

Partnering to Pay for MCH

June 6, 2006

AUDREY YOWELL: Good afternoon. Welcome to our webcast. Partnering to pay for maternal and child health. I'm Audrey Yowell. A public health analyst at the US Department of Health and human services, health resources and services administration, maternal and child health bureau. Before we start, I want to review links that you can use to your computer interface during the webcast. Slides will appear in the central window on your screen, and should advance automatically. The slide changes are synchronized with the speakers' presentations, you don't need to do anything to advance the slides. But you may need to adjust the timing of the slide changes to match the audio by using the slide delay control at the top of the messaging window. We encourage you to ask the speakers questions at any time during the presentation by typing your question in the white message window on the right -- on the right of the interface. Select questions for speaker from the drop down menu and hit send. Please include your state or organization and your message. We will e-mail a response to you after the Web fast. We encourage you to submit your questions at any time during the broadcast.

On the left of the interface, it's the video window. You can adjust the volume of the audio using the volume control slider, which you can access by clicking on the loud speaker icon. Those of you who selected accessibility features when you registered will see text captioning underneath the video window. At the end of the broadcast, the interface will close automatically and you'll have the opportunity to fill out an on line evaluation. Please

take a couple of minutes to do so. Your responses help us plan future broadcasts in this series and improve our technical support.

The next slide, please. The idea for this webcast emerged out of the concern of maternal and child health bureau grantees who participate in our alliance for information on our MCH programs, called AIM. It's a collaborative maternal and child health bureau grantee. The AIM grantees are national membership organizations whose members include decision makers within state and local government, and MCH profession, foundation, the health insurance industry in business as well as advocates for families. The purpose of the AIM collaborative is to help members of these organizations make well informed decisions affecting public health policies and programs for women, children and family, as well as to alert the maternal and child health bureau to emerging maternal and child health issues across the nation. The grantees under the two MCHB programs are part of the programs for partnerships to promote maternal and child health, which is composed of grantee organizations whose members focus on maternal and child health specifically. Grantees under the improving UIMCH program include organizations whose members have decision-making responsibilities for maternal and child health as well as many other areas of concern.

Next slide. We have 16 AIM partners and they are listed on the slide that you now see on your screen. Maternal and child health bureau is the 17th equal partner in this collaborative. In looking down the list, you may note that the first -- note the diversity among the types of organizations that participate in AIM.

Next slide. The value of the IUMCH and PPMCH grant programs alone, we believe there is a great deal of added value in convening the two programs together. It provides opportunities for these organizations that have very different perspectives to share their expertise and concerns and to educate one another as well as the maternal and child health bureau about emerging issues and promising practices in MCH. During the first AIM meeting that we had in February 2006, a great deal of concern was expressed by AIM grantees about how to continue to support and maintain essential MCH programs and services in the current climate of fiscal austerity. This webcast is the first of two that emerged to address this challenge.

Today 's webcast is going to explore the perspectives of decision makers in business, health insurance, and philanthropy. We will be holding a second webcast on September 20 of this year to address the thinking of organizations representing state and local government officials. For more information about the AIM collaborative, or the September webcast, you can reach me by e-mail at ayowell at hrsa.gov or 301 - 443 - 4292. And now, to I didn't know our discussion of partnering to pay for MCH, I'm pleased to introduce our first presenter. Ron Finch, director for the center of prevention and health at the National Business Group on health. Ron ? Ron ?

RON FINCH: Yes. I lost connection. I'm Ron Finch, vice president of the National Business Group on health and I'm here to discuss our concerns about ongoing funding and with maternal and child health issues. I'm grateful to be invited to attend this webcast. Let me tell you a little bit about the National Business Group on health. Next slide, please.

We're the national voice of large employers, are members of the fortune 500 companies, and we develop healthcare solutions and strategies for our members so that they can address their ongoing healthcare issues. We are not a lobbying organization, but we do get asked to give positions about different policy issues. More lately around the Medicare prescription drugs and as well as consumer driven healthcare. We have about 2 45 members. It's a fairly dynamic membership. In that our members sometimes buy each other from day-to-day, and so that influences the number of members. We currently have 62 of the fortune 100 companies. And they provide healthcare coverage to over 50 million beneficiaries, retirees and their family members. Of About 17 million of the beneficiaries are children and adolescence.

The National Business Group on healthcare was formed in 1974, so it's been in Washington for a while. I'd like to discuss a little bit about, the next slide, the employer problems. I talked a bit about what the problems about healthcare actually is. Our healthcare costs have been rising, and yet there has not been a parallel in the rise in quality. Costs for employers has more than doubled in the past six years. And drug costs is rising for prescription medicines. One of the issues that we're dealing with is the current obesity epidemic and we crossed, as a result of obesity, the costs continue to rise. We currently see no end in sight in this increase in costs. Next slide, please. If we take a look at our costs in the US, as compared to other countries, we are the most expensive in the world and we have problems of mistakes and mismatches. The ILM reports that we have between 44,000 and 98,000 deaths each year in hospitals that are a result of preventable mistakes. That is an aircraft jumbo jet crash every day of the week. And there are a few

incentives in our medical system and our payment system that will be incenting change, and a change in quality.

Let me outline the -- next slide, please. If we continue to pay for the -- we continue to pay for the same quality of care we pay the same amount for poor quality as for excellent quality. Right now, we are wasting, for example, over \$500 million every year for the inappropriate and the antibiotics that we are prescribing. If we look at the Rand study, the Beth McGlinn study, we are only driven at delivering healthcare as recommended only about half the time.

Next slide please. And this actually shows the -- how care is actually delivered as a percentage of recommended care from a very high, 68.5 percent for low back pain. But if we take a look at alcohol dependence, we are only actually delivering 10.5 percent of the care that is indicated. That means that 85 percent of the care that is indicated is actually not being delivered. And we take a look in this particular slide, we can see that there are a number of chronic conditions that are being treated very badly. Next slide, please. And as our costs are -- our costs are projected to continue to go up. By 2011, our healthcare costs will equal 17 percent of the gross domestic product. That is, if we take a look at 1980, we can see there is only about 5 percent of the GDP at that time.

Next slide, please. Our immediate problem is that our costs are going up with that unequal quality. The cost is up 50 percent in the last few years, including 14 percent in 2003. 14 percent in 2004 and another increase of 10 percent in 2005. Although our Medicare

coverage will be capped in terms of the employer responsibility, the Medicare costs will explode as the baby boomers move into Medicare over the next few years.

