



The Origins of the Urban Health Initiative

What were the motivations of those who developed the UHI as a large-scale community change effort? When early decisions and choices were made, what factors were considered? How did the UHI represent a different approach to grantmaking within The Robert Wood Johnson Foundation?

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About the Urban Health Initiative

The Robert Wood Johnson Foundation (RWJF) established the Urban Health Initiative (UHI) in 1995 to determine whether a concerted, collaborative effort can bring about region-wide improvements in multiple measures of youth health and safety. Five campaigns comprise the UHI:

- Baltimore's Safe and Sound Campaign
- Mayor's Time (aka The Youth Connection of Greater Metropolitan Detroit)
- Safe Passages (Oakland)
- Philadelphia Safe and Sound
- Youth Matters (Richmond)

UHI campaigns work to implement proven strategies at such a large scale that citywide statistics will improve significantly. To do that, UHI campaigns must be change agents to secure systemic policy and fiscal changes necessary to get strategies to that scale. The UHI was designed to be non-prescriptive, allowing communities to craft implementation plans based on local conditions without assumptions, mandates or imperatives set forward by RWJF.

The National Program Office (NPO), based in Seattle, provides guidance, technical assistance and oversight to the local UHI campaigns in a number of areas, including research, management, systems change and communications. The NPO also helps campaigns attract and develop the local leaders essential to bring about and sustain change in their cities. Former Seattle Mayor Charles Royer is national program director.

About the UHI's Lessons Learned Project

The UHI campaigns and NPO have learned many lessons with regard to developing change agent organizations, and securing and sustaining change in large cities. The NPO is working to catalogue these lessons so they can be put to use by the campaigns in the final years of the UHI, and so they can benefit future change agent organizations and their funders. Several topics have been covered. All papers can be found on the UHI's website, www.urbanhealth.org. More topics will be covered in the coming months.

All papers should be considered works in progress. The UHI is not yet complete, and many individuals who have been heavily involved with the UHI have yet to be interviewed. As new or different insights are gathered on a topic, the papers will be redrafted and reprinted.

Anyone who has comments, suggestions or questions about the UHI Lessons Learned Project or individual topics can contact Jerry VanderWood, UHI Director of Communications, at 206-616-3692 or jerryvw@u.washington.edu.

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By Paul S. Jellinek¹

After Los Angeles

The origins of the Robert Wood Johnson Foundation's Urban Health Initiative can be traced back to the Los Angeles riots of late April 1992, following the Rodney King verdict. Fifty-four people died, the highest death toll in a civil disturbance in this country since the New York City draft riot of 1863.

Almost before the smoke had cleared, Congress held hearings to try to understand what was going on in urban America and to determine what, if anything, could be done to prevent similar outbreaks in the future. Among those called to testify were a number of foundation presidents, including Steve Schroeder, the president of the Robert Wood Johnson Foundation (the Foundation).

In preparing his testimony, Steve asked his staff to search the Foundation's extensive grants database to see what the Foundation had done in the past in the area of urban health. He had only been at the Foundation a little under two years at this point, and the data base went back to 1972, the year the Foundation had gone from being a small local philanthropy in New Brunswick, New Jersey, to one of the biggest private foundations in the country.

But what Steve had thought would be a routine request turned out to be a major headache for his staff. The problem was that the database wasn't organized to identify urban grants. The Foundation had made plenty of grants to institutions and organizations in the nation's cities, but they weren't coded as urban. And so instead of simply clicking on "urban" to get a printout of all the Foundation's previous urban grants, the search had to be done by hand—a process that took days instead of seconds.

The reason was simple enough. The Foundation's mission was to improve health and health care—not the well being of the nation's cities. But this glitch in the database flagged the issue in Steve's mind and prompted him to begin wondering aloud at some of our staff meetings whether the Foundation was in fact doing enough to help the nation's cities.

In particular, he wondered about the big cities. In reviewing the manually prepared list of the Foundation's past urban grants, he had noticed that the nation's biggest cities—including Los Angeles—seemed to be underrepresented. This troubled him. After all, it was the biggest cities that had the greatest health care needs and faced the toughest health challenges. Why weren't they getting their fair share of the Foundation's grants? What was going on?

As we discussed this at staff meetings, it quickly became clear that part of the problem lay with the Foundation's usual and customary approach to grantmaking. Most of the Foundation's grants were made through competitive national demonstration programs. Typically, the size of the grants awarded under these programs was the same—regardless of the size of the community to be served. This meant, for example, that a big city like Los Angeles or Chicago would have to show that it could mount an effective program to deal with the health care needs of its large homeless population with the same amount of money that a smaller city—a Little Rock or a Davenport—would receive to deal with its much smaller homeless population.

Added to that was the fact that in its recent programs—for the homeless, for people with AIDS, for drug and alcohol abuse—the Foundation had increasingly insisted on active collaboration among the organizations and institutions in the cities that it funded. And, again, this kind of collaboration was much more difficult to pull off in a big city than a smaller one. In the AIDS Health Services Program, New York City had to bring its 19 public hospitals to the table, while Dallas only had one public hospital in the entire city (although in that case, both cities were funded).

In the aftermath of the riots, the Foundation did make a grant to Los Angeles. Specifically, we funded a group chaired by a physician at the University of Southern California that was exploring ways to improve access to health care in the city's low-income neighborhoods. Also, one of the Foundation's trustees, Linda Griego, later headed up Rebuild LA (although not in her capacity as a trustee).

But, from the standpoint of the Foundation's future grantmaking, probably the most important upshot of the riots went beyond Los Angeles. Prompted by what he had now learned about the Foundation's track record in urban health, Steve Schroeder challenged us to come up with new ideas for how the Foundation might help the nation's biggest cities address the special health-related challenges that they faced.

View From the Trenches

As it turned out, some of the same concerns about the Foundation's past grantmaking had been raised in a report that had just been prepared for the Foundation by Charles Royer, the former mayor of Seattle who had chaired the National Advisory Committee for the Foundation's health care program for the homeless and who was now running the Institute of Politics at Harvard.

Entitled *A View from the Trenches*, the report was based on a series of interviews that Royer and a pair of consultants had conducted with past and present Foundation grantees in Boston, Miami, Minneapolis and Seattle.

