

# The Urban Health Initiative

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## *Editors' Introduction*

From the draft riots of the 1860s to the racial riots of the 1960s, urban violence has signaled major problems in American society. In 1992, Rodney King, an African-American, was beaten by Los Angeles police officers after a traffic stop. The beating was recorded on video. The acquittal of the accused police officers triggered a riot in which 55 people were killed, more than 2,000 were injured, and the damage to property was extensive. This riot led to congressional hearings, and it forced government agencies and foundations trying to improve social and economic conditions to re-examine their work in America's cities.

Prior to the Los Angeles riots, the Robert Wood Johnson Foundation had awarded few large grants to improve health in inner cities. A result of the post-1992 re-examination was the development of the Urban Health Initiative, a major effort to improve the health and safety of children living in five medium-size and large cities. What made the Urban Health Initiative unusual was its commitment to improving the health of a significant number of children in the five cities. It was not just a pilot project or a demonstration to test new approaches; rather, the Urban Health Initiative was a program with the ambitious goal of making a positive difference in the cities' health statistics—in effect, undertaking a role usually played by government.

The chapter raises an interesting and important question: how can foundations fund programs of sufficient size to improve the health of a significant number of people living in distressed urban areas? The resources of foundations, after all, pale in comparison to those of government. The Robert Wood Johnson Foundation, the nation's fourth-largest foundation, awards between \$400 million and \$500 million a year in a \$2 trillion health economy. The annual budget of the City of Los Angeles is \$6.7 billion.

This question of scale led the Urban Health Initiative to create what it called *the denominator exercise*, which asks (1) How many kids are in need of help? (the denominator) and (2) What will it take to have an impact on a substantial percentage of those kids? This exercise provides an indication of the size of the effort required to have an impact.

Paul Jellinek, the author of this chapter, played an important role in the development of the Urban Health Initiative when he was a vice-president at the Robert Wood Johnson Foundation. This chapter provides Jellinek, now a partner in a consulting firm that advises foundations, an opportunity to take a retrospective look at a program that he helped launch over a decade ago.

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“My aunt and uncle in Detroit who raised me didn’t speak any English, so I never had any help with school when I came here from Puerto Rico,” recalls Luis Cartagena, a single father who still lives in Detroit. Luis, who has silver hair and a gentle smile, is now raising his six-year-old son, Adam. “I don’t read or write, and I have been on my own since I was 16,” he says. “I have been surviving my way through life. Because of that, I knew I would have a hard time educating Adam. I needed help—and I got it, from Latino Family Services and its summer and after-school programs.

“Adam has been through a lot,” Luis continues. “I thought if I could get him around a group of children his age, that would be good for him. He looks forward to coming to the after-school program. He is here [at Latino Family Services] from 3:30 until 6:00 five days a week. He has a chance to learn things, to be social, and to pick up skills. He plays on a computer. The staff helps him with his reading and homework; they do arts and crafts and take the children on field trips. The program has helped interest him in learning, and he has learned how to get along with other children. His behavior has dramatically changed since coming here.”

Luis pauses. “If this place wasn’t here, I wouldn’t have known what to do,” he says. “I’d be lost. This place gives him a better chance to succeed than I had.”<sup>1</sup>

This is the kind of good news that one hears all too rarely in media stories about big cities like Detroit. Yet what may be most significant about Adam’s story is not simply that he wound up in an after-school program that his father believes has changed his life. It is that, according to recent statistics collected by Mayor’s Time—a nonprofit organization based in Detroit and funded by the Robert Wood Johnson Foundation through its *Urban Health Initiative*—the chance of a school-aged child in Detroit finding and getting into such a program in the first place is today more than double what it was six years ago, when Adam was born.

In 1999 it was estimated that only one in five school-aged children in Detroit was involved in after-school activities. By 2006, Mayor’s Time reports, that number had jumped to more than 50 percent. And Detroit’s annual After-School Fair, which began in 2001 and enrolled 30,000 children in after-school programs over its first four years, signed up 31,000 more children in 2006 alone. An increase of that magnitude, with its potential to improve the health and safety—and ultimately the life chances—of tens of thousands of Detroit’s children is indeed good news, not only for Detroit but also for other cities across the country struggling to make a better life for their children.

