real-time data.

To be sure, these three elements are not sufficient to assure success. Our experience suggests that another key ingredient is a central organization to set overall goals, hold participants accountable, allocate resources, and support learning *(see endnote)*. I do not focus on those important elements here, but on the three lessons Mrs. Gates draws from Coke's successful global marketing efforts, which can be useful tools for philanthropy and nonprofits to use in their efforts to create a healthy future for kids, families, and communities.

I discuss in this essay how these three elements have been incorporated into the Packard Foundation's Insuring America's Children: Getting to the Finish Line (IAC) grantmaking strategy. Formally launched in 2007, IAC builds upon the ongoing work in states across the country to cover children. The long-term goal of IAC is to inform and advance federal policies to cover all children. IAC provides support to state-based groups working to expand children's health insurance coverage through investments in advocacy, policy analysis, communications, technical assistance, cross-program learning, and training.

Next, I consider how these elements, combined with a continued focus on children's coverage, can be used to support the successful implementation of the Patient Protection and Affordable Care Act (ACA). Because the ACA has the potential to increase access to necessary health care, improve the quality of care and the equity with which care is delivered, and promote health maintenance and disease prevention, successful implementation can provide the foundation for a healthier future for children, families, and communities.

↗ ***Use Aspirational Messages.*** Coca-Cola is known for its marketing skills and effective use of positive, aspirational slogans and ad campaigns. As early as 1887, Coke used slogans such as "Delicious! Refreshing! Invigorating! Exhilarating!" to sell its product. More recent variations include "Things go better with Coke" and "It's the real thing." However, perhaps Coke's most aspirational

[1] For a video clip of the Melinda Gates speech, visit http://www.ted.com/talks/melinda_french_gates_what_nonprofits_can_learn_from_coca_cola.html

message is one used recently in India: "Whatever you wish will come true, enjoy Coca-Cola!"

In contrast to the aspirational messaging used by Coke, the traditional messaging used to motivate action to address problems with the U.S. health care system is primarily negative, focusing on problems and not solutions. Such messages call attention, for example, to the large number of uninsured and to the risks that being uninsured can pose to the health and economic security of individuals, families, communities, and the nation. Although such negative messages may be useful in building awareness about a problem, our experience suggests that positive, aspirational messaging is frequently more useful in building movement toward solutions.

In the middle of the past decade, the foundation engaged Spitfire Strategies to help develop a positive message frame to use in our work to advance children's coverage. The nation had made good progress in expanding kids' coverage in the years following the 1997 enactment of what is now called the Children's Health Insurance Program (CHIP) with the growth in Medicaid and CHIP. However, progress appeared to stall mid-decade in the face of mounting concerns about the growth in state government spending on the programs and an increasingly hostile political environment in Washington, DC. In that environment, Spitfire worked with foundation staff and several leading national policy advocacy grantees to develop the Narrative Communications Project.

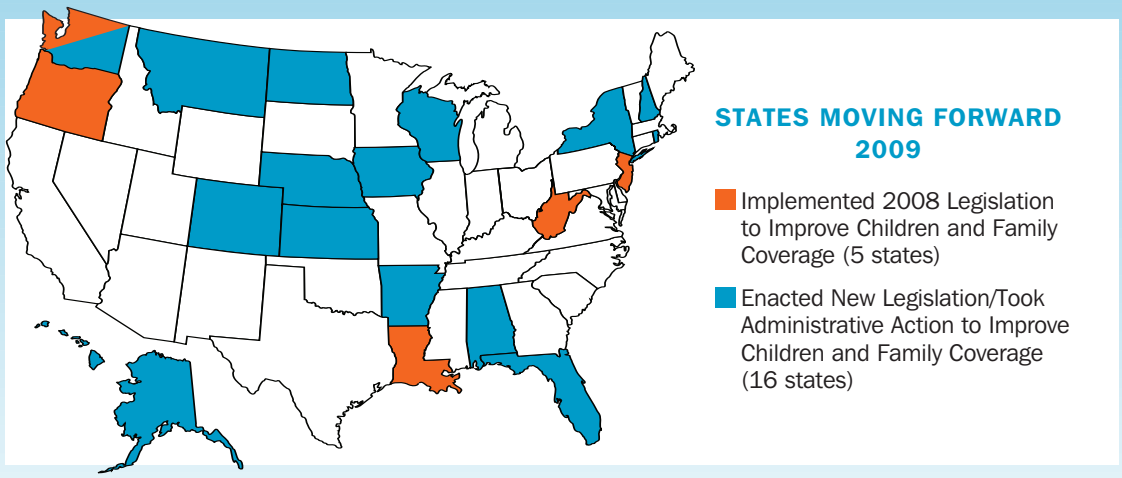
The narrative has two components. First, it provides a set of messages in support of children's coverage that follow a narrative arc and is designed to be used at different stages of the work on children's coverage. The idea is to engage with effective messages in the debate on children's coverage at different points along the arc, from major problem to problem solved, and to move discourse and action forward to the next stage on the path to a solution. Thus, an advantage of the narrative is that it provides messages that can be used in different venues and at different times depending on relevant circumstances.

A second and perhaps more important aspect of the narrative is that it employs positive, aspirational messages. Rather than focusing on the uninsured and the bad things that flow from being uninsured, the narrative calls attention to the number of formerly uninsured children who can get the care they need to grow and thrive because of Medicaid and CHIP. It celebrates progress on reducing the rate and number of uninsured children, calls attention to government programs that are working well, and challenges state leaders and ordinary citizens to do even better.

There are numerous examples of how Packard grantees have used narrative messages in their work on kids' coverage in the past few years. Perhaps the most visible use of this type of message is found in the campaign launched as part the Robert Wood Johnson Foundation's Cover the Uninsured Week effort in 2007. Unlike previous campaigns that featured the problems of the uninsured, the campaign focused on the successes of CHIP and the need to finish the job of covering kids. A print ad from the campaign (reproduced here) highlights this messaging.

Over the years, advocates have succeeded in inserting these messages into hundreds of news media stories and commentaries and have helped other stakeholders adopt the new approach. Using repetition and consistency – just like Coca-Cola does – they were able to change the conversation about the issue to one more supportive of progress.

When, in 2007, CHIP reauthorization legislation was vetoed twice by President George W. Bush despite strong bipartisan and public support, advocates employed narrative messaging to characterize the need to reauthorize the program as "unfinished business," which helped establish CHIP reauthorization as a high priority for the incoming Obama Administration. Within weeks after it convened in January 2009, Congress passed and sent to the President the CHIP Reauthorization Act. Many states took immediate advantage of the new federal legislation to expand and improve their children's coverage programs despite the dismal economy in 2009. The rate of uninsurance among children continued to decline in that year, even as the adult rate continued to increase (see map).



Source: Based on a review by the Center for Children and Families of state initiatives in 2008 and 2009, as of July 27, 2009

↗ ***Rely on Entrepreneurship on the Ground.*** Coke's long history of success in the third world is built on local entrepreneurs who distribute its products through channels that are appropriate for the environment in which they operate. While Coke relies on a modern transportation system to distribute products to supermarkets, convenience stores, and other outlets in the developed world, Coke is distributed in the developing world on donkeys, bicycles and hand carts, and even sometimes on the backs of small business men who purchase the product and earn a living by reselling it. Coca-Cola encourages this localized approach, making deliveries to town squares and busy intersections to make distribution more cost-effective for entrepreneurs and more effective for Coke.

