

## **AMCHP 2008 ANNUAL CONFERENCE**

### **WE ARE MAKING A DIFFERENCE:**

#### **Evidence-Based Practices for Organizing Family-Centered, Community- Based Services**

March 1st to 5th, 2008

DEBORAH ALLEN: First, I want to say just a word about the capacity in which I'm speaking to. I am mostly here for most of my conversations with people up to now in this conference has been in my capacity as part of the staff of the Catalyst Center. But I'm taking that hat off and putting on my hat as part of a state wide consortium in Massachusetts that really is not related to the Catalyst Center, just so people can keep this, this straight. And my day job is as a member of the faculty in the MCH funded training program in the Department of Maternal and Child Health at Boston University. So, what, given that I'm in an MCH program, what I'd like to do is to talk about the development of the consortium in Massachusetts from a developmental perspective. And as I've thought about this, the metaphor of child development really seems to me to work quite beautifully in describing the various stages of development of our consortium and just as sort of cut to the chase, I think where we are now is late adolescence and really at that corny moment where you worry about whether you have the capacity to make it as an autonomous adult or whether you have to go back home to mom,

so just to be honest about the dilemmas that are facing us but also the opportunities.

The reason the consortium was born, was, we were a non-planned pregnancy (laughter) and we were born because in the late '90s after the definition of Children with Special Health Care Needs was published, there was a lot of interest in Massachusetts, it's a very academic state, there was a lot of interest in doing research on children with special health care needs and their families. And at sort of a variety of sources came all kinds of upwelling of research curiosity and it turned out that there were 11 different projects that we're planning to do surveys of different subgroups of children with special health care needs and their families in Massachusetts and it suddenly occurred to all of us that we would be calling families and they would say to us, oh no, I just answered your survey last week, unless we did some careful planning. So we, this was a completely defensive move that brought together this 11 diverse projects that we're about to do research and it included a couple of state agencies, several academic groups, parent organization, and a few non-profits. Some of them were working together but, you know, altogether there were 11 different projects involved.

And as we talked about how to conduct our research in a way that wouldn't be mutually incompatible, naturally, the discussion began to progress to what kinds of questions are you asking, why are you asking those questions, an

overlapping sense about what the needs were that were unmet in the state, I mean, it all, you know, this is Massachusetts, it's a state with a lot of medical resources. In general, the surveys we were preparing tended focus on the unmet needs of families for support, for information, for care coordination because all the previous research in the state had pointed in those directions as the primary unmet needs. And in fact, you know, even now, if you look at the CSHCN survey from Massachusetts, those are the kinds of things that you find as standing out. So it turned out that in addition to the need to sort of not tread on each other's turf, there are actually was a lot of real shared interest and a lot of shared need to understand the population better on, and a sense of, a shared sense of understanding the needs of the population we were interested in. And then people began to feel that there was a sort of intellectual charge in the room. We met a few times and people began to really value the conversation, having now gotten the past the point where we were worried we would be knifing each other in the back.

And I remember very vividly one meeting at which we had began to, people began bringing other people to these meetings, they'd go, wow, this is a pretty interesting conversation. And finally, one provider from Children's Hospital looked around the room and said, you know, everybody may need to make a major change in this state. It seems to me to be sitting in a room now. So, why don't we think about whether we want to do that? And I suppose that was the moment of birth; that was when we emerged from the womb. And the next stage which I

think about is our childhood. This was in the late 90s. It was '99 to 2003 and we went through a series of steps which I described up here. The red being sort of what we are talking about at that step.

So the first was a clearing house 'cause everybody comes and says what they're doing and we talked about it. The second was, once that went on for a while, it became clear that there were opportunities to work together. So, you said, you know, what could we do to help you clarify your embarked on. The third was asking, are there some things we could actually do together and that was the point at which we began to ask, is there a basis here for an organization? And the point at which we really began to sort of move from childhood into adolescence was thinking about a shared agenda and then really beginning to be conscious about constructing an organization. And I think what was very interesting to me, looking back, is that, up to this point, nothing happened very self consciously. I mean, it was really like childhood. It's kind of you go play in the sandbox and anybody shows up in the sandbox, you play, with them but you don't really think about, how hard, you know, you don't think about like, who would be really attractive to have in the sandbox? That's sort of more a task of adolescence and so we weren't quite there yet. So the tasks of our, of our adolescents to get from childhood beyond to this sort of self-conscious stage were, as we identified them then were, articulating the mission, being clear about what the appropriate structure was and that was particularly challenging, I'm going to spend a little time on that, identifying how we want, who were members,

and how we wanted to identify our membership. What made you, what gave you the right to vote? What defined you as a member?

