We are engaged with them and look forward to our continued work with them going forward. We're now moving into our tenth panel, and this panel addresses an issue and a theme that's come up along the way. Certainly, it emerged in the last panel as well, which is that many of our local public health agencies are struggling with how, in the context of the box of categorical funding can they effectively carry out their broad functions, and how, given the kinds of patterns of release of RFPs, the blizzard of RFPs that are coming out for a variety of very disease-specific or community-specific, content-specific elements; how do these pieces fit together?

How do we do this work in a more coherent coordinated and potentially far-reaching way in our communities?

What are the opportunities in collaborative policy development, policy advocacy?

So we have two terrific panelists that are going to begin to address those issues and look forward to our continued dialogue. First up and representing an organization that has come up throughout this meeting who is a key player in conducting community assessments and participating in broad-based community health improvement initiatives, we have Judy Darnell, who is the director of public policy for United Way of California, and she will both represent that perspective, as well as that of the National United Way. And she will be followed by Gary Nelson who is a long-time friend and colleague and also the President of the Healthcare Georgia Foundation. Judy, I have a clock up here to help track your time. Oh good. That's a lot of pressure, a lot of pressure. Okay.

So good morning, and I'm absolutely thrilled to be here. It's been really interesting the last two days. This is a different organization than I usually -- a different group of folks than I normally hang out with, and, usually I'm either with my United Way colleagues or with a lot of legislators and politicians.

So it's been incredibly informative and interesting to listen to everybody. I want to share some insights and some examples of taking assessments to action and also making sure that we integrate policy in that work. Actually, wait a minute, other way. There we go. Okay.

So just a little bit about me; I always have to talk about me. I've been heading community collaboratives for about 20 years, and I've been with the United Way for 12 years. Most of that has been with -- well about half of it was as director of community building at United Way of Santa Cruz County, a local United Way in California; and then the last seven years, I've been the director of public policy for our state association, working with all 36 United Ways throughout the state in collaborative, policy, and advocacy work. I also serve on the United Way worldwide health advisory council, and I think that's why I was tapped to be here today. And I would just like to quickly ask because I am appreciative that so many people have mentioned United Way. How many of you have actually worked with a local United Way?

Okay. I'll really race through the United Way overview slides.

So our mission has changed. United Way has changed a lot in the last 15 years, and most of you are probably aware of that. Our mission is to improve the lives by mobilizing the caring power of communities around the world to advance the common good, and we galvanize and connect a diverse set of individuals and institutions and mobilize resources to create long-term change. It kind of sounds like what we've been talking about the last couple of days. We do this in three ways and we do it in three different areas; education, health, and income, and we don't look at them as silos anymore. We look at them as one system. And these are basically the things that we think that everyone needs to have to have a good life; a quality education that leads to a stable job, enough income to support ourselves and our families through retirement, and healthy communities and healthy people. We do have a business model, and we execute this business

model. I highlighted the two areas I felt were most relevant to this discussion, and we execute it by working on things that matter to people, by getting agreement on strategies, giving everyone in our community the chance to support the plan and telling people about the results. We do cover 92% of the United States. We are in every county in every state, and we have 1,200 United Ways across the country. This is just -- how does that look. These are just a few of the community assessment examples that I have been either personally involved with or know of the work. Most of them are in California, a couple in other states. And in Santa Cruz County the one I am most familiar with, it is a comprehensive community assessment project, not a community health needs assessment. There are examples. There's one comprehensive book out on the table, and there's some summaries. But we do have gotten together with all the partners to come up with a book that they don't have to duplicate the work and the involvement of the community.

But we know that the community health needs assessment, community assessment project, whatever you want to call it, is not the end, it's only the beginning. And this, we have a cycle for our needs assessments. This is the one that was used in Santa Cruz County. And number seven is when you actually publish your report, your community needs assessment, and we know that's where we begin. What we really see in the work that we have done over the past 16 years -- Santa Cruz County is now in its 16th year of annual community assessment -- is to know that it's all about collaboration and the diverse partners that we bring to the table and get agreement and share ownership with. And we have mentioned a lot of different partners over the last two days. I just want to review a few of them. Obviously the hospitals are at every one of our initiatives. It's their initiative. It's their community benefit project as well. Public health departments are there, public health nurses, the United Way, obviously, governmental bodies, we always invite our board or supervisors. We always invite our staff of our state legislators and our congressional members, schools, nonprofits, police departments. Somebody mentioned yesterday what about public safety. Public safety is key. Churches, University, especially if you're dealing with something like Together for Youth, which is an alcohol and drug prevention initiative; and neighborhood groups, really the community grassroots folks, and the Parks Departments, and others.

We have some collaboratives that have as many as 90 organizations that come together, and we have meetings that are usually very often the size of the group in this room. Here I'd just like to really skip to the fourth bullet and focus on the fact that as we engage the community for results and we do this work, we really want to have the resulting alignment and realignment of human, financial, and organizational resources that can lead to larger policies, systems, and environmental change. United Way, as some of you may know, has gone through a very painful process over the last 10, 15 years, realigning its funding strategies and looking at how to align our funding and our donor support with the issues that we care about in health, education, income areas, and also to align it with community goals. It is uncomfortable work to do at some point. If a community is used to you doing one thing for a hundred years and all of a sudden you change to realign your staffing and your financial resources, it can take a while. And we also look to foundations.