Somewhat analogously, the IAC strategy relies on state-based advocacy organizations to advance the children's coverage agenda in their states by pursuing near-term objectives that the state groups feel have a high probability of success and impact. Grantees are also encouraged to use the advocacy techniques that are most likely to be effective given the objectives being pursued and the environment in a state. Grantees are chosen through a request for proposals process with clearly specified goals to substantially reduce the number of uninsured children and/or support the development of statewide programs to cover all children. In their proposals, grantees are expected to present a set of objectives that will accomplish the specified coverage goals, as well as a work plan detailing how the objectives will be achieved given the resources the foundation can supply in grant and technical assistance support, as well as other resources grantees may bring to the work.

The IAC included the Finish Line and Narrative Communications projects, as well as an evaluation component and support for the National Academy for State Health Policy, to provide technical assis-

tance to states on children's coverage programs. Following a multistage competitive process in 2007, the original Finish Line grants were awarded in early 2008. The grants provided support over three years so that grantees could focus on longer-term objectives and strategies. In contrast, the Narrative Communications Project grants, first piloted in 2006, are much smaller in amount, only come with a single year of commitment (though many have been renewed several times), and are primarily focused on improving the communications work of the recipients. Appropriately, the objectives identified by Narrative Communications Project grant recipients are less ambitious than the objectives proposed by the Finish Line group. Communications support is provided to both sets of grantees by Spitfire Strategies, while the Georgetown University Center for Children and Families provides customized technical assistance on policy and advocacy strategies to the Finish Line grantees.[2]

Although the state groups have independence in choosing their objectives and strategies, there are also commonalties in their approaches to reducing the number of uninsured children. Two briefs recently published by Mathematica Policy Research, *State-Based Advocacy as a Tool for Expanding Children's Coverage: Lessons from Site Visits to Six IAC Grantee States* and *Strategic Engagement of Policymakers Is Key to Advancing a Children's Health Care Coverage Policy Agenda*, document the variety of gains made on children's coverage in states where Finish Line groups have been active, as well as the different policy and political environments in which the groups have had to operate.

Coca-Cola sets sales objectives, but then trusts local entrepreneurs to analyze their particular circumstances and devise locally relevant solutions, and then helps them do more of what's working. Likewise, our IAC strategy sets coverage objectives, then trusts advocates to analyze their own state's circumstances and devise state-relevant solutions, focusing our technical assistance provider role on facilitation and the dissemination of effective approaches.

↗ ***Make Decisions Based on Real-Time Data.*** One of the distinct advantages that for-profit businesses such as Coca-Cola have when compared with nonprofits and philanthropies is access to real-time data with which to distinguish between successful efforts and failures, help identify problems that need to be addressed, suggest options for corrective actions, and share success stories for replication. Product sales can provide a timely measure of whether a marketing campaign is working, a new product is catching on, or a distribution channel is reaching customers. While nonprofit activities that focus on the delivery of services may rely on similar metrics, efforts that focus on systems, policy change, or improved health outcomes often lack comparable real-time information. Funders typically rely on after-the-fact evaluations to measure the returns on their investments, but these do not provide the kind of information that allows for real-time decisionmaking. They may even be met with limited interest by those who have moved on to their next initiatives by the time the evaluations of previous initiatives are completed. To address this shortcoming of traditional evaluations, funders have increasingly attempted to employ so-called real-time evaluations to monitor progress and make timely midcourse corrections. A variety of approaches to real-time evaluation have been tried in different programs of the Packard Foundation, but anecdotal evidence suggests that they are not yet ready for primetime decisionmaking.

The IAC work on children's coverage suffers from similar limitations on access to timely, actionable real-time information, but we do have access to some information that can aid in decisionmaking. Data on the lack of insurance among children is available periodically and can be used to measure trends, suggest which interventions might or might not be effective, and minimize the prospect that there will be unpleasant surprises when the initiative is over. More immediate information on whether specific policy and/or programmatic objectives are being met can inform decisions about how to proceed from a given point. Perhaps the most immediate feedback loop is provided in the work on communications and messaging. The measure here is whether the messages used by

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[2] In 2011 the Finish Line and Narrative Communications projects were consolidated as the IAC: Getting to the Finish Line grantmaking strategy. The new strategy continues elements from both the previous strategies.

proponents of children's coverage are echoed by the larger audience of decisionmakers, including some of the opposition, and thus become the basis for the discussion about how to move forward. Following the model of the narrative arc, once the discussion is framed in ways that are supportive of positive actions, it is easier to achieve the desired outcomes and then move on to the next stage of the process. This message echoing effect can be detected by systematic listening by grantees and others, as well as through various forms of media tracking. These activities focus on content as much as the frequency of mentions. Not hearing the desired echo is a clear indication that messages are not catching on and that a different approach may be warranted.

Lessons for Creating a Healthy Future for Children, Families, and Communities

Other funders have mounted successful multiyear, multisite initiatives that have had lasting positive effects on the health and well-being of children and their families. Nonetheless there are lessons provided by the IAC work (and the success of Coca-Cola) that may be helpful in future work. These lessons would seem to have particular relevance for the work to support successful implementation of the ACA. Although successful implementation does not guarantee a healthy future for children, families, and communities, it can provide a foundation for continued progress. However, the ACA is extremely complex and in a polarized political environment has generated controversy and efforts to repeal and/or significantly modify its provisions. Moreover, given current economic conditions, the resources needed to successfully implement the law are likely to be less than what is needed. In this challenging environment, a continued focus on children's coverage, as well as aspirational messaging, entrepreneurship on the ground, and data-driven decisionmaking, provide a platform for continued forward movement.

- ***Continued Focus on Children:*** The growth in children's health insurance coverage to historically high levels in the face of declining adult coverage, rising health care costs, and a weak economy has laid the groundwork for continued progress. CHIP reauthorization legislation and the ACA provide incentives and reforms that create opportunities for continued progress in the next few years, and provide the results and good news stories to help sustain continued progress. In addition to benefitting children directly, many of the program and policy improvements that can be implemented for children in the next few years will provide a glide path for systems changes that can benefit other population groups when more comprehensive reforms take effect in 2014.
- ***Aspirational Messaging:*** So much of the messaging in the period leading up to enactment of the ACA and since has been confrontational, with opponents stressing the risks of reform and proponents focused on the problems with the existing system. While public opinion polls consistently show support for many elements of the ACA, that support has not been sufficient to blunt efforts to derail it. As implementation moves ahead, supporters of reform will need to change the conversation, focusing not only on the potential benefits of reform, but also celebrating the gains that are made. Many of these early gains can be in the areas of children's coverage, but other groups, such as those on Medicare, will have experienced improvements in their coverage also worth highlighting.
- ***Entrepreneurial Efforts on the Ground:*** The model for the health care finance and delivery systems in the ACA is much like the federal-state model currently used in Medicaid. Accordingly, states will need to play active roles in implementing and administering the program. But states differ with regard to their readiness, ability, and desire to take on the responsibilities assigned to them in the legislation. Some states such as California appear eager to move ahead with implementation, while others are engaged in lawsuits to block implementation. Most lack the resources to engage fully in the work. In such an environment, state and local nonprofits will need to be nimble to adapt to local political, policy, programmatic, and market conditions to effectively advance a reform agenda state by state. The resource needs of those engaged in this work will be substantial. Many will look to state and local, as well as national, funders to exercise their own entrepreneurial skills to respond in new and unfamiliar ways to the challenges and opportunities that present themselves in this time of transition.