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### **Sometimes the Cards Are Stacked Against Big Cities**

The dramatic increase in after-school enrollment in Detroit was brought about through the hard work of many individuals and organizations, but a pivotal part of the story can be traced back to an event that occurred more than a decade earlier and more than 2,000 miles away: the Los Angeles riots of 1992. Sparked by the Rodney King verdict, the riots sent shock waves across the nation, all the way to Washington, D.C., where Congress convened hearings to try to understand what had happened and to determine what might be done to prevent such outbreaks in the future, both in Los Angeles and elsewhere.

On the roster of expert witnesses were several foundation presidents, including Steven Schroeder, then-president of the Robert Wood Johnson Foundation. In preparing his testimony, Schroeder, who had joined the Foundation just two years earlier, was startled to discover that although the Foundation had made many grants to urban organizations and institutions since becoming a national philanthropy in 1972, the nation's largest cities—including Los Angeles—were notably under-represented. Moreover, it appeared that few of the Foundation's grants that *had* been awarded in the largest cities were of sufficient scale or duration to have had more than a marginal impact on the immense problems and health challenges facing those cities.

This finding was echoed in a report prepared for the Foundation by Charles Royer, the former mayor of Seattle, which noted that the Foundation tended “to gravitate toward the same cities” in many of its competitive 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.”

Following his appearance before Congress, Schroeder called a meeting of the Foundation's program staff. He expressed his concern that the Foundation hadn't been doing enough to help the nation's largest and most distressed cities, and he challenged the staff to come up with fresh ideas for a program that would help those cities tackle some of their most urgent health needs.

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### The Federal Spigot Was Being Turned Off

It was a tough challenge. For one thing, since the mid-1980s, the Foundation's major programs in areas of concern to cities, such as homelessness, mental illness, AIDS, and substance abuse, had called for collaboration among the key players in the funded communities, primarily because most of these problems were too big and too complex for any single agency or institution to deal with on its own. But getting local grassroots AIDS agencies to collaborate with the one public hospital in Dallas or New Orleans was one thing; fostering the same kind of collaboration with New York City's *nineteen* public hospitals was an entirely different ballgame.

Of course, one approach to working with larger cities might be to focus on a section of the city rather than trying to take on the city as a whole. This was what the Foundation had been doing with some of the larger cities in Fighting Back, its program to reduce demand for illegal drugs and alcohol.<sup>2</sup> However, as the staff was learning from its experience with the Fighting Back program, a subsection of a larger city by itself often didn't have the political clout to bring about the kinds of policy changes needed to make any headway.

Meanwhile, at the national level, a development with potentially profound implications was taking shape: the federal government, faced with record budget deficits, was beginning to cut back sharply on spending for new health and social programs. This went to the heart of what, until then, had been the Foundation's principal strategy for bringing about large-scale change—big national demonstration programs designed to test new ways of delivering health services, especially to the poor and underserved. The idea was that if these new ways of delivering health care proved to be effective, the federal government would step in with the resources necessary to replicate the approach nationwide.

Recent examples included the replication of the Foundation's program of health care for the homeless through the McKinney Act, and the replication of its AIDS health services program through the Ryan White Act.

But now the federal spigot was being turned off. Not only did this knock the legs out from under the Foundation's demonstration and replication strategy for leveraging social change, but it also left the nation's cities to fend for themselves as they tried to get their arms around a dizzying array of health and social problems.

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### **The Health and Safety of Children**

In 1992 I was a program vice president at the Robert Wood Johnson Foundation. On June 22, 1992, less than three months after the Los Angeles riots and shortly after Steven Schroeder's challenge to the Foundation's staff to come up with a new program specifically for the nation's big cities, I sent a memo to Richard Reynolds, who was then the Foundation's executive vice-president, suggesting that the Foundation begin to develop a major, long-term Foundation initiative to secure the health and safety of children in some of the nation's biggest cities.

The memo recommended that the initiative should "deliberately target our biggest cities" and that its length should be nine or 10 years—more than double the four-year life of the Foundation's typical national demonstration program. It also recommended getting policy-makers involved at the outset, and urged that close attention be given to the role of the media, because public awareness and support would be essential to the ultimate success of the initiative.

Reynolds liked the idea and suggested that those on the staff interested in pursuing it should form an informal working group to do the necessary groundwork and prepare a paper for discussion by the full staff. The result was a 13-member staff working group on urban health. It was chaired initially by Ruby Hearn, then a Foundation senior vice president, and later by Rush Russell, at the time a senior program officer at the Foundation.

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### **A Different Program Design**

The members of the working group began by immersing themselves in the literature—wading through stacks of books, journals, evaluation reports, conference proceedings, and foundation papers. They then fanned out across the country, meeting with a diverse array of academics, policy experts, experienced practitioners, and staff members from other foundations that had a track record in the urban arena, including Annie E. Casey, Ford, Rockefeller, Pew, and Sierra Health.