That had been a completely informal question up to then. And then what kinds of initiatives seemed most conducive to being effective and keeping our participants engaged? After a lot of debate, we ended up deciding that we should tie our mission to this six 2010 objectives for children with special health care needs. And a lot of the debate is the same debate that went on all over the country about, is this too parochially Title V and will it turn everyone else off? Can anybody stand the word medical home? I actually, I'm one of those rare people who actually likes it. I'm willing to admit it this late date. But I was unusual in liking and then other people considered it tolerable or sort of functional at best because it was widely accepted.

So there were a lot of arguments that went into getting to this stage. But ultimately people felt that the, that tying what we were doing to a national context, gave us a clout that would otherwise be missing. And I think that's been a shared experience around the country that those six objectives have really been a huge tool in sort of placing what one does locally or in a state level in a broader context. Secondly, to this question of structure, as we were becoming self conscious, we decided to spend a little bit of money a consultant to do a survey of our members and to get some information about what they thought was important in structure. Because we were very worried about that common

experience that you get all excited, you bring people together, you form an organization, and then you spend the rest of your life developing by-laws and everything is gone by the time you've got the absolutely perfect set of by-laws.

So this is the set, this is the list, and this links so well with what I am saying. This is about what people said what is important to them. And what people said universally was what they valued, was the different stakeholder groups together in the room, that the state agencies loved the doctors where they are. DPH gets to talk to doctors, but the Department of Mental Health doesn't get to talk to pediatricians. And they loved the doctors were there. The doctors loved the families were they, because they don't get to talk to families in an organized way. The state agencies, the doctors, the families, and payers, loved, that, all those three loved the payers were there. And the payers were self-selective group. They weren't sort of the (word?) of managed care organizations in the country. They were the relatively quality-oriented manage care organizations that tend to dominate in Massachusetts. But they were very excited about being, sort of invited to participate in the discussion that wasn't simply about asking them for more but had some sense of their commitment to quality.

Second, was a sense that people felt it was very important to focus on family participation in a couple of ways. One was to assure and support it. And that meant things like developing a process whereby when we asked people to register in advance for meetings that we had. We were now having big state-wide

meetings a few times a year. And we asked people to register in advance just that we knew how many were coming and where they were coming from were. And one thing we used that pre-registration for is if a new family person registered, we would have a more experienced family representative for them, find out whether they had any questions and we were very solicitous about questions ranging from things like, what do I wear? You know, to, do, people do I need to speak? If my I comment, is this going to be like an AA meeting where you know, I'm expected to be confessional in some way.

And you know, to those of us whose lives are just divided into meetings, that role is complete, I'm not, you know, just take me to a meeting anywhere, I can sort of tell what the structures can be. But for other people whose lives are not organized that way, it's a very intimidating idea walking into this very foreign environment. So on the one hand, there was a lot of attention to have you bring family members along in a short family participation. But the other thing that was very important was not so presuming family participation that it turned into a family organization given that first point, that what people really wanted was some sense of balance and what we've learned, for us, is that what works is about 30 percent, about a third family participation. And if it gets much higher than that, it loses that character of diverse and multi-sector.

Third, very importantly, given the different sectors that are there, is to leave room for disagreement. I mean, I think, I think there's a spectrum of opinion within the

leadership of the consortium about how, I mean, my own feeling and this is completely my own feeling, is that ultimately, as we move to really changing policy in the state, there will be some members for whom the environment is going to become uncomfortable. That advocacy ultimately is going to lead to discomfort for some members and then that would be down the road and sort of developmentally appropriate at that point. But up to, I mean, we would like to sustain everyone's participation as long as we can. And, so, one of the things that means to us, and this really also goes along with the non-judgmental atmosphere is we are very careful to educate people that this is not the place to come to nail the Department of Mental Retardation about why they didn't pay for your van. But it may be the place to come if you talk to six families who are having trouble getting vans paid for, but it's not a place to handle personal questions of interactions with state agencies. And that's been a really important ground rule.