We have some very, very supportive health foundations in California and hospital systems that support this change and work with several communities to create this change. Real quickly, this is just an example of four community initiatives that came of the community assessment project in Santa Cruz County. You can kind of read it. I'm not going to go through all this, but there's the Healthy Kids, which provides universal health care for children; Together for Youth was the very first one that I was involved with back in the '90s to decrease drug and alcohol use because our community assessment, both secondary and primary data, showed that we were, you know, right up there. We figured out it would be easier to go out and get the rest of the country to drink more than it was to decrease the drinking in our community. But we have made huge increases or progress on turning the curve on that one. One interesting result for the public health folks, we found that as we lowered the rate of alcohol and drug use among teens in the county, that the rate of binge drinking actually went up, so the initiative has changed its focus over the years. Go for Health is our

childhood obesity initiative; and then the Safe School and Healthy students, I'm going to skip that. That just kind of goes into the more coordinated action around the one Healthy Children focus area, what the community goals were that were set as a result of the community assessment project and how we went to getting the results. I didn't really skip it, did it?

So the -- taking the CHNAs to change initiatives, these three examples I'm going to talk about are ones that I was a little bit more involved with, and they were ones that the hospitals were either major leaders. They all came out of the community assessment project, again, and they were -- the community was actively involved in the hospitals, and public health were actively involved in the action plans. The health foundations have invested in various components of the plan that the community developed, including the advocacy and public policy change areas. All three of them have active -- address policy change as it relates to the goals and every one of the planning collaboratives has a policy committee. The way that we take the assessment to action is to form the collaborative, break into issue areas based on the various goals. We look at a very environmental social determinant, very comprehensive goals to solve the problem and turn the curve, and we always have policy as one of the main focus areas that leads to the advocacy for change. Kevin asked us to address a few of the challenges in creating and maintaining. Okay. Challenges would be ownership, obviously. Organizations are used to doing things themselves. Lack of knowledge about collaboration, we've done a lot of training over the years around collaboration with all of our partners. The time it takes, it takes a lot of time but it's worth it; and policy, policy is really scary for some people, but policy is a part of the work. And this is why United Way went into the policy and advocacy area because we realize that some of the change we wanted can't be addressed by programmatic funding and we've got to address it at a systemic level.

So we study the best policy alternatives using all the science, best practices, what other communities do, we build that community involvement by providing leadership training, advocacy training, how to tell their stories, and then we go out and educate and advocate with policymakers. Some of the policy change as a result of those, we've done school wellness policies, we've worked with city councils and board of supervisors on walkable communities and how to build parks. In the Together for Youth, we've done shoulder-tap ordinances, we've done alcohol licensing, we've done party ordinances; and then, of course, in Healthy Kids we've worked on the health cover access, both at the state level and the local level.

So when you're rethinking investments, I think that the needs assessment is obviously only the first step. Hospitals, foundations, United Ways, and others are investigating have to invest in the policy change because to make all of the change we need, we need those systemic changes. It's crucial to have that outcome data and to show trends, but also to be patient because public policy sometimes we have to wait for that window of opportunity, which can be a long time, and you need to build the capacity but you need to inform your community and your funders and all of your partners that it does take time, and it can be pretty uncomfortable refocusing at first on those areas.

So in summary, you want to consider how to invest in the communities to support the goals derived from the needs assessments, including the needed policy changes. You want to have the community collaborations that can unite the nonprofit hospitals with the diverse community partners to build long-lasting change and maintain it. You want to be able to share that ownership of goals, action plans, policy development. It's really important to keep people at the table. One thing I didn't mention was in the planning process, you can't take too long to plan. You've got to start bringing in some resources and get to action in some area or your community might lose interest. And we've had that problem and we figured out, we think, how to solve that. Advocacy for policy change needs to take place at the local, state, and federal level. A lot of times we spend determining and educating our own partners and community members about what level is appropriate. You don't want to go advocate at the Board of Supervisors if it's a -- I had one United Way that wanted to talk about immigration with her Board of Supervisors, and we had to talk about where immigration policy comes

from. And as you do all this work, and it sounds like a lot of you do, is to remember that United Way can be a strong partner. We have that strong brand.

We can span the country. We do have millions of supporters and volunteers who are our communities. Health is a major impact area of ours. We know how to convene and engage communities. We do it all the time, and that's what we pride ourselves on and we love to do it. We build coalitions of multi-sector diverse partnerships. We are very strongly nonpartisan. We can talk to both sides. We look at our advocacy as a major education initiative where we need to give them information on how policies affect their communities and how it's affecting the lives in it. And the other thing we can do, brought up today, is we can ask to act as a fiscal agents for some of these community initiatives. We do that a lot in Santa Cruz County. Sometimes that make it just easier for a non-profit local United Way to act as the fiscal agent for part of your plan, take the money in, and then with a steering committee, with a collaborative decide who's -- put the money out into the community to work on various parts of the issue. That's it. Well, good morning. I, too, wonder why I'm here. Based upon the conversation and the excellent panels yesterday, the fact that I'm not from California, North Carolina, or Massachusetts, although I did live in California. I do want to thank Kevin and the public Health Institute and CDC for the opportunity to come together. I'm here to represent, I hope, a funder's perspective on this issue. How a funder thinks about -- a philanthropist, how they think about community needs assessment, community benefits assessment, the planning, the implementation, and evaluation of that. It's interesting; I had to leave yesterday afternoon for this very reason. I attended a meeting in a local health department about 10 miles away from here, engaged in the MAPP process, mobilizing through community partnerships and planning effort. And it's interesting, we were talking about community needs assessments, and there were three hospitals and the key leadership in those hospitals were at the table discussing how this local Health Department was about to pursue its local accreditation process.