As a result of this background work, Hearn and Russell became convinced that if this new urban initiative was to be successful, it would need a different program design. "We were not aiming to replicate a promising model as in many previous Foundation programs," Hearn recalls. "We had learned that substantial changes of the kind we envisioned would require a level of political will that could result only from broad community engagement."

Over the next several months, as the new initiative began to take shape, some of its key distinguishing features emerged:

- A more rigorous site selection process than usual, including in-depth reconnaissance and analysis up front to assess the readiness of each candidate city to undertake the initiative.
- A commitment by the Foundation of up to 10 years.
- A citywide focus, even in the biggest cities, that would reach tens of thousands of children or more. This, it was believed, would elicit greater local political support for the initiative than if the focus were limited to a relatively small section of the city.
- A regional strategy through which the cities would try to enlist the involvement of suburbs and other communities in their region to obtain the necessary support and cooperation at the county, state and federal levels.
- Local self-determination—meaning that the cities would decide for themselves what specific children’s health issue they wanted to tackle. This contrasted with the traditional demonstration program, in which the participating sites were generally replicating a prescribed model to address a common problem.
- Communications as an active intervention in its own right, rather than simply a public relations tool—both to generate public support for the necessary systems changes and as a means of promoting positive health behavior.

Ultimately, it was the emphasis on the large-scale expansion of services that lay at the heart of this new initiative and that most sharply distinguished it from most of the Foundation’s past programs. No longer was it sufficient for a Foundation program simply to serve a couple of hundred young people in a model clinic in the hope that the model would be picked up and “taken to scale” by the federal government. Now the program itself would have to do the heavy lifting, helping cities to figure out new ways to reach very large numbers of at-risk children and youth—in fact, enough children to change the health statistics for the city as a whole—*without* a major infusion of new federal dollars. In most cases, that would mean using existing dollars that were already in the system in sometimes radically new and more effective ways. And that, it soon became clear, represented a whole new programmatic paradigm, both for the Foundation and for the grantees.

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### Fraught with Risk

In the fall of 1994 the working group presented a detailed 28-page report describing the proposed new initiative to the full program staff. After a lively debate about whether the idea was *too* big, a proposal for a new urban health initiative was drafted and presented to the board of trustees. In January of 1995 the board authorized an initial three-year, \$4-million grant to get the program off the ground in up to five cities.

With the authorization in place, the staff working group quickly assembled a team of senior consultants from around the country with expertise in urban health and policy to assist it in identifying the most promising cities in which to carry out the initiative. A list of 20 potential sites was drawn up; it included major cities such as New York, Chicago, and Philadelphia, as well as some smaller distressed cities such as Oakland, California, and Richmond, Virginia.

Next, detailed statistical profiles of each of the 20 cities were prepared, press coverage from each city was carefully reviewed to get a sense of current local priorities and the local political climate, and calls were made to knowledgeable observers in each city who could provide an honest assessment of the local leadership's capacity and its potential interest in an initiative of this kind. Based on these preliminary assessments, teams of staff and consultants visited many of the cities on the list, meeting with key officials and community leaders to get a better sense of their record of local collaboration and their appetite for a major new initiative to improve the health and safety of their city's children.

In May a letter went out over Steven Schroeder's signature to leaders in these cities inviting them to apply for two years of development funding under the program, which at that point was called America's Promise. (In 1997 the name was changed to the Urban Health Initiative, after a Presidents' Summit chaired by Colin Powell adopted the name "America's Promise" for its national youth initiative.) After an intensive review process, eight cities—Baltimore, Chicago, Detroit, Miami, Oakland, Philadelphia, Richmond, and Sacramento\*—were awarded two-year development grants, with the understanding that after the first two years, up to five of them would receive substantial additional support to help implement the initiative for a period of up to eight years.

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### Lost in All of the Process Details

Charles Royer, the former Seattle mayor, whose report had helped to make the case for a special focus on big cities, had been among the group of senior consultants who had helped the Foundation select the eight cities, and he now agreed to serve as the initiative's national program director. This meant that he and his staff, operating out of a national program office (NPO) to be established at the University of Washington in Seattle, would manage the initiative on a day-to-day basis and would provide technical assistance and direction to the grantees.