And frankly, the way it's been effectively enforced is by having parent leaders, who talked to other parents who have any confusion about that. And it's a natural confusion to have and people are very passionate about these questions. But it's not the kind of thing over which we want the organization to fall apart. Fourth, need room for lots of levels of participation. Let people be members basically as long as they want to be members. That's the level of commitment it takes. And the way we operationalize that is, we ask people to go online, fill out the form and say what they're willing and able to do which could include, read something every

now and then, you give us feedback. That's membership. So we define it, you have to sign on, but the price of signing on is doing whatever you can do. It's a commitment, not an obligation to work. I suppose that's involvement not commitment for 50 years' perspective. But we want to keep the door very open.

I talked about a non-judgmental atmosphere. We really try to chair meetings in ways that invite questions that really create, that there's no such thing as a dumb question environment. A lot of effort at sharing leadership at cross sectors and really being thoughtful as we developed projects to assure that there's leadership from different groups in each of our projects, from parents, from payers, from providers, etc. At the same time, is there is this sense of really wanting openness. There was a sense that there were going to be times when we want to be able to respond to something that's coming down on the pipe quickly. So the group was very interested in how do you combine that openness with the more, with some sort of rapid response capacity. And I'll get to that in the second. And the final thing was this point about, please no discussions of by-laws.

So what we ended up with was a kind of two-level structure. We have a steering committee and this lists the members. There are a few required categories of members. For example, DPH is a required member of this steering committee. Our feelings we are a child of Title V in the broad sense and need that active commitment in participation but there has to be at least one other state agency as well. There have to be at least three parents. At least one group has not, has

to be not working for anybody that gets any state money, etc. So, there is a specific category for reasons that will probably be obvious to you. The other thing we do is we have work groups that are actually where projects get carried out, often chaired, but not always, by a steering committee member but always including members of the steering committee so that there is linkage between the steering committee and the workgroups. And then we often have ad hoc or sort of temporary advisory groups when we have a project that just needs one advice. We also have a couple of local affiliate groups; one in central Massachusetts and one in western Massachusetts.

But I'm not going to spend time on them 'cause I'm focusing, in my talk, on the state level. If people are interested, I can tell you about them. Membership can be individuals. It can be organizations. We definitely look for broad participation but when we go after organizations, the way we tend to do it is to say, boy, we don't, we really would like to have somebody from the Massachusetts Commission for the Deaf and Hard of Hearing. Does anybody on our steering committee know somebody who works there who's a good guy? And not to go to the Commissioner of the Massachusetts Commission on the Deaf and Hard of Hearing and say, can you appoint an organizational representative? Because there's such a sense of wanting the mutual kind of attraction to be what brings people together rather than somebody being appointed to be there. I'm dragging the conversation and mood down by being resentful, disinterested, bitter, whatever. And although, so membership, I said before, is completion of the form.

We've had a lot of discussion about do's and have, I think the question sort of revisits us, or we revisit it every year. It's a little mysterious 'cause we have members that are Massachusetts Blue Cross, Blue Shield and members that are Suzy Jones (sp?), you know, who lives down the block and how you reconcile that into a do structure, so it's a little confusing. I'm not going to spent time on our project. I think they're listed in the, the handouts, there are handouts for (mumbles) so, you can look at them and I'd be glad to talk to you about them.

UNKNOWN SPEAKER: We chose not to print copies of all the (unintelligible). But they will be available on the website (unintelligible).

DEBORAH ALLEN: Okay.

UNKNOWN SPEAKER: (Unintelligible)

DEBORAH ALLEN: But I, it's sort of more, I want to give you a sense of the diversity of things we're doing. Just so it's clear, on the left is the name, in the center is what it's about and on the right is what's the source funding. And the implementation and financing grants were both Maternal and Child Health France grants; the foundation grant is a local foundation. And we also have money that we've gotten from member organizations as donations, which is of course, lovely, cause it's discretionary money; it's not tied to a particular project. What I want to

end up though with is talking about our current status which is, as I said earlier, the move to adult autonomy.