Next slide. We have this uncertainty in our economic conditions that we -- as we take a look at the paper today. We see that the fed chairman is talking about inflation at the same time as an economic slow down. And the markets are starting to reflect these concerns. In the early 2000s, we went through a recession with earning losses. Our economy lost over \$2 mil -- over 2 million jobs. Thankfully we are starting to see job growth again. But our recovery continues to be relatively weak. And we start to see that our pay packages and our increases in salaries are relatively flat. Our benefit packages and costs of healthcare are going up and that forces employers to make decisions about whether to continue to offer healthcare benefits or whether to put that money into salaries. Most employers are continuing to choose to pay healthcare costs with little cost being passed on to the -- with little cost being passed on to the beneficiaries or the employees.

The next slide gives us a sense of the increase in costs. Family coverage in 2001, the cost was a little over \$ 7,000 for that family plan. In 2006, we will see that cost rise to about \$14,500. That cost will continue to increase. But it will also cost smaller and mid sized employers to re think their role of providing healthcare coverage. We have seen a number of uninsured go up and we're seeing the projection that the number of uninsured will rise this particular year will be up to 5.1 -- about 5.1 million or up to 54 million people in this country will be uninsured. And we need to think in terms of what are the effective cost control measures that are needed? The picture for employers will continue to be more and

more complicated. The next slide. And looking ahead, we have an aging workforce and employers will be continually reliant on this workforce to stay in the workplace. There is not a cohort of workers behind this current workforce to replace the current workforce. And we are looking at -- and those who are entering into the workforce, they are less healthy than previous generations. Those employees that are being hired now are actually requiring employers to rethink their benefit strategy and think about programs of health promotion to keep even the younger workforce healthy and on the job and productive. Our children are less and adolescents are less healthy, primarily due to the lack of activity that is causing obesity. We're now starting to see metabolic syndrome in children. That was something that was not seen normally a few years ago. The incidence of hypertension is increasing, something that was not seen in children very often, just also just a few years ago.

Next slide. This slide just shows how the population is projected out to 20 50 by age group. You can see by this particular slide, there is this aging of the population and without that sufficient number of younger people entering the workforce. And this is a really significant problem for employers. Next slide, please. Why do we have the problems in care and the costs ? There is currently a lack of standardization of the kind of delivery of care and the payment for care. There is a lack of standardization on what is purchased by payers, and there is a lack of standardization of what services are needed across populations. For example, one particular employer may pay for certain kinds of services for children while another employer may have a totally different approach to benefits for that same population. There is also a lack of integration across geography as well as

among provider types. That is kind of horizontal and vertical integration that we talk about. The result is that there is a fragmentation in the delivery of care. A real obvious example of that is the lack of coordination between the behavioral health delivery system and the general medical system and then further detached from that is the fragmentation between general medical care and pharmacy benefits. And on top of that, there is a general lack of accountability across -- from payers and from providers. And that is prompting employers to take a look at new approaches of paying based on the delivery of evidence based services as well as poor performance strategies.

This leads to the conversation of why we need MCHB. We here at the business group have been very fortunate to have a longstanding relationship with MCHB. We are in a contract that will take us through 20 years of services and work with the individual organizations. It has acted as a unifying force, not only among the different types of organizations that MCHB contracts with. It's acting as a unifying force with our employer members, and MCHB brings to us, this organization, care standards that are needed that we here as an organization that translate science into practical usable solutions for employers. They bring those standards of care that we can translate and then employers actually use. Beginning back in the early '90s, the standards for breastfeeding in the workplace and now the designing of benefits for children and adolescents and mothers. They also bring to us standard of measurement and evaluation where we can start to take a look with working directly with employers to evaluate the benefits and programs that are in place to insure that excellence is achieved in the delivery of healthcare services.

Next slide. And this says why do we need MCHB? The innovative practices that come out of the discussions that we have with MCHB and the innovative practices get manifest in different types of benefits. One of the concerns that we have -- that we have had as we move by employers to consumer directed healthcare, highly deductible programs. It's important that we ought to line for employers the type of services that are needed by children and adolescents and mothers in those types of services. It would be easy, I think, for some not to think about these populations that need to be included in these programs, and we need to define very specifically the services that are necessary for good health. For those of you who do not now work with employers, there are various types of healthcare programs that employers actually have in the workplace, especially the fortune 500 companies. There is the healthcare plan. The healthcare benefits. Some of you may refer to this as insurance. But the fortune 500 companies don't really purchase insurance. They are self-insured and they buy care through a healthcare company. So it's the healthcare benefit design that can be influenced and is influenced by the services from MCHB.

Employers have health promotion programs or wellness programs. Some of these are in the worksite, some of these are sponsored through other organizations. Those programs need to be based on science and programs of health promotion and wellness for children and adolescents need to be examined more care fully, and we are using the science from MCHB for development of those programs. There are disability management programs, and we are very concerned that employees become disabled as -- or work as a result of being a caregiver, we are very concerned about maternal depression and the disabling of

maternal depression, how that affects children and we have specialized programs for employees and employers to help in those areas. Employee assistance programs. The number one problem for employers is surrounding family issues, especially raising children and the kinds of healthcare issues that are presented -- that present for children across the population. Employee assistance programs are in a continual search for material and information to help employees and their families so we are continuing to provide information from MCHB to employee assistance programs. So those four types, healthcare benefits, healthcare wellness, and disability that we are concerned about providing. That concludes my presentation. Our next speaker is Nancy Chockley, president and CEO of the national Institute for melt care management foundation. Thank you -- Healthcare Management foundation. Thank you.

NANCY CHOCKLEY: Thank you, Ron. And thank you, Audrey, for organizing such a great webcast. We're just delighted to participate in it. And it's a very important topic. I'd like to start out by going through three areas. One I'd like to tell everyone a little bit about the national institute for Healthcare Management foundation. And what our commitment is to maternal and child health. I'd like to then talk about some of the trends that Ron has already brought up that really affect both the public and the private sector and talk about how health plans are re responding to that. But you'll see that there is a feeling that we have to partner. These issues are too big for one sector to address. Then I'd like to conclude with some examples of what health plans are doing to address maternal and child health needs.

Next slide. The foundation is a nonprofit organization based here in DC. We were created in 1993. Our mission is really to promote public and private sector partnerships to try to help solve some of these pressing problems. We're governed by a board of directors that include CEO s of ten Blue Cross/Blue Shield plans and an advisory board of some of the most well-known names in health policy. Our ten CEOs that run the ten health plans, they account for about 28 percent of the insured lives under 65. They cover about 28 percent of the market. So we have a very focused relationship at the top with these health plans.