Right off the bat, there were problems. Because of various processing delays, by the time the university actually received the funding from the Foundation to set up the office and hire a staff, the eight cities had already had their grants for a month, and a number of them were in dire need of technical assistance. As the NPO's first annual report to the Foundation drily noted, "The sites were funded January 1, 1996. The National Program Office was funded a month later. As a result, the time normally used to refine programmatic ideas and approaches, develop systems to assist sites and monitor grants, plan major activities, and establish administrative functions was eliminated."

The delay in setting up the NPO was not the only problem. The fact that the eight cities would be competing for five much bigger implementation grants just two years down the road made some of them reluctant to ask for help, afraid that such a request would be taken as a sign of weakness. By the same token, Royer and his staff sometimes found themselves holding back on providing the level of technical assistance that they felt was needed, because they didn't want to appear to be favoring one city over another while the cities were locked in competition with one another.

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\*Ironically, given Los Angeles' role in sparking the initiative, that city was not included. It was still very much preoccupied with extensive rebuilding in the aftermath of the riots, and the Foundation had already provided separate funding to Los Angeles to support health services planning as part of the rebuilding effort.

But the biggest problem, it soon became apparent, was that a lot of people simply did not understand the initiative. Specifically, what wasn't sufficiently clear at that point was the *scale* of the Foundation's vision: to reach enough young people with effective interventions to change the child health statistics for the city as a whole. That meant serving thousands, or even tens of thousands, of children in each city. Looking back, Royer observes, "That was the biggest piece of the initiative, and the most attractive. But it got lost in all of the process details early on. So people didn't really realize it until later."

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**The Denominator Exercise**

One immediate result of this misunderstanding was that most of the cities initially hired the wrong people to serve as project directors. Although many of the project directors had extensive hands-on experience working in their communities, few had worked on the kind of large-scale systems change that this initiative was all about. Consequently, most of them didn't understand the kinds of influential people they would need on their boards or the kinds of data that would have to be collected. Nor did they understand why it was so critical that they develop "the right connections," both within their region and with officials in state government, or why the Foundation kept insisting on the importance of developing a sophisticated communications strategy. The upshot of all of this was that the Foundation and the eight cities spent much of the first two years talking past each other, with the NPO caught somewhere in between.

The turning point, recalls Cynthia Curreri, the program's deputy director, came during a site visit to Chicago near the end of the second year. "The police chief came in, and went on about this program he was going to do that sounded wonderful, and then [someone on the site visit team] says, 'How many kids will you be able to get to, Chief?' And the chief says, '85,' or whatever the number was. And suddenly I realized, 'OK, this isn't going to work. That's never going to make a meaningful difference in a city the size of Chicago.' So that was the moment when it really all came together for me—that one question to the chief. And that's when I decided that we had to have a way for people to work out how many kids they would have to get to in order to make it worthwhile. We had to have some way for them to put numbers to it."

As soon as Curreri returned to the office in Seattle, she began drafting what came to be known as the denominator exercise, a quantitative tool to help the project directors calculate just how many of their city's children they would need to reach in order to have a real impact on the citywide statistic for the particular health problem they were trying to address. What's more, by plugging in the cost per child of the chosen intervention, they could calculate how much money it would take to get there.

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**Ramping Up**

As the first two years came to an end, the eight cities submitted their proposals for implementation funding. Following another round of intensive review, five of them—Baltimore, Detroit, Oakland, Philadelphia, and Richmond—were selected.<sup>†</sup> Given the small number, they were a surprisingly diverse group, not only in size and geography but also in terms of where their projects were housed. Richmond’s project, for example, was run by the Greater Richmond Chamber of Commerce, whereas Philadelphia’s was based—at least initially—in city government.

Although these five cities now had sizeable implementation grants to carry them for the next four years, with the possibility of an additional four-year renewal, they were hardly home free. The implementation grants came with significant conditions attached, including, in several cases, the need for new leadership with a better grasp of the dynamics of large-scale systems change. Moreover, all of the cities still had a good deal of work to do on their denominator exercises before they would finally be in a position to put hard numbers to their goals and begin developing realistic strategies for achieving them.

In the meantime, both the Foundation and the NPO began ramping up their own efforts to support and learn from the initiative. The Foundation had funded Beth Weitzman and Diana Silver, two experienced researchers at New York University’s Robert F. Wagner Graduate School of Public Service, to plan an independent evaluation of the initiative. In addition, Ruby Hearn and James Knickman, then the Foundation’s vice president for research and evaluation, wanted to create an ongoing forum that would bring the Urban Health Initiative grantees together with leading scholars in the field. “We believed that it was crucial to promote a dialogue between academics studying community change and practitioners trying to bring about such changes so that they could learn from one another as the initiative unfolded,” Hearn recalls. “We were very fortunate to enlist the help of William Julius Wilson, the country’s leading urban researcher, to develop and conduct the seminar series at Harvard University.”