We have been blessed by being, that we are housed in a free-standing, non-profit organization that many will, if you would have heard of, in previous years and currently called New England Serve. New England Serve has sort of been the foster mother, if you will, to this developing, this developing child. But the foster mother is interested in retiring from her job. (laughter) And I think there is also a sense that if we've succeeded, the child ought to be able to become autonomous. That's what, that's really and important test. This is there the basis here for a free-standing organization and so we thought a lot about what will it take to allow us to spring free of New England Serve.

And the first thing, obviously, is a stable funding base. As you might note from what I said just now, all of our funding are grants or donations from members and none of that is stable. So, the first is a stable funding base. Second, is real clarity about the commitment of the Department of Public Health to this. We are unusual probably in the room in that DPH, I worked for DPH when this got started, but it was never housed at that the Department Of Public Health in the Title V program. There has been this special relationship to Title V broadly but Title V was not the parent of this organization. Fourth, is having a sense of sort of what are realistic programmatic expectations. What can we achieve that's, that's doable? What can we achieve that's sort of out in the future and pushes us to really change the

state? And then I think the final thing in terms of, you know, like any other adolescent springing free, is willingness on the part of both mom and the kid to take risks. So we feel a little as if we're diving off of the end of a cliff here but hope that, that there's a parachute.

The way that we see the parachute working is that we are engaged in discussion now with the Department Of Public Health about actually allocating funds to the permanent funding base of the consortium and we see that commitment from Title V as a necessary prerequisite to go to our other partners and say, we want you to chip in too. Your chipping in to this public/private partnership and the public part of is committed. That we think has been a challenge up 'til now because we haven't had that Title V commitment. Not in a sense, I mean we've had enormous moral support but we haven't had that investment. That's really hard 'cause Title V in Massachusetts, it's a rich state, it's not a bridge program, I know that. I was its director. And, its, Massachusetts has a reputation for going after grants very aggressively, that's because that's how we funded that CHSCN program, that's the dirty secret. So, an investment in this consortium is an investment of scarce funds based on the idea that it's really critical and to convince the Title V program that that's a worthwhile investment, we've had to think very hard, as Diane said.

Our mission is quite clear. Our mission is those six outcomes but we've had to think very hard as Diane said about what's our function. What do we offer the

Title V program? And that's what is listed here as our mandate. It is pure coincidence that there are six of those as well. I tried really hard to think of a seventh just so that it wouldn't get confused but, so here's what we feel we offer to the state. And I think for those of you who are in Title V programs, I think it's a way of thinking about what kind of coalition like this or a consortium do for you.

The first is that we feel we can promise this kind of diverse leadership organization that includes all the stakeholder groups I mentioned and that takes responsibility for advancing policy in the state, which would mean, without ownership by New England Serve, without sole ownership by the Department Of Public Health that we can really make this agenda belong to all those stakeholder groups. The second is that given that leadership, we can go out and build a broader constituency among parents, providers, state agency staff, etc. around our agenda for children with special health care needs. The third is that with that broad constituency, we can build visibility for children with special health care needs for the consortium and we think for the Title V program, which seems to me absolutely critical to make and particularly for the agenda and the population. I think too often, children with special health care needs are not terribly visible on the policy radar screen and that's a commitment we need to make to the department. The way that gets operationalized and measured and monitored and so on, I think, is going to be through things like promising a certain number of legislative events every year, probably seeing a certain number of press events every year. So, there's a, there's a measuring part that I'm not going to talk about but it follows from this.

Fourth, and I think sort of most why, what the consortium has done so far, is that because we bring together such diverse stakeholders, we can promise a really creative approach to program and policy in the state in a way that the Department Of Public Health alone can't muster. We can bring parents who know day to day what goes on at, when they visit the emergency room at children's hospital with people like me who are in touch with states all over the country and know that there's a new, clever thing like Colorado did that otherwise, you know, families in Massachusetts and providers wouldn't know about. So, creativity about program and policy. Fifth, and I think is terribly important and not sufficiently addressed in most of our work is really highlighting the role of government that we can be a voice for Title V in a way that Title V cannot be voice for Title V and really make the case that none of the rest of us, that you will not have effective program and policy if you don't have oversight agencies that can train, monitor, measure quality, etc. and I think that that sort of cheerleading for Title V is a very important role and very heartfelt one within the consortium. And then finally, we are very interested in being a voice within the Department Of Public Health but beyond the Title V program and throughout the state government in advocating the collection of data around visibility.