The next slide you'll see is a list of the CEO s that make up the board members and our advisory board. Our commitment to maternal and child health really started with our relationship with the bureau. We have had a relationship going back ten years and through that I think we have really built a pretty effective capacity on this issue. Again, our relationship has really been to try to highlight maternal and child health issues to our health plans, but also promote what health plans are doing within the health plan community. So, you'll see we focused on a number of areas, including women's health, children's mental health, childhood obesity, adolescent and young adult health, et cetera. Currently, we're focused on healthcare disparities in children. We feel like our work with MCHB has had real impact with the health plans. They have adopted a number of the programs that we presented at our different forums. And in addition, we have leveraged our relationships with maternal and child health bureau with other agencies, such as CDC, to try to cost effectively promote women and children's health across a broader arena. In addition, NIHCM foundation conducted research we did research with Rand, looking at the effect that PE has on kindergarteners and first grader, both on the BMI and also their

mental health and school performance. Where we saw the greatest impact was PE programs have a tremendous impact for sedentary girls. And, in fact, if we could only increase PE one additional hour a week, it would reduce the number of overweight five and six year old girls by as much as 10 percent. If all the schools provided the recommended amount of PE, about five hours a week, we would actually be able to reduce the number of girls that are overweight by 43 percent. And those at risk of being overweight by 60 percent.

So, we feel very strongly about promoting PE programs in schools. It has a tremendous effect. We did produce three peer review journal articles. We got an AP story out of it and it was picked up in about 25 papers. Now, I'd like to finish the commercial about NIHCM and our commitment and talk about the broader healthcare trends. I'd like to talk about them as they affect both the public and private sector, because these issues are things that we need to come together and address. Like Ron, I'm starting out with healthcare costs are going up. And this has tremendous implications for everyone. The Federal Government, the state and local governments, for employers, for the consumers and the uninsured. In 20 11, we have the baby boomers retiring. That is going to blow the budget of Medicare and Medicaid. Ron has already talked about the pressure on employers. We have all heard the story about how the cars coming out of Detroit have a -- the healthcare costs are a greater percentage of the cost of the car than the seal is. And in an increasingly global world, employers are suffering under the weight of the increasing healthcare costs. Consumer wages have not kept up with the increase in healthcare costs,

and they are suffering. And we see the growing ranks of the uninsured. So everybody is suffering under the high healthcare costs.

The next slide talks about the key drivers of healthcare costs. The number one -- one of the most important drivers is the increasing prevalence and treatment of chronic conditions. That is asthma, diabetes, and most importantly obesity and obesity related diseases. We have the aging of the population of course contributing, as Ron mentioned, addressed in technologies and new drugs also contribute to the increase in costs. You have market changes, you have hospitals consolidating, et cetera, and that there is less competition. One of the key drivers that health plans are really focused on is addressing chronic conditions. And this is one where we really need to join together to work on it. 80 percent of healthcare spending is associated with chronic conditions. And it's estimated that over the last 20 years or so, the increase in prevalence of obesity accounted for 27 percent of the increase in total care -- total healthcare spending. What health plans are doing to respond to this is they are developing more wellness programs in conjunction with employers. They are doing disease management. Pay for performance. They are trying to identify people at risk earlier, and they're doing name of community-based programs.

So as healthcare costs are escalating, let's look to see who is paying for healthcare costs. And you can look at the percentages for 2005 as a reference point we have put on the percentages for 1975 as well, and then the changes. And what has happened is private insurance has actually picked up a larger piece of it, now about 35 percent of the total. Out

of pocket has actually shrunk. This is counter intuitive to what we all feel every day and what we read about. But as a percentage of the total out of pocket has actually shrunk. But in absolute dollars it increased, in 75 it was 37 billion. In 2005, it was \$2 36 billion. And that's why we all feel it. But total healthcare costs are growing at a much faster rate than that, so the percentage is shrinking. Other private, it's been about the same. State and local has been the same. A modest shrink and the Federal Government picked up a greater percentage of the total.

The next slide talks about insurance products and one of the drivers to the shrinking out of pocket percent is the shift to managed care, which began to cover drugs. It offered prescription drug coverage and it also covered coverage of routine care, preventive care, checkups, et cetera. You'll see that in 1988, about 73 percent of the market was in what fee for service or indemnity. Now that is down to about approximate percent and pretty much everybody is in managed care. Like it or not, it has helped without of pocket costs. Going forward, there is the growing interest by employers in consumer directed products. The high deductible products Ron mentioned, enrollment has doubled in 2005 -2006. 6 million people. It's still a very small percentage of the total. The good news on that is about 30 percent of the people who are enrolling were previously uninsured. However, there is a lot of concern about these high deductible products, and that they may be better suited for healthier, wealthier people than the people with chronic conditions. So it will be interesting to see how the market moves on that. But currently it's the product that is -- it's a product that is growing. Over time, because of the expense of insurance on the next slide you'll

see that private insurance is decreasing as a percentage of the total coverage and that a greater percentage is being picked up in Medicare, Medicaid, and in the uninsured.

Private insurance in absolute dollars, though -- in absolute people has been increasing. This trend is likely to continue. We wanted to focus on where do women and children get coverage. Let's start with women. Most women do get their health insurance through their employer. You'll see 63 percent get it through employers. The individual private market, about 6 percent. Medicaid, about 9 percent. Other public, about 3 percent. And about 19 percent of women are uninsured, which is higher than the average. Women -- than the average. Women are critically important to the consumption and the delivery of healthcare in this country. We are the key decision makers in their families for their own health and for the health of their families. So they are targeted with a lot of the information that is being sent out. In addition, they are growing important in terms of delivery in medical schools this year over half of the entering students will be women.

The vast majority of nurses, nurse practitioners, midwives and hospital aides are women. In terms of children, most people get their health insurance through the family coverage, through employers. But you'll see that Medicaid and SCHIP has about 26 percent of the total. So a lot of children are getting their healthcare from Medicaid and SCHIP.

