THE WHITE HOUSE

WASHINGTON

November 3, 1994

Dear Colleague:

It is with great pleasure that I send you the enclosed reports on *Comprehensive Strategies for Children and Families.* Both of these documents represent our continuing interest in exploring ways for practitioners and policymakers—federal, state and local—to work together to make programs affecting children, youth, families and communities more effective as well as more efficient.

From its earliest days, the Clinton/Gore Administration has made it clear that this White House is open and eager to listen to the American people. It is in this spirit that we held a July 15 meeting—to ensure that the federal government is making decisions based on the real stories of individuals who are the most affected. The subsequent October 4 seminar, held in cooperation with the Policy Exchange of the Institute for Educational Leadership, built on the July meeting. Moderated by IEL Policy Exchange Director Margaret Dunkle, this seminar provided an opportunity for thoughtful and candid interaction between the Executive and Legislative Branches of government.

By convening these groups, we were able to focus on both barriers and solutions to going to scale with some of the best practices. The reports on these two events provide guidance for making changes necessary to develop and implement comprehensive and effective strategies for children and families.

I hope that you will find these reports helpful. If you would like additional information, contact Gaynor McCown, Senior Policy Analyst at the Domestic Policy Council, at 202/456-5575.

Sincerely,

William A. Galston
Deputy Assistant to the President
for Domestic Policy

THE WHITE HOUSE

WASHINGTON

Comprehensive Strategies for Children and Families

Report on an October 4, 1994 Seminar

Sponsored by
the Domestic Policy Council
in Cooperation with
the Policy Exchange
of the Institute for Educational Leadership

INTRODUCTION

On October 4, 1994, the Domestic Policy Council, in cooperation with the Policy Exchange of the Institute for Educational Leadership, held an invitational bipartisan seminar on "Comprehensive Strategies for Children and Families." Participants were senior staff members of the chairs and ranking minority members of many of the Congressional committees and subcommittees, as well as representatives from relevant Executive Branch agencies, with jurisdiction over federal programs affecting children and families. Seminar participants are listed in the appendix to this report.

Featured guests from the Clinton Administration were Bill Galston (Deputy Assistant to the President for Domestic Policy), Elaine Kamarck (Senior Policy Advisor to the Vice President), and Isabel Sawhill (Associate Director for Human Resources of the Office of Management and Budget). Margaret Dunkle, Director of the Policy Exchange at the Institute for Educational Leadership, moderated the discussion.

This seminar built on a meeting the Domestic Policy Council convened last July that brought together practitioners and policy makers from across the country to share what they were doing and to spark a broad inquiry into "going to scale" with promising comprehensive strategies for children and families.

> At the July meeting, it became clear that local schools, human service providers, foundations and others are doing the hard work of building local coalitions that strengthen families, foster learning and provide a focal point for community re-integration.
>
> It also became clear that the current system has too many fragmented programs, confusing and conflicting eligibility rules, multiple budget cycles, and too many funding streams that must be combined in order to effectively serve children and families at the local level.

(The July 15, 1994 White House meeting is summarized in a report, *Comprehensive Strategies for Children and Families: the Role of Schools and Community-Based Organizations*, that was published in September 1994. For additional information about this meeting, contact Gaynor McCown at the address listed in the appendix.)

The October 4 seminar moved the discussion from the July meeting one step further, providing a forum to explore ways in which the Administration and the Congress could work together to make programs affecting children, youth, families and communities more effective as well as more efficient.

The seminar was spirited and constructive. It was a rarity in that it crossed branches of government and political parties. Yet, the comments and ideas expressed were not predictable by branch of government, by political party, or by committee or agency. The dialogue addressed both practical and philosophical barriers and suggestions for making governmental efforts for children and families work as well as most policy makers would like—and the American people deserve.

Issues and Questions About Comprehensive Strategies for Children and Families

The two and one-half hour October 4 seminar was designed to surface ideas, not to reach consensus. What follows are some of the themes—the issues and the questions—that emerged.

The conversation began with a summary of the responses seminar participants had given to open-ended questions on their RSVP forms.

> When asked to identify the most important barriers to comprehensive programs for children and families, participants cited categorical programs and piecemeal solutions, lack of flexibility, the Congressional committee structure, turf, conflict over resources and money, and lack of consensus about who is responsible, what strategies should be pursued, and what the right solutions are.
>
> In response to a question asking what should be done to overcome these barriers, participants suggested: consolidating programs and making them more flexible, focussing on families, providing leadership, supporting local decision making, simplifying the system, and training professionals more effectively. One person added that "divine intervention" would be required.

Against this backdrop, Bill Galston opened the dialogue, saying that President Clinton's belief that the federal government is at its best when it provides "top-down support for bottom-up reform" led the Domestic Policy Council to pursue the issue of comprehensive strategies for children and families.

"We Have Met the Enemy and He Is Us"

Underlying much of the discussion at the seminar was the assumption that the federal government—and consequently the participants sitting in the room—is a significant part of the problem. Both the Executive Branch (the President and all of the departments) and the Legislative Branch (the House of Representatives and the Senate) are seen as

creating a structure of programs, convoluted eligibility requirements, regulations and administrative procedures that makes it far more difficult than it has to be for people to come together and work effectively at the state and local levels. One participant lamented: "What Congress does not mandate in statutes, the agencies mandate in regulations."

This depressing conclusion was tempered by the parallel realization that, with sufficient political will, hard work and tenacity, the federal government also has the potential to become part of the solution.

Federalism

The federal government does not have all of the answers and often does not even ask the right questions. Too often, improvements and innovation at the local level are stifled by the structural relationships between the states and the federal government, making it difficult if not impossible to respond to local needs. What is the appropriate federal role on issues affecting children and families? How can the Congress and the Administration work together, and with state and local governments, to be an asset in efforts to rebuild communities and families, rather than part of the problem? What policies will foster new governance entities that build consensus and engage new voices as states and localities plan and operate programs?

There was lively discussion about the relationship between states and the federal government around the issue of welfare reform. Should states have broad options to start with, should they be allowed to apply for waivers from specific requirements, or should the federal government impose mandates that states cannot waive or ignore?

Turf

The fragmentation and turf battles at the federal level are mirrored at the state and local levels. In fact, they are often more fierce, more personal and more hostile at those levels. How can carrots and sticks be fashioned so that they do not create bogged-down prescriptive processes (by, for example, describing too precisely exactly what a "partnership" should look like)? Should there be more federal incentives for local comprehensive approaches, such as the "glue money" in the recently reauthorized Elementary and Secondary Education Act? One participant said: "If the thing that is driving turf battles at the state level is the federal funding structure, then you have to change the federal funding structure."

Vision and Values

There is not widespread agreement about what the role of government should be when it comes to children and families. A straw poll during the seminar showed that participants varied widely in the degree to which they thought the federal government could effectively address these issues. While more than half thought the federal government could play an important role, only a few participants indicated that the federal government could, by itself, solve the problems.

Should the federal government simply "set the goals broadly and give states big blocks of money," as one seminar participant suggested? Or should the federal government work with communities to "achieve a consensus vision for children and families, so that we [the federal government] can then begin to shape a system and a series of laws and regulations" to meet these goals?

Performance Measurement

The recently enacted Government Performance and Results Act (GPRA) has moved the discussion of looking at outputs and outcomes—rather than inputs and processes—from theory to reality. Now performance measurement is the law of the land, and 100 GPRA pilots are being operated by the Office of Management and Budget.

But how can the federal government get rid of the "process junk" and move to outcome measures? How can there be meaningful and measurable outcomes for governmental programs if there is not a clear vision about what these programs are supposed to achieve?

Several participants indicated that clearer goals and benchmarks were the key to providing local flexibility. One participant said: "The flip side of moving to measuring outcomes is a new mode of checking each other and untying so much of the red tape that binds the system." Another commented that, until there is some consensus about what programs are trying to achieve—and until we have the ability to measure whether or not programs have been successful—it is almost impossible to provide local flexibility because there isn't any accountability against a set of benchmarks.

One participant suggested three broad and measurable goals for the child welfare area: "We don't want those kids in foster care very long. We want a quick decision about whether they are going to be returned to their family. And, if not, we want them quickly adopted."

Multiple Roles of Government

An example from the seminar illustrates that government, no matter what the level, has many roles and implementing clear performance measures may well require re-thinking what these roles are and how they are filled. The budget for the municipal records department in Sunnyvale, California contains only one item: "The city of Sunnyvale shall give its customers necessary records in under five minutes 85 percent of the time." It does not specify all of the inputs, such as the number of staff and desks and telephones, to get to this goal. Rather, when officials review the budget, they ask: Have you delivered records in under five minutes 85 percent of the time? If so, can you do it with less money? And, if not, why haven't you?

This is a clear goal. But what, speculated one participant, would happen to this outcome measure if a very aggressive newspaper reporter investigated the records department and found that Hispanics only received their records in under five minutes 50 percent of the time? Low-income people only received their records in under five minutes 37 percent of the time? Employees of the records department were paid 30 percent more than comparable employees in the private sector? And 30 percent of the records were inaccurate?

The Current Rule-Driven System

The typical governmental reaction to a problem is to add more rules. Efforts to prevent abuse by the three percent may prevent the 97 percent from doing things in an innovative or particularly effective way. How do you make government a learning organization, allowing the flexibility for well-intentioned people to make honest mistakes while quickly punishing people who make severe mistakes (such as fraud)? How can federal programs be accountable without imposing bureaucratic barriers that divert the energy of practitioners and the children and families who are the ultimate customers?

One participant asked: "If we want a government that is the kind of government we *say* we want—more responsive, more efficient, less rule-bound and less hide-bound—there is a price to pay. Bureaucracy was invented to ward off the worst case. And warding off the worst case can prevent the best case. Is the American public willing to tolerate a greater dispersion of outcomes and behaviors in these programs? I don't know what the answer is, but if the answer is 'no,' then we are stuck with the rules."

Leadership

Who leads and who follows came up during the seminar in a number of ways. Should we look to the Congress to collapse the many categorical funding streams into a few with clear measures of success? Or is the Congress unable or unwilling to make those tough choices? Is it the responsibility of Congress to insist on clear accountability mechanisms for spending federal dollars? Should the responsibility for tying programs into a seamless web lie with states and localities? Or should the Administration take the lead by proposing major consolidation of categorical programs, something that may well take years, not months?

Trust

The public is skeptical about the ability of government at any level to do things well. In a time when there simply isn't enough money to do all of the things we want to do, we need to figure out ways to do things differently—to build public confidence and to make resources go further. There is a need for more trust and communication across political parties, levels of government, and the Legislative and Executive Branches. There are far too few opportunities to have this kind of discussion: the frank discussion at this seminar was the exception, not the rule.

WHAT NEXT?

The seminar ended with brainstorming about ways to improve federal programs for children and families. In response to the moderator's request to think about the programs they know best and to identify what they would most like to see happen in the next year, seminar participants offered some concrete suggestions:

> Have a single point in the federal government where a local organization, city or town, or state could apply for a grant. Then, let the federal government figure out what programs the request fits under.
>
> Have the federal government, across agency lines, take seriously the Oregon benchmarks project to see if, at least in one place in this country, we could pull the programs together and support a local government that has determined outcomes.
>
> Have the Administration refuse to fund programs that are appropriated but not authorized.
>
> Consolidate job training programs, rather than have 154 separate programs. "When people need a job, they need to be able to go some place. It doesn't matter *why* they need a job."
>
> Have a national child care policy, and use that policy to fund programs.
>
> Since most family and children's programs aren't run by the federal government, have the federal government develop more and stronger partnerships with states and communities.
>
> In youth development, look at the whole range of preventive services for adolescents and pre-adolescents (from drug-abuse prevention to pregnancy prevention and dropout prevention). "It's all the same kids, it's all the same interventions. Put that money together and get it out to local governments."

Have the federal agencies ask the Congress for enough money in their budget submissions to fund the development of performance measures. "This is an expensive activity, but it will be essential if we are going to move ahead on these matters."

Have more opportunities for the type of discussion we have had during this seminar—an engaged and unfettered discussion across the lines dividing one branch from the other and one party from the other.

About a third of the participants shared their thoughts about the seminar on an evaluation form. Of these:

More than half said that the most important thing they gained from the seminar was an exchange of ideas from different points of view. "Differing views from agencies/hill." "Congress *might* be open to some change."

Several people cited the discussion of performance standards as the most important aspect of the seminar. "An understanding of the real tensions and contradictions masked by banners such as 'performance standards' and 'flexibility.' Everyone is for them in the abstract, but, as usual, the devil is in the details."

About half said that they would use what they had learned at the seminar in the context of their regular work. "Consider performance standards in budget discussions." "I will try to keep in mind consolidating legislation." "When welfare reform or other issues that I handle come up next year, I will ask [such questions as]: What should be the federal role in allocating funds, in setting standards? And will Congress give the states a chance to experiment?"

And, finally, all but one participant indicated that he or she had met new people or made useful connections at the seminar.

As these comments show, this seminar was a beginning, not an end. The Domestic Policy Council plans to move ahead by continuing the discussions with the Legislative Branch and working with federal agencies and interagency teams on this agenda. And the IEL Policy Exchange will continue its efforts to foster effective and cross-cutting initiatives for children and families through seminars, site visits and other activities.

APPENDIX
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OCTOBER 4, 1994 SEMINAR
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THE WHITE HOUSE

WASHINGTON

Comprehensive Strategies for Children and Families: The Role of Schools and Community-Based Organizations

Report of the July 15, 1994 White House Meeting

September 1994

Acknowledgments

We are grateful to many people for their help in planning the July 14-15 meeting and producing this report. The Annie E. Casey Foundation and the Danforth Foundation provided essential funding for both activities; Tony Cipollone of the Casey Foundation and Janet Levy of the Danforth Foundation had instrumental roles in planning the discussion and reviewing this document.

Bill Galston, Deputy Assistant to the President for Domestic Policy, conceived the idea for the meeting and was an observant and diplomatic facilitator. Carol Rasco, Assistant to the President for Domestic Policy, offered a heartfelt and insightful luncheon address. Peter Edelman, Counselor to the Secretary of Health and Human Services, and Tom Payzant, Assistant Secretary for Elementary and Secondary Education, gave perceptive and informative presentations on legislative and policy matters.