So it's alive and well in Georgia, believe it or not. Our work at the foundation came to my attention because my board wanted to know the extent to which uncompensated care is a part of the community benefit effort. And because of that question, I brought Kevin in and put him in front of the board, and we had a little board education and board development. But I have to say that most of our direct work in this area is through an organization, and Holly is here in the audience, but represents Georgia Watch and the Hospital Accountability Project. But in addition to that, a lot of our investments, I would argue, in communities are about creating the conditions to make -- for the community benefit assessment process to come alive. I represent the Healthcare Georgia Foundation. It's a Blue Cross/Blue Shield Conversion Foundation formed in the '90s, and we've been in operation for about 10 years. By most state standards, we're a relatively small foundation, doing about $5 million a year.
And I would argue that because of that, and because of the limited number of health foundations, we find ourselves focusing exactly on what Judy mentioned, and that's on policy and advocacy. I'm hoping to conclude my comments, as brief as I will be here today, with an example, a local example with Grady Hospital and how we see the opportunity for foundations, public health, community-based organizations, and hospitals coming together for the benefit of the community. I would argue that most foundations -- and just a reminder, that a lot of health foundations have some common interest, whether it be population health, underserved populations, systems change -- excuse me -- moving the needle, or social justice. And I would, as I reflect upon our work in the last year and the emergence of this new IRS requirement, I see a lot of challenges going on in community health improvement. The current environment in any community is dealing with health reform, a struggling nonprofit sector, a changing demographics of those who don't have access. Mergers and acquisitions are going on in many of our communities, and there's a history of program tombstones and demonstration boutiques.

So there's a lot of skepticism and a lot of caution, and I should say in this state particularly, you may find a politically contentious environment for doing some of the work that I think we would want to do together.

So with that -- like most organizations, our foundation begins with the question of who's got the problem, why do they have it, to what extent do they the problem, what are we doing about it, what should we be doing about it?

And I think the role of a foundation in this case in the community benefits assessment process is to make sure that there are voices that typically aren't heard, are heard. That we are seeing faces typically not at the table, and I can think of a couple of examples in this case. Children, migrant workers, those with mental illness, and persons with disabilities have not been at the table with respect to community benefit planning and assessment in our experience. In addition to that, we think that there are some very unique opportunities and unique methods of community assessment that are taking place, and one that I will share on the back end is the use of Photo Voice and response analyzers, and I think part of the foundation's role is to publish that kind of work when it's working well. The second question is why are they falling in?

And like most foundations, I think we have moved beyond an understanding that it's all about behavior, and I think we're pushing community-based organizations and others to think about the broad social and economic determinants of health. I'm willing to put everything on the individual patient client or consumer. With that in mind, I think it's also important for us as we fund community-based organizations -- and that's why we fund community-based organizations, because they represent that perspective and can reflect on that population. We found a lot of the non-profit organizations that we fund fascinated with health impact assessment and pursuing health in all policies, I think, two ways in which the community-based organizations, the nonprofit sector can add value to the community benefit planning process. Who typically gets rescued?

From a foundation perspective what I want to share here is we think it's important to understand the institutional culture and systems issues that drive unequal access, unequal treatment, and unequal outcomes; and we think that's particularly important to understand that perception from the perspective of clients, patients, and consumers, which explains why we work so carefully with community-based organizations and the safety net. And I might add that I didn't think the community-based organizations were really spoke to or addressed that much yesterday, and I would advocate that they be a part of that process and that partnership. And so where do we go from here?

In terms of understanding the evidence of need, the evidence of demand, the evidence of effectiveness, I would suggest to you that, much like the communities that we fund and the issues that we try to support, this process is about some choice points, some choice points that community-based organizations, public health, and others need to be at the table and need to be involved in making those decisions. I'm trying to speed up here and make sure I'm in time. Some of those choice points, individual versus population health, we see that constantly as an issue and a choice point for a lot of new organizations working upstream and downstream; addressing need versus what works and where those investments are directed; addressing the immediate versus delayed. I think Steve would argue, Steve Fawcett would argue yesterday that a lot of time is spent focusing on delayed outcomes that community-based organizations, the community benefit process deserves and needs so desperately and that is evidence of early wins; immediate versus delayed; important versus changeable. A choice point, I think, in community benefit planning. The issue -- and I note somebody in the last panel mentioned this, at least from the audience, about the issue of evaluation; and I do think, from a foundation perspective, there's a need for two kinds of evaluation, evaluation focused on continuous improvement and documenting progress and demonstrating accountability. But I also think that, as the person from the audience mentioned, there is a need for a different level of evaluation and rigor where we want to contribute to evidence-based practice. The issues of contribution and attribution has come up in our discussions around community benefit planning. Who gets the credit and who is responsible for the results achieved?