↗ ***Data-Driven Decisionmaking:*** The timeline for implementation of the ACA is very short, with many key provisions (Medicaid expansions, implementation of insurances exchanges, and new income tax-based subsidies for moderate-income families) to begin in 2014. With such a short time frame, it is unrealistic to develop sophisticated new data and reporting systems to monitor progress and aid decisionmaking. At a minimum, however, it would seem useful to develop a work plan with detailed milestones that would capture the work that needs to be accomplished to meet the implementation schedule in the law. Such work plans could be used to not only guide the work, but also to track progress and establish accountability. Reference to the timeline could identify where things are working well and where more effort or a change in plans is indicated. Successes could be celebrated and problems identified in time to be remediated. If the process was transparent, it would likely help inspire support for reform and a willingness to engage honestly in addressing the sticky issues that are sure to arise.

In the United States today, confidence in our ability to assure a healthy future for children, families, and communities is challenged by the recent economic crisis, ongoing efforts to control terrorism, burgeoning deficits, deterioration of essential services, and acrimonious partisan bickering. Progress in addressing some of the shortcomings of our health care system and assuring access to quality health care for children and their families is not only a highly desirable goal in its own right, but could serve as a confidence-building stepping stone to other accomplishments.

Beyond children's health, or beyond even health reform, our experience with the IAC grantmaking strategy has shown that the ideas pioneered by Coca-Cola and highlighted by Mrs. Gates – trust those closest to the problem to develop locally relevant solutions, track progress as it happens and make timely course corrections, and give your audiences hope that progress is possible – are worth consideration for designing any social change effort.

ACKNOWLEDGEMENT

Ed Walz originally brought the speech by Mrs. Gates to my attention and commented on its relevance to the Packard Foundation's Insuring America's Children strategy. Ed also provided helpful comments on earlier drafts of this essay, as did Minna Jung, Liane Wong, and Mary Ho. They are, however, in no way responsible for any of the opinions expressed or factual errors that may remain in the essay, which are my responsibility alone.

ENDNOTE

In the implementation of a multistate, multiyear initiative such as Insuring America's Children (IAC), the Packard Foundation and its technical assistance (TA) providers the Center for Children and Families at Georgetown University and Spitfire Strategies assume roles similar to those assumed by large multinational businesses such as Coca-Cola in managing its operations. First off, the TA providers assist the state-based organizations with expert advice on policy and advocacy strategies and in communications. But the TA operation also helps facilitate, through conference calls, webinars, a password-protected website, and face-to-face meetings, cross-group learning, as well as an esprit de corps, that help foster momentum not only in the grantee states but more broadly. The foundation can play a role in fostering excitement and an esprit de corps as well, but its main roles are to set clear, long-term objectives for the funding strategy and then make the funding (capital allocation) decisions on who to fund and for what amounts based on the plans, performance, and progress of the participants in the work, as well as the resources available for the work. While the foundation has been able over time to maintain its support for the IAC grantmaking strategy and for most participants in the work, it has exercised its prerogative in reducing support for some state-based organizations while increasing support for others, and has had to reduce overall funding levels in response to the reduction in available grant dollars resulting from the recession.

Reflections on Philanthropy Grounded in Science, Built on Partnerships, and Focused on Results

Gary D. Nelson, President, Healthcare Georgia Foundation

If we have learned anything from our decade-long philanthropic efforts and investments to improve individual and community health, it is this: Solid science, strong partnerships, and positive results go hand in hand. During Grantmakers In Health's annual meeting *Creating a Healthier Future for Our Kids, Families, and Communities*, we at Healthcare Georgia Foundation reflect upon our mission to improve the health of all Georgians and to expand access to affordable quality health care for underserved individuals and communities. During our 10-year pursuit of many seemingly intractable and assuredly wicked problems, a new social contract has evolved with important implications for our direct charitable activities and grantmaking. It is prudent to take the time to examine these effects.

For those of us about the business of improving the health of our children, families, and communities, these are interesting times. Attention to health and health care issues has never been greater, nor so urgently needed in this country. While the national stage is currently focused on who has access to care, the quality of care, and who is going to pay for this care, we know that the more robust discussion – the depth and breadth of issues affecting the health of individuals and families – should be happening at the community level.

Yet Georgia, like many states, too often has faltered in efforts to measurably improve the health of its residents. History shows an unfortunate record of allowing poor health conditions to persist long after problems have been identified and solutions developed. We witness firsthand the effects of declining resources, the absence of leadership, public complacency, and the spiraling costs of poor health outcomes. In Georgia, as in the rest of the nation, political ideology without the benefit of civil discourse pervades today's health policy. Meanwhile, Georgia continues to rank at or near the bottom among all states on numerous measures of health status. To create a healthier future, we can and must do better!

Healthcare Georgia Foundation stridently pursues this goal through efforts that are grounded in science, built on partnerships, and focused on results. As a learning organization committed to continuous improvement, we share the following five lessons in the hope that others might learn from our successes, as well as our occasional missteps.

LESSON ONE:
Listening to Communities – Why We Do What We Do

William J. Foege, former director of the Centers for Disease Control and Prevention and a foremost leader in public health, suggests that if we are to be successful in our work of improving health it is because "in everything we do, behind everything we say, as the basis for every decision we make, we are willing to see the faces."

Like many of our philanthropic colleagues, we are a statewide foundation with a commitment to understanding, working with, and improving our communities. We aim to actively engage residents, health care providers, nonprofit organizations, and others in cooperative efforts to improve individual and community health. We have sought out not only the faces, but also the voices of those on the frontline of community health.

As such, we each have stories to share about the communities in which we've focused our efforts – stories that tell of despair and hope, isolation and connectedness, daunting challenges, and heartfelt victories. The stories have become the "means testing" for our grantmaking. Since its inception, the foundation routinely canvasses Georgians for their insights and opinions through three distinct strategies:

- ***Listening tours.*** The foundation has commissioned four statewide listening tours during the past 10 years, each consisting of half-day convenings in multiple communities. Herein, we seek input from and listen to the voices of health providers, consumers, residents, policymakers, elected officials, and other concerned parties. These facilitated discussions help identify health issues that are uniquely *place based* as defined by geography, population, or provider setting.
- ***Public opinion polling.*** Two or three times each year, the foundation conducts statewide polls of registered voters to gauge public opinion on a host of health policy issues. These polls are a valuable means of understanding the perceived roles of individual residents, communities, and government in the structure, delivery, and financing of health care. The polls have been instrumental in the design and evaluation of foundation-funded and foundation-directed health advocacy campaigns, including one initiative to establish a statewide trauma system and another to advance public health in Georgia.
- ***Statewide convenings and capacity building.*** One of our most effective methods of promoting partnerships and collaboration has been through the foundation's biannual statewide conferences for grantees, partner organizations, and other nonprofit health organizations. Since 2002 the foundation has convened four, two-day capacity building/networking conferences, reaching approximately 250 organizations per event. To date, the foundation-hosted conference is the only venue in Georgia providing an opportunity for multiple sectors – hospitals, safety net providers, public health professionals, community activists, advocates, academicians, and others – to connect, communicate, and collaborate. Initially the need for, and benefits of, this convening were underestimated by both the foundation and its grantees. Over time, however, all parties have come to look forward to and appreciate the conference as a way to progress toward a healthier future for all Georgians.