So we want to promise that we will argue with state agencies that they ought to be using the CAMI screener in all programs that serve children and that we need to identify a consistent, a comparable adult screen. And there are many possible

candidates for that, that get used in programs that serve adults in the state so that the state has the capacity to do measuring and monitoring not just in Title V programs but for example in WIC. But do we know whether WIC serves children with special needs and if so, can we distinguish they're outcomes match those of other children? We think that part of our task in influencing state government in that direction. I'm going to stop there but invite questions, comments, thoughts about how we further our maturation into adulthood. Thank you.

DIANE BEHL: If Diana said, here's our purpose essentially to share some findings on what we have learned from the literature and provide you with some great examples of State Level Coalitions in Massachusetts and Community Level Coalitions in Colorado. For, but let me first kind of get a feel from you all in terms of why you choose this session, maybe just with the raise of hands tell me perhaps if you are working in coalition right now. And [inaudible] with the coalition effort.

Okay, so, maybe about a third, alright, how many of you are thinking about getting involved in a coalition? Okay, alright, some in there, to just take maybe just a couple of minutes to give me a flavor of the kinds of issues related to coalitions that perhaps brought you here, just raise your hand and let me know please. Okay, yes, thank you.

UNKNOWN SPEAKER: Okay, I'm [inaudible] interested in knowing [inaudible] what we're doing in the community,

DIANE BEHL: Great.

UNKNOWN SPEAKER: I'm hoping that we go beyond the [inaudible] status of coalition that we believe in working [sp?] but just primarily [inaudible] are not get have stood up [inaudible]

DIANE BEHL: Okay.

UNKNOWN SPEAKER: And how to get those aptitudes on [inaudible] what the outcomes for the trials and the use of family result from the coalition?

DIANE BEHL: Okay. Alright, thank you. So, that's one of the things we will touch based on is in terms of, of measurement. Great, other questions, issues that are in peoples minds? Okay, well, hopefully we will raise some interesting issues as where going along and please we want to make these a real interactive session. And also hear about your own experiences with your coalitions. If you can kind of substantiate some of the things we're finding as well as raising some challenges please.

Okay, so, my portion is going to focus on, what are the evidence based practices in coalition building? And this is work that we did as part of champions from inclusive communities and one of the things you have on the table up there is one page fact sheet. Talking about champions, 'cause when we talk about services being organized, so, families can use them. One way of doing that is through coalition bringing partners together, to be looking at developing more efficient services, more comprehensive services.

And so, the why get to stand up here, I'm really representing the work of all my staff. Rich Roberts as the principal investigator with champions is here with us and Cora Price in front who was just critical in terms of finding and analyzing the literature. Okay, so, let me begin by what's a coalition? Goes by all kinds of names that we found in literature search, collaborate of partnerships, community forum, task force, consortium, coordinating council and so, one of the things we we're doing was looking at these definitions. And one that seem to make sense to us was it's something that's talking about a mutually beneficial relationship between individuals. Taking families for example, youth with special health care needs, government agencies, private and or public sector organizations, think of things like faith based organizations, Rex Center, all those key people in the community, that are based on achieving common goals.

Here are the levels of evidence that Diana run through, and to just kind a give you a general forms of the evidence that I'm going to be referring to is falling

primarily in that first level which is research that's been published in referee journals. However, when you look at literature related to coalitions like care coordination's etc., it's really hard to find any studies that have any kind of comprising groups for example; a lot of it is pre-post sometimes post only and so, that's one of the issues in looking at these literature. But all those levels we look primarily research. And so, how do we identify them? Well, one of the things we did was do a search of the literature and actually the dates wrong, we went back to 92 and one of things we found where last of individuals studies but there are some great literature reviews that have had already been done. We found eight published literature reviews, that in each one of those reviews reflected 18 to 87 that they've looked at and so, one of that valuable things to do from the start was to say, let's look at what we can do from those literature reviews that have done such a good job. And so, all of the studies where community based coalitions, all had a health focus which is one of the things we want to look at. But the target populations varies some of them for example looked at decreasing risky adolescent behaviors. Other might perhaps look at first cancer screenings increasing that, but you know the thought was we can really benefit from learning about these coalitions even though they weren't organized just on children's special health care needs.