And then finally, I think there's an issue around the distribution of resources, whether it's done equitably or disproportionately, based upon need or inequalities.

So what changes in policy are needed?

That was the question that Kevin posed to us, and I do think, from the standpoint of community benefits assessment, we'd like to see performance metrics, incentives, or even mandates around these kinds of issues. Oh, you don't see the issues. There we go. Community engagement, the diversity of those responsible for community benefit planning, the need to push beyond silos, accountability, and transparency. Nothing has been more of an obstacle here in Georgia in terms of community benefit planning in our experience than access to availability of data, timely and complete access to data, collaboration and partnership and the uneven participation in the collaboration. And I would echo those comments earlier about the need for a lot of training for all members participating in a collaborative. I think we are looking, and I think it makes sense to any community involved in this process to know that the results will matter. It will lead to something. It will change something. It will result in a different way of doing work. It will drive resource allocations if nothing else. We think changes are needed in terms of governance. I note the last panel talked about criteria for governance. There are three duties of nonprofits that I would point out to you, the duty of loyalty, the duty of obedience, and the duty of care that I would suggest to you also be applied to the structure and governance of any community benefit activity; in addition to that, upstream investments in term of policy changes that are needed. Moving on. I'm skipping a slide here somewhere. Very quickly, historically philanthropy and charitable organizations were formed some 300, 400 years ago to address and to allocate resources towards relief, reform, and innovation; and I would suggest to you that foundations can bring resources for each of those three purposes. As Judy mentioned, I think we have an important role in advocacy and serve as a change agent, both with our resources and through our direct charitable activities. We have an opportunity as a catalyst to promote programs that work, to serve as a nonpartisan analyst, to give voice to the underserved, to model effective giving, and to make sure the issues of social justice are addressed.

So I'm going to skip on for the purposes of time here. I want to close with one example. It began with a conversation with the Grady Foundation, and its community benefit committee and our foundation, and the need expressed was that of inappropriate emergency room utilization for individuals seeking primary care in the emergency room at the State's largest public hospital. And that resulted in a very small grant, which enabled Grady to place patient navigators in their hospital, helping individuals navigate to primary care. But the more important issue, an opportunity that came from this, which I think speaks to the benefits of community work in general, was that the data behind this led to small area analysis in neighborhoods surrounding Turner Field and the baseball stadium if you know the area, five different neighborhoods. And these hot spots were identified where a number of health issues. These frequent fliers were coming from these neighborhoods, but further analysis provided an opportunity to understand more broadly the health needs of this community or these neighborhoods. And what happened was really quite interesting in the sense that the data drove decision making and engagement in the community; and it drove community building to the extent that community-based organizations adopted new services; for example, a community health center, as a result of this hot-spot analysis; added mental health services to its scope of care for African American women in this neighborhood. The community residents adopted Photo Voice, if you're familiar with Photo Voice, and response analyzers and made some interesting decisions. Kevin mentioned yesterday the dilemma about communities think that speed bumps are more important than what stands out in terms of epidemiological data. Well in this case the community arrived at mental health but also blight, the physical blight of the community. And what happened in this case was the use of data to inform city and local government to rid the community of abandoned homes and to redirect those properties to more effective and functional use.

So I see that as an example of what could take place with regard to community benefit planning and the implementation and evaluation.

So I'll stop there and open it up for conversation.

Thank you.

Thanks to the panel. You have shifted us as we need to begin to shift now to how do we translate this work, how do we translate the implementation into implementation and how do we begin to move towards addressing some of the policy obstacles to these issues. In the interest of time, I've got some questions for you folks, but I want to go directly to the audience questions; and if we run out of questions in the audience we'll go to my questions, so please. I appreciated both of your comments and would appreciate your perspective on an issue. We talked yesterday about collective impact and some of the key learnings from education and other areas, and one of the lines in that article that has really struck me is that we need to get organizations and leaders that are ready to move beyond leadership of an organization to leadership on a mission or what I would call, leadership of a virtual system. My observation has been over the last couple of days, and I think United Way and Foundations are in that boat too, is, are we ready to move from being the leader of community benefit in a hospital or the leader in community health improvement in public health or the leader of United Way on a particular issue or foundation to that broader definition of leadership?

And I see us struggling with that because we all have our own organizations to protect. And I would appreciate your observations about your experience, and not a story of how it worked well but what are the critical things collectively we need to do to move to that definition of leadership?

Great. Next comment or question. I have two right here. For the past three days we've talked about the ideal, and occasionally, talked about the real. And, Dr. Nelson, you had raised some pretty lofty policy suggestions in terms of effective governance, accountability, community engagement, etc. And I'd like to suggest that in the current construct that we're not going to get there; that where there is the visionary leader and the strong leader in the health department, the hospital, we'll get there, and we've seen that demonstrated over the past couple of days. But in the majority of communities that really does not exist. And so I would like to suggest that if we truly are looking for the accountability, the governance, etc., that, a hospital, a community-based organization, etc., their CEO is accountable to their board of directors. Their board of directors has a prime responsibility for the fiduciary responsibility of the organization, and that's the bottom line, which is the bottom line. And so the Health Department, however, is accountable to the community and the health of the community. It is the only body within a community that's responsible for the entire community, which can serve as a neutral convener. And so I'd like to suggest that the IRS regulations actually require the Health Department, where feasible -- and it's not always feasible -- the Health Department serves as that neutral convener, where it can bring together multiple parties, multiple hospitals if needed. And how do you know feasibility?