In summary, the purpose of these important strategies has been to discern the most significant barriers to healthy communities, the assets each community has to make improvements, and the tools and resources each community needs to move forward. The results of four listening tours, plus eight public opinion polls, plus four statewide conferences add up to one profound lesson. As Dr. Foege suggests, these strategies enable us not only to see the faces, but also to hear the voices of Georgia's diverse communities.

> ***"…in everything we do, behind everything we say, as the basis for every decision we make, we are willing to see the faces."***
>
> ***– William H. Foege, M.D., M.P.H.***

LESSON TWO:
Formulating Priorities – How Taking Pulse and Temperature Can Halt the Futile Dollar Chase and Truly Advance Knowledge

Margaret J. Wheatley, president of the Berkana Institute, a global charitable leadership foundation, tells us, "There is no power for change greater than a community discovering what it cares about." The same is true of our foundation. Over time, we have become increasingly aware of the importance of focusing limited resources on battles, which are *winnable* – or, at the very least, able to advance the cause. Too often in the past, the foundation and its partner organizations (including our grantees) have been driven by less than rigorous methods of setting priorities. We now believe the greatest opportunities to improve health and health care for underserved populations (that is, the most likely

battles to be won) occur when we have aligned our resources with three critical pieces of evidence, which help shape our priorities:

Evidence of Need	+	***Evidence of Demand***	+	***Evidence of Effectiveness***	=	***Priorities***

With this formula in mind, we can remain focused on initiatives aimed at creating healthier futures for our children, families, and communities. Let's take a closer look at the equation.

- ***Evidence of Need.*** The problems can be multitudinous, the burdens to communities overwhelming. Consider just a few: the epidemiology behind morbidity, mortality, disability, and the costs of bad health outcomes. As expected, our funding priorities, as well as the priorities of the communities we support, are strongly rooted in existing data systems that reflect changes in demographics, morbidity, mortality, disability, health care delivery, risk factors, health expenditures, and other factors. Most, if not all, of our grant recipients to date have mastered the skills of documenting and defining need. These definitions can be drawn relative to the past, to the performance of others, or to conditions elsewhere. *Need* can also be defined by examining current status relative to a standard of acceptability. Evidence of need is necessary in applying philanthropy to healthier futures; in our judgment, however, need alone is insufficient to warrant the allocation of philanthropic resources. There is more to the equation.
- ***Evidence of Demand.*** Public declarations that a problem needs attention, that something must be done, that doing nothing is no longer an option all help to create a climate of public urgency – a demand to address an unmet need. Focus groups, public opinion polls, exit interviews, and listening tours all promote greater public awareness and acceptance of an issue as a priority. So do health champions who become the face and/or voice for a particular health issue. Consider the Susan G. Komen for the Cure or the Michael J. Fox Foundation for Parkinson's Research. Grassroots organizations like Mothers Against Drunk Driving can bring a health issue to the fore, as can the authoritative voice of the U.S. Surgeon General riveting our attention to any number of public health matters. Foundations are uniquely positioned to capture and communicate both the "evidence of need" and "evidence of demand," particularly when advancing policy agendas.
- ***Evidence of Effectiveness.*** Promising practices, if not best practices, exist for many specific health issues that have been the focus of our grantmaking. Ironically, we often find insufficient attention to, or inadequate adoption of, evidence-based programs in the ensuing feeding frenzy to address an urgent issue and/or capture available funding. This was plainly evident in the flurry of funding available to address childhood obesity. As a foundation, we have learned that we can play a key role in program quality assurance by applying the knowledge we have gained to determine potential program effectiveness. Lastly, we continue to be puzzled by the number of nonprofit health organizations unprepared to present a case statement and funding request driven by documented accomplishments or a solid performance record.

> ***"There is no power for change greater than a community discovering what it cares about."***
>
> ***– Margaret J. Wheatley***

To summarize, we now advance the view, both within the foundation and among our grantees and organizational partners, that all three elements of evidence – need, demand, and effectiveness – must exist in order to constitute a priority that warrants the allocation of charitable resources. In doing so, we are more likely to avoid the undisciplined and untested *magic bullets*, those funding requests that frequently come to us in forms that promise little benefit to our communities, which want and deserve more.

LESSON THREE:
Managing Threats to Success – How to Stem the Epidemic of Demonstration Boutiques and Program Tombstones

John Gardner, the noted educator, said, "We are all faced with a series of great opportunities brilliantly disguised as insoluble problems." We are at a time and in a place in which accountability, transparency, and effectiveness frequently trump need. Decisions regarding the allocation of scarce resources are more likely to follow the path of an organization's performance, accomplishments, and contributions versus the ability to document a need. Setting aside the issue of attribution, we seek to determine what success looks like, what level of evidence we are willing to accept, our tolerance for risk and failure, the level of engagement (time and resources) of all parties, capacity requirements, and our foundation contributions.

In creating healthier kids, families, and communities, we have discovered the benefits of being skilled at recognizing and preventing three significant threats to success.

- ***Theory Failure.*** This is best described as the inability to accurately diagnose the cause of, or solution to, a problem. Although considerable attention has been given to the use of logic models to explain the linkage between inputs and outcomes, we as a foundation continue to be at risk of funding so-called *interventions* that address symptoms only, of supporting programs that presume to be immune to changes in their environment, and of embracing programs based more on notoriety than impact.
- ***Implementation Failure.*** This is the inability to carry out a program as it was intended. It is often associated with the phrase *if only*…as in, *if only the evidence-based programs we support reflected sufficient intensity and duration to achieve the desired result*. As a consequence of the wide variations in program delivery among the organizations we fund, the foundation has had to become better at diagnosing and monitoring program quality from the start.
- ***Measurement Failure.*** Simply defined, this is the inability to accurately measure the effects of a program. It is unfortunate indeed when errors in evaluation limit our ability to detect true results. Failure to negotiate success, define outcomes of interest, and apply measurement methods in a rigorous way leaves us with little more than politely smiling faces, a handful of anecdotes, and many unspoken questions such as: *Are we truly confident in what these results are telling us?*

> ***"We are all faced with a series of great opportunities brilliantly disguised as insoluble problems."***
>
> ***– John Gardner***

LESSON FOUR: Making Change through Policy

Policy and advocacy represent the most promising approaches for a small, statewide foundation like ours to take in creating a healthier future for kids, families, and communities. Whether the topic is health reform, pandemic flu, access to affordable prescription drugs, disparities in health care quality, or the obesity epidemic, these issues take center stage for policymakers, health care providers, and health care consumers. A philanthropic investment in health policy formation and change helps create the conditions for direct, sustainable investments in health and health care.

The foundation's approach to health policy, adopted in June 2003, emerged from our board of directors' commitment to leverage its resources to advance the health of all Georgians. These leaders also recognized that changes in health policy were needed to support systems and programs that will have a sustained, long-term, positive effect on the health of underserved individuals and communities throughout Georgia.