The national program office, which felt liberated to provide much more extensive guidance and technical assistance now that the cities were no longer in competition, also came up with a number of ways to inspire and support the often beleaguered project directors and their staffs. For example, Royer and his staff set up an urban fellowship program in each city to engage a cross-section of local leaders—such as judges, business leaders, and journalists—in the initiative. And every year Royer would take a group of leaders from each of the five cities on a so-called “Inter-City Leadership Visit” to a city outside the Urban Health Initiative that was doing something especially innovative or relevant to the initiative. Finally, to assist and advise the Foundation and the NPO as well as the cities themselves, a national advisory committee of experts in health, urban policy, and youth development was assembled, several of whom became deeply committed to helping the cities succeed.

The first step for each site was to determine on which specific aspects of children’s health and safety to focus. Although existing health statistics were clearly an important part of the process, it was also

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<sup>†</sup> In April 1997 the Foundation awarded \$24 million over two years to implement the Urban Health Initiative. Four years later, it awarded another \$24 million. Additionally, the Foundation authorized funds to enable the national program office to manage the program.

essential to hear what local leaders and local residents—including the city’s young people themselves—had to say. Otherwise, as past experience had shown, there wouldn’t be sufficient buy-in for the initiative to succeed. All five of the sites reached out to their communities to elicit their views, but the Baltimore project went perhaps the furthest, convening some 7,000 city residents in a spirited public meeting that generated more than 30 initial priorities for improving the health and safety of the city’s children—an extraordinarily ambitious list that eventually had to be whittled down to a more manageable number. As a result of the data and the public input they had received, most of the sites identified the reduction of youth violence as one of their top priorities, with reductions in substance abuse and teen pregnancy not far behind. Several sites also wanted to improve birth outcomes and school readiness and to reduce child abuse and neglect.

The next step for the sites was to determine what kinds of interventions were out there that they could use to tackle these problems. In particular, they were looking for programs and policies that had been evaluated and had been shown to be effective—preferably with hard numbers documenting just *how* effective and at what cost.

After-school programs turned out to be a popular choice at almost every site. Nurse home visiting services for pregnant teenagers and their children—which had been found to improve birth outcomes, reduce child abuse, and delay subsequent pregnancies—were another popular option, as was an intensive interagency homicide reduction program that had first been developed in Boston several years earlier. Richmond, taking the long view, decided to focus on having all of its children reading at grade level by the time they entered the third grade—which, the research suggested, was a powerful way to reduce pregnancy rates during the teenage years.

With their interventions in hand, together with the basic statistics on the number of children in their city who had the particular problem that they had decided to target, the sites were ready to start working on Curreri’s denominator exercise. Largely because of difficulties in understanding the exercise or its utility, as well as challenges in obtaining the necessary local data, this proved much harder than expected. But with the pain came some important gains. “Sites that moved on [the denominator exercise] quickly and completed the exercise for the first strategies being implemented—Richmond, Baltimore, Philadelphia—were very surprised at the results,” the NPO’s third annual report recounts. “All three [sites] have significantly modified their plans based on the information gained. Richmond phased implementation of [its] strategies and dropped one altogether... Baltimore phased implementation and set up a whole new committee system to trace and plan how to realign and increase resources upon learning the frightening cost of their initial strategies. Philadelphia expanded outside its initial ‘target areas’ for two strategies and is considering dropping a third on learning what they must do to achieve scale.”

In other words, once the city projects had worked their way through the denominator exercise, the result was some pretty serious sticker shock among the project directors and their boards. “That’s when the light went on for a lot of them: when they saw that it was maybe going to take hundreds of millions of dollars—way more money than they had in their grants,” Curreri recalls. “And so what’s their strategy? What services can be identified that are currently being funded but that aren’t

doing a good job, and how can they get that money moved from one place to another—which requires a very heavy political strategy? That’s really the main story of the Urban Health Initiative.”

Although the sites hoped to raise at least some new money from the government and from the private sector, they quickly realized that to fund effective programs at the level needed to achieve “scale,” they would have to persuade the major public and private funders to redirect some of the vast sums of money that were already in the system for children toward these programs—and that would indeed require a substantial political strategy.