Unfortunately, still 12 percent are uninsured. One of the important trends that is facing children, but all of us in this country, is the growing diversity of the US population. And our healthcare system needs to respond to that. Nearly half of the nation's children under 5 are from racial or ethnic minorities. People of color make up nearly a third of the US

population today. But by 20 50, it's projected they will make up nearly half of the US population. This has a lot of implications for everybody who is working in healthcare, particularly the delivery of healthcare. For health plans, what it means, though, is working to understand and eliminate disparity in care. As I mentioned, that is our focus area for this year with the maternal and child healthcare partners. We need to make the system work competently, and we are designing and marketing affordable products to increase minorities' access to coverage. With that, I'd like to now turn over the discussion to what are health plans doing to address the needs of women and children. And health plans address the needs of women and children by serving their general members.

The next slide, please, through their general member, through the commercial Medicaid and Medicare population. They are also developing programs specifically for women and children. And they are also funding community-based programs affecting women and children. And I'm excited to announce today, because it just came out yesterday, that Highmark has given their foundation -- Highmark foundation, \$100 million to work on children's health in their local community. So that is a very exciting development. And they have had a long track record on doing a lot in their community for children, and this just shows their commitment. Ron mentioned wellness programs, health plans are working with employers to develop wellness programs. All of the health plans have programs. I've got a couple highlighted here as examples. We have Highmark working with their system trying to promote healthier behavior in children. WellPoint, offering better beginnings programs. Actually, preconception and prenatal care. And then we mention here Horizon, Blue Cross/Blue Shield of New Jersey sends out quarterly healthcare newsletters,

bilingual reminders for annual exams, and utilizing a telephonic health reminder system. And this -- reminder system.

This sounds routine, reminding women to get their checkup. But I have to tell you that it actually saved my mother's life. She got a letter from her health plan saying that she had not been in for a Pap smear for five years. She went in and she had cancer but it was detected early enough and she recovered from that. While this is low tech, I can tell you it has very important implications. Treating and preventing chronic conditions. As we talked about at the beginning of the presentation, it is, you know, the number one issue facing our healthcare system. It's what is driving up the cost of our healthcare system. It's making us live unhealthy, more said ten tear lives. Some of the things that the health plans are doing, I'll start with Primera. It's an unusual program, but I thought the group would be interested in it. In conjunction with Microsoft, they developed a program to reach out to the advertiseic children in their -- the Autistic children in their employer base. It's intense therapy for these kids, and it's because in the employer community there, they had a disproportionately high autistic rate, and this is what they did to address it with Primera. And I think it's really a noteworthy program. More typically, though, is what you see health plans doing in terms of asthma and diabetes.

Asthma is the most common disease affecting con -- chronic condition affecting children. Today over 6 million kids have asthma. And Blue Cross/Blue Shield of Maine created the asthma health program, and using a lot of intervention, has really moved the needle on keeping the kids healthy. That also saves money, it keeps them out of the hospital. Also,

die beat tea is a big -- diabetes is a big issue for everybody, but particularly women. Blue Cross/Blue Shield of Georgia has a program to again through a lot of intervention, help women try to be empowered to take on a more active role in self managing their condition. So, more -- most typically it's kind of the asthma programs and the diabetes programs, but I did want to mention the P rim era program on autism. Health plans are also addressing the needs of women and children by improving access to insurance. One is through kind of a market based activity. WellPoint developed a tonic program. They market health insurance to 19 to 20 year olds, which is one of the big segments that is uninsured and without insurance. They have done a lot of very interesting marketing research on this. And they developed a very successful product. They are actually in the process of developing some other products now aimed at the uninsured.

They report that over the last two years, WellPoint companies have provided new individual policies to an estimated 7 5 3,000 people. So, it does seem that there is a market need for these low cost products, tailored to specific segments of the uninsured. More typically is what health plans are doing in terms of trying to increase enrollment into some of the state programs that they're in partnership with. An example of that is what Blue Cross of California is doing to increase the enrollment in California's healthy families program, the safe low cost health program for kids. And they are out in parks, in vans, et cetera, looking for people to enroll in these programs. I'd like to conclude with talking about what health plans are doing in community programs. As I mentioned, you know, the big news is Highmark's \$100 million, and everything will sound small compared to that, but they are very active in the communities with these health plans, with their foundation,

looking at ways to help vulnerable populations, oftentimes particularly women and children. Highmark I'll skip, because we talked about their bigger programs, but Blue Cross/Blue Shield of North Carolina, the active kids program, to help support the activity level of the children in North Carolina. North Carolina has one of the highest rates of childhood obesity. WellPoint foundation funded about a 500 thousand dollars effort insures healthy futures grant initiative. Here they are helping community organizations that develop innovative ways to enroll with 1 50,000 low income children and adults who are eligible for Medicare or BADGER CARE.

On the next slide, there is a list of healthcare foundations websites and you can go on the Web sites and see some of the activities that you're doing, see if they don't meet the criteria of things that they are funding as well. They have very specific criteria, so you'll want to make sure there is a match there. In conclusion, the next slide, again, it really starts and ends with healthcare costs are increasing rapidly. That affects both public and the private sectors. And while we're all responding to the growing healthcare costs, we need to do more particularly on pre venting chronic conditions in this country. Reducing desperately needed dollars to the most vulnerable population serves no one and only leads to cost shifting to the insured population and increased costs for aw. so we're all in this together. We all must make the case for continued funding for maternal and child health services. Our children in particular are particularly vulnerable right now to live shorter lives and sicker lives than our generation did. So we really need to focus our efforts on them. And health plans are an important partner in serving women and children. My last slide is just thank you. It's our contact information. And on it has Katherine

Cushner 's project director on this grant. Thank you. Now I'll turn it over to Elise Desjardins, the program associate for Grantmakers in Health.

ELISE DESJARDINS: Good afternoon. Thank you. I want to thank the maternal and child health bureau and Audrey not only for giving us the opportunity today, but also for providing funding that really helps a lot of the work that we do. I work for Grantmakers in Health. It's a national organization, over 200 foundations and corporate giving programs throughout the country that have a priority in funding health. We basically will generate and disseminate information about health issues and grant making strategies for these funders. Part of our core mission is really to build bridges between Grantmakers and policy makers. My goals for the day are to help you understand a bit more about philanthropy, to see how it can collaborate with government and also discuss some of the challenges and opportunities associated with that. And to highlight some successful efforts that have been made. So let's begin with some history and a few definitions, just to make sure we're all on the same page. Essentially, philanthropy can be defined as an active effort to advance human beings. Modern philanthropy was said to begin around the beginning of the 20th century, when individuals used personal and community wealth to seek ways to combat problems of social injustice, hunger, disease, poverty, and little to conduct research and promote science. And this personal wealth and community wealth is channeled through foundations, which were not designed to help the poor people directly, but if you work on the larger -- but to work on the larger social issues and to be instruments for reform. Because of this history and the fundamental common ground, foundations see themselves more as agents of change and not just simply check writers.