Here, here're something things of the outcomes achieved by these coalitions and related to those help out promise that you are wanted to know about. If you look at the studies, there were some that dealt with things like reducing risky

behaviors, improve access to health, to improve access to services, reduce blood poisoning etc. Reduce infant mortality rate, reduce adolescent pregnancy rates. These outcomes were found in some of the studies, essentially if you looked at one of the key literature reviews by Russell and Faucet for example, they've looked at 34 studies of coalitions. And 10 of those 34 had some health distal health outcomes like this to report. And so, that gives you a sense of how many studies are looking at coalitions affect to down to that health level. Not very many, okay.

The other thing that's, that's tricky in terms of looking at outcomes of the literature is really being able to get that causal relationship. In terms of was it in fact the coalition that made that difference. And so, in looking again at the outcomes associated with evidence based practice, a lot of them where tied if you looked at they essentially had something like 55 outcomes that one of the literature reviews associated with coalitions. You know 55 factors and so when we looked at these factors identified across the multiple lit review. There's seemed to be a real pattern that could easily fall into a very simple CQI process that Diana delineated earlier. In terms of strategies for building partnerships, developing plans, implementing those plans in communities and measuring and monitoring. So, what I'd like to do next is provide you with the sense of what were those key ingredients related to those four steps? And then, you'll going to see some first hand examples from the work in Massachusetts and Colorado. Okay, here are the first steps for example, key ingredients in building partnerships. If

you look at these things here they start with having that idea of having mutual respect, understanding and trust among members, and one of the things that got typed in there by mistake was when you look at these key ingredients how do they measure this things?

This is one that was typically by coalition members self report. That's how a lot of this information came to be. And when you talk about one of the things, one of our graduate student, Odessa Knowles did a great job of was at looking at coalition building particularly in trying to reach culturally diverse children and families. And these first steps here was just the most critical in terms of ensuring that you're using really culturally competent practices that relationship building is something that you need to spend a lot whole more time on, then we're typically used to in our kind of administrative approach. Second, include persons representing all levels of position power and decision making. Meaning not just a key headed administrators but having direct service providers involved and also service customers. Who are serving in terms of your families? Your youth very critical to have there. Third, clearly established roles for coalition members and coalition staff to prevent confusion and conflict that people understand what the coalitions, as a coalition member what's going to be expected of them? And this was especially true, I remember with a previous project we had, opening doors to rural communities. What we heard from families in particular is what exactly were my role be in this? And wanting to have a real sense of the amount of time commitment, what they can contribute, and how? Having clear rules on how to

handle conflict or differences, having that from the get-goes important. Building the skills, knowledge and positive attitudes of their members. In this effective coalitions that they were going through some training and technical assistance to help them be good coalition members.

So, what team partners with links to resources and that represent those broad sectors? Again thinking not just of your typical governmental agencies but who else is in your community? In terms of key players perhaps for example, it's the local transit district that plays a key role of ensuring that families can get to services. So, be thinking broadly. Selecting, excuse me, diverse membership regarding ethnicity, age, socio-economic status in the citizen's impact. And making sure that you're really getting representations from all those groups, particularly those that are having the most challenges in accessing services that's who you want at the table. And the last one, this is benefits of the involvement or should be clear and out way the cost to members. As many of us, I'm sure who are participate in coalitions you know, you go to all these meetings, how long are we going to have to be at these meetings? And what am I going to get out of it?

The last part on building partnerships centers related to strong leadership. Using incentives to [inaudible] and motivate could be, you know having those M&M's at the table and people come but also be thinking of things like for example, how are you honoring your participants that are really working hard for those efforts?

Can they get some kind of award be it from the coalition or recognition in the community through the newspaper? How are building in those kinds of incentives?