Well, feasibility can be determined by national or state accreditation. It can be determined by a health department having gone through the National Public Health Performance Standards Program. It can be determined by health departments having gone through JCAHO or other accreditation or certification.

So I'd like to suggest that we really push the envelope here and not be blind to the reality that if we wish to achieve what you're talking about that we are going to need to push, and we are going to need to require a little bit more than we may be comfortable doing, and it's going to stretch us on both the governmental side, as well as the hospital side. Next. Hi. I'm Barbara Laymon with NACCHO. We're the nonprofit that represents local health departments. And I woke up this morning to the news on television about the debt ceiling, and I've been thinking all day about healthcare costs and our contribution to that whole problem.

And I heard the word incentives come up on this latest panel, and I appreciate that thought. And I wonder, public health has struggled with this for a long time, how do you incentivize prevention?

And maybe the IRS can figure this out for us, but what would we suggest for them?

Great.

So we have question about this notion of moving towards a more geographic model, a more institutional model, and a suggestion that perhaps the Public Health Board may play a more definitive role in helping to determine the role of the investments in communities; and this question about incentives and how do we -- what are ways in which we can pick up on that. I'll jump in in response to the first two comments around leadership. I would agree that efforts in community health improvement demand a new type of leader, and I think we've seen evidence of what it takes. We invest in -- Leadership Atlanta, we invest in training of local boards of health, and I think part of the solution is in addressing board development and board education as well to stretch. Just like an organization needs permission to go beyond its boundaries, I think CEOs and executive directors do as well.

So I would argue that part of that conversation is about educating and informing a board about the kind of new leadership that's demanded, required to achieve this. Public health boards in our state are very diverse and are mandated in terms of the composition of those boards; but they, too, will require -- and hospitals must be at the table. But I think they, too, are a prime target for board development and board education.

So a quick comment about board development and its role in leadership. I couldn't agree more. I think that your comments really resonated with me because I've seen that change and I've seen the conflict and the struggle. There is, in many areas, a new leader emerging. I thing it's a generational thing. Leaders that do see the mission, they're leading a mission; they're not leading an organization. The conflict, at least within United Way, is always we have donors and we have boards, and I think the board development issue is huge. As we went into public policy and advocacy, there was some major, major pushback. That's not our mission. We raise money. We give money. That's what we do. And it has taken 10 to 15 years to get some change in leadership, in CEOs. But the boards hire the CEOs, so it's got to be that change in boards, and a lot of times it's a matter of change, but hopefully it can be some education as well.

So I think that it's absolutely a perfect point, and I think that it is generational, it is evolutional, but it is starting to change. Judy, I would like to follow up with you on that a little bit. You mentioned a couple -- a number of specific policy advocacy efforts that were successes. Could you share with us any emerging lessons from those experiences?

What were some of the difficulties you confronted along the way and what are ways you overcame those difficulties?

Well, I can talk to the specific ones from Santa Cruz County and some of the changes that have been successful. I think that initially the community -- I'm thinking of the -- we actually formed some youth groups that had to do with our Go For Health, the childhood obesity collaborative, and turned leadership over to some teens that were made responsible for going in and speaking with school boards and speaking with city councils. One was about school health and nutrition policies, and the other one was about the walkable communities, and just parks and space, the public space. And there was some immediate resistance from, well, who are these teens coming in?

Who are these young people?

So we were trying to do some in a very different way. It was something they weren't used to. We had to do a lot of training with the teens, as well as we have done with other community members, about how does the public policy system work when you start in advocacy and you're involving your community, and I find this as well with our United Way boards and our United Way system. If you haven't been -- if you aren't familiar with it and haven't been working in it, it is really scary. It's very intimidating. It's like, Oh, I don't want to go talk to a legislator. I don't want to go talk before a board. Once they do it, once they know how it works, once they know that they actually hold the power because they are the ones with the community knowledge, they're the ones who are being affected by policies, and they're the ones that know how the policies are affecting their families, their communities; and that they actually probably know about this issue, about how do I get to school safely or how does my child get health care, whatever the issue is. One of the big messages we always give is, you are going to know a whole lot more than 99.9% of the policy makes you're talking too, maybe not as some of their staff, but of the policymakers. They're regular people. They're elected. They work for you. They work for us, and it's okay and it's absolutely needed for you to go in there.

So I think that's been one of the biggest lessons learned and biggest successes in all of our policy areas is to be able to empower the people that are educating and advocating our policymakers and giving them the tools to go in there and talk to them. That's great. Gary I want to follow up directly with you on that. In our discussion, and you referenced in your presentation, the lack of data, lack of timely data, in fact, on the impact of current policies. It impedes our efforts to have the evidence-base to move forward. Certainly having compassionate people from the community is one way to begin to challenge existing policies. What would be your recommendation on ways in which we can demand the data that we need?

How do we move that part of the agenda and what kinds of data?