Among its findings, Royer's report noted that the Foundation tended "to gravitate toward the same cities" in many of its national programs, and that "sometimes the cards are stacked against big cities because of the difficulty of making a difference with the amount of money available." In addition, the report encouraged the Foundation:

- to take a more systematic approach in its grantmaking "rather than demonstrating specific models of fragmented care;"
- "to recognize the increasing role of state and local governments and the importance of differences in local circumstances;"
- "to recognize the growing importance of racial-ethnic diversity in different regions of the country;"
- "to actively explore factors affecting health status other than health care... and to identify interventions likely to deal with root causes;"
- and, last but not least, to "invite communities to propose programs to achieve the objectives which recognize their distinctive needs and circumstances."

All of this added up to a distinct departure from what had been the Foundation's principal grantmaking strategy in the past: testing new models for the delivery of health care which, if successful, could easily be replicated on a nationwide scale by the Federal government.

The problem with that approach, Royer's report suggested, was that, with the advent of "new federalism" in the 1980's and the unprecedented Federal budget deficits of the early 1990's, the Federal government had become less of a player in addressing community needs, transferring much of that responsibility to state and local governments.

Moreover, prescriptive piecemeal approaches designed to improve one component of an otherwise dysfunctional system were no longer doing the trick. A more comprehensive approach—responsive to the particular needs and priorities of each community—was needed as the Foundation entered its third decade as a national philanthropy.

Fighting Back

In some of the Foundation's programs, we had already started down this road. The AIDS program, the program to provide health care for the homeless, the program for the chronically mentally ill—all of these had taken a big picture approach, calling for collaboration among multiple organizations and agencies, rather than expecting a single medical center or health department to solve the problem single-handedly.

But the program that had probably gone the farthest in this direction was Fighting Back, a major new initiative operating in 14 communities. Launched in 1989, the purpose of Fighting Back was to help communities mount a concerted effort to overcome their drug and alcohol problems. Our hope was that, if just a few of the funded communities were successful, the program could begin to restore people's sense of optimism that the seemingly intractable substance abuse crisis could be resolved without having to call in the National Guard or other draconian measures. In this sense, it was about trying to restore confidence in the system.

In designing Fighting Back, we had emphasized broad-based collaboration—including both those affected by the problem as well as those in a position to do something about it—and we had given the participating communities a great deal of latitude in setting their own priorities. But at the same time, we insisted that whatever they decided to do should be done on a scale sufficient to result in significant improvements in the targeted substance abuse statistics for the community *as a whole*.

In other words, it was no longer enough to provide services to a few hundred individuals if there were thousands—or tens of thousands—of people in the community who needed help. Whatever the interventions were, they would have to reach enough people "to move the needle". This explicit focus on population-level outcomes represented a marked departure from most of the Foundation's earlier service demonstration programs.

Realizing how tough this challenge would be, we did initially limit program eligibility to cities with populations of 100,000 to 250,000. But when it appeared that many of the nation's larger cities were also keenly interested in the program, we decided to amend the eligibility criteria to allow "communities" with populations of 100,000 to 250,000 that were *parts* of larger cities to apply as well. A number of larger cities were subsequently funded under Fighting Back, including Kansas City, Milwaukee, San Antonio and Washington, DC.

A Focus on Children

In June of 1992, soon after Steve Schroeder's challenge to us to think of new ways for the Foundation to engage the nation's big cities, I met with Dick Reynolds, the Foundation's executive vice president, to share some my thoughts about what we might do. I suggested that we focus on the health and safety of children. Given what had happened in Los Angeles, it seemed to me that a focus on children might give us a way in to the highly charged climate that now existed in some of our biggest cities.

Following our conversation, Dick asked me to summarize my thoughts in a memo, which I will quote in its entirety. Dated June 22, 1992, it was titled "Follow-up on our conversation about urban initiative":

As we discussed, I am increasingly convinced that we should begin to develop a major, long-term Foundation initiative to secure the health and safety of children and youth in some of our biggest cities. Why? Because it seems to me that a community that cannot assure the basic health and safety of its children is hardly a community at all. A community that cannot safeguard its children has in effect relinquished its future, and without hope for the future there can be no real sense of community. And of course until a sense of community is established, nothing else is likely to happen.

There is another reason why a focus on the health and safety of children makes sense to me as a point of entry on the urban problem: health is relatively non-controversial; there are some resources in the system; and it is sufficiently focused that communities can get their arms around it and make demonstrable progress. Also, as communities begin to develop their strategies in this area, they are going to come up against a lot of non-health problems, so there will be real opportunities for partnerships with government funders and other private foundations. But above all, this issue is fundamental to the very concept of a viable community.

So, how do we proceed? As I said in our conversation, I believe some of the principles underlying Fighting Back may be applicable here. We don't prescribe a model; instead, we support a process through which the community develops its own set of priorities, to be achieved through a detailed strategic plan that clearly spells out what role each of the participating entities will play in a collective long-term effort. One of the real advantages of this approach is that it changes the relationship between the funder and the grantee from a traditional top-down "contractor-contractee" model to more of a partnership model...

A second important element of the Fighting Back approach is that it calls for what we have called "community-wide involvement." Everyone that is affected by the problem and everyone that has a potential role to play in addressing it needs to be represented in the process. This is a departure from the end-run grassroots approach that got the OEO programs in trouble, as well as top-down approaches that have gotten others in trouble... It's not easy, and it very quickly forces people to reexamine the whole issue of race relations in their community, but the preliminary evidence from Fighting Back is that it can be done.

There are some things that I would do differently from Fighting Back. First, we would deliberately target our biggest cities, although we would probably want to focus on natural communities within those cities (maybe more than one per city) rather than taking on each city in its entirety. Second, the length of commitment might be extended from seven years to nine or ten years, although of course the further we extend the time horizon, the greater the risk of disruption to the program through changes in political and community leadership. Third, we may want to strengthen the policy loop up front; that is, as the communities encounter policy barriers to what they're trying to do, have a mechanism to feed that information directly to the appropriate policy makers so that they better understand the way their policies are playing out at the ground level. Fourth, we may want to pay even more attention to the role of the media... And finally, we may want to structure this more as a funding partnership with other foundations and government agencies...

Obviously, a lot of groundwork would be required to develop an initiative along these lines, including further staff discussion... In any case, I would appreciate your initial reactions and your suggestions for next steps, if you indeed believe we should move in this direction.