Gaynor McCown, White House Fellow, took the lead role in planning and organizing the meeting. Other planners included Terry Peterson and Judy Wurtzel, Department of Education; Margaret Dunkle, Institute for Educational Leadership; Sheldon Bilchik and Reggie Robinson, Department of Justice; and Ellen Haas, Department of Agriculture.

A special thanks to Policy Studies Associates' Leila Fiester, who documented the meeting and wrote the final report, and Elizabeth Reisner, who provided editorial guidance.

Contents

Andre was 16 when he met Urban Family Institute president Kent Amos. Andre's father had been killed by Andre's mother eight years earlier. A self-described gangster, Andre carried a gun, dealt drugs, and had witnessed a murder. But under Amos' guidance, Andre learned to read and to enjoy simpler pleasures, like trimming a Christmas tree. Andre flourished; he became animated and alive--until a drug dealer from his past gunned him down.

"We have to understand these children run a gauntlet every day, a gauntlet of fear and terror," Amos says. "Our children are crying out to us in the only way they can. We have an obligation and a responsibility to give them more than platitudes."

Summary

Andre's compelling story was one of many shared by participants in a discussion about comprehensive strategies for helping children and families and the role of schools and community-based organizations in developing and implementing these strategies. The working meeting, held July 15, 1994, in Washington, DC under the direction of President Clinton's Domestic Policy Council, convened a diverse group of 56 people with practical insights and policy experience concerning comprehensive strategies. The group included experts on education, social services, and policy development from foundations, universities, and non-profit organizations. Participants were local practitioners; public and private funders; representatives from federal and state governments; policy analysts; academicians and researchers; consultants; and journalists.

The purpose of the meeting was to spark a broad inquiry into "going to scale" with promising programs that already exist, in response to President Clinton's premise that every problem in the United States has already been solved by someone somewhere in the nation--and that the real problem is not inventing solutions, but disseminating and replicating them. "We are drawn here by a shared understanding that most of our children and young people need more opportunities to develop and to thrive than they now enjoy....[Yet] the fragmented ways that we typically try to help them are part of the problem," said meeting moderator William Galston, deputy assistant to the President.

The meeting acknowledged the fact that in communities around the country, schools, human service agencies, and community-based organizations are collaborating to develop comprehensive strategies for helping children and families. Schools and community-based organizations are staying open in the afternoon, evenings, and on weekends to allow students, families, and community members access to recreational and educational activities; coordinating with other agencies to provide social and health services; opening their doors to parents and other community members for adult

education programs; and forging partnerships with businesses to provide on-the-job training, paid apprenticeships, and training in entrepreneurial skills. Although this meeting focused on school-based and school-linked programs, participants recognized that these efforts are only part of a larger set of issues involving comprehensive services--and that these strategies are part of a broader agenda of reform in education, health, and human services.

Domestic Policy Council staff asked participants to address the following questions:

- What are the key issues regarding the development, sustainability, and effectiveness of comprehensive strategies for helping children and families?
- What are some of the federal strategies to promote comprehensive strategies?
- What are some of the specific federal, state, and local barriers to developing school-linked or school-based comprehensive strategies?
- How might the federal government play a role in reducing these barriers?

The resulting discussion included reports from participants about activities in local communities--the "front lines" of education and social service reform, a similar assessment of state-level efforts, and an update on proposed federal legislation that will affect efforts at all levels. Although participants in the diverse group advocated differing approaches, for all participants the objective was the same: building strong children, families, and communities. As participants shared their experiences with each other and with the Administration representatives, the following themes emerged as central to current efforts and expected needs:

Effective support for children and families requires changes in philosophy and focus. Educators and funders should shift their efforts as much as possible from fragmented, piecemeal, and often inadequate supports and services to comprehensive strategies that emphasize development, opportunities, and prevention, viewing children and young people as assets rather than bundles of problems. Moreover, children and youth are best served in the context of families, and families are best served in the context of communities.

Both schools and community-based organizations have a role in "community partnerships" that are essential to meeting the comprehensive needs of children and families. Leadership may vary among communities or even neighborhoods, and a variety of effective models exist. Regardless of who leads the effort, true collaboration requires shared planning, implementation, and assessment.

Community-building efforts should be an important component of comprehensive strategies. These efforts involve not only services but the active and meaningful engagement of all stakeholders.

Effective, comprehensive strategies require new funding structures that are more flexible and reliable than current arrangements. Possible approaches include consolidation and decategorization of federal programs, improved waiver options, and more options allowing units of local government and community-based organizations to deal directly with federal grant programs. Participants did not unanimously endorse any of these changes, however.

Comprehensive strategies must be held accountable to outcomes. Implementing this priority will require the improvement of current evaluation methods for monitoring and assessing the impact of these programs.

Certain policies, practices, and realities are barriers to comprehensive strategies. These barriers include: hostility or contradictory philosophies within entities necessary to successful collaboration; lack of trust or participation by parents or communities; an overly competitive, inflexible, or categorical funding process; differing eligibility rules for funding; lack of funding; cultural misunderstanding or insensitivity; community violence; and turf battles.

This report highlights these themes and summarizes the discussion by participants in the meeting. Enclosed as appendices to the report are a list of participants and a summary of pending legislation.

This report is intended to be a jumping-off point for further action. Domestic Policy Council staff will next determine key areas that must be addressed at the federal level and will ask federal agencies or interagency teams to develop additional plans for addressing these issues and identify existing initiatives that are relevant to comprehensive strategies for children and families. The agency plans may include:

- Recommendations, such as improved mechanisms for federal interagency coordination (e.g., consultation on policy guidance, development of agreed-upon principles, or procedures for funding comprehensive strategies)
- Possible regulatory or statutory changes
- Changes in policy guidance
- Improved or coordinated technical assistance
- Coordinated research
- Evaluation strategies

After the plans are developed, the White House will work with the agencies to develop a strategy for further efforts.

What's Happening on the Front Lines

Participants laid the groundwork for discussion by describing comprehensive efforts in selected local communities. These projects included Intermediate School (I.S.) 218 in New York City; the Beacon Schools in New York City; the Austin Project in Austin, Texas; two initiatives in Chicago sponsored by the Chicago Community Trust and the MacArthur Foundation; New Beginnings in San Diego, California; the Vaughn Family Center initiative in Los Angeles; Caring Communities in St. Louis, Missouri; Birmingham, Alabama's Community Schools; the Healthy Learners program in Miami; Kentucky's Family Resources Youth Service Center initiative; and the Youth Futures Authority in Savannah, Georgia. Participants described their projects' goals, philosophies, structure, activities, partners or collaborators, resources, and accomplishments.

Goals and Philosophies

The inspiration for most of these programs arose from community concerns. "Most successful programs have deep roots in the community. They are not 'parachuted' into communities, but carefully integrated with specific local community needs and strengths, so that local communities share a genuine sense of ownership," noted participant Lisbeth Schorr. The Beacons, for example, began as a drug reduction and prevention effort that would simply extend the school day, but a wave of crime and violence stirred interest in funding broader youth programs and led to priorities on crime prevention and community building. The inspiration also came from successful efforts already being conducted by community-based organizations within schools--and a recognition that these organizations have strengths that schools can build on, including organizational flexibility and the ability to link with communities.

Participants listed active community involvement as both a goal of comprehensive strategies and a crucial element of program success. With this orientation, the school becomes "a presence of change" in the community and students are empowered by making a positive contribution to their environment. The Urban Family Institute in Washington, DC, tries to create a "village" mentality--in which community members have clear expectations of positive behavior and achievement--by providing intervention, guidance, and support to at-risk children and youth. A Beacon School in Central Harlem built community support by asking residents to clear their cars from the school block every weekday morning so children could play in the street. Young people established connections with the community by going from door to door asking residents to agree to the plan, and residents had to make a conscious commitment to support the effort and create a safe place for children. Slowly, the relationship grew; now students help keep the street clean and have raised money to plant trees on the block. Beyond the block, students help register voters and hold hunger drives to feed

homeless people. "We're trying to give people a sense that Central Harlem is a place on the rise," explained Geoffrey Canada, president of Rheedlen Centers for Children and Families. "We wanted to instill a desire to become part of that change."

Community and neighborhood involvement is closely related to building family strength and individual empowerment. "Successful programs do not work with one generation alone, but with two and often three," Lisbeth Schorr observed. "Successful schools, Head Start programs, and family support centers make special efforts to nurture parents so they can nurture their children." The Beacons, for example, focus on the "upbeat factors" associated with healthy development and create opportunities to cultivate those elements:

- Caring adults are available for interaction with young people consistently and during extended hours. "Programs alone are not enough," said one Beacons representative; the school offers "somewhere to go, something to do, someone to be with."
- Beacon schools use high expectations and clear standards to establish respect and motivate achievement for the neighborhood and school.
- Participating students have opportunities to engage in the same high-quality after-school and weekend activities as more economically advantaged students.

The Chicago Community Trust Initiative, described by University of Chicago professor Harold Richman, also builds on the notions of investment and community building--not merely services to children--to serve children and families. Richman and others make a distinction between asset-oriented services that promote youth development, and deficit-oriented efforts that focus on treatment. "We'll succeed when it's as easy to enroll a kid in Little League and to buy a uniform as it is to buy an hour of counseling," Richman said. The community trust's strategy was to "broaden and deepen the sense of what it means to deal with a child," Richman said: Broaden by including activities such as Little League or library visits as much as traditional services, and deepen by involving all levels of government. The resulting $30 million project in seven Chicago communities revolves around collaborations that are representative of each community.

The Barrier: Institutions that deal with only a small part of people's lives
The Solution: Expand the range of services in response to community needs to include literacy, sports, and community efforts that benefit children and families

In one racially mixed community in Chicago, a very traditional library used the Community Trust collaboration to create a Little League team. When the team wins, each player receives a book instead of the traditional T-shirt. When the team loses, players get a story hour. Players' parents also meet at the library. In another community a library holds a "lock-in" sleepover for neighborhood children, who read together and tell ghost stories.

New Beginnings in San Diego, which placed integrated social and health services at a school-based center, began as a partnership among public agencies with the goal of making the service delivery system more holistic and responsive to clients. New Beginnings focuses on serving families rather than individual children, with a prevention-oriented approach that uses public funding where possible.

A foundation representative noted that local program administrators have to be trusted--and allowed--to make their own decisions regarding program operations. Administrators at all levels must face some tough issues, including what services should be offered, who should have access to them, how the quality of services can be improved, how continued funding can be obtained, what structures are needed to operate the program, and who should be responsible for decision making.

Several programs, including New Beginnings and the Vaughn Family Center initiative in Los Angeles, turned to parents to help establish goals and make decisions. The Vaughn Family Care Center program--a collaboration between the Los Angeles Educational Partnership and the United Way--devoted an entire year to planning, with the mission of eliminating educational barriers in a community of high crime, single-digit test scores, and families so poor that some lived in chicken coops or cars. Parents identified a need to focus on health services and child care. "My job is not to set the agenda...but to hold up mirrors in front of this community and say, 'See how brilliant you are? See how much you know?' and to turn up the light," said program director Yoland Trevino. The result? "Nobody asked for parenting classes...[or] financial help," Trevino said wryly. "They were asking for opportunities to do for themselves." Through a partnership with Head Start and a local child care resource center, the program began to address the community's child care needs; now, 20 homes provide licensed care. A partnership between a local hospital and the UCLA Medical

Center provides education and prenatal support services to expectant families, using trained mothers in the community as mentors.

Similarly, based on needs identified by a parent group, a collaboration in Miami established a bilingual information center in the school, staffed by trained parent volunteers. The center has served more than 500 families that are more comfortable with the volunteers than with traditional counselors or social workers, giving the professional counselors more time to perform other work. The program also negotiated with the school to open its library in the evenings for monitored homework sessions. These after-school sessions now serve about 200 students a day, with aides provided by the parents' group or paid by the local Boys and Girls Clubs.

The student-operated CARES Program in Birmingham allows participants to set their own agenda. This initiative brings social service agencies into the school on a weekly basis to address student needs. Activities include AIDS awareness and testing; special classes in schools, churches, and community centers; paid employment, community service credit, and free training for youth as tutors for younger students; counseling; a dropout prevention program funded by the Job Training Partnership Act; nutrition education; GED classes; and computer instruction.

In some cases, such as Caring Communities in St. Louis, inspiration for a comprehensive program came from a combination of efforts by state agencies (i.e., Health, Mental Health, Social Services, and Elementary and Secondary Education) and private concerns (i.e., the Danforth Foundation). In these cases, participants noted the importance of uniting multiple providers under one vision with a strong director. Caring Communities, which provides school-based comprehensive services, focused on addressing the fragmentation of available services, lack of access to services, and the challenge faced by schools in dealing with children's multiple problems. Like other programs described in the meeting, Caring Communities' goals included promoting school success for all children, increasing safety for children and families, and building a moral and ethical foundation in the community to increase family support and improve opportunities for education, housing, and employment. "Communities are to families what families are to children," said Director Khatib Waheed. "To focus on one without focusing on the other would be a serious mistake."

Caring Communities' activities include an early-morning latch-key program for school-age children with working parents, co-dependency counseling intervention, behavior therapy, periodic "respite nights" for parents in which students participate in a sleepover at the school, and drug marches and rallies in the community. These activities, which reaffirm the program's commitment to the community, often have dramatic results.

The Barrier: Violence that hinders access to services
The Solution: Using programs to establish a community support system, not just to provide services to individuals

In 1993, the father of a student at a Caring Communities school tried to organize his neighbors to push drug dealers out of the community. Under threats from the dealers, however, he stopped--until Caring Communities began anti-drug marches on his block. After 20 community members attended a meeting in the man's home, his house was fire-bombed. Caring Communities responded by holding a support rally with 100 participants, and Caring Communities members stayed in the man's gutted house every night for two weeks to protect his home. The drug dealing decreased.

"This was a support system we felt we had to provide," said Director Khatib Waheed. "These are the kinds of challenges many of us need to face if we're really going to deal with the problems children face...in order for families to feel a sense of hope."

Finally, participants noted that it is not enough simply to add new services; comprehensive strategies must focus on clear and specific outcomes, addressing what comes out of a program as well as what goes into it.