As such, foundation leadership identified seven areas in which the foundation would invest in building health policy capacity:

- Nonpartisan research
- Targeted dissemination of results
- Training and capacity building for nonprofits
- Nonpartisan tracking and analysis of health legislation and regulations
- Fiscal policy analysis
- Public education
- Advocacy

The foundation has chosen to build health policy capacity in Georgia by working through existing organizations and by promoting the incubation of new organizations, which are not necessarily exclusively devoted to health but include a focus on health policy as part of their mission. Rather than establishing a new, full-service, nonprofit health policy institute – a move that would require substantial and continuing financial support – the foundation instead chose this alternative strategy for two reasons: 1) to stimulate innovative health policy research and build capacity across academic institutions and nonprofit organizations throughout Georgia, and 2) to promote added investments in health policy research and advocacy from other Georgia funders and national foundations. In this way, as the primary funding source for health policy activities in Georgia, the foundation has been able to stretch our resources by engaging other funders and organizations with broader missions in addressing health and health care needs.

An effective health policy strategy must be timely and nimble, and able to take advantage of often narrow windows to influence the policy process. An effective strategy also will adapt to changing needs, an evolving political environment, and emerging opportunities for the foundation to use its influence and grantmaking to be an effective catalyst for better health and health care for all Georgians. Finally, we must acknowledge the inherent risks associated with policy and advocacy strategies, particularly in those instances when the foundation steps out front on the issue.

Lasting solutions to our state's most pressing health challenges will require a wide array of strategies, most notably informed health policy. We realize that major policy changes are rarely the result of a single individual, organization, or grant. The successes we have attained thus far in areas related to trauma, childhood obesity, and advancing public health have occurred because of the organizational capacity of those we fund and their uniquely collaborative approach to public policy advocacy. That said, our policy successes thus far also have been met with some concern by those opposed to our agenda. In advocating for healthier futures for our children, families, and communities, the foundation has learned that while we may not please all of the people all of the time, we *will* inform them.

LESSON FIVE:
Respecting Community Ethos – Ethics and the Potential Collision of Charitable Principles

Foundation efforts to promote and protect the health of populations frequently bring to the surface ethical conflicts, requiring a special skill set to navigate a complex maze of individual values, neighborhood cultures, and community ethos. As we steer this course, we bear in mind four ethical principles, as well as their potential for conflicts, and we ask ourselves many hard questions.

↗ ***Autonomy.*** As commonly understood today, autonomy is the capacity for self-determination and the acknowledgement of a person's right to make choices and take action based on his or her own values and belief system. As Henry David Thoreau once remarked, "There is a fine line between care and concern for the well-being of others and respect for persons as people of their own choosing

and creators of their own destinies." As a statewide foundation seeking to achieve measurable improvements in the health status of the population, we frequently find that the policy options most likely to attain desired results are at odds with personal choice. Through grantmaking and/or direct charitable activities, we frequently assume the role of change agent. Many times, we take on that role in situations wherein the individual, family, or community's freedom to choose is at odds with the science of the improvements we are proposing. So if an individual's choice endangers himself or herself, puts the public's health at risk, potentially harms others, or requires scarce or limited resources, are we as grantmakers prepared to make decisions that affect or restrict the individual's autonomy?

- ***Paternalism.*** In support of community priorities, to what extent do we allow funding to interfere with a person's freedom for his or her own good? In other words, through the programs and policies we promote, are we in essence making decisions for others on the grounds that *funders know best*? Although the question and the opportunity are not new, the current climate dominated by political ideology seems to have created an environment where even seemingly innocuous health policies (think seatbelts, tobacco use, immunizations, and accessible prenatal care) have hostile overtones. As grantmakers who respect people and accept them as they are, can we assume an effective, paternalistic role by helping them become even better than they are?
- ***Beneficence/Nonmaleficence.*** We believe in the principle of conferring benefits and, at the same time, in its corollary of doing no harm (nonmaleficence). It is said that those in health care hurt far more people through errors of omission. The things we don't do can cause great harm – for example, the vaccines not given, the science not shared, the limiting of services and support to people because they live in "have not" communities. Whether an act of omission or commission, how does what we do or don't do in the name of priorities affect our effectiveness as change agents and public health advocates?
- ***Distributive Justice.*** This term refers to what society, or any larger group, owes its individual members in proportion to: 1) the individual's needs and contributions to the group, 2) the resources available, and 3) the organization's responsibility to the common good. Designed to address unequal access, treatment, and outcomes, our mission-related grantmaking seeks to nullify the adverse effects of programs, policies, and practices that create further distance between the haves and have nots. For us, the first step is addressing the indifference to the health impact of programs and policies. As The California Endowment asserts, "The inequities are unacceptable, but the opportunities for change are undeniable."

> ***"There is a fine line between care and concern for the well-being of others and respect for persons as people of their own choosing and creators of their own destinies."***
>
> ***– Henry David Thoreau***

Who will stand up, even if alone, and address issues of social injustice and inequality and elect to navigate through political landmines, all in the pursuit of better health outcomes for individuals and communities? Communities today are required to face tough decisions about the delivery of goods and services, the application of research, and the allocation of resources, wherein the fundamental issues of autonomy, justice, paternalism, and beneficence are on the line. As a foundation, we must be sensitive to, and respectful of, the community ethos and the underlying ethical conflicts that arise from our work.

The Journey Continues

In our efforts to improve health and health care for children, families, and communities, our grantmaking has supported organizations that drive positive change; promote programs and policies that improve individual and population health; and connect people, programs, and resources across the state. We

believe the road to better health for all will be paved by efforts that are grounded in science, built on partnerships, and focused on results. On some paths, we have faltered; on others, we have succeeded. Throughout, we have held firmly to our commitment to be a learning organization seeking to achieve greater accountability and transparency. We look forward to the next leg of the journey toward a healthier future for all Georgians.

Thinking about What's Next

Sterling K. Speirn, President and CEO, W.K. Kellogg Foundation

In describing some of his research on how organic molecules initially gain autonomy and become alive, the theoretical biochemist and MacArthur Fellow, Dr. Stuart Kauffman, recently articulated his concept of the "adjacent possible." In a universe of vast but limited potential, the "adjacent possible" is the catalog of potential occurrences at a given moment; in a given place; under existing conditions; with the materials, tools, abilities, and information currently available.

Thus, tomorrow's adjacent possibilities are largely derived from those realized today. Yet within this essentially non-linear process, progress is by no means certain. Expanding into adjacent possibilities enlarges the universe of what can happen in subsequent orders of change. Among the first-order possibilities, some will offer greater potential for change than others.

Dr. Kauffman's construct is particularly timely in a discussion about generating a healthier future for our kids for several reasons. First is the complexity of the word "healthier" as a category of adjacent possibilities. In fact, it's that complexity that has led to significant changes at the W.K. Kellogg Foundation over the last few years. Previously, our programs operated out of separate divisions with distinct and largely discrete areas of focus. Educational programs operated apart from food systems and nutrition programs, which, in turn, were managed separately from health-related programs, which typically were conducted apart from our civic engagement work, and so forth.

Our organization and our strategic framework recognize that in propelling vulnerable children to success (what we regard as a "healthier future") these factors are inextricably intertwined. A family's economic security has a direct bearing on its ability to put nutritious food on the table. That directly affects a child's physical and cognitive health and therefore her performance in school, which ultimately becomes a significant factor influencing the health of the family she may have as an adult. When these factors are seen as the interconnected systems and feedback loops that they are, the field of adjacent possibility becomes richer and more complex than it might have seemed previously.