Dick liked the idea, agreed there was a lot of groundwork to be done, and encouraged me to get moving. He suggested that those of us who were interested in this should get together as an informal group and produce a paper that eventually could be shared with the full staff.

So we did that, but for the next six months nothing much happened. The problem was that most of us already had very full plates. For example, among other things, I was deeply involved with Fighting Back at that point and was in the middle of developing Faith in Action, a major new program to set up interfaith coalitions in hundreds of communities around the country to provide volunteer support to homebound elderly and disabled people. And the rest of us were equally over-committed.

Aware of the problem but eager for the Foundation to move ahead on this new urban initiative, Ruby Hearn—a program vice president who later became the Foundation's senior vice president and who played the leadership role in the development of the Urban Health Initiative—recruited Rush Russell as a senior program officer in her unit.

Rush, a savvy and energetic Texan who had until recently been on Senator Bill Bradley's staff in Washington, DC, joined the Foundation in December 1992. Billed as a guy who could hit the ground running, Ruby immediately assigned him to the urban initiative. He would chair the staff working group² and he would write the paper for presentation to the staff—and, if all went well, to the Foundation's Board of Trustees.

Learning from Others

The first order of business in developing the new initiative was to learn from what others had done. What had been tried? What had worked? What hadn't? Where were the land mines? And where was the cutting edge?

Rush and others in the urban health working group began by reading the existing literature—books, journals, evaluation reports, foundation papers, whatever they could get their

hands on. Some of it was quite useful. For example, the Casey Foundation had recently produced an unusually candid report reflecting on what it had learned from its recent New Futures initiative.

Rush also reviewed the evaluation reports of some of the Foundation's own past programs, and sat down and talked with those of us who had been involved in some of those earlier programs to get our perspectives on "lessons learned".

But to really understand the field, we knew we had to get out and talk to people face to face. And so Rush and Ruby—and occasionally others of us in the working group—began a series of meetings with experts around the country. Among those consulted were:

- John McKnight at Northwestern University, who emphasized the importance of taking an assets-based approach
- Robert Woodson at the National Center for Neighborhood Enterprise, who stressed the role of neighborhood organizations and expressed skepticism that big foundation programs did much good in addressing community needs
- Walt Rostow at the University of Texas (formerly LBJ's national security advisor), who maintained that the War on Poverty was perceived as a failure because its programs had never been implemented at an adequate scale and was trying to take Austin's anti-poverty programs to scale as a demonstration
- Martin Gerry at the University of Kansas, who had worked with Rostow in Austin and also provided a federal policy perspective from his experience in the first Bush administration
- Robert Ross, the health commissioner in San Diego and, before that, in Philadelphia
- Blair Sadler, the head of San Diego Children's Hospital

They also met with staff from other foundations that had sponsored urban initiatives in the past, including Casey, Ford, Rockefeller, Kellogg, Pew and Sierra.

It turned out to be a very useful process, not only because of the insights that people shared but also because it gave Ruby and Rush an opportunity to let the field know what we were thinking about doing. The following are some of the insights that emerged from these meetings:

1. ***Collaboration is often a necessary but not a sufficient condition for success.*** That is, while most of the initiatives that had made positive gains involved collaboration, not every collaborative effort was successful. In particular, collaboration could be overdone. If there were too many players at the table—each with their own agenda—the process could eventually grind to a halt. We later saw this happening ourselves in some of the Fighting Back sites.
2. ***Focus matters.*** Initiatives that had a clearly defined focus were less likely to bog down than those in which each community was trying to achieve a range of seemingly unrelated goals.
3. ***Local "ownership" of the initiative's priorities also matters.*** In those initiatives where the goals and strategies were expert-driven rather than having been defined by the community itself, local commitment soon waned and the initiatives eventually ran out of steam.

4. ***Governance should be balanced to include both grassroots and formal leadership.*** For example, when the Atlanta Project, spearheaded by former President Carter, left neighborhood representatives out of the decision-making process, their subsequent opposition paralyzed the project until they were brought into the loop. By the same token, grassroots groups acting alone rarely appeared to have had the leverage necessary to bring about change on a meaningful scale.
5. ***External linkages are vital to success.*** Because public policy and financing affecting the poor is largely in the hands of county, state and federal decision makers, you had to find ways to engage them. This might require alliances with suburban leaders, business leaders, other urban areas within your state, and advocacy groups.
6. ***Change takes time.*** Repeatedly, we were reminded that the problems facing urban America didn't materialize overnight and therefore we shouldn't expect any quick fixes. Recognizing this, the Kellogg Foundation, for example, was making an unprecedented twenty-year commitment to its youth initiative in Detroit.
7. ***The three most important determinants of success are leadership, leadership and leadership.*** But you had to be willing to pay for good leaders, and you had to support them along the way to keep them from burning out or being hired away.

Ruby and Rush's consultations with the experts and with our fellow foundations began in early 1993 and continued into 1994. During this same time period, Ruby and I were very much involved with the ongoing Fighting Back program, which had completed its two-year planning phase and was now in the early stages of implementation in most of the sites. And in the course of this work, we were discovering something else that turned out to be highly relevant to the emerging Urban Health Initiative: *most of the grantees did not understand what it meant—or what it took—to go to scale.*

Again, this was central to what we were trying to achieve with Fighting Back. We wanted each community to reach enough of the target population with effective interventions—whether those were services or prevention messages or price increases, or whatever—to change the population-level statistics for whatever substance abuse problem they had chosen to focus on. But with the exception of one site—Little Rock—our grantees didn't seem to understand what we were talking about.

They would proudly tell us, for instance, that they had doubled the number of adolescents in the community receiving substance abuse treatment from 50 to 100, but when we asked them what the denominator was—that is, how many adolescents in their community *needed* treatment—they had no idea. In fact, they didn't really understand why we were asking. So we would try to explain that if there were only two hundred kids in the community who had substance abuse problems and who were in need of treatment, then treating 100 of them should make a real dent in the community's adolescent substance abuse statistics (assuming, of course, that the treatment was reasonably effective); but if there were two *thousand* kids in the community with substance abuse problems, then doubling the number in treatment from 50 to 100 probably wouldn't have much—if any—impact on the community-wide statistics.

But while this issue of scale seemed clear enough to Ruby and me, we were having a very hard time getting the point across to the grantees. And so we realized that we would have to find ways to communicate it more effectively—and right up front—in the Urban Health Initiative. Getting past this conceptual hurdle would be a vital first step.