And so their next step was to determine how much money was actually being spent in each city for children—all of it, both public and private—and to ascertain precisely where the money came from, who controlled it, and what the particular constraints were on each of the myriad funding streams that went to children’s services. As Royer told the project directors, “You have to find the one person in your city who really understands the guts of the budget, and get to be their best friend.” Ernest Jones, the longtime chair of Philadelphia Safe and Sound, which runs the Urban Health Initiative in that city, points out that “prior to Safe and Sound, nobody knew how much the city spent for children’s services.”<sup>3</sup>

Then came the truly challenging part: using the numbers to try to educate both policy-makers and the public to make the system “work smarter for kids,” as Royer put it. Philadelphia Safe and Sound, for example, made the results of its budget analysis public, holding a press conference and issuing a “report card” each year that presented the most recent data on juvenile crime, teen pregnancy, and other key indicators, together with a “children’s budget” that showed how all the money in the system for children was actually being spent. By making these kinds of data public and pointing out some of the obvious misalignments between where the needs were and where the resources were going, the sites eventually helped to bring about the reallocation of hundreds of millions of existing dollars toward more effective interventions.

Money wasn’t the only issue. The sites also paid close attention to nonfinancial resources—such as the hundreds of school buildings that often stood empty during the after-school hours. Recognizing that there was no conceivable way that the cities could afford to build all of the new facilities that would be required to provide after-school programs to large numbers of additional children, the sites, using their data and working with key partners in their cities, were eventually able to bring about changes in school policies and to break through long-standing barriers that had kept the schools closed to after-school activities. The Baltimore, Detroit, Oakland, and Philadelphia sites, for example, negotiated agreements with their local school districts that allowed private and community organizations to make their programs available to children within school buildings during nonschool hours. As the NPO noted, “These arrangements...were critical to achieving scale, as expansion could not occur without access to low cost, or no cost, physical plants in which to operate.”

Despite the assistance and the hundreds of thousands of dollars they received each year from the Foundation, these five projects were, in fact, very small Davids going up against some enormous

Goliaths. As Diana Silver, of the evaluation team, notes, “They were up against people who were deeply invested in not having those policies, [including] certain principals and others in the school system, as well as... people who would no longer be able to dole out favors the way they had in the past.” This conflict took a toll. “I can’t tell you how many times I had people in tears on the phone,” Cynthia Curreri recalls. “They were just so frustrated, and they’d say, ‘I just can’t do this another day. It’s so *hard*.’”

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### Five Sites, Five Approaches, and Many Common Challenges

As the five Urban Health Initiative grantees strengthened their analytic capacity and expanded their networks of relationships, they gradually established themselves as trusted intermediaries, committed to improving the health and safety of their cities’ children by deploying existing resources more effectively. Among their activities:

- Baltimore’s Safe & Sound Campaign spearheaded the creation of a citywide data collaborative to keep track of what was happening to the city’s children and leveraged more than \$10 million a year in public and private funds to support its strategies. With the data and additional resources, Safe & Sound worked with agencies in the city to develop a comprehensive array of initiatives, including the Success by 6 Partnership, which helps families with young children to prepare them to succeed in school; Reading by Nine, a program in the school system to increase the number of students reading at grade level by age nine; Operation Safe Kids, a partnership between law enforcement and public health officials to provide high-risk young people with intensive case management (as an alternative to incarceration), and a variety of after-school programs.
- In Detroit, Mayor’s Time raised millions of dollars from government, foundations, and the business community in support of its after-school strategy; worked closely with the Skillman Foundation and state and city agencies to secure federal funding for free breakfasts and lunches for young people participating in summer programs; and secured an agreement from city government to invest \$400 million of casino tax revenues to improve and expand recreation center physical plants and activities over the next 10 years. In addition, Mayor’s Time developed a citywide information system, which for the first time began collecting youth participation and outcome data from hundreds of after-school providers, and launched an interactive Web site to enable parents and children throughout the city to identify after-school opportunities available in their neighborhoods.
- Oakland’s Safe Passages brought together senior officials from city and county government, the school district, and community-based organizations in an unprecedented collaborative effort to provide the full range of supportive services needed by city’s at-risk children and adolescents. Major components included an early intervention program to promote reading, language skills, and positive social interaction among preschool children; a case management and mental health program for at-risk middle school students; an after-school strategy; and Pathways to Change, a program that provided intensive case management to repeat youth offenders. Violence-related school suspensions declined by 78 percent in one year among students in the Pathways to Change program.<sup>4</sup>
- In addition to its annual Report Card and Children’s Budget, Philadelphia Safe and Sound created the an online after-school and child-care program finder, which provides information on more than 700 programs, and began developing an ambitious integrated data system to improve the coordination and delivery of services for the tens of thousands of at-risk children and adolescents served by city agencies. Also, as a result of Safe and Sound’s efforts, nearly

\$80 million a year in new and redirected funds was raised in support of an array of services that included nurse home visiting for pregnant teenage mothers, life skills training for at-risk youth, youth violence reduction, and expanded after-school programs.