The second factor making Dr. Kauffman's construct so timely is that while our approach to our work is becoming more integrated and holistic, the need for effective action is growing. Across the country, and particularly in the Kellogg Foundation's three priority states of Michigan, Mississippi, and New Mexico, the weak economic recovery is causing states and municipalities to cut essential services to balance their budgets. Proposed cuts to a wide range of services affecting vulnerable children and their families put increased pressure on foundations and the practitioners they support to become even more effective at protecting the interests of these children and families.

In an age of increasing complexity and competition, ensuring a healthier future for our kids and taking advantage of their fully developed talents and skills have vital implications for our social stability and our national economic health and security.

Finally, it seems possible that the field is ripe for movement into adjacent possibilities. That was the clear message of the Monitor Institute's report *What's Next in Philanthropy*, published in July 2010 with support from both the Robert Wood Johnson Foundation and the W.K. Kellogg Foundation. Speaking to philanthropy overall, Monitor concluded that the coming decade will require all of us to "act bigger" (to more effectively leverage resources and connections) and to "adapt better" (to get smarter, faster).

Writing in the *Stanford Social Innovation Review*, John Kania and Mark Kramer (2010) make a similar case for foundations to pursue "collective impact." In their description of a more advanced version of interfoundation and intersector collaboration, they envision a long-term social change

process that would expect and thrive on adjacent possibilities, rather than pursue isolated impacts or one-dimensional solutions.

The question for practitioners then becomes: In seeking to secure a healthier future for our kids, into what adjacent possibilities might we move? What kinds of immediate actions and implementations are most likely to produce the most diverse and promising sets of future adjacent possibilities?

A Strategy for the Future

I've been thinking about these questions for some time now, and the Kellogg Foundation has been moving toward some answers since we began work on our strategic framework in 2007.

That framework is itself a good example of a very high-yield "adjacent possible." First we sharpened our focus on vulnerable children. Then we identified our core competencies, as well as our legacies in Food, Health and Well-Being; in Education and Learning; and in Family Economic Security. We then lifted up our two-pronged commitment to work to confront the barriers of structural racism and to promote racial equity, and to unleash the inherent capacity of communities to help themselves. Next we picked three states – Michigan, Mississippi, and New Mexico – in which to concentrate 60 percent of our annual grantmaking over time on an integrated, place-based approach. Finally, we decided to commit at least half of our annual grantmaking (including a portion of the 60 percent devoted to our priority places) to develop integrated programs that build developmental continua and the foundations of lifelong success for children from conception and birth to their completion of third grade, or "zero to eight."

Reorganizing to reflect our new framework and to adapt our integrated strategies into our priority places has opened the door to a range of efforts and possibilities that we hope will have a significant impact on a healthier future for our most vulnerable children.

Empowered Program Managers

For example, we've expanded the role of our program officers. We've given them a new set of guidelines and challenged them to use those guidelines, not only to invest, but to trigger positive change within a community. Doing so drives an entire process of community engagement in which we partner with the community to define its aspirations and the means by which to achieve them.

Effective community engagement alone is an expansion into an adjacent possibility. In many cases, I expect its yield to be a range of second-order possibilities for positive change that are specific to the community in question, and ideally, also relevant to other communities.

A Systematic Approach

Moving from a theory of action to on-the-ground practice requires us to establish an *executional* framework that corresponds to our *strategic* framework. We already have strong, high-level alignment around our key approaches, our place-based focus, and our emphasis on success by the end of third grade.

Our next steps must be to integrate similar alignment in execution throughout the organization. This means connecting strategy directly to tactics. And it requires that we clarify and hone our theories of change for creating a healthier future. To do this, we are now developing a "playbook" that will help us codify and prioritize the ways in which we can expand into the "adjacent possible" in our key places.

The sports metaphor is intentional. Seeing philanthropy as a *team* sport captures our business model of operating in an integrated, multifaceted approach requiring close coordination between our element strategy officers and our place-based officers. Seeing philanthropy as a *contact* sport captures our commitment to work in relationships with all kinds of partners in our places: residents, informal and formal leaders, small grassroots organizations and larger nongovernmental organizations (NGOs), local and state governments, business leaders, and public systems like schools and community health centers.

Finally, the constantly shifting dynamism of a sports contest can be the perfect social metaphor. It captures the spirit of those pursuing adjacent possibilities for positive social change through an adaptive approach that allows for varied kinds and sequences of plays, while still being held accountable for succeeding within the rules and boundaries of the playing field.

A playbook isn't definitive for process, nor is it prescriptive or encyclopedic in addressing every conceivable circumstance. But our playbook does reflect the integrated approach of the strategic framework and our vision of "whole child" development. It does start to provide guidance for the processes by which staff can enter a community, assess the degree of fit with our program criteria, and begin to build the relationships necessary to establish and sustain our work. And it does provide a common tool kit to help determine the content and sequence of core program strategies, depending on circumstances within a given place.

For example, we have worked for several decades on food systems and food issues, and are heartened that so many other funders are taking up this work in both local and national arenas. Over the seasons, we have helped develop some very strong "food plays." Today, with hard-won new provisions in the Child Nutrition Act, the mainstreaming of farm-to-school programs, and new companies like Revolution Foods competing for market share, the school cafeteria has become one of the key arenas for fighting childhood obesity. Now, when our Education and Learning team develops relationships with an elementary school to talk about kindergarten to third-grade literacy and math programs, they will eventually be joined by their Food colleagues who will talk to the same school leaders about the state of the school's food. And their Health and Well Being colleagues will ask about the status of school-based health services and inquire about support for oral health care. Any one of them might ask, "Do any of your second grade teachers use cooking as a way to teach math, vocabulary, and nutrition?"

Triggering Change

Along with our strategic and executional frameworks and our organizational refinement, we're looking at a range of actions and approaches to expand into adjacent possibilities and to ensure that the possibilities we explore and develop offer high potential for yielding significant positive change. At the most fundamental level, we're starting to look at the triggers of social change themselves.

An exciting line of recent reportage – from Malcolm Gladwell's *Tipping Point* to Thaler and Susstein's *Nudge*, from Chip and Dan Heath's *Switch* to Kotler and Lee's *Up and Out of Poverty* – makes it clear that change occurs differently in different contexts and at different times: a community changes differently than a state, and both change differently than a family or an individual. By the same token, organizations and institutions change in different ways than policies do.

And it's the *spark* as well as the *process* of change that vary and that may be subject to influence. Some change might be called "inside-out," triggered by internal experiences, beliefs, motivations, or observations. Other change might be considered "outside-in," triggered by external conditions. (Of course, some changes – like those the paleontologist Stephen Jay Gould called "exaptations" – are effectively sparkless: happy accidents we can't influence.)

This insight opens up a spectrum of adjacent possibilities. I am optimistic that by knowing the optimum target for change in a given area and by being able to refine a constellation of tactics (the new school of behavioral economists is helpful here) in a given sequence, leveraging the appropriate triggers of change for that target can make us far more effective in building a healthier future and creating conditions of success for our children.