As it later turned out, despite our efforts to be explicit about scale from the outset, it proved to be almost as difficult for people to understand what we were talking about in the Urban Health Initiative as it had been in Fighting Back. It wasn't until several years into the program, when Cindy Curreri in the Urban Health Initiative's National Program Office developed the so-called "denominator exercise", that the grantees began to understand what we were talking about. And it was only then that some of the other elements of the program started to make sense to them.

A Fresh Approach

As the initiative began to take shape, Ruby repeatedly emphasized the need for a fresh approach. While we wanted to learn from the past, we knew that needed to go beyond the kinds of things that we and others had done before if we were going to achieve the kind of large-scale change we were after—especially given that our focus was on the biggest cities.

Some of the elements of the program that emerged, such as the need for a longer time frame, were things I had talked about in my June 1992 memo to Dick Reynolds. Others came out of our discussions with others and within the staff working group. In no particular order, they included:

1. A more rigorous and more intensive site selection process

Although occasionally the Foundation would handpick the grantees for one of its multi-site national programs without allowing applicants to compete, most of its national programs were relatively open-ended competitions. We would specify eligibility criteria at the outset, and all organizations or communities that met those criteria were welcome to send us a proposal. The proposals would be reviewed by a national advisory committee appointed by the Foundation, site visits would be made to those with the strongest proposals, and the strongest of *those* would be recommended to the Foundation for funding.

While this process had the advantage of casting a wide net and prompting large numbers of people to focus on our issue, it also wound up disappointing a lot of people—although some of them, once they'd gotten the ball rolling, would find other sources of funds to implement their ideas.³

But what really concerned us in the case of the Urban Health Initiative was the sense that this standard site selection approach wouldn't give us the kind of in-depth information about a city's track record, its capacity, and the seriousness of its commitment that we would want before placing our bets in such an ambitious and complex undertaking.

With that in mind, the selection process we came up with included:

- A detailed statistical profile of each eligible city, developed by John Billings at New York University, to give us an accurate picture of the scale and nature of the health problems that city's children, including recent trends;
- A review of recent press coverage in each city to get a sense of the major issues and priorities and the political climate;
- Advance telephone calls to knowledgeable local observers within each city who could give us an honest appraisal of local leadership capacity and the potential level of interest

in something like the Urban Health Initiative (and yes, in some cases we were in fact warned that while a particular city might make all the right noises to get a grant, they probably would not be seriously committed to it);

- On-site reconnaissance site visits in advance of any call for proposals, in which teams of consultants and Foundation staff would spend several days in a potentially eligible city meeting face-to-face, one on one, with a cross-section of local political, professional, civic and community leaders to sound them out personally on their potential interest in doing something substantial to improve the health and safety of the city's children.

We later convened a group of first-rate consultants with expertise in urban health and city politics to assist us in this fairly arduous process. Along with John Billings, the group included Thomas Chapman, the CEO of George Washington University Medical Center; Howard Fuller, the former superintendent of schools in Milwaukee; Margaret Hamburg, New York City's health commissioner; Arthur Kellerman, director of the Center for Injury Control at Emory University; Sally Kohn, deputy director of Opening Doors, a program funded by the Foundation to reduce sociocultural barriers to health care; Judith Palfrey, chief of pediatrics at Boston Children's Hospital; David Rosenbloom, head of Join Together, a national center on substance abuse; and Charles Royer, the former mayor of Seattle who had produced the View from the Trenches report for the Foundation.

2. A longer time frame.

Typically, the Foundation's previous national programs had run for four years and were non-renewable.⁴ Because most of these programs were designed to demonstrate a new model for the delivery of health services, that kind of time frame seemed adequate. The services could be implemented, debugged, and used by enough patients over a long enough period of time that the model could be evaluated. The hope was that, if the evaluation results were favorable, other funders—including the federal government—would step up to the plate to keep the program going and expand it to other sites around the country.

The Urban Health Initiative, on the other hand, was about social change. And social change, we knew, would take more than four years. We were trying to change outcomes for vast numbers of children, a process that would require changing public attitudes and priorities, as well as rewiring large public financing systems where the real money for children's services was to be found. And so we proposed that the initiative be funded for ten years. Even ten years seemed like a fairly tight time frame given the ambitious goals we had in mind, but at the same time, we realized that if the sites couldn't demonstrate fairly substantial progress over a ten-year period, the initiative wouldn't have much relevance to the real world.

We also understood that this ten-year time frame increased the risk of turn-over among key leaders—both within the program sites and within the Foundation itself. And indeed there has been extensive turnover on both ends.

3. A broader focus

In my memo to Dick Reynolds, I had suggested that in working with some of the nation's biggest cities, we might want to focus on "natural communities" within those cities rather than trying to tackle the city as a whole. This, in fact, was what we were already doing in some of the Fighting Back sites where we had allowed a *section* of the city with a population of 100,000-250,000 to apply.

But since I had written my memo, Ruby and I had become aware that some of these sites were experiencing real difficulties in getting the political support they needed within local government. In particular, they found themselves competing with other wards or districts within the city—districts that often contained more middle class voters, and consequently had more political clout. Even more disturbing, with only one seat at the table, they lacked the political muscle to bring about the kinds of system reforms that would ultimately become necessary in order to operate at scale.

And so we realized that our focus within the Urban Health Initiative really would need to be city-wide—and even region-wide, as discussed next—in order to get the political critical mass needed to achieve the goals of the initiative. At the same time, of course, while this city-wide focus may have made things easier for the grantees on the political front, it raised the bar dramatically in terms of the numbers of children to be reached, especially in the largest cities.

4. A regional strategy

Probably one of the most challenging—and, initially, bewildering—features that set the Urban Health Initiative apart from prior urban programs was our insistence on the need to form regional alliances, especially with suburban political and business leaders. Our reasoning was simple: you needed the support of those constituencies in order to change county, state and federal policy. And county, state and federal government controlled much of the public funding available for kids.

In addition, some of the most serious problems affecting urban children and youth were not confined to the cities. Drug abuse, for instance, clearly was a problem in the suburbs as well as the cities, with suburban demand fueling much of the urban drug trade. This meant that ultimately you would have to do something about the suburban buyers if you wanted to get the urban drug abuse and its consequences under control.