And so the next slide, this is the foundation center's definition of a foundation. And they are sort of the penultimate group and experts on knowing what foundations are. And so for here, you can read it yourself. But I bolded the important words, which are really making grants for charitable purposes. And that is really the essence of what a foundation or what philanthropy is. There are more than 66,000 foundations in the United States today. And on the next slide you'll see the four different types of foundations. Independent foundations are the most prevalent types in the country. And they tend to have been established by the -- by a person or family of wealth. So when you hear Rockefeller, Ford, we are talking about the independent family foundations here. And most of the new health foundations, some of the ones that Nancy referred to, those were created when non profit healthcare organizations would convert to for-profit status. A lot of hospitals. Or they were sold to a for-profit company.

There were statutes that some of the assets had to be given for charitable purposes. And so that's what we commonly refer to as health conversion foundations. Also, we have corporate foundations, and those were created and funded by business corporations to give money for charitable purposes, and still fit in with their mission. So we have Pfizer, Johnson and Johnson, those have big foundations. Operating foundations are a bit of a different animal. They were established to operate research, or to operate programs, social welfare programs, that were deemed worthwhile by the governing body of the foundation. However, they are not grant making foundations. And so they don't give money away. I have a coworker who used to work for Kaiser Foundation, which is a good

example of an operating foundation, they do research and policy analysis. She used to joke when she worked there, she went to meetings and under her name tag it said "I do not give away money." so that gives you an idea of the operating foundations. Community foundations are supported by and operated for the benefit of a specific community or region. The first three foundations listed there are credit foundations, whereas community foundation is public.

On the next slide, you can see the various ways that philanthropy shows its diversity. There is extreme diversity in the field. Foundations can differ from each other in many ways, including asset size, staff size, mission, strategies that they use. Foundations have assets ranging from \$1 million to over \$7 billion. And staff that range from two people to over 2 00 people. And so within that, there is just many different variations of foundations. Some were formed earlier, at the turn of the century. And others are very, very new. Foundations can fund nationally, internationally, and others may focus on a particular county, city, state or region, depending on how they are set up. And some will fund health exclusively, particularly the health conversion foundation. But other foundations will use health as one priority area to really address the issues in the community or society as a whole. They also may work on issues of housing, income security, education and poverty. And even those who do fund health fund it very differently. Foundations priorities can range from mental healthcare to biomedical research, to women's healthcare. It really, you know, running the -- runs the gamut of the very best health sector.

Strategies are also different and I think this is really important to note in relation to collaboration, especially with government. Foundations may be best known for funding direct service. But foundations also really invest in several education campaigns, academic research, follow policy analysis, policy reform. And the way that funders choose to approach this work can create interesting tensions and dynamics when working with the public sector. And the next slide, we will just -- we're going to go into funding trends here. A little data for you. Funding health reached a record high in 2004. 3.4 billion. This was the most recent year for which data are available. And it's a very high percentage of total foundation giving. It's about 22 percent of total philanthropy is dedicated to health. But what we need to remember is that it's an extremely small percentage of national spending on healthcare. In fact, I think in 2004, the total dollar amount, national spending on healthcare, was \$1.4 trillion. \$3.4 billion sounds like a lot of money, but compared to 1.4 trillion, it's really pocket change.

The next slide will show you where philanthropy is spending its money. Health is one of the top three, education, health and human services. These data come from the foundation center and are representative of about the top 1100 foundations in the country and represent I think about 50 percent of the total grants. So, while these data cannot necessarily be definitive, I do trust that they are suggestive of the trends and from what I've seen in my own research.

The next slide will show you how the grant making dollars are parsed out within house. Most funding is direct service and program support. And so you can see -- these are kind

of the areas in which health dollars are allocated. And the categories are somewhat troublesome. If you think about a particular grant or initiative, it may fall under several of these or two or maybe nothing. And so that is kind of, you know, again, suggestive not definitive. There is good news. Funding for children is on the rise. I think Dr. McGencey will explain a bit of this later, but children are the number one population funded within health philanthropy. So that is very good news. So what is the case for collaboration? Why do foundations need to collaborate in order to pursue their missions? Well, I think there are a lot of qualities involved here. And a foundation's purpose, really, the history that they are based on is more than just throwing money at the problem. I think that in light of having this small percentage of total health funding, philanthropy needs to be strategic about how it spends its money and really leverage its resources and form partnerships, because this is, you know, it's obviously not just the money that is going to work, it's the partnerships and the relationships that are formed as a result.

Foundation can have very specific missions and visions, and so they have to adhere to the missions and visions in a way that may not be obvious to everyone. And you know, there are other restrictions, too. When the economy is in trouble, you know, it kind of hits every sector sort of in different ways. And so if the economy is in trouble, there are fewer tax dollars to spend, corporations have trouble with their bottom line and grant making budgets also fall. And so in these times of lean dollars, funders are also among those who are forced to make really difficult decisions about what to do with their money. And so, you know, adhering to their mission of really maximizing their grant making dollars, it's very important as it is in government and as in business to really make the right decision about

what to do with their money. Some of the barriers to collaboration are really based on the perceptions -- perceptions and differences between organizations that are trying to pull together. When one side does not clearly understand the other and vice versa, problems can and often do arise. And so it really may take time to get past the pre conceived notions, but it's successful for a -- but it's essential for a successful partnership. There is that perception that philanthropy can come in and fill those gaps and fix all the problems. But the reality, again, as I'll say and I'll probably say it again is that the total grant making dollars just simply cannot, they are not up to the task of meeting that challenge. And really those dollars pale in comparison. Some can argue that foundations should increase their pay outs, and spend more money on their grant making. But the reality is that the foundations were created to exist in perpetuity. And so they are really there to fund issues in social justice, health and poverty, for generations to come and not just in the short-term. So, they have all of these things to think about when giving out money.