Location and Structure

Participants agreed that comprehensive programs can be located at a variety of sites and controlled by a variety of stakeholders, as long as the program is accessible, versatile, and family-oriented. For example, after conducting an extensive feasibility study of parents and front-line workers in education and social services, New Beginnings' planners realized that parents viewed schools as a place that they trusted--but didn't think that schools had a system for providing services. Thus the school became the site for New Beginnings services, but the program added extensive partnerships to form a structure that reached far beyond the site.

Educators in Kentucky based comprehensive services at Family Resource and Youth Service Centers within schools because they viewed schools as the institutions that were most accessible to all community members, said Charles Terrett, superintendent of schools in rural Fulton County, Kentucky. Operating under a formal agreement among the schools, social service agencies, and business community, the Centers focus on building community pride, involvement, and program ownership.

Locating comprehensive services at school sites can help solve a "disconnect" between schools and communities and clarify the relationship between the two, said an organizer of the Beacon Schools in New York. Geoffrey Canada said the group chose an old, run-down elementary school in Central Harlem as one of the first Beacon sites because "it was extremely important to us to face the same challenges that children and communities face in making collaborations work." This was not a hollow choice; the day before the school re-opened under the Beacon plan, a man was fatally shot in front of the school. But with its year-round schedule, open seven days a week from 8 a.m. to at least 11 p.m., this Beacon School now offers a safe zone where children can learn and play.

I.S. 218 in New York City demonstrates the power of a school site working in collaboration with a community-based organization, in this case the Children's Aid Society. The school is open six days a week, from 7 a.m. to 10 p.m., for before- and after-school programs, teen and job-related programs, and adult education. More than 1,300 students and 1,000 parents use the school weekly; services include a health and dental clinic and an in-school store, and assemblies draw standing-room-only crowds. Success came from developing "real, organic" partnerships between the entities instead of a host-and-guest arrangement, said Children's Aid Executive Director Philip Coltoff. The impact: "Before, the community was isolated from the schools," said I.S. 218 principal Mark Kavarsky. The effort also has had an "internal" impact on families who now view the school more positively and have become involved in designing new programs.

The question of location is not simple; sometimes, programs occur at a combination of sites. New Beginnings, for example, found it most effective to work with families of preschoolers in the place where parents are most comfortable--their homes. In conjunction with home visits, however, a Women, Infants, and Children (WIC) program clinic is available three times a month at the New Beginnings school, providing a nonthreatening way to help families make connections with other services. Clients don't come to New Beginnings in convenient, class-sized groups, noted San Diego Schools Administrator Jeanne Jehl; staff must try to reach clients individually and as families.

Location needs also vary depending on activities. The Caring Communities program in St. Louis found that adults participating in evening education activities at the school felt threatened by the presence of youth participating in after-school programs at the same site. Although this situation was not a defining issue for the program, it did raise complications that leaders had to address.

The Austin Project emphasizes neighborhoods, not schools, in order to promote full employment, strong communities, and healthy children and families. The project, which serves 50,000 Hispanic and African American residents with incomes below the poverty level, has no eligibility requirements other than residence in the targeted neighborhood. The project's support

structure relies on tax abatements, waivers, and money from private capital markets. However, the project began with the backing of the "white, upper-middle class and upperclass power structure" in Austin--not with a structure that solicited involvement by the targeted community. In an attempt to rectify this gap, the project established five neighborhood development committees, whose locally elected members form part of a larger advisory council; at least half of the project's $100 million budget will be controlled by these committees. In addition, project leaders decided to rehire the social workers who will be displaced by the planned system reforms, in part so that they will not become barriers to the project.

Although the structure and leadership of comprehensive strategies varies, all successful programs share a view that people who are to be "served"--children, families, and community members--must have a significant role in identifying their own needs as well as designing and operating programs. The Vaughn Family Center in Los Angeles, for example, uses an advisory committee of whom half are parents and half are service providers, public agency representatives, and public officials, in order to "equalize" the relationship between service providers and recipients. Approximately 25 parents volunteer daily to help teachers at the family center.

Partnerships and Collaborations

Successful partnerships require preparation and true collaboration, participants said. "We only wanted [the I.S. 218 program] if it was going to be a partnership...and we were not going to be invited out once we started to cause trouble," said Children's Aid's Coltoff--a statement echoed by others. In the case of I.S. 218 and Children's Aid, the agency insisted on a legal resolution ratified by local boards of education that invited the organization into the school. "That was very important in terms of the structure and our ability to participate from the beginning of the project," Coltoff said. Now, "we're accomplishing as a social service agency what we believe in...and we're finding educators aren't too tough to deal with."

Partnerships also require flexibility. Although the Beacon Schools program provides guidelines for each participating site, the structure and activities of each site are individually tailored by local community advisory councils that consider each site's cultural, size, and demographic differences. The Chicago Community Trust collaborations are dominated by "citizen collaborators," not professionals, according to Harold Richman. As a result, commitment is strong--but progress is slow. "When you're trying to work with a community from the bottom up, ability is variable and it takes time," Richman advised.

All collaborations require attention to leadership, noted Edward Tetelman, director of legal and regulatory affairs for the New Jersey Department of Human Services. New Jersey's School-Based Youth Services program has learned the following lessons about leadership:

- Strong state leadership can keep programs politically viable at state and local levels
- Local collaborators need plans that address both core services and optional service needs
- States should be flexible and avoid establishing extensive hierarchies when they create state and local collaborations
- Collaborative programs that are spread across all areas of the state reinforce statewide investment--programmatically and politically
- State technical assistance to local collaborations is crucial to success

It isn't always easy for foundations and government agencies to form partnerships with communities, but it is essential for foundations to try, several participants said. One problem is that many collaborations involve subordinate-superordinate relationships rather than equal partnerships. "The pain of watching foundations ask communities to be partners...and then [showing] their own inability to model that behavior is very corrosive" to efforts, explained Richman. The same problem exists in some partnerships between public agencies and local communities. "We have not clearly articulated what the terms of such partnerships might be," Richman warned--and until those terms are clear, local communities are likely to view public agencies with distrust. Finally, if programs are to become self-sufficient, collaborators must learn to trust local administrators to make their own decisions.

Resources

Many projects draw from a variety of funding sources and find that funding must constantly be considered. The Beacons, for example, receive direct funding from New York City but also help sites draw child welfare funding from city agencies and blend these sources to form a basis for programs. The politics of funding can have an impact on programs beyond material support, however. In the first round of Beacon funding, political issues prevented the local board of education from participating in Beacon site planning; now that those issues have been resolved, a joint decision-making process allows principals from the schools targeted for change to become more involved.

Some programs encountered unexpected funding dilemmas. When the Vaughn Family Center in Los Angeles gained charter school status and the new school found it could save $1 million through more effective practices, auditors wanted the school to return the saved money. "What incentives are there to be accountable?" asked Yoland Trevino. "If you're making a difference, they punish you."

Participants also described cultivating human resources to build support for comprehensive strategies. Beacon Schools are organized around membership rather than a client-provider relationship; participants have identification cards and are asked to contribute their time to the program. "Everybody who comes is seen as a resource instead of someone who wants something," said Michele Cahill, a Beacon funder. Tania Alameda, director of Miami's Bureau of Children's Affairs, agreed:

> We have got to rely on our families as resources. They may be dysfunctional in some ways, but they are very functional in others. We have to learn how to identify those strengths in families....If we rely more on their expertise, we're going to feel a lot more satisfaction and have a lot more help in what we're trying to accomplish.

The Barrier: Health needs that affect education
The Solution: Cultivating parent and community involvement; focusing efforts on families and communities as well as children

When Tania Alameda realized that many children in Miami were missing significant amounts of school--as many as 60 days a year--because of head lice, she organized parents to solve the problem. The parent group formed a "Lice Busters" patrol; armed with a small vacuum cleaner, detergent, and donated treatment supplies, parents visited the homes of children with the most severe cases. One parent even gave haircuts.

The Lice Busters' success increased parent involvement at school in other ways, as educators began asking parents for advice on improving attendance. When parents offered to visit the homes of absent students to help address the extenuating circumstances--health needs, lack of clothing, or parents' scheduling problems--contributing to truancy, the principal agreed to help. She gave parents access to normally confidential home addresses--and then watched the attendance rate shoot from last to first place in the district.

Accomplishments

In addition to the stories of individual lives saved, participants described the development of program infrastructure, improvements in academic achievement, and positive impacts on communities

as major accomplishments. Building on its infrastructure, the Beacon project has noted decreased crime rates and increased reading skills. Caring Communities focuses on mental health and removing other barriers to education so that teachers can focus on academic improvement.

Urban Family Institute founder Kent Amos had many success stories from his experience of "adopting" 87 urban youth into his own home. Seventy-three of these youth attended college, 49 graduated from college, and 7 obtained advanced degrees. The Vaughn Family Center's Trevino was also able to provide hard outcomes. Test scores for students in this program rose 48 percent, the high transiency rate among students fell, and the attendance rate improved from "horrific" to 99 percent. Trevino also described her program's success in eliminating the "us versus them" mentality that fosters gang rivalry. When Trevino noticed one self-described gangster urinating outside the school, she learned that he felt unwelcome inside the building--so she invited him to join her "gang." That youth is now the center's program coordinator. "If we create this kind of opportunity for youth, the money you provide for gang diversion will not be necessary," she told meeting participants.

Accomplishments can be difficult to assess, however; program evaluation is an important aspect--and predicament--that most participants noted. Furthermore, services, programs, goals, and structures alone do not guarantee success. One participant likened the situation to a game of musical chairs in which 12 players compete for eight chairs:

> We tend to blame the participants because they don't get a chair. We want them to move quicker, position themselves better, try harder. We should really look at the game: Four people are always going to be left out....We can only do so much with support services and counseling, and then people have to find a way to live.

What Needs to Be Changed?

Participants discussed many barriers that they have experienced or anticipate. In some cases, participants suggested needed policy changes; in other cases, they simply warned colleagues about situations that can be avoided or ameliorated.

What Are the Barriers and Where Do They Come From?

Participants identified the following challenges to developing and implementing comprehensive strategies for children and families:

Philosophical barriers. Community-based activities require providers and planners to have a philosophical "investment" in providing adequate services, supports, and opportunities for children and families. "Every day, the normal world...is fighting this philosophy," said one participant. For example, the parents of students not targeted by comprehensive strategies often have trouble understanding the need for the services within schools and may oppose them. Such "hostility" makes it important to regularly reiterate the underlying vision of the initiative, focusing on positive development rather than punishment and control.

Effective programs take nothing for granted; goals, issues, and services must be revisited and addressed continuously. In particular, effective community participation is "a hard-won treasure"; the goal of participation and development of the capacity to participate are not givens and must be addressed early in a program's evolution, participants said. Programs may have to cultivate participation skills in community members. One participant described holding three informal meetings for every one formally scheduled by her program--one meeting to explain to parents what they would be expected to discuss, one to hold the actual discussion, and one to evaluate the discussion and formulate responses.

Effective programs also must solicit feedback from clients at least as much as from experts, several participants said. In Miami, an attempt to create a full-service school--combining education and access to multiple social services under one roof--failed at first because it provided services selected by experts, not families, a participant said. After realizing their mistake, planners successfully redesigned the school with only eight agencies providing services--but chose the services most wanted and used by families.

Funding barriers. In addition to the funding issues discussed earlier, the nature of funding for comprehensive programs can present barriers. The bidding process for state and federal grants creates competition rather than collaboration, many participants said, leading programs to "cannibalize" each other. Even after funds are awarded, different providers may retain a competitive orientation. Programs need to find ways to erase the distinctions between providers and focus on common goals, participants said. "We've learned that cooperation is easy, but collaboration hurts a little bit," said one participant.

In some cases, state and federal funding is so inflexible that programs are unable to address certain issues that affect school attendance, participants said. Many called for fewer federal restrictions linked to funding, which would allow programs greater flexibility to address needs that affect students' ability to attend school--say, to purchase eyeglasses. Leaders of the Lice Busters group, for example, had to turn to donations to pay for lice detergent because Medicaid would not cover it. Other programs find it difficult to use federal funding to pay for staff development, transportation, and evaluation. "Maybe all we need from the federal government is a little help and empowerment to make our own decisions," said a participant from a rural area.

The categorical nature of federal programs "forces us to squeeze people into boxes and then go around trying to find ways around the boxes," agreed a participant from an urban area. Chapter 1, the Job Training Partnership Act, and Medicaid are among the programs that should allow schools and agencies to provide services to all members of communities in which a high percentage of members meet program guidelines, several participants said. Categorization "labels the poor as special, needy people, which they are not," said one, adding that the problems addressed by these categorical programs are not limited to poor people. But decategorization is not a simple solution, nor is categorization the only barrier, other participants warned; it is naive to think that simply decategorizing funding will solve these complex issues.

The multiple eligibilities required for various similar but separate federal programs also produce funding barriers, participants said; the differences among requirements create inefficiencies and make it difficult for children and families to qualify for the services they need. Eligibility requirements such as the assets tests used by AFDC, the food stamp program, and in some states Medicaid, are particularly troubling because they pose access barriers to major federal programs that meet basic family needs, said consultant Sarah Shuptrine. "The asset test for the family automobile should be eliminated if we want families to be able to get to work, training [opportunities], and health care," Shuptrine said.

Health care financing presents another barrier to comprehensive strategies, by making it difficult for schools to be access points for health services. Recent trends in health care, including managed care, pose significant barriers to financing school health by restricting access to providers or failing to cover basic preventive and primary care. Under many plans, schools will not be reimbursed for all the health services they provide to students--making a comprehensive approach to student well-being less feasible. In addition, schools find it extremely difficult to obtain Medicaid reimbursement for health services because of the heavy paperwork burden and because they are unable to bill Medicaid until they have first billed families; in poor communities, billing families generates overwhelming paperwork but little revenue.

Cultural and contextual barriers. Cultural issues present additional barriers; these are solved only by extensive community outreach and a willingness to adapt to local context. For example, the Vaughn Family Center in Los Angeles discovered that pregnant Latino women in the community were not using existing health services because doctors and nurses treated them impersonally. "[Latinos are] not going to tell you anything about ourselves unless we have established a relationship with you," said center director Trevino.