It was our hope, in fact, that this connection—the fact that many of the problems affecting the health and safety of children spilled across urban/suburban boundaries—might help to foster the kinds of regional alliances we were looking for. It would be in everybody's interest to work together. Moreover, we knew it could be done. It had happened, for instance, in Bridgeport, Connecticut, in the 1980's when data collected by the United Way showed that cocaine use was at least as high among suburban youth as it was among kids in the city.

But this whole issue of regionalism turned out to be a very hard sell. And even once the sites understood the logic, it proved to be an extraordinarily frustrating aspect of the initiative for them to implement. They found that fear and mistrust—on both sides of the city line—often ran very deep.

5. Self-determination

In talking with the experts and veterans of past urban initiatives, Rush and Ruby had encountered two general approaches that were commonly used to establish goals and priorities: a *prescriptive* approach in which the goals were set by the funders (or by outside experts working with the funders), or a *local decision-making* approach in which the goals were determined based on the expressed priorities of local residents.

In the past, our programs had been largely prescriptive in the sense that we were demonstrating a particular model of service delivery designed to address a particular health care need—for example, the St. Vincent’s Hospital model for providing health care to the homeless. While there was some flexibility to account for variation in local conditions, the basic model that the grantees were expected to implement was defined by the Foundation.

With Fighting Back, we had deviated from this approach. While the overall focus was on reducing drug and alcohol abuse, applicants to the program were given a great deal of latitude in deciding what aspect of their local substance abuse problem to pursue and how best to pursue it. We had done this for three reasons:

- There were extensive differences across communities, both in capacity and in the nature of the problem. Newark had a big heroin problem; in Santa Barbara, the biggest problem was alcohol.
- An initiative like Fighting Back required genuine buy-in by the community in order to succeed.
- There was no single model—no magic bullet—that had been shown to work in overcoming a community’s substance abuse problem.

This same reasoning, we felt, applied to the Urban Health Initiative. While the general focus might be on the health and safety of children, local priorities were likely to vary (and indeed they did, as we learned once the program was implemented); community buy-in would be key to generating the political will for large-scale systems change; and, although there were promising interventions that the sites might make use of in pursuing their goals, there was no proven “model” of what we were trying to do.

6. Communications as an intervention

In the past, the Foundation had viewed communications largely as an adjunct to its national programs, using it to spread the word about a new program and to disseminate “lessons learned” after the program was over.

In the Urban Health Initiative, however, we realized that communications would have to be front and center. Unless polls and other measures indicated that the health and safety of children had become a public priority in the participating regions, elected officials could not be expected to act in support of the initiative’s goals. And raising public awareness and concern about children would require aggressive use of communications.

Communications could also become a powerful intervention in its own right for addressing risk behaviors, especially given the large numbers of at-risk children and youth in these cities.

7. The right leadership at the ground level

We understood that getting the best possible project directors at each of the sites would be key to the success of the initiative. Given the scope of the initiative, we wanted people with the experience and sophistication to mobilize the public and to engage institutional, business and political leaders in support of large-scale systems change.

Accordingly, in initially costing out the UHI to determine how much money would be needed to fund it, we budgeted the project director position at a higher salary level than normal—high enough, we thought, to attract people at the level we were seeking. Unfortunately, the

budgets that were submitted by the grantees for the initial two-year planning phase included substantially lower salary levels than we had projected (as low as \$35,000 in one case); those levels were not increased until the implementation phase.

However, we were seriously handicapped by the fact that the Foundation—or the National Program Office, acting on its behalf—could not intervene in personnel decisions by grantees, including the hiring and retention of project directors. This proved to be a major problem in several of the sites, which—despite our efforts to provide clear upfront guidance about the qualifications that the position would require—hired individuals who soon found themselves in over their heads. A good deal of time and political capital was lost before more appropriate leadership was eventually brought in by those sites.

8. The right leadership at the national level

Because of its health-related mission, the Foundation typically selected physicians or other health professionals to run its national programs. In this case, however, in spite of the children's health focus of the new initiative, we wanted someone who not only had a sophisticated appreciation for what it took to bring about large-scale change in a major city but who had actually *done* it. And that, we knew, would probably mean going outside the ranks of health care.

9. One size does not fit all

Going back to Steve Schroeder's observation, also cited in the Royer report, that the biggest cities were often at a disadvantage in competing for the Foundation's national programs by the uniform—and, from their standpoint, inadequate—size of the grants, we decided to try to calibrate the size of the grant to the size of the city. The grants would not necessarily be directly proportional to the size of the cities, since there were basic fixed costs that were likely to be fairly constant across sites, but some adjustment for size would be factored in. We would also try to factor in differences in cost of living across the sites.

10. Commitment to Ongoing Learning

As a rule, the Foundation supported independent evaluations of its national programs, and the Urban Health Initiative was no exception. An independent evaluation by Beth Weitzman and Diana Silver of New York University was funded by the Foundation to determine to what extent the sites were able to implement the initiative as planned and what impact, if any, it had on the child health and safety outcomes they had targeted.

However, in addition to the evaluation, Ruby and Jim Knickman, the Foundation's vice president for research and evaluation, wanted to create a forum for ongoing learning during the course of the initiative that would periodically bring together some of the nation's leading urban scholars with those who were carrying out the Urban Health Initiative, including the project directors, the National Program Office, and others. The hope was that this would help to advance the thinking of both groups.

How Big Is Big?

By mid-1994, we were beginning to pull these elements together into a reasonably cohesive whole. In July, we made a presentation to the Foundation's board about what we had learned from some of the Foundation's past urban programs. By September, Rush had drafted a 28-page concept paper for staff discussion.

The title of the paper—*A Foundation Initiative to Ensure the Health and Safety of Children in Distressed Urban Areas*—reflected an important shift that had occurred in the evolution of the initiative. While the initial impulse for the initiative had been Steve Schroeder’s observation that the Foundation had historically under-invested in the nation’s largest cities, the title of the paper referred to “distressed urban areas”, which might *include* some of the largest cities but wasn’t necessarily *limited* to them.

How did this happen? Primarily, it reflected what we had been learning over the past year and a half about the potential readiness and receptivity of various cities to something like the Urban Health Initiative. Increasingly, as the initiative had begun to take shape, the principal question became: which cities are best positioned to take this on? A related question was: how meaningful would it be, in the larger national context, if a given city were to succeed? This second question was related to need—our sense that succeeding in a hard-pressed city like Detroit or Newark would be more meaningful than succeeding in a relative affluent city like Santa Barbara or Princeton. Hence the emphasis on “distressed” areas.