- In Richmond, Youth Matters began with the specific goal of ensuring that by 2010 all of the city's children would be reading at or above grade level by the time they reached the third grade. Subsequently, Youth Matters helped to create a 150-member coalition to increase the availability and improve the quality of early childhood development programs throughout Richmond. As a result of these efforts, home visiting services have been provided to at-risk children, and many of the city's young children are receiving improved preschool services. In addition, a book bank created by the coalition to help improve reading readiness has distributed 85,000 books since 2001.<sup>5</sup>

Most of these accomplishments did not come easily. In Richmond, James Dunn, president of the Chamber of Commerce, which housed Youth Matters, recalls, "Getting the different stakeholders—elected officials, school boards—to the table and getting them to put the interests of the kids first—that took a lot longer than I would have thought. There was lots of caution, lots of skepticism, and lots of suspicion. Everybody was asking each other, "What are *you* trying to get out of this?"

Compounding the problem of mutual mistrust was the fact that key players in the system kept changing. Naomi Post, who ran Safe and Sound in Philadelphia for several years, points out that over the course of the initiative, the Philadelphia School District went through a state takeover and had three different superintendents. This constant turnover, she says, required "continuous engagement with different leaders, with varying priorities, to ensure the sustainability of services based in public schools." In fact, the same kind of continual turnover was occurring in all five cities—not just with school superintendents but also with mayors, city managers, police chiefs, health and human service commissioners, city council members, county commissioners, and others.

Then, of course, there was the economy, which had been in reasonably good shape during the first few years of the initiative but started going downhill in 2001. Judge Freddie Burton, Jr., who chairs the board of Mayor's Time in Detroit, puts it bluntly: "Our biggest challenge has been money. We here in Michigan are experiencing some major downturns in our major industry, and that has slowed us down. We have achieved our goal of 50 percent participation [in after-school activities], but I wish we could get closer to 100 percent. There is still such a need."

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## Summing Up

After a decade of activities, what has the Urban Health Initiative accomplished?

In its final report to the Foundation in early 2006, the NPO offered this statistical summary:

*Though sites varied in their success, four of the five final sites either achieved scale in one or more of their strategies or demonstrated that they were on a trajectory to reach scale within a reasonable period of time. Detroit's Mayor's Time, at the end of 10 years, will have reached over 40,000 young people in its after-school strategy. Baltimore's Safe & Sound Campaign reached nearly 3,000 families with home visitation and center-based care, and its after-school strategy reached nearly 24,000 young people. Philadelphia Safe and Sound reached over 45,000 young people with its after-school effort, and about 600 with its Youth Violence Reduction Partnership, which targeted a small number of particularly high-risk offenders. Oakland's Safe*

*Passages achieved or exceeded scale in two its strategies, after-school activities for middle school youth and integration of mental health services into the school day. Richmond's Youth Matters, the only site failing to demonstrate adequate movement toward scale, still reached nearly 10,000 children with enhanced teaching experiences as a result of its strategy to improve the quality of preschool.*

In other words, according to the NPO, four of the five sites had either reached, or were within striking distance of reaching, enough children in their cities with effective interventions to make a substantial dent in their “denominators.”

Whether this will translate into a corresponding improvement in the cities’ child health statistics remains an open question—in part because, as the NPO notes, it could take several years of sustained service at scale to significantly change outcomes, and in part because the kinds of health outcomes that the sites were targeting—youth violence, substance abuse, teen pregnancy, child abuse and neglect—are ultimately subject to a wide range of influences that lie beyond the control of the sites. Not the least of these, according to the evaluation team, is the extensive migration both into and out of the five cities over the 10 years of the Urban Health Initiative, meaning that any changes in city health statistics that are detected may have more to do with changes in the population than with the impact of any specific interventions.

In addition to programmatic activities, the sites have leveraged a considerable amount of money. “In total,” according to the NPO, “the sites report that they will have succeeded in establishing continuing investments in their strategies of well over \$200 million annually.” If this level of funding is maintained over time, it will represent an impressive rate of return on the \$65 million that the Robert Wood Johnson Foundation invested in the Urban Health Initiative over a 10-year period.