Making sure that your task are directly linked to, to the goals you want to accomplish, shared leadership that emphasizes exchange of ideas and voices and that collective leadership based on democratic principles. So, things are seemed to be what kind of governmental infrastructures so to speak is important in those effective coalitions. Okay, I only have five minutes so, I'm going to try to go through these quickly 'cause you really want to hear these examples. In terms of developing plans, what's really critical is having that concrete clear mission. And focus, and again think of that leadership being critical and keeping the focus on those priorities, developing some short term goals and open frequent predictable communication methods. As you're developing these plans that everyone is hearing collectively, they do have the communication going on the development. Okay, just kind of give you, what your appetite in terms what you'll be hearing from Colorado. They have a logic model or a better name; I think is going to be an action plan. An action guide, that's even better that you know, essentially, you know, is there a plan and you'll see that example and how to utilize the family leaders. And then from Massachusetts, how are they're developing, how they develop clear functions to guide their efforts? For implementation, what would you do, when you take, when, you looked at those coalitions that really were able to implement their plan.

First service mentioned that often needing to change those community attitudes. For example, when you think of the coalition focusing on breast cancer screening, there are those communities, it's not just making sure that they get in to do the screening initially that your going for. But kind of really taking a look at what the attitudes towards preventative health, towards cancer identification, those kinds of things. Accessing training opportunities, technical assistance and support is something that can really help you with your implementation.

The third one is biggie, and I'm thinking having allocated paid staff was one of those key indicators with the coalition. Something important to keep in mind and having those financial resources of course for your activities, making sure you've got skilled leaders to deal with conflict management and planning for setbacks. In terms of measuring and monitoring, what do we see from the literature? One was that importance of working with the community or using a real participatory action approach and saying to the community, what would you think would be some indicators of us achieving what we are? What we want? Establishing that measurement plan based on what you've heard from the community. And the third one was interesting, holding members that accountable for creating change. So, even if they don't change the policies themselves to get that coalition with the idea that they're responsible blow [sp?] for getting the public opinion behind them. As a coalition member, what are you doing to convince your legislators or agency heads to change those policies?

Okay, celebrating those accomplishments frequently again tied to those rewards and that last one is real important to kind of furthering our research literature. Keeping records on what you've accomplished? How often did you meet? Who attended? What happened? Because that's what we really need to be learning more about. Just some quick points in terms of the literature in itself, what are the some of limitations? The first is a kind of inconsistent use of the dependent versus the independent variables. And to give you an example, in some studies with coalitions they looked at active member participation as an independent variable that was maybe tied to what they've accomplished in terms of their child health outcomes. For some other studies they looked at the same variable active member participation, and they said, that's our dependent variable. We want to see if our coalition was going to be effective and the way we decide that are as if they were stronger member participation. And so when we looked at it, it was overwhelming, just how your kind of left trying to sort out the mess related to outcomes associated with coalitions.

As I've said, a lack of control studies, paucity of that treatment information. What exactly do these coalitions do? So if you want to replicate it you can. And lack of outcomes demonstrating the increase of system efficiency in integration in terms of really saying okay, did we, maybe families where able to, nor easily, able to access services but did that result in any efficiency from the agencies. Quite if

you think, that you'll cost benefit concept that's something that I think will be very worth while to be taking to look at.

Okay and we are making a difference, one other thing that I'd like to mention, I'm sorry I was distracted by my colleagues. Oh, yes, so you're saying that's a cliché by this time I'm already on Monday afternoon. One of the things that Champions is tried to do and make a difference is to be identifying some communities that are working hard to organize services. And it could be a matter that your doing these through coalition building, or it could be that you've got communities that you worked with, or that you know of that are using other strategies to make services more easily used by families.

And so one of things that was up on the table was an announcement by Champions, that we be real interested in letting, having you let us know about those communities. And so, if you can give us some information about those or go to our web site, call us, that would be great. Because what we like, with Champions will be doing is having a recognition program. An opportunity provides that continued incentives and rewards for community's hard work. So, we look forward to hearing from you on that part. At this point what I like to do is turn it over to Deborah Allen, who's going to be talking about the Massachusetts consortium.