The concept paper presented to the staff in September did not specify a price tag. We did this deliberately in order to keep the focus of the staff discussion on the *concept* rather than on the money. Nevertheless, many of our colleagues’ comments did touch on funding:

- “Set limit for how much we plan to invest in this area.”
- “This is an important initiative that gives the Foundation a platform to speak out on urban issues. I would rather see us focus more on that objective than the number of sites...”
- “We may be able to reduce the number of sites...We may not need years 7-10.”
- “Suggest structuring funding to be on a project-by-project basis...”
- “Reduce planning grants size (dollars) to encourage more buy-in by communities.”
- “How does the potential size of this program fit with our recent discussions about reduced pay-out, small (more strategic) programs? Let’s look for ways to leverage our dollars.”
- “It is... experimental and, as such, we may want to limit to three sites.”

Aside from the funding issue, probably the greatest concern voiced by our colleagues had to do with the relatively non-prescriptive nature of the initiative, especially with respect to the interventions to be used by the sites. As one person put it, “I suggest that the first, up-front efforts are to systematically document ‘what works’ (ie, review the scientific literature) and promote specific models that are known to work.” And this, in fact, was exactly what we did.

But the funding issue was not as easy to resolve. Steve Schroeder himself favored starting out with two or three sites to see whether what we were proposing was even feasible. Given the high bar we had set for the initiative, he saw it as a very high risk venture.

But it was for precisely that reason that we were reluctant to limit the initiative to such a small number. Because of the very real risk of failure, we argued against putting all our eggs into two or three baskets. Instead, we suggested that the Foundation consider funding as many as eight to ten cities.

In the end, we arrived at a compromise. The Foundation would fund up to eight cities for two years to develop a comprehensive strategy, but the end of the two years, those eight cities would compete for up to five four-year implementation grants. In other words, three sites

would be dropped. The implementation grants would be renewable for another four years if the sites were judged to be on track toward achieving their quantitative goals.

The advantage of this “staged competition”, as we saw it at the time, was that after two years of development, we would have a better sense of which sites were the strongest and most likely to succeed. Also, we believed that keeping the competitive fires burning during the first two years would motivate the sites to do their best. The downside, however, was that the competition inhibited collaboration and information-sharing among the sites during those critical start-up years. It also placed the National Program Office in the awkward position of trying to provide desperately-needed technical assistance to the sites without inadvertently favoring any one site over the others.

In November, we presented a revised paper to the staff—this time including preliminary dollar figures—and we received the go-ahead from Dick Reynolds to present the program to the Foundation’s board of trustees with a request for \$4-million for the first two years of development funding.

Getting Started

Rush presented the \$4-million authorization request to the Foundation’s board in January, 1995, and it was approved for a three-year period: one year to choose the sites followed by two years of development support for the sites themselves to flesh out and begin implementing their strategies. At that time, we projected that the total cost of the initiative over a ten-year period would be in the \$20-30 million range. Over time, however, the cost of the Urban Health Initiative grew to a total of \$64 million, plus roughly \$11 million for the evaluation conducted by New York University and more than \$1 million for the urban seminar series conducted by William Julius Wilson at Harvard University as a forum to bring the sites and leading urban scholars together—a total of more than \$75 million.

By the time of the January board meeting, we had already contacted a number of the consultants we hoped would assist us in the selection process—including Charles Royer, who by the end of 1995 would become the program’s national director. With his 12 years of experience as Seattle’s mayor and his subsequent stint at Harvard’s Institute of Politics working with local political leaders from across the country, he understood our vision for the Urban Health Initiative and what it would take to make it happen on the ground. He also understood something about how the Foundation operated, both from his role chairing one of our national advisory committees and from his work on the *View from the Trenches* report.

With help of these consultants, we started gathering data on specific cities, reading their newspapers, making calls to knowledgeable insiders and fanning out across the country to meet with some of the leaders in those cities face to face. By April, we had identified 20 cities that we thought might be good candidates for the Urban Health Initiative: Baltimore; Bridgeport, Connecticut; the Bronx; Chicago; Cleveland; Dallas; Denver; Detroit; Kansas City, Missouri; Memphis; Miami; Milwaukee; New Haven; Oakland; Philadelphia; Richmond, Virginia; Sacramento; San Antonio; San Diego; and Washington, DC.

While the list included three of the five biggest cities—New York City (the Bronx), Chicago, and Philadelphia—it did not include either Houston or, ironically, Los Angeles. What’s more, it included a number of relatively small cities—Bridgeport, New Haven, Oakland,

Richmond, and Sacramento—an outcome that Steve Schroeder expressed concern about, given the origins of the program.

In any event, on May 1, 1995, a letter went out under Steve's signature to at least 20 individuals and organizations⁵ in each of these 20 cities inviting them to apply for funding under the Urban Health Initiative. The letter indicated that cities that were interested should submit a single letter of interest, "no longer than five pages, single spaced," and that it would be due July 31—giving them less than three months by the time they got Steve's letter.

In an effort to help the cities understand what we were looking for, we attached a three-page addendum to Steve's letter in which we tried to spell out how the Urban Health Initiative differed from past programs they might have been involved in:

Increasingly, community leaders have come to realize that bringing about change on a scale sufficient to improve the health and safety of all children in their city may require a fundamentally different approach: a strategic approach that is predicated on a shared understanding of the true nature and extent of the health and health-related problems facing the city's children and the underlying causes of those problems; a common vision of what needs to be done; and a collective effort to realize that vision...

In general, the initiative will target the most serious health problems facing young people... However, specific priorities are to be set locally, based on local conditions, preferences and, in particular, the potential for real impact on the overall health status of the community's children.

Because of the strong emphasis on collaboration, it is essential that all those who have a potential role to play in improving the health and safety of the community's children be represented in the collaborative process, including the young people themselves and their parents; community leaders and service providers, both from the city and from surrounding suburban communities; the media; and government officials, including representatives from the relevant state and federal agencies. Also, it is important that, as appropriate, the initiative build on, rather than compete with, any collaborative effort focused on children that may already be under way.