The second issue is risk. In the public sector, there -- and in the corporate sector, there are different calculus -- there is a different calculus for risk. In a foundation, there are no re-elections, there are no taxpayers to A p p e a s e necessarily and in a corporation there are no stakeholders. The bottom line is definitely different. And so while foundations do have to adhere to their mission and, you know, answer and be accountable to their Board of Trustees or board of directors, they have much greater opportunity to take risks. And so partnering with the public sector can really get some innovative programs down the pike and kind of open up that area. And there are also differences in culture. I think these are probably the first and most obvious. Philanthropy and government have vastly different

ways of doing things and what needs to happen is they really need to understand each other, understand the way each organization works when they come together to start a partnership or a relationship. We really need to speak each other's language and be able to bridge those differences. I think that is very important. And I also think that understanding these barriers, knowing that they are there, is really half the battle. Because they are not insurmountable. I think it takes extra time and patience and willingness. And so the opportunities for collaboration are very -- there are several. And they are very vast. I think that once there is an agreement to pursue collaboration, it can really result in a multitude of opportunities to work together.

The first few on the side, accessing and delivery system really go together. I think at in point that a foundation chooses to fund access to healthcare, they are going to have to collaborate with the government in some way. That's just a given. And learning opportunities are another way that philanthropy can really get involved in the community and reach out to public officials. For instance, public officials may rely on the research and the reports that a foundation compiles about a specific issue in their community, in their state or across the nation. And so this research and these analyses are very important and can help push and drive the really emerging and important issues in the sector. Another way that foundations can enhance learning is to convene the public. And so to really organize a community around an issue or organize a group of public officials around a certain issue, and they are very good opportunities for the foundation to bring in -- to bring together the public. And they are meant -- foundations kind of have a neutral sort of position, and so it really helps facilitate some of these conversations.

Policy analysis. Again, foundations are meant to be seen as neutral. But, you know, these -- the work that they can do and the things that they can fund are very broad. And so they can really work on these issues. Providing direct support. Not only can foundations provide direct support for human services agencies or health agencies based in their community or across the country, they can also provide direct grants to government agencies, usually at the local level for direct delivery of services. Usually it's local departments of health that are funded, school based health centers, or healthy start programs. But this is the area kind of where the controversy seems to emerge. I think the thing that is on the minds of money funders is really the question where government responsibility ends and where foundation opportunities begins. And so that is another discussion that needs to be really brought on the table. The government clearly has the infrastructure in place, the programs are being operated, and maybe not reaching as many people that are in need, and this is kind of where philanthropy can come in, leverage its resource, and spread the wealth, so to speak.

And so now, I think we will focus on some important grants examples. And this list is by no means meant to be exhaustive. There are millions of things, thousands and millions of things that foundations are doing to promote maternal and child health. I've chosen to focus mainly on increased -- increasing health access, healthcare access. Foundations can work in a number of ways. To facilitate enrollment in public insurance programs, head Medicaid and SCHIP. Most children are eligible for those programs, and so it's a matter of getting them in the programs. Probably the most well-known is the covering kids initiative,

which was launched by the Robert Wood Johnson Foundation in 1997. Wildly successful. The purpose of this initiative was to help state and local communities to increase enrollment in public coverage, thereby decreasing the number of uninsured children. At first, the foundation's board authorized \$13 million to run the program in 16 states. But the response was so overwhelming that the board re-extended and increased the amount to \$43 million to serve in all 50 states and the district of Columbia. And so this program is very well-known and has played a key role in increasing enrollment in public programs. The foundation actually extended and created a follow-up program for -- created a follow-up program called "Covering kids and families in 2001." programs have also been run on the local level.

The John Watson in North Carolina foundation has done a lot to help. These programs were successful and increased the numbers of children enrolled by 14 to 18 percent. There are various ways that foundations use to get involved in increasing access. But, with all of this talk about insurance, we must recognize that having insurance is not always sufficient. And so many foundations choose to work on the delivery system itself. And this for maternal and child health can mainly be seen in the area of school based health. And I think it was the Robert Wood Johnson Foundation that did a study and said that one in ten school based health centers, you see funding from a foundation. And so it's a hot issue and one that receives a high rate of philanthropic dollars. And to be sustainable they need financing and public support. There has to be a lot of public education, work in the schools, work with the families, in order to stay alive. The third way that foundations can make an impact is to support program evaluation. And I think perhaps one of the most

well-known evaluations and initiatives is the Commonwealth Funds, A, B, C, D, which is assuring better health and development. They worked in collaboration with the national family of state health policy, to enhance delivery of developmental services for low income children. And this program has also been successful and has been expanded and I think they are on their third phase now. So it's promising and interesting to see how the collaborations can work and get issues tackled. In conclusion, I guess I would say that public / private collaborations are essential to improving health. Each side needs to really focus on its strength, what it does well and what it can bring to the table and use those strengths to develop sound relationships. That being said, I think partnerships of any kind are hard work. Challenges -- challenging ways of doing business is huge. It's always difficult. And the patience, commitment and flexibility I think partnerships may really be -- and I'm convinced that partnerships are really what we need to build a strong and sustainable health system. Now I'd like to turn it over to Stephanie McGencey, Executive Director for Grantmakers for children, youth and families.

STEPHANIE MCGENCEY: Good afternoon. Thank you for the opportunity to be on the Web cast today and very specifically to Audrey for your good friendship, partnership, and leadership of the AIM program. All of us are very much indebted to working with you to make this all successful. Elise provided an outstanding overview of philanthropy which I'll try hard not to repeat anything that she did say. But to emphasize and speak specifically about one sector of philanthropy, which is children, youth and families. Grantmakers for children, youth and families, it's a membership association of grant making institutions. We currently work with -- we currently work with over 400 philanthropies engaged with us in one

form or another and have been doing so since 1985. Like GIH, we are not a grant making institution. However, we do work well with the foundations center and others to provide excellent help to you or can provide help to you in your search for foundation dollars. Our mission as shown on the slide is to increase the ability of organized philanthropy to improve the well-being of children, youth and families, and we do that in a number of ways. We serve as a forum to educate grantmakers on key issues, to review and analyze grant making strategies and a caveat to that is to stress five grant making strategies. Exchange information about effective programs. Facilitate partnerships and leverage scarce resources, and that is becoming more and more a big part of our work. Examine public policy development. And to maintain ongoing discussions with national, state and local organizations working on children, youth and family issues.

Next slide. The children, youth and family sector of philanthropy is extremely robust. It's the fastest growing area of philanthropy. Children and youth provided for the largest share of grants in 2004, about 22 or 23 percent for a total of 2.6 billion in actual grant awards. But if you look at that totality of all funding efforts, it's probably a little bit closer to \$4 billion that very specifically focus in on children and youth. One in three grant dollars supports economically disadvantaged children. And one in eight grant dollars support ethnic oration minority children. We have many common goals and on this slide are just a few for public health and philanthropy. I'll confess to being a public health geek, graduate of the University of Michigan public school of health and very much am looking forward to extending our members' understanding of how important public health is in partnership with philanthropy. And so some key ways in which we all work together towards the same

issues. First and foremost, is strengthening families and neighborhoods. Children don't grow up in programs, children grow up in families. The families live in neighborhoods. Services are provided to them in the community context.