Starting at the Beginning

There is understandably tremendous pressure on both government and NGOs to make a difference on behalf of vulnerable children *now*, to get food and health care and better education to kids who need it *today*, to help the parents of vulnerable children find jobs that will help them build a financially stable

and secure future *today.* And those should be, and are, high priorities for many of us.

But it isn't enough simply to catch people when they're falling, nor could we begin to catch all of them even if we chose to do so. The key to the kind of social change that will create a healthier future for our kids, as opposed to a more tolerable present, must be greater attention to the earliest interventions that shape and set a positive life course for a newborn child. Ironically, this is the strategy with the longest lead-time to fruition. But I believe it is also the only strategy that offers the realistic hope of profound and sustainable social change.

Recent research and literature provide ample support for movement in this direction. For example, as Dr. Jack P. Shonkoff, founding director of the Center on the Developing Child at Harvard University and chairman of the National Scientific Council on the Developing Child, said in describing the council's report, *From Neurons to Neighborhoods* (2000):

> … children are born ready to learn…wired to experience and to master the world around them …(O)ur job is to provide an optimal environment…(T)he quality of the relationships that children have with the important people in their lives…and the interactions…and the feelings that go with those relationships actually influence the emerging architecture of the brain. They sculpt the wiring of the brain. There is no part of the brain…that isn't influenced by these interactions.

The Nobel Prize-winning University of Chicago economist Dr. James Heckman, who has extensively studied early childhood education as an economic development strategy, supports these insights. For example, in a 2005 interview with the Federal Reserve Bank of Minneapolis, he cited the findings of the Abecedarian program:

> …an intensive child enrichment program targeted toward disadvantaged children, that starts at 3 or 4 months after the children are born…Lasting substantial differences in IQ are found between those in the program and those not…Thus, if we start early enough and offer enriched environments, we can raise the IQs of disadvantaged children.

To my mind, the primacy of these early interactions on a child's full, healthy development suggests giving very high priority to a wide range of zero-to-eight interventions and implementations that address social and emotional, as well as cognitive, skill development. Even a short list of such interventions would include:

- focusing on healthy mothers and healthy birth outcomes;
- emphasizing first food (mother's milk) and early food experiences that give kids a nutritional and immunological jump-start on life;
- encouraging high-quality, high-frequency parent-child interactions that provide the social, emotional, and cognitive stimulation essential for healthy development;
- encouraging high-quality, high-quantity socially interactive language between parent and child, beginning at birth, providing a solid foundation for later learning and successful interaction;
- developing and providing culturally based early childhood care and education;
- delivering programs that build the social capital and collective efficacy of parents, neighbors, and residents in building community and raising children;
- providing social and economic supports for parents and their aspirations for their children to thrive; and
- creating community-based pathways that guide transitions from infancy to toddlerhood, to preschool experiences, to crossing the schoolhouse threshold.

In short, at the heart of our beliefs on how to break the cycle of poverty and inaugurate a cycle of success for vulnerable children is the overwhelming evidence that it is the quality and quantity of these earliest experiences that most powerfully and fundamentally shape and set the life trajectory for a child at

the beginning of the continuum. And it is that through-line of continuity – from the child who successfully navigates that early part of the continuum, to the adult she becomes, to her future children and *their* children – that can delineate a healthier future for *all* of us. It stands to reason then that the healthiest possible *future* is the one we can facilitate by working to create the healthiest possible *present*, from the moments of conception and birth. Leveraging adjacent possibilities that do so will be a major focus of W.K. Kellogg Foundation work moving forward.

The Obama Administration's Commitment to Creating a Healthier Future for Children and Families

Mary K. Wakefield, Administrator, Health Resources and Services Administration

As a nurse whose professional career working in health care, public policy, and academia has always been propelled by a drive to extend health care to those among us who need it most, it is particularly gratifying to work for a president with such a strong commitment to children's health.

In the midst of competing demands, one of President Obama's first actions upon taking office was to push for and sign on February 4, 2009, the reauthorization and expansion of the Children's Health Insurance Program (CHIP). That act boosted insurance coverage from 7 million children to 11 million children from low-income families.

After CHIP's successful reauthorization, President Obama oversaw passage of the Affordable Care Act (ACA), which has guided U.S. health care into a new focus on care quality, access, wellness promotion, and illness prevention for all Americans, including the youngest among us.

The President's priorities are recognizable in the mission of the Health Resources and Services Administration (HRSA), the agency I head, which is part of the U.S. Department of Health and Human Services. The first goal of HRSA's strategic plan is to improve access to quality health care and services.

The historic legislation, signed into law on March 23, 2010, recalibrates health care in this country in ways that are essential if we are to decrease financial and other burdens, even as we improve the health of children, families, and communities. Some of the long-overdue changes that eliminate barriers, which too often stand between families and good health, include:

- preventing insurance companies from canceling health insurance policies except in cases of intentional misrepresentation or fraud;
- allowing young adults – a demographic group with some of the highest rates of uninsurance – to stay on a parent's plan until they turn 26;
- making certain preventive benefits, such as immunizations and screenings, available at no cost to policy holders; and
- removing pre-existing condition exclusions for children (as of September 2010, children under the age of 19 cannot be prevented from buying insurance because of pre-existing medical conditions).

The last benefit extends to the entire citizenry when the law is fully implemented in 2014.

All of America benefits from the ACA, but the legislation includes a clear focus on the health of infants and school-aged children. For example, a lesser-known provision in the legislation authorizes $1.5 billion over five years for a Maternal, Infant, and Early Childhood Home Visitation Program. Three percent of total funds ($45 million) are set aside for tribal organizations. Under this program, nurses, social workers, and others will visit expectant mothers and their families in high-risk communities. There they will provide counseling and intervention services designed to improve health outcomes for mothers, infants, and families. The evidence behind the program clearly indicates that providing this intervention sooner decreases the need for more costly clinical care later. That theme runs throughout much of the ACA.

The ACA also authorizes $200 million over the next four years for the construction, renovation, and

expansion of school-based health centers, part of the network of 7,900 HRSA-supported health center sites across the nation that provide preventive and primary care to all who enter their doors. With the additional school-based sites, even the most disadvantaged kids can get care conveniently – and before major health problems take root.

The investment in school-based centers is but a sliver of the total investment in primary health care, by any measure an important and cost-effective component of health care. In the ACA, $11 billion over the next five years is designated for the operation, expansion, and construction of health centers throughout the nation. And this investment in primary care services follows an influx of $2 billion for health centers contained in the Recovery Act that President Obama championed and signed in 2009, after a month in office. The result of that Recovery Act investment, made during the darkest days of the recession, allowed health centers to treat an additional 3.3 million patients in 2009, including more than 1.8 million people who found themselves without health insurance.

Even as we push out primary care infrastructure, the ACA has accompanying provisions to strengthen the ranks of primary care providers. With staffing challenges in mind, lawmakers who wrote the ACA dedicated $1.5 billion over the next five years to support and deploy clinicians from another HRSA program – the National Health Service Corps (NHSC).