The addendum went on to say that while the Urban Health Initiative was designed to allow for considerable local flexibility in setting priorities and choosing interventions, we would "make available extensive technical assistance on demand to ensure that the participating communities have access to state-of-the-art information about the effectiveness of existing approaches and interventions."

On top of that, we said we were prepared to support "an initial survey of children and youth *in the participating metropolitan areas* [emphasis added] to identify their concerns regarding their health and safety," the results of which we would then make available to the sites to help them in setting their priorities. This particular item, which I'm afraid I was responsible for, was intended to help the sites document the fact that many of the problems facing kids cut across urban/suburban lines—thus, providing at least some basis for regional cooperation. Unfortunately, I didn't do a good job of explaining the logic—or maybe I did and the sites

simply didn't agree with the logic. Whatever the reason, they made it clear in the early stages of the program that they weren't interested, and so we let it drop.

A few weeks after the letters went out to the twenty cities, we met with a small group of researchers experienced in evaluating collaborative community initiatives to begin discussing how the Urban Health Initiative might be evaluated. They strongly encouraged us to clarify our specific objectives and our "theory of change" for the Urban Health Initiative—that is, what was the sequence of steps by which we expected the initiative to achieve the ambitious goals that we had set for it?

In June, we held a meeting in New York City with several of our fellow foundations, including Ford, Rockefeller, Casey and Pew, to give them an overview of the Urban Health Initiative—both as a courtesy and with an eye toward possible collaboration down the road, particularly if some of the cities funded under the Urban Health Initiative turned out to be places where they were also active. (The Casey Foundation did eventually become a major philanthropic partner with us in Baltimore's initiative.)

By July 31, all the letters of interest had come in. Of the 20 cities that had received Steve's letter, 16 had responded. Only Memphis, Milwaukee, New Haven, and Washington, DC, did not. (The fact that three of the four—Milwaukee, New Haven, and Washington—were involved in Fighting Back did make me wonder whether perhaps they were already having all the fun they could stand. On the other hand, three of the cities that *did* apply were also funded under Fighting Back—Kansas City, Oakland and San Antonio.)

Those 16 cities were then invited to what we called a "reverse site visit," meaning that they came to *us* rather than the other way around. These reverse site visits took place in a Chicago hotel over a two-day period in early September during which we, together with our consultants, met with representatives from each city for roughly an hour and a half in an effort to get a better sense of their interest in the initiative and what they thought they might do if they got the grant. Based on those meetings, we narrowed the list to 13 cities that would receive "true" site visits (Bridgeport, Cleveland and San Antonio were dropped).

Over the next two months, teams of Foundation staff and our consultants visited all 13 cities, and then reconvened in Newark in early November to choose the final eight that would be recommended to the Foundation for two-year development grants. It was a lively session. Each team gave a brief summary of their site visit and their conclusions, and then the floor was open for discussion, some of it impassioned. Among the most heavily weighted criteria in choosing the eight were:

- The potential for success. New York City, for example, did not make the cut because of unresolved tensions between the mayor's office and the Bronx borough president's office over who would take the lead. Sacramento, on the other hand, was already moving in the direction of the program with support from the Sierra Foundation.
- The potential significance. This was a factor in choosing Detroit—if the program succeeded there, the group felt, it would send a very encouraging message to the rest of the country about the potential for progress even under the most difficult circumstances.
- Geographic diversity across the program as a whole. We wound up with two in the south, two in the northeast, two in the Midwest, and two on the west coast.

- Diversity in sponsorship. This was why Philadelphia made it—they were the only city government to apply, and the group felt it was important to find out what a city government could do to improve the health and safety of children. Similarly, Richmond, which applied through its Chamber of Commerce, was the only business group to apply.
- The potential for regional collaboration. This was a factor in Detroit, where the new mayor was reaching out to the surrounding suburbs for the first time in 20 years, and in Richmond, which already had a track record of regional collaboration in other areas.

When the smoke finally cleared at the end of the day, the eight sites left standing were: Baltimore, Chicago, Detroit, Miami, Oakland, Philadelphia, Richmond, and Sacramento. Their grants began less than two months later, on January 1, 1996.

The Road to the Final Five

While the cities got out of the starting gate on January 1, the National Program Office under Charles Royer at the University of Washington did not get its grant until a month later on February 1, forcing him and his staff to scramble to catch up. One of his first hires, fortunately, was Cindy Curreri. Cindy not only understood how government and other big systems worked—she understood how *people* worked, a tremendous asset in those early days as the grantees got over their initial euphoria at being funded and started to understand what they were up against.

And there were plenty of frustrations on both sides. For example, despite our efforts to be clear about the qualifications required for the project director position and the fact that we had budgeted the position at a level sufficient to attract relatively senior individuals, the project directors recruited by the sites tended to be fairly junior and inexperienced in large scale systems change. This not only made it difficult for them to know what to do, but it also indicated that the cities' leaders who had appointed them either didn't fully understand the initiative themselves or weren't seriously committed to it.

Meanwhile, the sites expressed their frustration that they were getting mixed messages from us. Too often, they said, the Foundation, the National Program Office, and the consultants were not on the same page, making it very hard for them to know whose advice they should follow. In other words, we needed to get *our* act together, too.

Added to this was the fact that the National Program Office felt hamstrung by the fact that the eight sites were still in competition with one another for the final five implementation grants. On the one hand, they wanted to be fully responsive to the project directors' requests for guidance and technical assistance. On the other hand, they didn't want to tilt the competition in favor of one site over another. At the same time, some of the sites were reluctant to ask for help, afraid that it would be construed by the National Program Office and the Foundation as "a sign of weakness".

The National Program Office also felt constrained by the non-prescriptive nature of the program, in the sense that, even where they saw a site headed in the wrong direction or veering off course, they felt that they could not intervene unless the site itself requested their assistance.

Finally, Ruby, Rush and I grew concerned as it became increasingly apparent that the project directors did not understand the concept of scale as we had thought of it in our design of the

program. At one of the national meetings halfway through the development phase, each site was presenting the data it had assembled thus far—and it was painfully obvious to us that they had no idea why they had been asked to collect these data or how to use them.

In fact, this issue of scale was proving to be a major stumbling block, just as it had been in *Fighting Back*. In part, this had to do with people’s past experience. Several of the project directors, for instance, had backgrounds in community organizing and were more accustomed to thinking at the neighborhood level rather than at the city or regional level. Others had backgrounds in community agencies where the tendency was to think in terms of the agency’s client or patient base rather than the population as a whole.