Foundations are interested in building a resiliency of children and in focusing on youth development, so they can build skills and ability to make sound decisions that will help them be successful in life. And most importantly, connecting families to resources and services in their communities. Why is GCYF interested in children, youth and families. There is a decreasing public -- a decrease in public funding and services for children, youth and family issues. Coupled with growing numbers and increasing severity of the needs that children, youth and families are presenting to the various systems today. We know that public health plays a key role in the lives of children and families in some very obvious ways and then not so obvious ways. And that private funding for children and youth is strong and increasing. All of that is happening in a very interesting context. The last bullet, philanthropy and had you been health or often working in parallel tracks in communities and we hope to bring them more closely in alignment, so there is better understanding of what is happening on both sides. You'll see here, or you may not be able to see very well, but you can see here that some of the top issues that are regularly funded by the GCYF membership, and in our survey in 2004, we asked them what do they fund? Youth development, clearly a top item, followed closely by early care and education. And in both of those, large topic areas, youth development, that can be everything from youth media to teenage pregnancy prevention, to a wide range of activities, as well as in early care and education, that can include school readiness initiatives. It can be looking at the quality and

availability and accessibility of child care and training for child care providers, and you know, the list is very long.

Followed by child abuse and neglect, parenting education and family support, as rounding out the top five. It's interesting that maternal and child health is at the bottom, but one of the things that we learned over the course of operating this grant over the last year is that a lot of that may have to do with language. It will be interesting to see in the 2006 membership survey if that number in fact increases. As the new MCHB grantee and I can't say how much we are appreciative of being awarded the grant, because we want to use the resources over the in four years now to address -- over the next four years to address the three key things listed here. First and foremost, improving and strengthening our members' understanding of maternal and child healthcare issues. So they will see that some of the things that they were funding that they may not be calling MCH do fall under a larger MCH umbrella. Build and strengthen the application of MCH evidence based research and best practices, and to private philanthropic grant making for children, youth and family. To build public and private partnerships, so we can enhance all of the investments that are being made to children, to support children, youth and families.

Next slide. We have encountered a couple very interesting things over the last year. Some of the key challenges that we have identified is first and foremost that there is a real need to broaden the understanding of the multiple public programs that intersect with what grantmakers are funding for children, youth and families. Like many other broad health topic, often there is a different language. What public health calls mentoring or mental

health, our members may call family support or some other title. So, bringing the gap or closing the gap on the language is going to be very key. And that public programs don't always shift very quickly and I'd like to offer to all of you watching today that private philanthropy doesn't always move as quickly as one may think either. And the speed at which change happens, and the pace at which change is maintained is a very important challenge that we're going to have to address, hopefully working in partnership with one another. And finally, this is a direct quote from a grantmaker that generally foundations don't know that MCH block grants are any different from other health related block grants, or how federal funds are connected at the state level. So how does women, infants and children's program connect with MCH funding and other Title V efforts over all?

Next slide. We have also learned some interesting things. Here are three more quotes from foundations, in terms of their perceptions of MCH. One is from a grantmaker who said she has been in early childhood work and grant making for 30 years. And didn't realize the public resources going into the public side -- the public maternal child health program. And this statement was made at a meeting that we did in January this year, in LA, where we brought four or five state MCH program directors to share what they are doing with a group of foundations. It was fantastic and we will replicate that in a couple different places. Another key learning is that foundations are frequently not invited to the table for strategic planning discussions. When public agencies, when you are planning a new initiative or struggling with moving the needle on a particular topic, I implore you, I ask you to consider inviting foundations, especially those that are in your local community. And to not always think about philanthropy in terms of the larger philanthropy. Over 60

percent of GCYF members only fund at the local or state level. So you have a whole new group of partners that you can call on to be a help and part of your planning effort. MCH is almost too broad a term.

Foundation boards need concrete ideas and specifics. Again, I think this is just a matter of language. And the more that we continue to talk across the table, MCH and philanthropy, we can close the gap here. I think the challenge to MCH programs and community-based organizations that work with children, youth and families is to think of grant makers as partners, and to ask yourselves these three key questions. The first is how do you work together while respecting the individual identity, needs, expertise, and resources of each partner? Take the time to research and learn more about the philanthropies that are in your community, that you choose to invite to be a part of your planning group, and to learn more about your work. The same way that you would study and look on the Web sites of and learn more about partners, other community-based organization partners. Many foundations produce annual reports and their annual reports are very useful pieces of information to learn more about what the philanthropy is interested in.

A second question to ask yourself is what is the range of partnership opportunities where your interests, goals and objectives intersect? So, it's not just to invite a foundation to be a part of a convening or to be a part of their collaborative, without knowing whether or not their grant making guidelines, which Elise described how that works, and how they are restrained in some ways to what their charters may say that they can fund have

relationship and connection to what you're interested in. Lastly, ask yourself where are opportunities to share data, common knowledge and training opportunities?

Next slide. I'm big on context in that all the work that we do most things that happen, do happen in some sort of context. And where we run into challenges is where we don't quite understand what that complete picture is. So I'll talk about three different things. You know, context within philanthropy, some of the I shall issues, I have reminders, admonitions for you and a brief listing of resources. In terms of the foundation context, and the notion that philanthropy is changing, grantmakers, just like your organizations, are feeling the pinch of decreased resources, both internally within the staff available to them and Eli s e alluded to that well, and they are seeking to increase their collaboration s with other organizations. Many of them have the same size of portfolio, now, I said on an earlier slide that the needs that children and families are growing, but philanthropies like many government agencies are facing the restrictions on the amount of dollars that they have available to grant as well. So they have the same amount of money available to them, but some may be choose, instead, to reduce the overall grant size so they can award more grants for more organizations. Some are not requesting any new application, some have reduced staff and their overall operating expenses, so the staff are over burred in ways that they were not before. And some are focusing on projects that they think are sustainable over time, even after the philanthropic investment is no longer available. Grant making for children, youth and families continues to be a high priority.