Rampant violence in some communities also complicates comprehensive programs because it requires them to focus on providing safe havens and transportation to children and families, in addition to actual services. Transportation, affordable housing, personal safety, and other basic human needs were recurrent issues that many participants identified as major barriers to program implementation.

Additional barriers identified by participants include:

- Lack of time allowed by funding cycles to develop collaborations
- Squabbles over turf and terminology
- Parents' lack of trust in agencies, government entities, and schools
- Differing confidentiality requirements of schools, medical providers, Aid to Families with Dependent Children (AFDC), the school lunch program, and other providers, which sharply limit information sharing and make it difficult to reduce duplicative paperwork for families and providers
- The political risks required to cause change--"We're talking about changing a bureaucratic system in which a lot of people have financial investment," cautioned one participant. "When you go into the structure...and start empowering those at the bottom of the food chain, that is not going to go over well."

- The "squeeze effect" that occurs in top-down, bottom-up reforms when the players in the middle--often local bureaucrats and service providers--no longer have a role to play or are asked to change substantially, and therefore resist the reform. Collaborations that may displace workers or need union support require strong communication among stakeholders to avoid resistance that can undermine progressive change.

- The difficulty of finding funding for capital budgets or infrastructure for community-based organizations. For example, state-of-the-art technology is a much-needed tool for documenting and implementing programs

What Are the Solutions? State and Local Responses

Participants proposed many solutions, some of which were hotly debated. Some solutions are transitional, while others require long-term commitment. The following menu of ideas represents the breadth of suggestions made by participants and is not an integrated plan; inclusion in this list does not indicate that consensus was reached on a particular solution:

Funding changes.

Funding streams:

- Re-examine the sources of revenues used for funding comprehensive efforts--whether through new or old taxation systems, new financing, or creative strategies for leveraging private funding. Examine the costs, effects, and political feasibility of each to find the most effective approach. Apply the same rigorous standard of return on investment that the private sector uses.

- Change federal eligibility rules to reduce barriers to federal programs. Eliminate the asset tests for family automobiles for recipients of AFDC, food stamps, and Medicaid.

- Promote funding linkages by establishing a new fund for investment in children, families, and communities that requires health, housing, transportation, and education systems to collaborate.

- Direct the federal government to take responsibility for negotiating state matching agreements. Allow states to negotiate rates for different programs; this would likely result in more funding that targets prevention and early intervention programs.

- Consider allowing units of local government and community-based organizations to bypass state governments and negotiate funding directly with the federal government if the state is uncooperative. However, some participants cautioned that cities and counties may need that requirement to enforce collaboration with the state, and others noted that bypassing states would not be a simple or productive solution.

Availability:

- Ensure that funding is permanent, stable, and reliable--not just allocated through demonstration grants--so programs can concentrate on maintenance of effort. "Some of you people are doing heroic things, but you're spending half your time on grant applications," noted one participant. "When we fix these kinds of systems, we cannot stop the fix when they cost too much money," said another. State and local governments and other organizations sometimes cannot match demonstration funding after it expires.

- Streamline the federal funding system by providing multi-year funding on a basis other than entitlement. Year-to-year funding is wasteful, inefficient, and encourages funding fads.

Competition and collaboration:

- Reduce the competition created by the federal discretionary grant process, which sets up "isolated islands" of change but excludes many other needy sites. Instead, concentrate on building links among all types of comprehensive efforts.

- Encourage state funding reforms, because fragmented state funding streams contribute to turf issues at the local level.

- Recognize that funding cuts for programs with large, single sources of funding, while not desirable, can motivate the program to build a stronger base by collaborating with private funders and diverse agencies.

Focus:

- Fund prevention efforts, not just crisis programs. Prevention programs have the additional advantage of being less stigmatizing for participants.

- Grant federal waivers to local programs where needed so they are able to implement comprehensive, radical improvements; consider statewide research and demonstration waivers.

- Retain arts and sports programs as legitimate funding recipients. "Everywhere you go, it's the first thing that's dropped...and then [communities] are concerned about young people and gangs," noted a project funder.

Accountability and evaluation:

- Improve accountability measures to gain a better understanding of who receives services, why, and with what results. Accountability works two ways, noted some participants: programs must answer to service recipients as well as politicians. One participant urged policy makers to link accountability for desired outcomes to the budget process.

- Evaluate program cost-effectiveness as well as achievements.

- Link funding to success rather than failure. "Getting money depends on the failure of programs, the failure of education," said one participant. As a result, programs aim for "studied mediocrity: You try to make things better but not so much better that you lose your job."

Philosophical changes.

Collaboration and community building:

- Have the federal government model collaboration in the ways that departments work together.

- Look at school, health, and education reforms not as separate reforms but as complementary components of "positive development."

- Market collaboration more aggressively among relevant service systems--both from the top down and from the bottom up--to build investment. Continue marketing efforts after collaboration begins.

- Emphasize community building when considering incentives and program evaluation, and consider how new interventions will affect communities. Comprehensive strategies and community building are not the same thing; for example, centers that offer one-stop shopping for a wide service area may force recipients to leave their local communities.

- Focus on empowering site-based professionals, neighborhood organizations, and families. Parent and community involvement is crucial.

Focus and approach:

- Don't focus on existing or potential barriers; be patient and remain optimistic. Don't let concerns about funding, facilities, or staffing prevent the establishment of effective programs or services, one participant advised: "If we are going to get stuck on barriers we have not confronted yet, we're never going to do anything." Maintain an evolutionary, long-term perspective on serving families and children; don't expect quick solutions.

- Require new projects to be built on best practice and research, not failed but familiar programs.

- Build backward from desired outcomes to design your efforts. Focus on outcome-driven projects based on a vision of a continuum of care and support that addresses children's various developmental stages. Focus on issues, not programs, that affect access and capacity for education--such as violence.

- Resist the urge to view school-based services as an innovation that will fix flaws in the education system. Comprehensive services do not let schools off the hook regarding other needed education reforms.

- Don't try to make all changes in all places at once. Concentrate resources in areas where you can demonstrate the applicability of the effort on a large scale.

- Focus on learning as development and schools as operating in concert with a "whole continuum of learning, in and out of school."

- Be realistic. Do not oversell programs; realize that they must operate within a broader social context that is affected by many contradictory forces.

Evaluation:

- Reduce the "hostility barrier" between program and evaluation components.

- Use evaluation data--regarding services, clients, families, and assessment processes--as a planning tool as well as a measurement of program success.

Program and service changes.

Collaboration and community building:

- In addition to formal programs, establish informal networks of supplemental services to address needs that don't fit into clear categories or that fall through the cracks. Remove the barriers between these and more formal education programs.

- Be certain that current reform efforts in education, welfare, and health care support rather than inhibit comprehensiveness and collaboration.

- Provide a continuum of care to children, families, and communities, with new elements added at each developmental stage; make transitions between programs smoother.

- Recognizing that community building is a difficult task, allocate more funding to prepare and sustain community-building efforts. Broaden the type of community involvement activities that programs can use federal funding to support.

- Find more innovative uses and better management systems for public spaces.

Focus and approach:

- Pay more attention to providing mental health services and find a better way to fund these services.

- Be serious about outreach. "We have a come-and-get-it system, [but] we need to be in homes, helping people access services," one participant said.

- Be aware of cultural differences and complexities. The Austin Project is one of several in which the complex politics and relationships between client groups--in this case the indigenous Mexican American, immigrant Mexican, and African American populations--can have an impact on the effectiveness of the program. "Errors have been avoided just by trying to understand that these are different groups of people," said one project director.

- Find better ways to institutionalize the effort to connect individual children and families with the services they need, in particular by improving training for program staff responsible for matching clients with services.

Structural changes.

- Recognize the difference between social services, which build dependence, and social support, which assists families and communities in rearing children effectively. Instead of only doing things to or for clients, include clients as full partners in planning and discussions.

- Improve the methods used to evaluate comprehensive efforts. Develop and use evaluation tools that measure empowerment and community building; emphasize knowledge development strategies and build co-learning models. "We need evaluations that take family empowerment seriously...and involve families in constructing at least some part of the evaluation," urged a research director. "The strategies we come up with have to be diverse enough and accommodating enough to deal with the community folks, the organizations, the families, and at the same time [outside evaluators]."

- Teach service recipients how to use the political process to bring about change. Increase political savvy at all levels. "We are insufficiently political in marketing our approach. It's not enough to be able to do the right thing," said one participant.

- To resolve turf issues and break the tendency of some agencies to deal only with their own constituencies, the federal government could consider requiring that states determine the allocation of federal funding that flows through them by using a collaborative process involving major state service providers and agencies.

Administrative changes.

- Promote state and local leadership. State leadership at the governor's level is crucial to sustainable, systemic change because it gives state departments clear goals to focus on and permission to collaborate on meeting the needs of families and communities. Although direct funding connections between local communities and the federal government are useful, state leadership must cooperate in order to make longterm change occur.

- To build support for state and local efforts, involve prominent government leaders in articulating the emerging vision of the changes that are required to better serve children and families. Consider convening federal auditors and inspectors-general to

discuss their roles and determine how they could reward high quality and vision, rather than taking punitive positions.

- Make federal regulations easier to understand. "The language is so tough...it's onerous to people in small districts [who] are not specialists," one participant explained.

- Use the information highway to administer programs more effectively. Use electronic databases to enroll program applicants, verify their eligibility, and coordinate services and benefits at one time. Establish a single client identification number, such as the social security number, that will facilitate this process.

No matter what reforms they advocated, all participants urged the federal government to take strong, immediate action to address the barriers outlined earlier. There was an overwhelming consensus that experts and those on the front lines know well what needs to be done. Now they want support in doing it. "I don't think you ought to wait three years," said a state legislator. "You ought to do it next week, or maybe next month."

The Administration Response

Carol Rasco, Assistant to the President for Domestic Policy, emphasized the importance of taking action--of finding "that fine line" that federal, state, and local players all can walk to improve collaboration. "Often, we aren't there to help [communities] build their dreams," conceded Rasco, a former teacher, counselor, state policy maker, and community activist. Rasco advocated efforts that bring together groups of people in local communities and help them realize what they can do through a problem-identification, problem-solving process. She reiterated the view expressed by many participants that families and communities must be an integral part of designing comprehensive strategies; solutions must be built from the bottom up, not imposed from the top down.

Rasco assured participants that the federal government is trying to build flexibility into its policies to allow communities to conduct their own strategic planning and create environments that foster collaboration among communities, foundations, and state or local agencies. Although she said it is too early to define a national youth policy, Rasco and William Galston have targeted late 1994 for action on developing such a policy, probably with an interagency group including Domestic Policy Council members.

Asked to address the problem of political pressures that result in resources spread too thinly to be effective in some communities, Rasco said the Administration's Empowerment Zones are a

movement toward concentrating resources. "We are also leaving room for foundations and other organizations to make themselves available to new projects," she noted. Collaborative relationships are key to success, Rasco added: "It would be wonderful if foundations would cultivate collaboration between groups," not necessarily with extra funding but by building collaboration requirements into grants. The Empowerment Zone planners also have discussed better ways to build rigorous evaluation components into the funding process, Rasco said in response to a participant who called the current state of evaluation "a crisis."

Thomas Payzant, U.S. Department of Education assistant secretary for elementary and secondary education, told participants that his department is committed to dealing with the changes within schools caused by changes in communities and society at large. Schools will continue to be logical sites for comprehensive program centers because they are closest to families and because schools are facing dramatic changes in the services (ranging from prenatal care to adult literacy) they are expected to provide to meet demographic changes, Payzant said. Payzant acknowledged the challenge of stimulating collaboration both across all levels of government and through relationships between communities and local, state, and federal governments, and he urged participants to find a nexus between the two types of collaboration. The real challenge, he added, lies in bringing solutions to scale.

Peter Edelman, counselor to the Secretary of Health and Human Services, echoed the theme of many participants in urging the experts to focus on "rebuilding, recapturing, rediscovering the idea of community" and creating a "specific, visible, identifiable place" in the community for children and families. Edelman also advocated a philosophical shift toward viewing young people as assets to be developed and toward providing incentives rather than punishment. He also emphasized the importance of focusing on outcomes. However, he recognized the difficulty communities face in assembling an effective balance of professionals, community representatives, and parents to implement change.

Clinton Administration officials already are responding to some of the needs identified by participants, Edelman said after the participants' discussion ended. These responses include: (1) discussions with developers of the Benchmarks approach in Oregon, which may have wider applications for outcomes-based initiatives; (2) discussions with officials in West Virginia and Indiana regarding negotiated decategorization in order to make funding more flexible; and (3) strong support for proposed federal legislation that provides a waiver option and negotiated local flexibility. In addition, the Administration is watching activities in several states to determine whether the federal government can play "a catalytic role" beyond funding to encourage collaborative approaches to violence prevention. Policy makers are also examining possibilities for providing technical assistance

to communities that submitted applications but are not designated as Empowerment Zones or Enterprise Communities. Other changes that may affect comprehensive strategies for children and families are embodied in the prevention portions of the crime bill, while still others, such as health and welfare reform, are still "very much open," Edelman acknowledged. The Administration's proposals include universal health coverage, which would give all children access to health care, and the establishment of more than 1,000 service centers nationally that would connect schools with communities.

Administration representatives assured participants that discussions between federal policy makers and experts in the field will continue--and that the federal government is not only sympathetic to local and state needs but is ready to act to improve policies. "We aren't always going to be able to do everything we want to do, but we'll die trying," Rasco said.