I struggle with, and it's an ongoing problem for me, and I think my colleagues here in Georgia might share the same experience or perception, and that is the timeliness, the equality, the availability, the completeness of data is struggling; and we actually need intermediaries to force the issue, to push the issue to make it. And so, it backs up -- for me it backs up to the social contract that organizations must have with the community to make that an upfront nonnegotiable deliverable for any effort -- planning effort or investment. But I don't know. I don't know the solution except for mandate it or to make sure that funding is aligned with the transparency and availability of that data. Can I follow up with that?

We have a case. Is there anybody here in the room from the California HHS?

Okay. Just checking. No, they're all good friends. We work with them very closely. Mark?

Oh, no, Mark knows about this one. In the current budget year, we had a situation where one the proposals was to move all of our CHIP kids into our Medicaid program. And our CHIP program, Healthy Families, is very transparent on data, posts it monthly, we know how many kids are in there, we know how many have disenrolled, we now how many what all the changes are, and it's really rich data. Not so much with our Medicaid office. It's really hard. It's usually only updated quarterly, and you can't really see.

So we, the advocacy community, have really been pushing back about that policy, and, one, we got it out of the budget process into a policy process and basically saying that, this cannot happen by saying promise -- Trust me, it's work. We need to have systems in place, and we need to have the data systems in place so we can see each and every month what children move from this program to that program, how many moved, did those people that actually got enrolled in Medicaid, are they now accessing a doctor?

Because access is the biggest issue we're worried about, and do we have data on what happened to the kids?

You move a thousand kids came out of Healthy Families and 500 ended up in Medicaid, where are those other 500?

And we're basically pushing back and saying until that data is available, this really can't happen. And there's a lot -- we've gotten the medical communities with us, and so I think there's just a lot; that collaborative advocacy because we work with a lot of different groups and go in and demand meetings. I mean they're friends, I mean so it's friendly, but we're also very firm in saying what's needed. That's good. I saw a lot of hands earlier when Judy asked who had partnered with United Way. Who among you have partnered with United Way directly on policy advocacy issues?

Much fewer number. There's a real at no time to build on those assessment partnerships. Anybody outside of California?

So let's get another round of questions and comments. Hi, Mary Pittman from the Polk Health Institute, and this question is for both of you, but primarily Gary. There large variations in how philanthropy engages in some of these community processes and sometimes can be doing harm by having their own priorities that may not be consistent with what's coming out of these very rich engaged processes with community-based priorities. Is there any conversation going on in the philanthropic spheres about how these community assessment and community priorities might be guiding some of the ways that philanthropy is supporting those community efforts and build that into perhaps a new way of engaging with philanthropy?

Great. Next. Well, I'm actually going to build on what Mary said because I think we're touching on something very, very important. Obviously, we want at the table a strong partnership with philanthropy. And in my experience in community coalitions and collaboratives, there's another choice point here, which is the idea that you can go on your own and get the results you want, the return on investment, and the recognition that seems to be very, very important and front and center over a board overseeing a philanthropy, versus sort of this distributed coalition recognition, reward, result sort of piece that we're talking about. I think there's a giving up, if you will, of not just ownership and governance, but this idea that it was ours, we had recognition, we saw our value clearly defined within something that really is a collaboration and everybody's at the table. And by the way, think that expands beyond just philanthropies. But those who bring resources to the table all have those objectives in mind. Mike's been passing me by late yesterday and today. He must know that I'm a consultant. But part of my comment may be self-serving. No, but I really are starting to see some things that I'd like to tie together in what Gary and Judy were saying, with what Elissa was saying with some the things I heard yesterday, one of which -- well the importance of policy and advocacy; and Elisa was mentioning, the 10 essential services, and as a public health assessment tool, policy is on there and advocacy for policy could be something you could be assessing on there.

So that's something that ties it together and brings in with Public Health, or liking that Gary had results that matter is something to measure because, of course, I'm the results that matter team. But another self-serving piece is when Elissa brought up Saint Claire County as, very quickly, a second example using Community Balance Scorecard. We were consultants to them in doing that; and interestingly enough, now bringing back to the 10 essential services, the 10 essential services we found can be what we call a top-level strategy map or a jumpstart framework to get local community health partnerships. Because in Saint Claire County it's not just the Health Department, it's a whole partnership of coalitions. As been done in other places, get a whole partnership or a health department or a hospital -- we've done with all three kind of formations -- to get to the complex idea of a balanced scorecard or to what we call a strategy map first step, very quickly, because the 10 essential services do cover such a broad systemic approach, that it gets them started and gets them to it very quickly. Interesting thing is when we first did it with a hospital taking the lead -- this is up in New Hampshire -- where this county has no local health department, it's the Cheshire Medical Center in southwestern New Hampshire, in Keene, I said, Do you think this will help you?

Because this is based on what health departments use. They looked at it and said, Take the numbers off because people won't reference the number of the essential services. Take the numbers off, but it works perfectly. Oh, change the words on one of them. But the wording on nine out of the ten worked perfectly, and they just had to change the words on another.

So it was the same framework that a health system or a medical center used as the community catalyst for community health partnership, developing strategy maps toward -- with the community-based groups on doing it. Same thing that health departments have done, state health departments have done, local health departments and local community partnerships, as in Saint Claire County.