Then, as we neared the end of the two-year development phase, I discovered that even the National Program Office wasn’t entirely clear on what we meant when we talked about scale. Cindy Curreri remembers the turning point: “In order to determine which sites would get implementation grants, we made site visits to talk with local leadership. The Chicago folks presented their plan and a police captain described an innovative and exciting new program approach to violence. The review team was definitely interested until Paul said to the captain, ‘How many kids will you be able to reach with this approach?’ The answer was somewhere between 300 and 600. Although the denominator was not explicit, all of us knew immediately that this approach would have little or no impact on Chicago’s overall statistics.”

The next morning, as we waited in the hotel lobby for the rest of the review team to reassemble for the second day of our visit, Cindy and I talked about this problem of the “denominator” and agreed that the problem was by no means limited to Chicago. Cindy told me that *all* of the sites were having trouble grasping this problem of scale: that you needed to know the scale of the problem you were up against (the “denominator”) in order to determine how many kids you would actually need to reach with your interventions in order to make a meaningful difference in the city’s child health statistics. As a result, the plans they were coming up with didn’t have nearly the scope needed to be successful.

It was that conversation in a hotel lobby that prompted Cindy to develop the so-called “Denominator Exercise”, which identified the number of children who had to be reached by each site-selected intervention and estimated the amount of money that would be needed to provide that intervention to that many children. It is described at greater length elsewhere.⁶ It was only after the sites had worked through the Denominator Exercise, which didn’t begin until early 1998 when we were down to the five finalists and their implementation grants had been awarded, that they gradually began to understand the true magnitude of the challenge before them—and why we had been harping so incessantly on the importance of having a serious media strategy and forming the political and regional alliances necessary to change the existing system of financing for children’s services.

All in all, then, the road to the Final Five was fairly rocky. While some of the sites could point to some impressive achievements during their first two years—Baltimore, for instance, brought together 7000 citizens in a huge public meeting to help arrive at its priorities—all had their share of difficulties. In fact, when the five finalists—Baltimore, Detroit, Oakland, Philadelphia and Richmond—were recommended to the Foundation for implementation funding in November of 1997, all of the recommendations came with conditions, including, in three cases, the condition that recruitment for a new executive director should begin immediately.

Nor was it all smooth sailing after that. By no means. True, the Final Five now had their implementation money and they were no longer in competition with one another. But three of them had to bring in new executive directors—two of whom had to spend at least part of their time and their political capital cleaning up after their predecessors—and all *five* of the sites, as they worked their way through the Denominator Exercise and began to understand the scale of what they were up against, realized that, in some ways, this was a whole new ball game.

If We Had It To Do Over

At this stage, it is premature to talk about “lessons learned” from the Urban Health Initiative in any definitive sense. The program, after all, is still under way, as is the evaluation. Any definitive conclusions about the program concept and its implementation should await the data.

That said, here are a few preliminary reflections—based on my involvement in designing and getting the Urban Health Initiative off the ground—about what, if we were to do it (or something like it) again, we might do differently:

- Figure out how to communicate the concept of scale—and all that it implies—more effectively from the outset. We knew from our experience with Fighting Back that this was a potential problem, yet it wasn’t until several years into the program that we were able to get this key point across to the sites or even to the National Program Office. Maybe applicants to future initiatives of this kind could be required to work through something like the Denominator Exercise up front as a major part of their proposal.
- Start the independent evaluation even earlier—in part to force greater clarity from the outset about the program’s “theory of change” and in part so that the sites can have available fresh baseline data on the problems they are seeking to address. Given the poor quality of much of the existing local indicator data, such baseline data would be invaluable to the sites and could be fed into the Denominator Exercise as soon as it became available to help the sites develop more accurate projections of the scale and cost of potential intervention strategies. An alternative approach would be to give the sites the resources necessary to collect new data themselves. While this might be less efficient in the short-run than a single data collection effort centralized in the evaluation, it could help to strengthen the long-term data-gathering capacity of the sites.
- While it probably makes sense to break the initiative into stages, don’t have the sites compete with one another for continuing support. Instead, make sure that there is adequate money in the overall program budget to continue to fund all sites provided that they successfully achieve whatever the expectations are for each stage. Those expectations would of course have to be clearly spelled out up front.
- Provide greater direction and greater clarity to the sites regarding the qualifications for key staff positions, in particular the executive director position. I believe that more can be done in this area than we did without overstepping the bounds of what foundations or other funders can do on personnel issues.
- Get everybody on the team—foundation staff, program staff, and consultants—on the same page up front in order to reduce the likelihood of mixed messages to grantees. Putting more of the foundation’s thinking on paper would clearly help in this regard.

Whatever the ultimate outcome of the Urban Health Initiative, with the continuing trend towards local responsibility the nation's cities and regions will need to find new ways to manage and respond to the needs of their people—not just a handful of people here and there, but all those who are in need. Hopefully, some of the lessons we are learning from the Urban Health Initiative will be of help.

¹ Paul Jellinek is a former program vice president of the Robert Wood Johnson Foundation, and, together with Ruby Hearn and Rush Russell, was one of the architects of the Urban Health Initiative.

² Members of the urban health working group eventually included Marilyn Aguirre-Molina, Michael Beachler, Tito Coleman, Donald Dickey, Catherine Dunham, Andrea Gurstenberger, Marjorie Gutman, Ruby Hearn, Janet Heroux, Paul Jellinek, Floyd Morris, Marguerite Rountree, and Polly Seitz.

³ As a matter of fact, in the case of the Fighting Back program, we got such a big response that the federal government developed its own program that wound up funding hundreds of communities that had applied to Fighting Back unsuccessfully.

⁴ There were some exceptions, including the School-Based Health Center Program, which ran for six years, and Fighting Back, which was originally planned as a seven year program and then was extended an additional five years for some of the sites.

⁵ The letter was sent to mayors, city managers, health commissioners, human services commissioners, school superintendents, police chiefs, juvenile court judges, United Way presidents, local foundations, community foundations, Chambers of Commerce, ecumenical organizations, children's hospitals, public hospitals, academic health centers, university and college presidents, local TV stations and newspapers, and any existing coalitions focused on issues relevant to the health and safety of children.

⁶ Jerry VanderWood, "Using data in the decision-making process."



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