List of Participants

Tania Alameda
Director, Bureau of Children's Affairs
Miami, FL

* **Tony Alvarado**
Superintendent, District Two
New York, NY

Kent Amos
Founder/President
The Urban Family Institute
Washington, DC

* **Sheldon Bilchik**
Associate Deputy Attorney General
Department of Justice
Washington, DC

* **Angela Blackwell**
Executive Director
The Urban Strategies Council
Oakland, CA

Cynthia Brown
Director, Resource Center on
Educational Equity
Council of Chief State School Officers
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Vice President
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New York, NY

Geoffrey Canada
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Rheedlen Centers for Children and Families
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Beverly Carlson
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Judy Langford Carter
Executive Director
Family Resource Coalition
Chicago, IL

Judith Chynoweth
Director, Foundation Consortium for
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Sacramento, CA

Tony Cipollone
Associate Director
Annie E. Casey Foundation
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Alan Cohen
Senior Advisor to the Secretary
Department of the Treasury
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Philip Coltoff
Executive Director, Children's Aid Society
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* **James Comer**
Maurice Falk Professor, Child Study Center
Yale University
New Haven, CT

Paul Dimond
Assistant to the President
The National Economic Council
Washington, DC

Margaret Dunkle
Director, Institute for Educational
Leadership Policy Exchange
Washington, DC

Angela Duran
Special Assistant to the Counselor
Department of Health and Human Services
Washington, DC

Peter Edelman
Counselor to the Secretary
Department of Health and Human Services
Washington, DC

* *Invited but unable to attend*

* **Frank Farrow**
Director, Children's Services Policy
Center for the Study of Social Policy
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Don Fraser
Consultant, Office of Special Actions
Department of Housing
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William Galston
Deputy Assistant to the President
Domestic Policy Council
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Martin Gerry
Executive Director, The Austin Project
Austin, TX

Beverly Godwin
Team Leader
National Performance Review
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* **Nancy Grasmick**
Maryland Superintendent of Schools
Annapolis, MD

Ellen Haas
Assistant Secretary for Food
and Consumer Services
Department of Agriculture
Washington, DC

Cheri Hayes
Executive Director
The Finance Project
Washington, DC

Jeanne Jehl
Administrator on Special Assignment
San Diego Schools
San Diego, CA

Cliff Johnson
Program and Policy Director
Children's Defense Fund
Washington, DC

Otis Johnson
Executive Director
Chatham-Savannah Youth Futures Authority
Savannah, GA

* **Elaine Kamark**
Senior Advisor to the Vice President
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Mark Kavarsky
Principal, I.S. 218
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Naomi Karp
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Teresa Knott
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Janet Levy
Program Director, The Danforth Foundation
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Gaynor McCown
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The Domestic Policy Council/
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Astrid Merget
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John Merrow
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Thomas Payzant
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Marcia Renwanz
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Director, Chapin Hall Center for Children
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*** Sharon Robinson**
Assistant Secretary, Office of Educational
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*** Ann Rosewater**
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Professor, University of Pennsylvania
Philadelphia, PA

Peggy Sparks
Director, Community Education Department
Birmingham Public Schools
Birmingham, AL

Gary Stangler
Director, Department of Social Services
St. Louis, MO

Isabel Stewart
National Executive Director
Girls Incorporated
New York, NY

** Invited but unable to attend*

*** Ruby Takanishi**
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The Carnegie Council on Adolescence
Washington, DC

Charles W. Terrett
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New Jersey Department of Human Resources
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Washington, DC

Judy Wurtzel
Special Assistant to the Under Secretary
Department of Education
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Ed Zigler
Sterling Professor of Psychology
Executive Director, Bush Center for
Child Development and Social Policy
Yale University
New Haven, CT

** Invited but unable to attend*

Summary of Legislation

"Let's give our children a future. Let us take away their guns and give them books. Let us overcome their despair and replace it with hope. Let us, by our example, teach them to obey the law, respect our neighbors, and cherish our values. Let us weave these sturdy threads into a new American community that can once more stand strong against the forces of despair and evil because everyone has a chance to walk into a better tomorrow."

President William Jefferson Clinton
State of the Union Address
January 25, 1994

Congress is well aware that policies and programs affecting children and their families must support and encourage the cooperation of existing organizations such as schools and community organizations. Several major pieces of recent or pending legislation present tremendous opportunities and challenges for schools and community-based organizations as they devise comprehensive strategies to serve children and families. The following list is not meant to be comprehensive, but it provides insight into the type of initiatives that promote comprehensive strategies.

Newly enacted or implemented legislation includes:

- **The Empowerment Zone/Enterprise Community Initiative**, administered by the Departments of Housing and Urban Development and Agriculture, is one of the Clinton Administration's most ambitious projects to promote community development and provide jobs and economic opportunities. Through this initiative, the federal government offers to create compacts with communities and state and local governments. More than 800 communities have submitted applications under this initiative; each application contains a comprehensive and strategic plan for change, with performance-based benchmarks. By participating in this initiative, community residents, businesses, financial institutions, service providers, neighborhood associations, and state and local governments can form or strengthen partnerships to support revitalization.

- **Goals 2000: Educate America Act**--the centerpiece of President Clinton's education agenda--recognizes and supports the need for a more comprehensive approach by providing resources to states and communities to develop and implement comprehensive education reforms aimed at helping all students reach challenging academic and occupational-skill standards. The law--which addresses school readiness; school completion; competency in challenging subject matter; science and mathematics achievement; literacy; safe, disciplined, and drug-free schools; and parental participation--asks states and local education agencies (LEAs) to create broad-

based planning groups that include educators; parents; business leaders; and representatives of health agencies, social service agencies, and community organizations that work with children and youth.

- **The School to Work Opportunities Act**, jointly administered by the Departments of Education and Labor and signed into law in May 1994, provides seed money for states and districts to develop programs that integrate challenging standards and workplace skills so that students graduate from high school with the knowledge and skills they need enter their chosen professions or continue their education. These opportunities can enable this group--70 percent of American youth--to find employment with career potential.

- **The Violent Crime Control and Law Enforcement Act of 1994** contains significant funding for efforts to prevent crime and violence among children and youth and in communities. The Ounce of Prevention Council, with $1.5 million available for 1995, will coordinate new and existing crime prevention programs, including many oriented toward youth; $88.5 million will be available for competitive grants between 1996 and 2000. The Community Schools provision, administered by the Department of Health and Human Services, will provide funding for supervised after-school, weekend, and summer programs. This provision will receive $37 million in 1995 and $530 million for 1996 through 2000. The Family and Communities Endeavor Schools (FACES) program, administered by the Department of Education, will provide $243 million in funding for in-school and after-school activities.

- **PACT (Pulling America's Cities Together)**, administered by the Department of Justice, recognizes that the needs of children, youth, and families vary dramatically from community to community. PACT, a pilot program located in five cities, is a locally planned and operated initiative that brings together the strengths and resources of these communities to meet the needs of each locality.

- **The Family Preservation and Support Program**, authorized as part of the 1993 budget agreement, includes almost $1 billion over five years for states to improve the well-being of vulnerable children and their families, particularly those experiencing or at risk of abuse and neglect. Because the multiple needs of these children and families cannot be addressed adequately through categorical programs and fragmented service delivery systems, states are encouraged to use the new program as a catalyst for establishing a continuum of coordinated, integrated, culturally relevant, and family focused services. Services range from preventive efforts to strengthen families by providing crucial support to services for families in serious crisis or at risk of having children removed from the home.

- **Youthbuild**, administered by the Department of Housing and Urban Development, was authorized as "Youthbuild (Hope for Youth)" under the Housing and Community Development Act of 1992. With $40 million available for program implementation and development in fiscal year 1993, Youthbuild's goal is to provide economically disadvantaged youth with education, employment, and leadership skills through opportunities for meaningful work with their communities. Training includes on-site construction work and off-site academic and job skills development.

- **Head Start**, administered by the Department of Health and Human Services, has an impact on child development and day care services, the expansion of state and local activities for children, the range and quality of services for young children and their families, and the design of training for staff involved in such programs. Head Start has served more than 13.8 million children and their families since 1965; grants are awarded to local public or private non-profit agencies.

Proposed or prospective legislation includes:

- **The reauthorization of the Elementary and Secondary Education Act** (ESEA), currently in conference, strongly encourages states and LEAs to coordinate services. ESEA's priority is high standards for all children, with the different elements needed for a high-quality education well aligned so that the education process works smoothly to help all students reach those standards. The proposal requires LEAs to identify in their Title I plans (distributed on a formula basis) exactly how they will coordinate education, health, and social services. The House and Senate versions of the bill both contain strong provisions addressing the need for collaboration.

- **The Welfare Reform Bill** would support teen pregnancy prevention programs at 1,000 middle and high schools. The programs would emphasize counseling and a skills-based approach while providing opportunities to develop sustained relationships with adults. National Service volunteers would play an important role in staffing programs.

Several other ongoing initiatives support the role of schools and community-based organizations in developing comprehensive strategies for children and families:

- **Safe and Drug-Free Schools and Communities**, administered by the Department of Education, supports comprehensive strategies that include drug prevention curricula and programs linking schools and communities; the version proposed for reauthorization has an increased focus on communities.

- **Youth Fair Chance**, administered by the Department of Labor, is designed to provide comprehensive employment and training services to youth (14-21 years old) and young adults (22-30 years old) in high-poverty areas of urban and rural communities.

- **Even Start**, administered by the Department of Education, is a family-focused program providing participating families with an integrated combination of early childhood education, adult literacy, basic skills instruction, and parenting education.

HEALTH CARE ACCESS FOR CHILDREN: WHAT'S POSSIBLE IN 1995

A Kids First...Kids Now Summit

Wednesday, May 17, 1995
8:30 a.m. - 12:15 p.m.

216 Hart Senate Office Building
Washington, DC

Sponsored by
The Columbia Institute &
The Children's Health Fund

The Children's Health Fund's **Kids First...Kids Now Campaign** is a public awareness initiative designed to build a national consensus of support for making appropriate health care available to every child in America. This **Kids First...Kids Now National Summit** has been made possible in part through the generous support of Blue Cross of Western Pennsylvania and Pennsylvania Blue Shield.

HEALTH CARE ACCESS FOR CHILDREN: WHAT'S POSSIBLE IN 1995

A Kids First . . . Kids Now Summit

Welcome to the Kids First...Kids Now summit, "HEALTH CARE ACCESS FOR CHILDREN: What's Possible in 1995."

We have gathered today in our nation's capital to take a critical look at how children will fare as we go about the business of re-inventing government. In the rush to fix the economy that our children will inherit, we are at risk of jeopardizing the same children that need our help today. Few events since the Great Depression have posed as much potential danger to the health of the nation's kids as some of the current legislative proposals, which could rip apart the already frayed and fragile child health safety net.

A national discussion about the health status of America's children must be informed by the following facts. The number of children with no health insurance coverage has climbed from 8.5 to 11 million in the past two years. Several million more are partially insured, lacking coverage for childhood immunizations and routine checkups to prevent common disease or chronic illness. At least 5 million children do not receive medical care regardless of their financial or insurance status because they live in health-professional shortage areas and simply have no doctor to go to. As many as 30% of American children under 18 years of age may not be getting the health care they need.

Our pediatric colleagues and many others who constitute the child health provider, policy and advocacy communities, are alarmed at the prospect that decisions which would have such enormous impact on the health of so many children, are not being considered more carefully. It is critically important that all of us, and particularly the child health provider groups, are assertive on behalf of the children we care for, almost as referees to ensure that the impact of what is proposed is clearly understood by government officials and the American public.

Today's summit marks another step in our ongoing Kids First...Kids Now campaign, a public awareness initiative designed to build support for making appropriate health care available to every child in America. We will examine how proposed restructuring of the health care system will affect children and how the health care safety net for children can be maintained and strengthened. We will also present examples of innovative programmatic approaches that have been successful in expanding child health coverage. Finally, we will host a focused discussion by polling professionals on how child health providers and advocates can effectively communicate the urgency of child health concerns in the current political environment.

We are pleased that all of you are able to join us today to set the groundwork for a collective effort to create a new framework of health security for our children. The Children's Health Fund extends special gratitude to editorial cartoonist Garry Trudeau for his effort on behalf of Kids First...Kids Now and to Bill Lowry, Blue Cross of Western Pennsylvania and Pennsylvania Blue Shield for the generous support which makes this summit possible.

Irwin Redlener, M.D.
President
The Children's Health Fund

Dennis G. Johnson
Director of Policy
The Children's Health Fund

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AGENDA

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MEETING AGENDA

8:30 a.m. **Registration & Coffee**

9:00 a.m. **Opening** **Irwin Redlener, M.D.**, President, The Children's Health Fund
Director of Community Pediatrics, Albert Einstein College of Medicine-Montefiore Medical Center

9:15 a.m. **Remarks** **Robert N. Butler, M.D.**, Chairman, White House Conference on Aging/ Brookdale Professor & Chairman, Department of Geriatrics, Mount Sinai School of Medicine

9:25 a.m. **Remarks** **Senator Nancy Landon Kassebaum**, Chairman,
Labor & Human Resources Committee

9:35 a.m. **PANEL I: The Health Care Safety Net for Children: Current Status, Future Prospects**

(Analysis of status of safety net and potential areas for expansion or development. Analysis of current proposals, including block granting.)

Moderator: **Peters D. Willson**, Vice President for Public Policy,
National Association of Children's Hospitals and Related Institutions (NACHRI)

Cheryl Hayes, Executive Director, The Finance Project

Paul W. Newacheck, DrPH, Professor of Health Policy & Pediatrics,
Institute for Health Policy Studies and Department of Pediatrics,
University of California, San Francisco

10:20 a.m. **Coffee Break**

10:35 a.m. **Remarks** **Senator Paul Wellstone**, Labor & Human Resources Committee

10:45 a.m. **PANEL II: Innovative Program Models for Providing Coverage and Access**

(Exposition and discussion of successful program models for expanding health coverage for children.)

Moderator: **Woodie Kessel, M.D.**, Assistant Surgeon General
Director, Division of Systems, Education & Science, Maternal and Child Health Bureau, U.S. Department of Health & Human Services

Charles P. LaVallee, Executive Director, Western Pennsylvania Caring Foundation, Inc.

Julia Graham Lear, Ph.D., Director, George Washington University,
"Making the Grade Program"

Zeil Rosenberg, M.D., Medical Director, National Programs,
The Children's Health Fund

11:30 a.m. **PANEL III: The Public Message: What Works, What Doesn't**

(National pollsters discuss successful strategic approaches for building public support for developing a comprehensive child health safety net.)