We have talked about the issues, all of the speakers that preceded me I think did a very good job of that. But one thing -- one reminder, I guess, or admonition here, is to be clear that you as a community-based program or a state or local government agency are not biting off more than you can chew. And I can tell you from being on this side of the grant making table, I like most of you, you know, was a grant seeker for most of my career. Many of the grant proposals that are submitted often promise more than can actually be delivered. So in thinking about grant making being a high priority for many foundations, and everyone wanting to do an earnest and good job, tempering that with the resources and making sure that what your planned outcomes are congruent with the resources that you have available to you. Another quick point or contextual piece around sustainability, some admonitions or reminders, to address the root causes of problems if you can. And to develop a theory of change and a logic model. They are very useful not just because they would help you to be responsive to federal and philanthropic grant proposals, but they are very useful management tools and very often we get stuck on oh, I have to do this because the grant requires it or the RFP requires it without thinking about how useful it can be for us. Measure outcomes and again make sure that they are congruent with the level of effort that you propose. -- that you propose. Diversify, diversify, diversify. Think about the public funding sources available to you, private and not just private philanthropy but businesses and other organizations, and public, not just government entities, but other organizations that exist to serve the public good. Build relationships on the past partnerships. Remember that this takes time. Be aware of delusions of grandeur in terms of not promising things that your organization may have not been able to deliver or the

theory doesn't tell us will follow from some of the program efforts that we implement.

Identify credible and articulate ambassadors to work with you in approaching foundations.

Lastly, be persistent but patient. So much of philanthropy is grounded and built upon building a relationship or establishing a relationship with philanthropy and you know a good relationship does take time to build. One last note on all of these, this contextual piece, is that if you have researched, talked to, you met with one foundation, you have researched, met with, talked to one foundation, Elise described beautifully the diversity that exists within philanthropy and it's important to remember that as you're seeking partnerships. So let's talk about what we mean when we talk about public/private partnerships. And again some key questions to ask yourself. Do we understand each other? How well do we know each other? How would a public/private partnership work? Sometimes it's not always the exchange of dollars as much as it is the bringing of resources to the table, and thinking about how we use our resources in complementary ways as opposed to competitive ways. What does public health know about grantmakers and vice versa? What do grantmakers know about the public health system? And everyone wants to maximize our resources and opportunities, but again, what does this mean and how do we make this happen?

Next slide. Building partnerships with philanthropy, keynote, is that funding is only one element of the partnership. Elise alluded to the fact that philanthropy is a great convener in a community. If you as a public agency had a hard time getting the right people around the table, I would bet, was it the saying, dimes to doughnuts or dollars to doughnuts, that if you can find a way to partner with a local philanthropy and ask them to be the convener of

a community meeting to talk about an issue, certain people might tend to show up for that conversation.

Next slide. But some of the key ways in which you can build partnerships with philanthropy is to rely on their content expertise. By asking them to be a part of your advisory group.

Become planning partners with you and assist in strategic planning efforts. When we look at our membership, nearly 20 percent of GCYM members worked in philanthropy for more than 10 years and 20 percent for more than 15 years. This implies that their knowledge of not only what their own foundation does, but their knowledge of philanthropy and what innovations exist within philanthropy is very deep and it very often will extend to how various philanthropies that partner with public and community-based agencies. Data and assessment. About 20 percent of our members are working on or currently funding social reporting efforts, like this and other data initiatives. Foundations, just like public agencies, have a keen interest in understanding the scope and nature of the problems and challenges facing kids and families today, so that they can better and appropriately place their limited resources to address those needs. About 60 percent of our members are working with or are funding direct services in their community. So they just like you, are invested in making sure that direct support actually makes it into the homes and hands of children, youth and families.

Lastly, Identifying and replicating evidence based programs. If you have an innovative program, philanthropy is interested in knowing about that. GCYF is interested in knowing about that, because it's a neutral goal of all of us to leverage the limited resources that we

have to direct them to the efforts that we know will yield the results that we're hoping for. Next slide. Where are public programs partnering with grantmakers ? Here are just a few examples. And I would encourage you after the webcast is over to take a look at some of the websites. This is a six state effort and it's grantmakers as well as public agencies. Colorado smart start, another very, very excellent partnership example between public agencies and philanthropy and broad based philanthropies within the State of Colorado.

Next slide. I'll conclude, because our time is running short or at least my time is running short, with a couple summary comments for you. And Nancy said this, Ron said this, Elise said this, no public program or philanthropy can do alone what needs to be done to serve children and families. You know, the problem is bigger than all of us. And I must admit that having -- since having been a grantmaker for children, youth and families, when I think about dollar figures, you know, when I said earlier that 2.3 builds in support for children, youth and families, again, like Elise said seems like a lot of money, but at the end of the day it's really not considering the vast needs that exist. Scale and sustainability. They are old challenges, they are not going anywhere. But we have promising examples for how to address them. Private funders have a growing interest in learning how to maximize the return of their investment by forming powerful partnerships with the public sector.

Last slide. This is sort of a pun on one of my favorite stores, home depot there, you can do it and we can help. Here are some of the organizations that are really available or that are available to help you securing not just foundations, information about foundations to help you secure a grant from them, but information about foundations so that you can learn

what resources actually exist in your community and what expertise is available to approach for partnerships. So the chronically of philanthropy, foundation commentary, foundation center, philanthropy journal and news online, all of these have listservs and ways that you can serve and find out -- you can search much and find out what is -- you can search and find out what is happening in philanthropy. All things are difficult before they are easy. Easier said than done as well. Hopefully we will start to think about public /private partnerships as easy, because we will stick with it as unique sectors, philanthropy and the public health side to work through the difficult parts of collaboration. Because it's never easy. I don't know about many of you, but we struggle just trying to find the time to get four or five people together on a conference call. So, you know, we can't even get together to talk, then how do we move forward on the collaboration? But I've been involved in a number of different partnerships, you know, in my work before coming to GCYF and I'm learning so much more about partnerships that exist between philanthropy and the public health system now that I'm here to know that it is well worth of effort. So I encourage all of us to stick with it. I look forward to receiving any questions that anyone might have. And working with my staff, hopefully put together a cogent response to anything that you might ask of us. So thank you very much. Audrey?

AUDREY YOWELL: Thank you. That concludes our webcast this afternoon. I have three quick reminders for you. Number one, as Stephanie said, we will be responding to the questions you sent us. We will respond by e-mail in the near future. Second, please fill out your evaluations. The short survey at the end of this webcast. And finally, please join us for our second webcast on this topic with state and local government representatives on

September 20th. I want to thank our great presenters and thank you all for participating in the webcast this afternoon and enjoy your afternoon. Thank you.