So that's a little bit self-serving, but I think it's worth bringing out, as it is something that's tying a lot of these together. One more point in tying together the evaluation and monitoring and the priority setting, it's also a nice tool for priority setting, but the questions raised in evaluation and priority setting about lack of evidence. These tools -- and not just these tools but with others -- you make your own evidence, and I think that's an important point in pulling these plans together and implementing these plans. Make your own evidence. If you build in, whether it's through a balanced scorecard or other means, build in the measurement, build in some of the rigor and the evaluation from the beginning and then make your own evidence as you implement it, and don't wait for the five year study. Every month, every quarter, every time you're getting information back, make your changes in your strategy, sharpen that strategy. That's what these kinds of tools will do.

Thanks. Great.

So the first question about how priorities in communities it and priorities among foundations can be more aligned and to what degree are we beginning to look at ways in which, in fact, not only individual funders but groups of funders can come together, if, in fact, we want to achieve that greater purpose. Gary, you mentioned it, this issue of attribution and credit is something else that is desired; and obviously, it is certainly one of the things that I hear as it relates to the amplification of reporting requirements for hospitals. Some, in fact, are beginning to be concerned about the degree to which they collaborate, if, in fact, they're being held accountable specifically. We're talking about moving to an environment of shared accountability. How do we and how can we reinforce that notion?

To what degree does one organization have to take credit in order for something to be legitimate, and how do we share that?

And those last points around the degree to which, in fact, there is a shared essence, if not language, between the kinds of things we're talking about and the 10 essential services in public health?

Is that all?

That's just it. Pick and choose. Well, let me begin with just the comments about philanthropy. Like many other sectors, philanthropy, historically, has not been very good about playing with the same sandbox with others, and I do think that outside pressures and inside pressures have caused foundations to be more responsive, more strategic, more outcomes oriented, and more inclusive. I don't think it's -- I think there are dynamics in each state that drive how the foundation world plays out. It's certainly different here than my experience in California when I was there and how the different foundations align and focus on outcomes of interest. But I would agree with you. I share that. I think this is part of the transformation of philanthropy as well, and that is understanding its role in a community and being accountable and not leaving and making sure that there's something left and that the investment is real. I do think that foundations wrestle with, both

from internally, as well as the organizations that it funds, the issue of attribution versus contribution, and I think both need to be addressed, both need to be invested in, and both have methodologies and purposes that are separate and distinct from each other. They're not -- I think we have a role to support both, and I think both will be necessary in the community benefit process. But I understand the political dynamics of everyone wanting to make sure that they claim their share of the success, their share of the contribution made; and I can think of advocacy efforts that we've engaged in in this state, advancing a statewide trauma system, advancing public health. Whose responsibility was it?

Who can take credit for it?

In the end, it's really about creating the conditions for long-term partnerships and further work. But someone's got to say that this was a shared effort, shared success, and it's worthy of future investment. Judy?

Well, a lot of you may be aware of some the efforts in California, the equivalent to the Conversion Foundation that Gary's over is the California Endowment, and they have their place-based, 14 places strategy, where, and it's a long-term investment, and I think this is an effort to not dictate what health outcomes the communities work on but to let the community go through that assessment and organization and collaborative process to get to the issues that they're going to focus on and then see how that plays out or over five or ten years. They're at fairly close to the beginning of it, and United Ways are involved in several of the communities; and I think it has a good chance of success, and I certainly hope so. And I know the other effort that I'm spoken to the group of the grant makers and health, and the grant makers and foundations in California really do make an effort to get together the funders, and they include first five and others to see what areas of focus each one of them is funding, wants to fund, where are the gaps, who's going to cover that?

And there's also an awful lot of demand for collaborative grant making, we have two funders that we work with, the California Endowment and Packard Foundation. We both are -- in both of them, we are part of large health coalitions with diverse organizations where we take the credit together. We work together. We bring different skills and different abilities to the effort, and we do share the ownership and share the attribution and contribution both. Gary?

Totally different topic, so I don't want to -- In that case, let me just do a quick follow up on the endowment effort. While it's difficult to replicate the scale of that effort, given the size of the endowment, I think it's important to note, and just to reinforce what you're saying the 10 year focus is on very upstream set of outcomes. Yes. But one of the real positive attributes of it, consistent with what we're talking about, is the identification of a variety of other kinds of measures of progress along that path, so we're not waiting 10 ten years to find out if we are having an impact, and those include a variety of systems changes, in essence, the way that different organizations and stakeholders change the way they do business as a function of the kinds of partnerships that they're engaged in.

So it's a very ambitious and very potentially powerful model that's being tested there. I just wanted to raise one additional comment about advocacy out of control, particularly given that this is a conversation about IRS requirements; and that is to understand when advocacy goes too far in terms of lobbying and the lobbying restrictions and requirements. And I think it's terribly important that we understand how far we can go and the use of partners strategically who can or who cannot engage in lobbying. But there's a spectrum of advocacy activities that I think a lot of organizations can bring to this effort in advancing community health improvement. Great point. Time for a couple more quick questions, comments. We've got two, you'll be one of them. Go ahead first, yes. Oh, thank you. Just actually a quick comment. This is Chris Palmedo, Northwest Health Foundation, Portland, Oregon. I just can't let it go unsaid that we are very deliberate about involving communities. We have a project called Community Health Priorities. All we do is go into the

community and convene conversations around what the community wants, what the community needs. We're actually just simply doing that and creating that capacity, kind of like what someone said public health departments should do, and there's kind of a merger about what public health departments do and communities and foundations.