Moderator: **Susan Nall Bales**, Director of Children's Programs, Benton Foundation

Celinda Lake, President & CEO, Lake Research

Steve Wagner, Vice President, Luntz Research

12:15 p.m. **Closing** **Irwin Redlener, M.D.**

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BIOGRAPHIES

Divider Title:_____

THE HONORABLE NANCY LANDON KASSEBAUM
U.S. SENATE - KANSAS

Senator Kassebaum is serving her third term in the U.S. Senate and is Chairman of the Labor and Human Resources Committee. Recently called "scrupulously fair" by Massachusetts Senator Edward M. Kennedy, Senator Kassebaum is currently overseeing the confirmation hearings of Surgeon General-designate Vincent Foster. She is known as a coalition builder in the Senate and has earned respect as an independent thinker. Senator Kassebaum is viewed as a moderate on social issues. She advocates greater government coordination of family and children's programs and has focused efforts on improving education and reforming the health care system. Senator Kassebaum earned her B.A. in political science at the University of Kansas and her M.A. in diplomatic history at the University of Michigan.

THE HONORABLE PAUL WELLSTONE
U.S. SENATE - MINNESOTA

Elected to the U.S. Senate in 1990, Paul Wellstone serves on the Senate Labor and Human Resources Committee where he has worked very actively on health care reform issues. As the Senate author of S.491, he is a national advocate for single payer health care reform. Senator Wellstone has focused his legislative work on parity for mental health/substance abuse services and physical health care; home-based long term care coverage and expanded access to community-based services; increased federal flexibility to allow state-based reforms; the Patient Protection Act; increased research into MS, Parkinson's, Alzheimer's, Breast Cancer and other promising areas; and allowing all Americans to have access to the same coverage available to members of the United States Senate.

SUSAN NALL BALES
DIRECTOR OF CHILDREN'S PROGRAMS
BENTON FOUNDATION

Ms. Bales has been a media strategist and practitioner for more than 15 years. For 8 years, she managed her own public relations firm, providing issue-oriented public relations services for 75 nonprofit advocacy groups, especially in the areas of civil rights, aging, children's issues and women's concerns. She served for four years as vice president for public affairs for the National Association of Children's Hospitals. She has supervised numerous focus groups and national public opinion surveys which probe the public's understanding of and support for children's programs.

ROBERT N. BUTLER, M.D.
CHAIRMAN, WHITE HOUSE CONFERENCE ON AGING &
BROOKDALE PROFESSOR & CHAIRMAN, DEPARTMENT OF GERIATRICS
MOUNT SINAI SCHOOL OF MEDICINE

Dr. Butler is a physician, gerontologist and psychiatrist. In 1982, he founded the Department of Geriatrics and Adult Development at the Mount Sinai Medical Center, the first department of geriatrics in a U.S. medical school, and is currently its Chairman. In 1975 he became the founding director of the National Institute on Aging of the National Institutes of Health. In 1990, he helped establish the U.S. -- Japan International Leadership Center on Longevity and Society which conducts studies of the impact of longevity upon society and its institutions. In 1976, Dr. Butler won the Pulitzer Prize for his book Why Survive? Being Old in America. Dr. Butler is a member of the Institute of Medicine of the National Academy of Sciences.

CHERYL HAYES
EXECUTIVE DIRECTOR
THE FINANCE PROJECT

Ms. Hayes is Executive Director of The Finance Project, a national initiative to improve the effectiveness, efficiency and equity of public financing for education and other children's services. With leadership and support from a consortium of private foundations, The Finance Project was established as an independent nonprofit organization in Washington, D.C. In January 1994, the Project began a three-year series of policy research and development activities, including policymaker forums and public education activities. Ms. Hayes has approximately 20 years of experience in public policy research on issues affecting the well-being of children and families. Before joining The Finance Project, Ms. Hayes served as executive director of the National Commission on Children, a bipartisan Presidential-Congressional commission charged with assessing the status of America's children and families and presenting a national policy agenda for improving health, education, income security and social supports. She holds an M.B.A. from Wharton, an M.A. in American history from Georgetown University, and a B.A. from Skidmore College.

DENNIS JOHNSON
DIRECTOR, POLICY AND PLANNING
THE CHILDREN'S HEALTH FUND

As Director of Policy and Planning, Mr. Johnson directs the organization's public policy initiatives and government affairs agenda. In this role, he has organized national summits engaging child health care providers, child advocates and Congressional staff. He has extensive experience in public policy and children's health and education issues. Prior to joining The Children's Health Fund, he worked at the Fund for New York City Public Education and The Business Council of New York State.

WOODIE KESSEL, M.D., M.P.H.
ASSISTANT SURGEON GENERAL &
DIRECTOR, DIVISION FOR SYSTEMS, EDUCATION AND SCIENCE
MATERNAL AND CHILD HEALTH BUREAU
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. Kessel is a recognized national and international authority on maternal and child health. He has first-hand community-based expertise in pediatrics and developing and implementing programmatic health strategies at federal, state and local levels. Dr. Kessel's focus has been improving access to health care for undeserved populations. Dr. Kessel developed the Surgeon General's Workshop concept, which enables the U.S. Surgeon General to assemble national experts to address public health problems in an interactive fashion. He directed the analysis of complex program and cost-effective information critical to the development of national policy for children which led directly to the formulation of a Presidential Healthy Start Initiative. Dr. Kessel also led the development of an initiative called The Healthy Tomorrows Partnership for Children, which brings pediatricians and local institutional resources together at the community level.

CELINDA LAKE
PRESIDENT & CEO
LAKE RESEARCH

Celinda Lake is President of Lake Research, a research-based strategy firm. Lake is one of the Democratic Party's leading political strategists, serving as tactician and senior advisor to the national party committees, dozens of Democratic incumbents and challengers at all levels of the electoral process, and democratic parties in several Eastern European countries and South Africa. Her most recent areas of concentration have been the changing politics of the Western states, health care in the 1990s, children as a political issue, and the environmental movement today. Lake is a pollster for U.S. News and World Report, and an advisor to the Wall Street Journal. Prior to forming Lake Research, she was partner in Mellman Lazarus Lake and has served as political director of the Women's Campaign Fund.

CHARLES P. LaVALLEE
EXECUTIVE DIRECTOR
WESTERN PENNSYLVANIA CARING FOUNDATION, INC.

Mr. LaVallee is Executive Director of the Western Pennsylvania Caring Foundation, Inc., and Director of the Western Pennsylvania Caring Program for Children, a health care initiative for children of the working uninsured. In this dual role, Mr. LaVallee is responsible for managing charitable, educational and scientific programs benefiting the economically disadvantaged and the elderly. He also directs the development and implementation of Caring Program activities, working with organizations nationwide to replicate the program. In addition, Mr. LaVallee is responsible for administration of the Western Pennsylvania BlueCHIP program, Pennsylvania's Children's Health Insurance Program.

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Dr. Redlener is President and co-founder of The Children's Health Fund and is Associate Professor of Pediatrics and Director of Community Pediatrics at the Albert Einstein College of Medicine-Montefiore Medical Center and Lecturer in Pediatrics at Harvard Medical School. He also developed and directs the New York Children's Health Project, the country's largest health care program for homeless children. Dr. Redlener is Chairman of the National Advisory Council to the National Health Service Corps. He served as a physician special consultant to the White House, as well as Expert Consultant to the Assistant Secretary for Health at the U.S. Department of Health and Human Services. Dr. Redlener was vice chairman of the Health Professions Review Group of the White House Task Force on Health Reform. He received his M.D. from the University of Miami School of Medicine and completed his internship at Babies Hospital of the Columbia-Presbyterian Medical Center in New York City.

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Dr. Rosenberg received his M.D. from the University of California, San Francisco, his master's degree in public health from Columbia University and his B.A. in economics from Stanford. His postgraduate medical training was completed at Cornell University Medical Center. He served as a fellow at the U.S. Agency of International Development (USAID), where he managed their global immunization project. Dr. Rosenberg subsequently served as Child Survival Advisor USAID/Jakarta, Indonesia for four years where he was technical advisor to the Ministry of Health's Expanded Program for Immunization. Returning to New York, he held positions as a Medical Advisor to the Deputy Commissioner, New York City Department of Health and Director, Family Health at the New York State Department of Health. In addition to his role at The Children's Health Fund, Dr. Rosenberg is Director, Fellowship Program in Community Pediatrics and Assistant Professor of Pediatrics, Montefiore Medical Center/Albert Einstein College of Medicine, and Assistant Professor (Adjunct) at the Columbia University School of Public Health.

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As Vice President at Luntz Research and Strategic Services, Mr. Wagner supervises political and international research and consulting accounts. Previously, he was for seven years the chief of European and Latin American research at the U.S. Information Agency (USIA). At USIA, he commissioned and supervised hundreds of surveys throughout Europe and Latin America on a wide array of issues related to security, trade, international events and bilateral relations. Prior to joining USIA, Mr. Wagner was political director of the National Republican Institute for International Affairs, the Republican Party's international office. Mr. Wagner was the founding executive director of the *Campaign for Prosperity*, Jack Kemp's political action committee, and has also served on the minority leadership staff of the U.S. House of Representatives. He is a graduate of Lafayette College and is working toward a master's in National Security Studies at George Washington University, where he has taught several courses.

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STATEMENTS

Divider Title:_____

Statement Of

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From the AARP Bulletin: A Publication of
the American Association of Retired Persons
In My Opinion, March 1995
Vol. 36, No.3, Washington, D.C.

"We Must Lead the Crusade to Insure Kids"

Last year's hopes for health-care reform may have been dashed, but the fact remains that millions of Americans are un- or underinsured, including an estimated 18 million children. This, the world's wealthiest country, can't afford to keep its children at risk.

Future health-care reform will likely occur in steps. Modest insurance market reforms will probably include ending denial of health insurance on the basis of pre-existing conditions and providing portability of health insurance for employees.

But the most critical step in reform should be universal access to health care for America's children.

This is not a new idea. The late Senator Jacob Javits, R-N.Y., suggested Medicare for children or "Kiddie-Care," some years ago.

The Kids First initiative, led by pediatrician Irwin Redlener, singer/songwriter Paul Simon, editorial cartoonist Gary Trudeau and others, joined by the Children's Defense Fund, the Academy of Pediatrics and the National Association of Children's Hospitals, all seek coverage of children by various means. Their financing proposals differ, but this should not obstruct the goal, which, I suspect would be acceptable to everyone along the political spectrum. Were we to begin a national campaign to provide health care for children, I believe the vast majority of Americans would support it.

Older people care deeply about children--their grandchildren and other children. They also care about the future of the country and continuing to contribute to their communities -- and their families--through donations of time and money.

In keeping with these concerns and speaking as an older person, geriatrician and grandfather, I recommend a national Grandpersons' Initiative for Kids First. All organizations representing older people should take the lead in calling for a health insurance program for all children like the one that older persons themselves enjoy today. This effort would go a long way toward eradicating the image of older people as "greedy geezers."

After the institution of Kids First, the next logical step in health-care reform would be to meet the need for home-, community-, and institutionally based long-term care. Forty percent of persons needing such care are under the age of 60, including many disabled children.

We older folks have the responsibility to help maintain our society and support younger generations. I very much hope that elders and the great organizations that represent them will lead a Grandpersons' Initiative for Kids First in America.

Statement Of

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Fact Sheet

MEDICAID: NATION'S HEALTH CARE SAFETY NET FOR CHILDREN

Medicaid is a nationwide health care safety net for children, because it establishes minimum standards for eligibility, medically necessary care, and access to appropriate care for low income children, including children of working families, regardless of where they live. Medicaid is critical to children receiving care from children's hospitals. It is the largest single program of public assistance for children's health care and the largest single payer of care by children's hospitals.

Who Are The Children Who Rely On Medicaid?

One fourth of all children and one third of all infants rely on Medicaid.

- **In FY 1993, 16.3 million children under age 21 were covered by Medicaid--one in four children and one in three infants.** Children were almost 50% of all Medicaid recipients. About 88% of all Medicaid-covered children were under age 15; 52% were younger than age 6. Nearly 60% of Medicaid-covered children under age 18 lived in low income, working families.

- **At the end of December 1993, Medicaid also covered more than 770,000 children with disabilities who qualify for Supplemental Security Income (SSI).** Examples of the types of disabilities include diseases of the nervous system and sense organs, congenital anomalies, mental disorders, and diseases of the respiratory system--these examples represented over 425,000 of all children assisted by SSI in 1993.

- **Together 23.8 million children and mothers represented 72% of Medicaid covered individuals.** Alone, mothers eligible for Aid to Families with Dependent Children (AFDC) accounted for 7.5 million or 22% of Medicaid covered individuals.

- **Although they represented over half of the new Medicaid covered individuals from 1988 to 1991 due to expanded coverage to working families, children and pregnant women accounted for less than 11% of the spending increase.** From 1992 to 1993, the growth in the number of Medicaid eligible children increased 26%, also due to expanded coverage for working families. But spending for children increased only 10%.

- **Medicaid assistance is much cheaper for eligible children than for eligible adults.** In 1993, medicaid spent $16.5 billion for children's health care-16.2% of all Medicaid spending. Medicaid spent $33.6 billion for the elderly--about 33% of all expenditures although senior citizens were only 12.5% of Medicaid recipients.

- **In 1993 Medicaid spent, on average, $1,012 per child compared to $8,220 per elderly adult.** Medicaid's cost for one elderly adult is the equivalent of the cost for almost eight children. An example of the allocation of Medicaid spending by type of service further exemplifies the low cost of caring for non-disabled children. In 1993, Medicaid spent 0.3% of expenditures on nursing facility care for non-disabled children but 62% on such care for the non-disabled elderly population.

Why Is Medicaid Critical to Children's Hospitals?

Medicaid pays for nearly half of the inpatient care for children's hospitals' patients.

- In 1993, on average, Medicaid-covered children represented 42.3% of all discharges from a free-standing, acute care children's hospital. They accounted for 46% of all inpatient days of care provided by the hospital, up from 28.8% in 1986.

FY 86	28.8%	FY 90	37.8%
FY 87	30.1%	FY 91	40.2%
FY 88	32.4%	FY 92	44.7%
FY 89	35.4%	FY 93	46.4%

- **Children assisted by Medicaid require more care than other children's hospital patients.** In 1993, the average length of stay in a children's hospital for a child assisted by Medicaid was 7.2 days--1.2 days longer than the average for all other children.