Perhaps as important as the amount is the fact that much of this leveraged money is being redirected into prevention services—a change that, as the NPO notes, “was not an easy task.” In Philadelphia, for example, the share of the city’s human services budget dedicated to prevention rose from 2 percent to 13 percent between 1999 and 2006; actual expenditures rose from \$7.8 million to \$85.2 million, more than a tenfold increase. Moreover, Philadelphia Safe and Sound played a major role in securing an agreement for two of the city’s professional sports teams—the Phillies and the Eagles—each to donate a million dollars a year to a children’s fund for the next 30 years.

Baltimore, meanwhile, has negotiated an agreement with its state government, called the Maryland Opportunity Compact, which, according to Safe & Sound executive director Hathaway Ferebee, “is a new financing and accountability tool that redirects funding away from custodial programs to interventions that produce positive results,” such as the provision of intensive case management services for foster care children whose parents have substance abuse problems. Based on a model program in San Diego, this case management approach is expected to reduce the average length of stay in foster care, yielding savings to the state of as much as \$30,000 per child.

The numbers and the dollars, however, are not the whole story. In the cities themselves, those close to the Urban Health Initiative see its effects as highly positive. In Oakland, David Kears—who, as the county’s long-time health director, has been involved from the beginning—sees its greatest accomplishment as “the true integration of the city, the county, and the schools—especially the

schools—not only within [the Urban Health Initiative] but also beyond.” In Detroit, Judge Freddie Burton says that the initiative “is galvanizing a partnership across lines, whether it be racial lines, ethnic lines—whatever.” Grenaé Dudley, the project’s executive director in Detroit since 1998, adds that after many years of widespread reluctance to become involved in after-school programming, “this year every Detroit public school was at the After-School Fair—all 280 schools!” Douglas Nelson, president of the Annie E. Casey Foundation, notes that “prior to the work of the Safe & Sound Campaign [in Baltimore] there was neither a centralized nor an accessible data source to inform public policy and public and private investments on behalf of children, youth, and families.”

The evaluation team, which has not yet completed its work, offers its own preliminary assessment of the initiative. In brief summary, the evaluators found that the Urban Health Initiative had had a measurable but modest impact in its major areas of focus. “None of these cities have been totally turned around by the Urban Health Initiative,” says Beth Weitzman, the principal investigator on the evaluation (which had not been published as this book went to press). However, she continues, “There is concrete evidence that each of the sites did achieve some tangible changes in the way business was being done, and some of them are remarkable, especially given the way that the economy tanked in 2001. Oakland, for instance, has really gotten into this sort of blending of funds, and thinking creatively about funding. We interviewed the new head of juvenile justice there... and he said the strangest thing for him was that he would go to a meeting with a problem like truancy, and the school system person and the health department person would each say, ‘OK, well, I think I can kick in this much toward that.’ He said he’d never seen anything like it before—and he was someone who’d been around.”

Finally, there is the perspective of Harvard’s William Julius Wilson, whose seminar series brought together the ground troops of the Urban Health Initiative with some of the nation’s leading urban researchers in an ongoing dialogue: “The Urban Health Initiative provides us with a unique opportunity to better understand how a focus on the organizational infrastructure of social service systems can produce lasting improvements in the way that cities address residents’ health and safety issues. Through the work of effective intermediaries who function as critical buffers between policy-makers and the people they serve, the Urban Health Initiative model warrants serious consideration as a mechanism for tackling complex problems.”

In the end, what do all of these numbers and all of these changes in complex urban financing and service delivery systems add up to at a human level? Simply stated, they mean that genuine positive change is possible, even in some of our most distressed cities, and that Luis Cartagena’s son, Adam—along with many thousands of children like him in the five cities of the Urban Health Initiative—does have a better chance than his father had to be healthy and safe and to succeed in life.

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**Notes**

1. Larson T, Sanoff A and Ellis M. "Five Cities Are Improving the Odds for Their Children: Here's How." Seattle: Urban Health Initiative National Program Office, Institute for Community Change, 11.
2. Wielawski I. "The Fighting Back Program." In *To Improve Health and Health Care, Vol. VII: The Robert Wood Johnson Foundation Anthology*. San Francisco: Jossey-Bass, 2004.
3. Larson, Sanoff and Ellis, 11.
4. Larson, Sanof, and Ellis, 12.
5. Larson, Sanoff and Ellis, 20.