And, again, that followed a $300-million investment under the Recovery Act to expand the corps, comprised of advanced practice nurses, physicians, dentists, psychologists, and others who agree to provide primary care in medically underserved areas for at least two years. In exchange, the federal government – through HRSA – gives them up to $60,000 tax free over that period to repay student loans. For a five-year commitment, the loan repayment amount can run as high as $170,000. Additionally, a number of NHSC clinicians have received scholarships to pay for their studies through the Recovery Act, or will receive them beginning in 2011 through the ACA. From a total field compliment of 3,600 providers just two years ago, the NHSC today is on track to reach 10,500 clinicians providing primary care services by the end of 2011. If historic trends hold, about half of them will accept positions in health centers.

This cadre of clinicians is particularly important given that the bulk of the ACA money for health centers – $9.5 billion of the $11 billion total – will expand preventive and primary health care services at existing health center clinics and create new health center sites in medically underserved areas. And by 2015, HRSA's health center grantees are expected to nearly double the number of patients they serve, from almost 19 million patients served in calendar year 2009. Of the total number of health center patients served in 2009, about 6.8 million were 19 years old or younger, including almost 4 million who were 9 years old or younger.

So a near-doubling of the health center system over five years will, if trends hold, extend the benefits of health center care to several million young people. That is progress on an epic scale, a scale equal to the passage of Medicare, and before that, Social Security.

Another part of that landmark legislation, Title V of Social Security, is one of HRSA's core responsibilities. The Title V program, operating today as the Maternal and Child Health State Block Grant Program, is an example of government at its best. These funds, set at $662 million in the fiscal year 2010 budget, support one of the longest running and most successful federal-state-local partnerships in the history of public health in America.

From its earliest origins, Title V programs have supported preventive care for pregnant mothers, infants, and children, as well as a wide range of medical services, and contain a focus on the care and development of children with special health care needs. The program pays for important services from doctors, dentists, public health nurses, medical social workers, and nutritionists. Six in 10 of all pregnant women in America benefit from Title V services. Also important, Title V administers established protocols and embraces standards that support evidence-based research to inform health care. The program stresses performance. All of the states and territories that receive Title V funds from HRSA

report annually on their progress toward meeting health targets on 18 national performance measures. These data are published on HRSA's Web site http://mchb.hrsa.gov/data/. The reported measures include metrics such as:

- the percent of mothers who breastfeed their infants at six months of age;
- the percent of 19- to 35-month-old infants who have received the full schedule of age-appropriate immunizations; and
- the percent of children with special health care needs ages 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home.

When state officials apply for their Maternal and Child Health Block Grant funds each year, as they are required to do, staff from HRSA's Maternal and Child Health Bureau (MCHB) engage them in discussions about their performance on these 18 measures. As needed, the conversation also covers strategies to improve performance.

Despite these great efforts, the United States still struggles with infant mortality. In fact, U.S. infant mortality rates remain high among developed nations, and that failure – especially striking among African Americans – is one of the most glaring defects of our current health care system.

To explicitly apply resources to the highest-need communities, the Healthy Start program, a separate MCHB effort, was launched as a demonstration project in 15 cities 20 years ago. This program targets the infant mortality problem head on in 102 underserved, largely minority communities around the country. The aim of the program is to bring together community resources to reach young, pregnant women in their homes and get them into prenatal care and nutritional and behavioral health counseling before birth, and after delivery to continue connecting these women and their infants to care.

The impact in most areas is striking. In 22 jurisdictions over 2008 and 2009, despite vastly different demographic and socioeconomic conditions on the ground – from Blytheville, Arkansas to Flint, Michigan; from Philadelphia, Pennsylvania to Los Angeles, California; in Wichita, St. Louis, San Antonio, and Fresno, and 14 other places in between – clients enrolled in the local Healthy Start program had ***zero*** infant deaths.

In another measure, the percentage of very low birth weight babies, the country has endured a historically glaring disparity between whites and African Americans. But in the area served by the Baltimore (Maryland) Healthy Start grantee, the percentage of very low birth weight African-American babies now almost equals the rate for white infants.

Each of these programs combines to strengthen the health care safety net. For example, with Healthy Start, the expansion of CHIP, and now, with passage of the ACA, when it comes to the health of infants and children, there is no doubt that we are headed in the right direction. Last July, Cecilia Rouse, a member of the President's Council of Economic Advisers, told a Senate hearing that the number of children without health insurance in 2009 had fallen to 8.2 percent, down from about 10 percent the year before. Rouse attributed the drop to what she called the "historic expansion of the Children's Health Insurance Program." This is particularly noteworthy given that the achievement occurred in a year that saw health insurance coverage fall among adults. And the number of children covered will continue to expand as more of the consumer protections contained in the ACA take effect.

Title V covers the bulk of the work HRSA's MCHB is engaged in, but the bureau also oversees research to improve children's health. Since 2001 HRSA has funded an effort to boost the quality of care for children called the Pediatric Emergency Care Applied Research Network (PECARN). With an investment of just over $5 million annually, PECARN conducts research on the prevention and management of acute illnesses and injuries in children through a network of 21 participating hospitals. This is a great example of partnership within pediatric health care and between pediatric health care and the federal government.

We are delighted with PECARN's efforts, and its research has led to improvements in clinical care for sick and injured children in two situations. The first finding resulted in improved treatment for bronchiolitis – a common infection of the respiratory tract in infants and a leading cause of their visits to hospital emergency rooms. The second led to improvements in treatment for head trauma in children. Making new knowledge actionable is a high priority for HRSA and the Obama Administration.

PECARN is funded through MCHB's Emergency Medical Services for Children (EMSC) program, which since its creation in 1985, has distributed funds to all states, U.S. territories, and the District of Columbia to support activities that improve, refine, and integrate pediatric care within each state's emergency medical services system. As with the Title V program, all of HRSA's EMSC State Partnership grantees are required to collect and report data on performance measures. The 10 measures in the EMSC program include metrics such as:

- the percent of prehospital provider agencies in the state/territory that have on-line pediatric medical direction available from dispatch through patient transport to a definitive care facility, and
- the percent of hospitals recognized through a statewide, territorial, or regional standardized system that are able to stabilize and/or manage pediatric medical emergencies.

HRSA's concern for children's welfare does not stop with MCHB activities. In our HIV/AIDS Bureau, which implements the Ryan White HIV/AIDS program that each year provides clinical care and lifesaving pharmaceuticals to over half a million low-income people living with HIV/AIDS, Part D of the Ryan White program provides family-centered, outpatient, and ambulatory primary medical care for women, infants, children, and youth with HIV/AIDS.

And HRSA is just about to unveil a new $5-million effort – another pro-child element of the ACA – to help children live healthier lives by eating better and exercising more. In late 2010, HRSA announced the establishment of the Healthy Weight Initiative. Starting in May, the initiative will begin to organize teams in all 50 states to implement and test a set of evidence-based interventions designed to reduce obesity. This initiative provides an opportunity for all stakeholders, including foundations, to work together on one of our most important health care challenges: overweight and obesity.

Clearly, the Obama Administration is deeply committed to the health of America's children. Starting with CHIP reauthorization and expansion, to his targeted efforts to improve access to primary care in the Recovery Act and the ACA, from his support for the Home Visiting program and school-based health centers, and from his continued backing of HRSA activities in the MCHB, President Obama leads an administration that is dedicated to expanding access to care and services for children, and indeed for all Americans.

HRSA is fully committed to advancing this administration's historic effort to improve the nation's health and health care delivery through the ACA. Pivotal to this work is the robust engagement of advocates; the public; and other key stakeholders, including foundations, that share this vision.