- **Medicaid payment falls far short of the cost of inpatient care provided by children's hospitals.** In 1993, on average, the Medicaid base payment was 80 cents for every $1 in inpatient care expenses the children's hospital incurred to care for a Medicaid-covered child. Even with the addition of disproportionate share hospital (DSH) payments, children's hospitals receive payments that on average are less than the cost of care.

- **Children's hospitals are major providers of outpatient care to children assisted by Medicaid.** Most children's hospitals provide a full range of outpatient services to children assisted by Medicaid, including primary, specialty, and emergency care. Outpatient visits for all children in children's hospitals grew 60.1% from 1986 to 1993 and 5.1% during 1993 alone. More than half of all children assisted by Medicaid used outpatient services in 1992. A 1992 unpublished survey of selected respondents reported substantial Medicaid losses, ranging from 20-65%, for the provision of outpatient care to children.

This fact sheet is drawn from Medicaid Statistics information supplied by the Health Care Financing Administration, fact sheets prepared by the Kaiser Commission on the Future of Medicaid, the American Hospital Association, NACHRI, and other sources.

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Excerpt From

RETHINKING BLOCK GRANTS:
Toward Improved Intergovernmental Financing
for Education and Other Children's Services
April 1995

INTRODUCTION

In November 1994, a critical mass of American voters called for dramatic changes in the way government does business. The Republican landslide was not just a bout of anti-incumbency fever. It was a profound expression of doubt about the ability of government -- especially the federal government -- to solve social problems and provide basic supports and services that enhance the quality of life in communities across the country. At least part of the message was that government is too big, too expensive, and it doesn't work very well.

Despite steadily increasing public expenditures for health, education, welfare, human services, and public safety over the past two decades, seemingly intractable problems persist. Nearly a quarter of U.S. children are poor and live in families and communities that are unable to meet their basic needs. Schools have become increasingly expensive. But student achievement hasn't matched the rising costs, and drop-out rates remain unacceptably high. Health care costs continue to go up. Yet, many Americans can't get the services they need, and with each passing year their health care dollars buy less. Criminal justice demands a rapidly increasing share of public dollars--for police officers and judges and jails--but neighborhood streets aren't safer.

Taxpayers say they want more for their money. They want government at all levels to operate more effectively and efficiently. They want it to invest wisely and live within its means. In response, the 104th Congress has made public finance reform a high priority. Significant energy and attention is focused on proposals to streamline and consolidate the many fragmented funding streams that channel federal aid to states and communities. In 1994, more than 480 separate federal programs allocated $398 billion for education, health, human services, housing, criminal justice, community development, and other supports and services for children and families. More than 90 programs, for example, funded employment and training services. More than 90 different programs funded early childhood services. Approximately 106 supported youth development activities. And 18 funded nutrition education and assistance for children and their families. Within each cabinet level department, multiple agencies oversee overlapping programs that serve essentially the same populations. Each of these programs has its own administrative requirements, eligibility rules, and performance standards.

The new Congress seems intent on simplifying this disjointed maze and, in the process, devolving more authority for the design and delivery of supports and services to states and communities. Most of the discussion of how to accomplish this reform is focused on creating block grants that would consolidate numerous federal categorical programs into a few unified funding streams. An array of emerging proposals is under consideration, including those contained in the Republican Contract with America and the National Governors' Association policy position on welfare reform.

The idea of creating block grants is not new, however. As far back as 1949, a report by the Commission of the Organization of the Executive Branch concluded that "a system of grants should be established based upon broad categories [of funding] as contrasted with the present system of extensive fragmentation." In the early 1970s, the Nixon administration attempted to reduce the federal role in program management and the number of federal categorical programs through special revenue sharing. In 1981, the Reagan administration created nine block grants that consolidated approximately 57 of the more than 300 federal programs providing assistance to states and localities at that time. A decade and a half later, block grants are once again a hot topic, and current proposals call for even more far-reaching consolidations of federal categorical programs than those of the early 1980s.

It seems likely that political forces will unite behind legislation to transform scores of existing funding streams into a few domestic social welfare block grants in 1995. In the process, federal grantmaking and intergovernmental relations could undergo more profound changes than at any time in the past 30 years. As they move to restructure the federal-state relationship and reduce domestic social spending, however, Congress, the Clinton administration, and the nation's governors and mayors will face a number of policy and political hurdles. Many of the programs targeted for consolidations are much larger and are fundamentally different from those that were folded into the Reagan block grants. They include the entitlements that make up the nation's social safety net as well as smaller discretionary grant programs. As deliberations proceed, it would be useful to recall past experiences and the lessons that were learned. It would also be useful to draw distinctions between current proposals and past programs, and to anticipate the special issues and challenges ahead.

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The Impact of Capping Federal Medicaid Contributions

Key members of Congress have proposed significant cutbacks in federal spending for Medicaid. The Senate budget resolution includes reductions of $175 billion in Medicaid spending over the next seven years. The House budget resolution would reduce federal Medicaid spending even further. Under these budget resolutions, the administration of Medicaid would be turned over to the states and poor families would no longer be entitled to benefits they now receive. These policy changes would substantially weaken the safety net for children and result in substantial hardship for low income families.

While there has been much discussion of the need to reduce government spending, we must recognize that programs such as Medicaid are of enormous value to children. For the last 30 years, Medicaid has played a vital role in providing a safety net for our children. And now with one in four children living in poverty, Medicaid has never been so important. Private health insurance is simply out of reach for these families and without Medicaid they would be forced to rely on charity care or go without needed services.

Medicaid serves two critical purposes. First, *for all American families with children* it provides a safety net during difficult economic times. Second, *for poor families* it provides a needed link to preventive care and ongoing illness care.

The vital role Medicaid plays as a safety net is illustrated by recent trends in health insurance coverage for children. Survey data from the Bureau of the Census show that the face of large scale losses of employer-based private health insurance coverage for children in recent years, the elastic nature of the Medicaid program has helped to provide millions of children continued access to health care.

The second important contribution of Medicaid is its role in linking poor families to needed preventive services and illness care. Medicaid's value in facilitating access to medical care has been demonstrated in numerous studies. In these studies, Medicaid is shown to play a powerful role in improving access to needed services for poor children. Medicaid helps to bring poor children's use of services up to near the level of nonpoor children.

We need to carefully consider the wisdom of making the draconian cuts proposed in the Senate and the House budget resolutions. They would weaken the safety net for all American families with children. They would cripple a program that is both effective and frugal. While these cuts may generate savings in the short term, those savings may pale in comparison to the costs incurred over the long term as children forgo needed medical care.

Statement Of

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HEALTH CARE FOR CHILDREN
Western Pennsylvania Caring Foundation: A Working Solution

In Western Pennsylvania, an innovative public/private partnership is providing comprehensive health care coverage to children from working uninsured families. The coverage enables families to obtain health care services for their children while significantly reducing cost-shifting.

In ten years, the Western Pennsylvania Caring Foundation (WPCF) has provided health care coverage to children with low-income families through the Caring Program for Children, and has replicated Caring Programs in twenty-three states across the nation.

This success is based on community grassroots commitment and support.

The Caring Program for Children was also the model for 1992 legislation which established the Children's Health Insurance Program of Pennsylvania, administered by WPCF in Western Pennsylvania, where it is called BlueCHIP.

The Caring Program and BlueCHIP offer the same comprehensive benefits package, so that seamless health care coverage is now available for children from working uninsured families in Western Pennsylvania, including children with pre-existing conditions.

The coverage is based primarily on preventive care, and also includes dental, prescription drug, vision, mental health and hospitalization coverage. These children utilize the same network of providers that is available to those who have Blue Cross/Blue Shield insurance.

The children's coverage is funded through a public/private partnership which has now provided 70,000 children with health care coverage.

Through these two programs alone, the total number of uninsured residents of Western Pennsylvania was reduced by 5% in 1994.

Total health care costs to the private sector in Western Pennsylvania have decreased by 1% due to these two programs, representing millions of dollars saved by regional businesses and individuals.

The public/private partnership demonstrates that providing health care coverage to America's children is clearly within our reach.

Statement Of

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School-Based Health Centers: A Strategy to Increase Access to Care for School-Age Children

School-based health centers provide comprehensive physical and mental health services to children in need of care at locations accessible to children and their families. Once considered controversial, these centers have come to be viewed as simply one of the ways communities address the unmet needs of young people. The health centers are found in more than 650 schools across the United States. Making the Grade: State and Local Partnerships to Establish School-Based Health Centers is a national program of the Robert Wood Johnson Foundation which supports 10 state governments and their community partners to initiate or expand school-based health centers.

While most children in the United States are in excellent health and receive good care, too many children neither see a physician at recommended intervals nor receive treatment for episodic or chronic problems. The difficulties confronting these mostly low-income children are made worse by the higher rates of health problems associated with poverty and the greater barriers poor children experience in securing care. In 1993, 15.7 million children (22.7 percent) lived in poverty.

The primary barrier to health care is financial and universal health insurance is an essential step towards universal access for children. However, insurance alone is not enough. Unequal distribution of physicians and other health professionals across the US, inadequate transportation services, cultural barriers and institutional practices all impede access to care. In Chicago, for example, the children-to-pediatrician ratio in poor neighborhoods is 5,887:1, in contrast to a national average of about 1,000:1. Even when physicians are present in a community they may refuse to see Medicaid-enrolled children or Medicaid rules and reimbursement rates may deter providers from giving care. For example, nearly half the state Medicaid programs do not pay for care by psychologists or clinical social workers, even when they are supervised by psychiatrists.

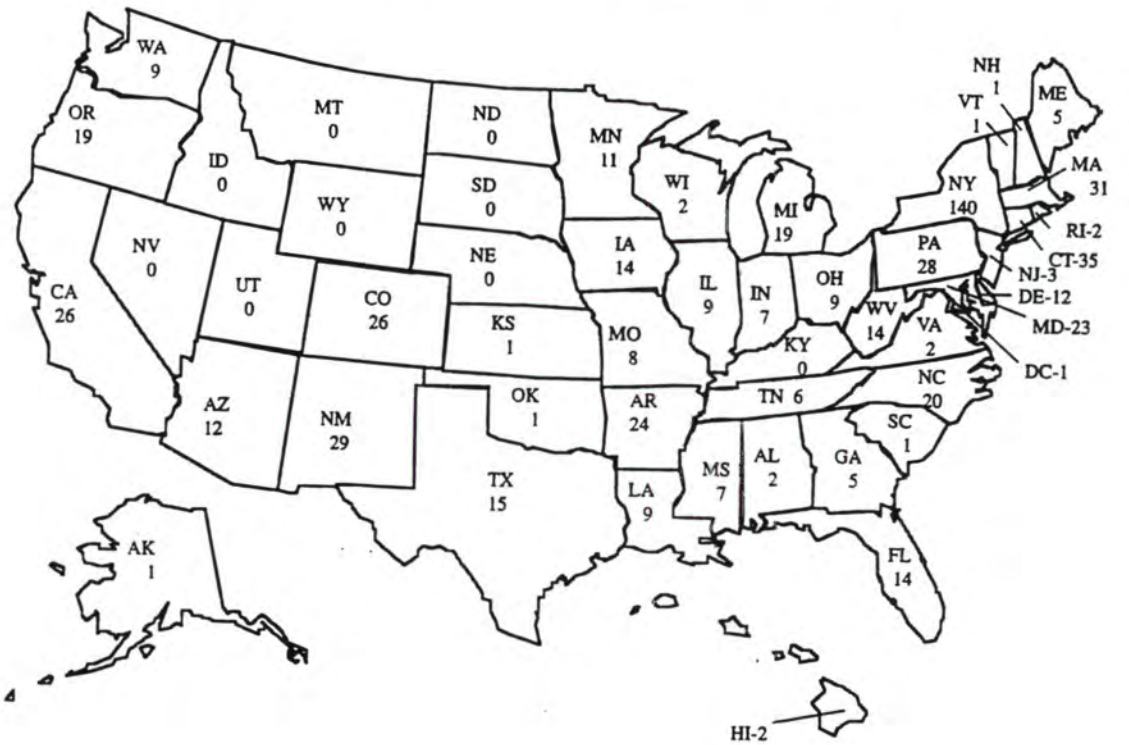
Adolescents face additional barriers to care. Adolescents are more likely than any age group to be uninsured. About 15 percent have no health insurance. Many, despite legal protections, are also unable to secure confidential services related to substance abuse, sexuality, or emotional problems. All adolescents confront a shortage of physicians or other health professionals trained in adolescent health care.

During the past 25 years, parents, school officials, health providers and public agencies have tested the effectiveness of school-based health centers in providing care to school-age children. The centers' recent expansion reflects the enthusiasm schools and communities have for this approach. The centers blend medical care with preventive and psycho-social services as well as organize broader school-based and community-based health promotion efforts. Data from a variety of these school-based health centers confirm that

- the centers are popular with parents -- more than 70 percent of parents consent for their children to use the centers,
- the centers are popular with students -- on average, about half the enrolled students use the centers and the average visit rate is 4 visits per year per student,
- the centers have increased access to care for young people who do not have access to regular providers, who have not see a physician lately and who do not have health insurance,
- the centers provide a range of physical and mental health services, with care for psycho-social problems an increasingly important service component, and
- the centers are beginning to participate in managed care networks as the managed care plans see the centers as opportunities to expand capacity to provide primary care to their enrolled school-age children.