So we're at communityhealthpriorities.org. I've been tweeting throughout the conference, and I would encourage you to check out what we're doing. One of the things, just real quickly, is engaging youth involved. Judy mentioned that. I noticed we're about 90% over 40 here, 80% over 50 at this conference, so we're really making an effort to bring youth into these conversations as well, because the millennial generation is the future, and they define leadership a little differently than the way the Baby Boomers do.

Thank you. Yes, thanks. As a physician, one of the ways I've learned the most -- I wonder if this could be incorporated in some process -- is to give my name and phone number to homeless people, to poor people.

So when they have medical problems they can call me any time during the day, evening, and I can try to help them with that. And I've learned more from that process, and if that could then be fed back. Let me give you one example. A guy, 43 years old, severe levels of blood pressure, severe diabetes, had to be admitted to a hospital because it was an emergency. He had had a stroke. His blood pressure was so high. He's admitted to the closest hospital he could go. By law he had to be admitted. They treat him for two, three days, then they discharge him, but discharged with no medicines and no money to get that medicine except to say, Well, you can apply for one of these pharmaceutical programs and maybe in three or four weeks you get them.

So blood pressure goes right back up, he bleeds into his eyes, now he's blind. He goes to another hospital, and then he's discharged from there without medicines. It was three hospitals before he could get medicines, and it cost three hospital visits that weren't going to be compensated for. If they could just let people go home with essential medicines they needed.

So from personally getting involved with these cases I learned more than from any place else. And if there could be some system to feed back to philanthropy and various other public health organizations, that input from some doctors in the community who would be willing to do that for a period of time, you could have a rotating cell phone, I think it would give a lot of information that could be helpful; but it would also put a face on these issues that might also help.

Thank you for reminding us what's at the core of a lot of what we're dealing with. We have one more quick comment. Hello. Bill Barberg, president of Insightformation, and I think foundations are making a lot more effort to get connected with the community priorities; but we still see where if there is a grant for, say, $100,000 for a particular issue that's important to the community, there may be 20 organizations in the community that all put a lot of time and effort into getting that grant. One of them gets the grant, 19 are burned for a lot of time and effort, and they resent the one that got the grant.

So if you look at the total hours that we're benefiting the cause versus the hours that were spent chasing the money, that $100,000 grant may have caused a net step backwards in advancing the cause. And I thought if large corporations allocated their funds that way, they would go bankrupt so quickly. And a lot of what we do as a consulting firm is help, both businesses and organizations, fund strategy, and one of the biggest issues that large organizations face is how do they prioritize their resources. And those that do it based on strategy MAPPs and the strategy management process tend to go from worst in their industry to best in their industry pretty quickly.

So if you look at communities coming together and developing a strategy and then having the foundations be a part of that team so they're collaborating on the strategy and take a much more focused and intentional and different approach to funding, I think there is the opportunity to have a lot less of the time wasted chasing the dollars and a lot more of the focus on the dollars doing good.

So I think there's progress, but I think there's a lot of room for improvement in aligning funding around strategy. Excellent point. Last quick comments. Your point about story telling is really critical. I agree in the need for repositories. Your point about grant making and foundations, I would just offer one comment. One of the most noticeable gaps and needs that I've recognized over the last 10 years is the need for communities to have a central point -- a grant making procurement vehicle or capacity that coordinates, integrates funding opportunities across systems. And in Georgia we've missed so many opportunities. We've left so much money on the table because we've not had the capacity to mobilize and to coordinate our procurement activities. Great point. Judy?

I was just going to say I came out of the private sector years ago and had a hard time adjusting to the fact that you had to constantly go after grants and chase the money in the nonprofit sector and have joked that if we could somehow capture all that time and money that is spent writing grants and going after grants, we could fund the nonprofit and public sector, probably for the rest of our lives. We had an interesting process in California recently, where several of the organizations that we work with applied for the CHIPRA Outreach Enrollment grants, and that's $40 million nationwide. We felt we should get all of it. And $1 million cap, which isn't enough either to make much of a dent in California. And this is similar to what happens when there's a large RFP that goes out and you have lots of organizations going after the same pot of money. We said, we don't want -- technically we're competing, but we don't want to do that. There was no way we could do a collaborative grant. They weren't big enough.

So we -- there was three or four of us that made an effort to find everyone in the state or as many people in the state as possible that were thinking of applying and convening them. I don't know the absolute number, but we got about eight to 10 groups that came together and said, Yes, we're thinking about it, or, Yes, we want to. It came down to about five groups that said, Okay, we're all going to apply. Some of them decided not to. And we're going to be very supportive of each other's grants. That's unusual. But we all gave each other letters of support. We referred to each other within the grants and showing how we would leverage off of each other's scope of work to make it a more robust program. We got letters from joint funders. We had to get letters from the state. One of the funders was ready to convene everybody they thought might apply to try to make us -- force us into some collaborative grants. And we said, we're way ahead of you. We've already done it. We've already convened on our own, and this is our plan. We'll see if we were successful later this week or next week. But I think that we need to try to do more of that. And funders may say, Well, we don't want everybody getting together and strategizing over who might apply But why not?

It makes sense. It makes sense if we're going to address the issues that we want to address. Okay. Please join me in thanking our panel.