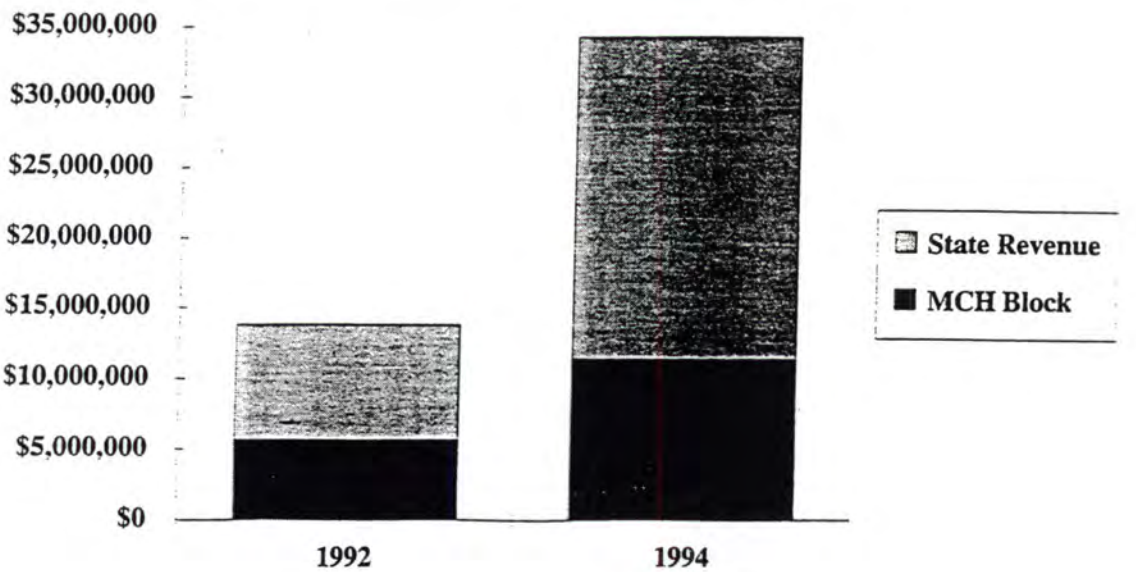
The centers began in just two cities -- St. Paul, Minnesota and Dallas, Texas -- in the early 1970s, grew to 50 health centers in the 12 years that followed and have grown to more than 650 in the past 10 years. The recent expansion has been fueled largely by state support. Well over half the states promote the concept, either as a distinct initiative or as a service delivery option among a broader school-related health services program. In 1994, states allocated $12 million of their Title V (Maternal and Child Health) block grant funds and $22.5 million in general funds to support the centers.

School-Based Health Centers, 1994

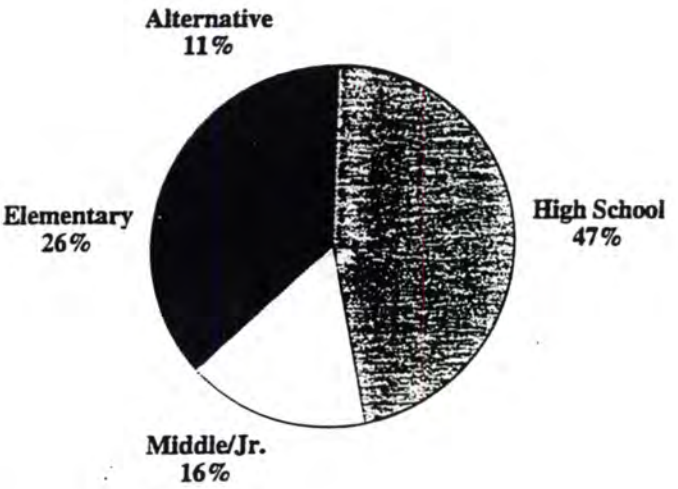


Source: Making the Grade National Program Office, 1994; based on national survey of state agency representatives.

State Financing for SBHCs, 1992, 1994



School-Based Health Centers, 1993-94



FREQUENCY OF DIAGNOSTIC CATEGORIES SEEN IN SELECTED SCHOOL-BASED HEALTH CENTERS WITH COMPREHENSIVE CAPACITY

	CT Elem.	NY M.S.	NY H.S.	CO H.S. (2)	OR H.S. (7)
Grade Level:	**K–8**	**6–8**	**9–12**	**9–12**	**9–12**
# Students in School:	1,200	1,700	1,700	3,926	8,858
# Enrollees in SBHC:	968	668	1,000	2,595	4,336
# SBHC Visits/year:	1,927	2,942	5,214	7,590	18,600
# Diagnoses/year:	2,253	2,942	5,942	7,590	23,343
Diagnostic Categories	**Total %**	**Total %**	**Total %**	**Total %**	**Total %**
Well Child/Adolescent	8%	15%	19%	14%	12%
Gynecology/Sexuality related	4%	4%	24%	9%	42%
Mental health/Social work	33%	26%	16%	42%	16%
Injury/Orthopedic	5%	6%	6%	6%	5%
Neuro/Ophthamology	10%	8%	3%	2%	<1%
Cardio/Respiratory	8%	4%	4%	2%	3%
Dermatology	6%	3%	3%	3%	4%
Hematology	<1%	2%	3%	<1%	1%
Gastroenterology	3%	4%	5%	1%	1%
Dental	9%	15%	8%	<1%	<1%
Ear/nose/throat	9%	3%	3%	2%	5%
Infections	3%	6%	6%	6%	4%
Drug and alcohol services	–	–	–	14%	1%
Other*	<1%	<6%	<3%	<3%	<5%

*Includes endocrine/obesity, urologic, allergic, and unspecified services

Source: The School Health Policy Initiative, Columbia University School of Public Health, 1994

Statement Of

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The National Children's Health Project Network (NCHPN) Model

The NCHPN is comprised of nine independent projects in seven states and the District of Columbia providing comprehensive primary pediatric care to some of the most medically undeserved and hard-to-reach children in the United States. These additional projects are nearing their launch phase. The projects serve special populations -- homeless, immigrant, low birth weight, and children with AIDS -- and work under harsh conditions including rural Mississippi and the South Bronx.

Projects utilize a variety of practical delivery strategies to bring high quality care into the community, including mobile medical units, fixed-site ambulatory clinics, school-based programs and outreach by community health workers. Unifying characteristics of our projects include: initial community health needs assessments; medical teams providing "medical homes" for children; project affiliation with a medical school Department of Pediatrics to ensure availability of sub-specialty pediatric referral service and to involve residents and medical students in the operation of the Project; a custom designed computerized medical record system and sharing of Project data; and working with community-based organizations.

Experience from these wide-ranging activities is used to inform the national policy advocacy work undertaken by The Children's Health Fund.

Statement Of

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Maybe we could all benefit from more time spent listening to America. Over the last few months, a group of children's health advocates have sat through nine focus groups, watching "ordinary Americans" grapple with our issue: children's lack of access to regular health care. It's not a problem they come to easily. In fact, to echo what political strategists told us earlier this year, when Americans think of who lacks access to health care, they rarely think of children. Our issue is virtually invisible, buried under millions of dollars of advertising that reframed the health care reform debate in other directions.

Nor is there a lot left of the old health care debate on which to build. As pollsters on both sides of the aisle have observed, children do not constitute unfinished business for health care reform. This may be a blessing in disguise, since most Americans these days appear more relieved than regretful that health care reform did not happen.

In short, we have entered a brave new era of child health advocacy, one in which the old conversation-- how to expand public coverage for children -- will need to be imbued with new realities, if it is to find favor with the American public.

The building blocks of this new conversation are to be found in the comments and silences of focus group panelists. Here we will find the clues to help us craft answers to the critical questions: Does the public know how many children lack coverage? Do they want to see the children of the working poor covered? How can we best position children's health needs to make sure children lose no ground in the current health care changes?

And finally, can children's advocates craft a proposal that engages bipartisan support and delivers expanded access for children? It depends. On how well we listen and how smart we are in rethinking our strategies. The two public opinion experts speaking at this forum can help us get from here to there, if we are willing to shred the old game plans and rewrite our tactics.

Children's advocates must be very careful not to fall into the trap of thinking that smart strategy is "pandering to public opinion." The unquestioned alternative is the old top-down dissemination of untested ideas and proposals created by policy elites without reference to public attitudes and values.

There is a middle road. It lies in democratic discourse -- understanding what people know and think about a particular problem, and creating strategies to engage them in reconsidering new evidence and approaches. But it means we must start where real people start -- with their concerns, discussed in their language, building bridges to our issues.

Expanding children's access to health care, then, may require something even more difficult than reinventing government. It may mean that we will have to reinvent ourselves -- messages, messengers, tactics, goals -- in order to win new ground for children in these hard times. But if we succeed only in naming the problem among ourselves and fail in our attempt to communicate to the public its urgency and a variety of appropriate solutions, children will hardly have reason to applaud our wisdom.

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THE CHILDREN'S HEALTH FUND

The Children's Health Fund, established by pediatrician Dr. Irwin Redlener and singer/composer Paul Simon, initiates and supports unique mobile pediatric programs designed to meet the complex health care needs of medically undeserved, homeless and indigent children. Since its inception in 1987, the project has gained national attention, receiving broad support from health care providers, policy makers and the public. The fund provides grants and technical assistance to establish Children's Health Projects in a variety of urban and rural communities. Its premier program, The New York Children's Health Project -- the largest provider of health care to homeless children in the country -- serves as a model for these national initiatives. In response to requests from more than 200 cities throughout the U.S., CHF has helped design and implement Children's Health Projects in Newark, NJ; Dallas, TX; Washington, DC; rural West Virginia; the Mississippi delta; South Florida; and Los Angeles, CA. Soon CHF will expand its national network to include sites in East Palo Alto, CA; Austin, TX; Little Rock, AR; and Eastern Long Island, NY.

THE COLUMBIA INSTITUTE

Founded in 1977, Columbia Institute is an independent public policy group specializing in conference management and research services. Combining policy expertise with organizational skills, Columbia Institute plans conferences and workshops, provides public policy research and consulting services and coordinates international business and political programs. Individually tailored projects advance the exchange of information and ideas and provide a basis for cooperation among leaders at all levels. When managing public policy initiatives, Columbia Institute maintains a non-partisan and independent position by ensuring balanced consideration of the issues at hand. Based in Washington, D.C., Columbia Institute coordinates projects in all fifty states and many foreign countries.

KIDS FIRST...KIDS NOW

Background & Summary

The Children's Health Fund **Kids First...Kids Now Campaign** is a public awareness initiative designed to build a national consensus of support for making appropriate health care available to every child in America. Potential reductions in support for public sector health programs may have significant impact on the health care status of many American children. **Kids First...Kids Now** will develop and disseminate innovative and pragmatic approaches to reaching the goal of making health care access a reality for all children. This builds on The Children's Health Fund's long-standing mission of public education and advocacy in addition to its role as one of the nation's foremost providers of health care to medically undeserved children.

Kids First was conceived and launched by CHF President, Irwin Redlener, M.D. and editorial cartoonist Garry Trudeau in the fall of 1994. In September of 1994, The Children's Health Fund convened a Capitol Hill meeting of nearly all major child health providers and policy and advocacy organizations to analyze and discuss the current status and future prospects for achieving access to comprehensive health care for all children. The clear consensus of national children's organizations indicated ongoing commitment to achieve this goal despite failure to pass health reform legislation in 1994.

The Children's Health Fund **Kids First...Kids Now Campaign** will consist of the following components:

PUBLIC AWARENESS INITIATIVE

The **Kids First...Kids Now Campaign** through the support of committed corporate partners, will mount a broad-based public education effort to raise public awareness about critical child health issues. As part of a national communications/media strategy to keep these issues at the forefront of the pubic agenda, **Kids First...Kids Now** will sponsor press conferences, disseminate reports and data analysis and participate in editorial board meetings.

CHILD HEALTH RESEARCH PROJECT

The Children's Health Fund has joined with the American Academy of Pediatrics, the National Association of Children's Hospitals and Related Institutions and the Benton Foundation in the development and implementation of the Child Health Research Project. This effort will conduct baseline qualitative and quantitative research to inform the development and positioning of **Kids First...Kids Now**.

CHILD HEALTH SUMMITS

The **Kids First...Kids Now Campaign** will sponsor a series of national and regional Child Health Summits that will be attended primarily by key child health providers and policy and advocacy organizations. The primary objectives of the summit are 1) to re-organize a critical mass of organizations whose influence can be brought to bear on child health reform issues and 2) to create a national, high-visibility vehicle for the development of bipartisan consensus around initiatives to improve the health status of children.

PHYSICIAN OUTREACH INITIATIVE

The **Kids First...Kids Now Campaign** will conduct a major outreach effort to prominent physicians/advocates and other health professionals. They will be asked to participate in fact-finding initiatives looking at access to care for children and develop recommendations for including the planned regional Child Health Summits.

POLICY FORUMS

Kids First...Kids Now will sponsor a series of Washington policy forums to engage the appropriate think tanks and policy organizations in the national discussion of child health issues. The primary target audiences for these events will be Congressional staff persons, child health policy and advocacy organizations and the national media.

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PARTICIPANTS

Divider Title:_____

HEALTH CARE ACCESS FOR CHILDREN: What's Possible in 1995
Kids First...Kids Now Summit

216 Hart Senate Office Building
Wednesday, May 17, 1995
8:30 a.m. - 12:15 p.m.

ATTENDANCE LIST

Almquist, Victoria
National Association of Childrens Hospitals

Armstrong-Dailey, Ann
Children's Hospice International

Arnett, Grace-Marie
Arnett & Co.

Avruch, Sheila
GAO

Bales, Susan Nall
Benton Foundation

Barkan, Scott
Center for Law & Social Policy

Barr, Ann
U.S. General Accounting Office

Batavia, Drew
Office of Sen. John McCain

Battistelli, Ellen
Child Welfare League

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Bleier, Terry
TX Office of State & Federal Relations

Bocchino, Camella
Nursing Economics

Bock, Sarah E.
The Children's Health Fund

Bolling, L. Robert
VA Dept. of Health, Office of Minority Health

Bouldin, Todd
Office of Rep. Bob Clement

Brown, Fish
AARP

Brown, Marcia
DC Dept. of Human Services

Buck, Jeffrey A.

Butler, MD, Robert N.
White House Conference on Aging

Byers, Terri
Office of Sen. Daniel Akaka

Chambers, Caroline
Office of Sen. Byron Dorgan

Clark, Deborah
Greer, Margolis, Mitchell, Burns & Associates

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Office of Population Affairs

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DOT/NHTSA/OEES

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Columbia Institute

Dolfini-Reed, Michelle
Center for Naval Analysis

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Doody, Kelly
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Hayes, Cheryl
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Healy, Joseph
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Mellman, Lazarus & Lake

Larson, Pam
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Young, Genevieve

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40 Pages
What's Possible?
Politics, Public Opinion, and
Children's Health Care in
1995, Symposium Summary

What's possible?

POLITICS, PUBLIC OPINION, AND CHILDREN'S HEALTH CARE IN 1995

Summary of a Symposium
Washington, DC
January 12, 1995

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