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I. Introduction

Mississippi’s children and youth face a host of significant health challenges. The state is consistently ranked near the bottom on a multitude of different health metrics. Mississippi has the highest teen pregnancy rate in the nation: In 2011, 57.6 of every 1000 live births involved a mother between the ages of 15 and 19, compared to a national rate of 31.3 teenage mothers for every 1000 live births. Further, around 10 of every 1000 babies born in Mississippi die before the age of 1, compared with only 6.1 of every 1000 babies born nationwide. This is due in part to the prevalence of premature and low birthweight babies in Mississippi. In 2011, the rate of infants born with a low birthweight (less than 5 pounds, 8 ounces) was 11.8%, compared to a national rate of 8.1%. Mississippi’s children also face high rates of obesity. According to one 2011 study, 17.2% of children were overweight and 23.7% were obese. (Nationwide, a total 32% of children are overweight or obese.) Childhood obesity has an established connection to higher rates of conditions like diabetes, asthma, high blood pressure and high cholesterol in children and adults. Compounding these critical health challenges is the fact that many children in Mississippi have only limited access to healthcare: Nine percent of Mississippi children are estimated to lack health insurance, just slightly higher than the national average of eight percent.

These expanding health challenges are compounded by a limited pool of available public health resources within Mississippi. However, committed actors throughout the state, including government and non-profit institutions, are working to tackle these challenges. Despite their

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1 This report was prepared by Divya Subrahmanyam, member of the Harvard Law School Mississippi Delta Project under the supervision of Desta Reff, Mississippi Delta Fellow. The following students from the Harvard Mississippi Delta Project were involved in research and drafting of this report: Maya Brodziak, Dakotah Burns, Anna Byers, Maggie Casteel, Andrea Clay, Zachary Greenamyre, Margaret Hazuka, Matthew Tako and Bret Thacher. Special thanks to Lisa Lana, Co-Chair, Mississippi Delta Project and Emily Broad Leib, Associate Director, Harvard Center for Health Law and Policy Innovation.

2 Mississippi Kids Count 2013 Data Book 44 (2013), available at http://kidscount.ssrc.msstate.edu/data/mississippi-kids-count/ms-data-books/ (citing Mississippi State Department of Health, 2012). The teen birth rate varies widely by county; in Tunica County, 122.1 of every 1000 live births involve a teen mother. In Lafayette County, by contrast, the rate is only 23 per 1000. Id.


5 Id.

6 Mississippi Kids Count 2013 Data Book, supra note 2, at 45.

7 Id. at 46.

8 Id. at 46.


11 For example, the Legislature has passed bills creating school health programs to reduce childhood obesity, such as the Mississippi Healthy Students Act of 2007. Mississippi Kids Count 2013 Data Book, supra note 2, at 46. The Mississippi State Department of Health has also made it a priority to reduce infant mortality by 20% or reduce it to 6 deaths per 1000, by the year 2020. Id. at 45.
best efforts, though, a lack of statewide coordination has led to redundancy, inefficiency, and occasional competition for scarce resources. As a solution, several stakeholder organizations within Mississippi have decided to create a Mississippi Child Health Council. This council would be made up of healthcare practitioners, nonprofit advocates, academic institutions, and governmental entities that will work together in a comprehensive and coordinated fashion to tackle the critical health challenges facing Mississippi’s youth. Specifically, the Council’s priorities will include teen pregnancy, low birth weight and prematurity, infant mortality, childhood obesity, tobacco use, and access to healthcare.

This policy brief examines a broad range of sources to extract recommendations for establishing a Child Health Council in Mississippi. First, this brief surveys some of the academic research on the efficacy of collaborative approaches to public health. Using this research as a framework, the brief then considers coalitions in other states with structures most analogous to the proposed Child Health Council as well as alternative approaches that could enhance or supplement the proposed model. Finally, the brief presents a set of recommendations for the Child Health Council.

II. The Efficacy of Coalitions in Public Health

Over the last generation, localized and statewide health partnerships or coalitions have become an established method of addressing issues in public health. In order to effectively address public health challenges, researchers say it is essential to “work across a wide variety of disciplines and to include a diverse collaboration of stakeholders at all levels of the health system; including the public, health practitioners, health administrators, policymakers and politicians, and the research community.”

However, although researchers have studied these partnerships, there is no academic consensus as to best practices, and empirical evidence remains limited. Nevertheless, the material that follows synthesizes some of the research on the challenges facing health coalitions as well as some of the modifiable factors that can improve partnership efficacy. A public health collaborative partnership is “an alliance among people and organizations from multiple sectors...to improve conditions and outcomes related to the health and well-being of entire communities.” These partnerships can take many forms, including alliances among service agencies, consortia of health care providers, and grassroots and broader advocacy efforts and initiatives. In general, researchers tend to examine smaller-scale, non-policy-oriented efforts, but the conclusions gathered are generally applicable to a statewide coalition.

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14 Roussos and Fawcett, supra note 12, at 370.
15 Id.
16 Id.
A. Challenges

The coalition approach faces some basic limitations, chiefly the short lifetimes of partnerships and a lack of data. First, a partnership may dissolve well before changes in broad health outcomes are fully realized. Population-level change requires time to take effect, but partnerships may be crippled by funding issues before they can fully implement their goals. And because most of the work of partnerships is fully voluntary and, typically, in addition to other roles that partnership members fulfill, attrition, loss of motivation and cohesion can threaten the longevity and success of community health partnerships.

Secondly, there is a dearth of empirically based, normative analysis of public health collaboratives. It is difficult to isolate cause and effect variables within the field of public health because of the range of potential causes—such as individual behavior, environmental factors, and external intervention—and the interactions among them. In addition, there is a lack of good data on community-level health change. For example, while data on statewide obesity or tobacco use might exist, it does not accurately reflect the conditions in a given community. Finally, there is no accepted theoretical framework for partnership construction, and although numerous metrics of effectiveness have been proposed, data on their validity or reliability remains sparse.

B. Factors influencing effectiveness

An examination of studies analyzing the factors affecting partnership efficacy does reveal some common findings. Some are obvious—for example, access to financial resources has a positive effect on partnership success. Others are less so: a focus on evaluation, diverse membership, complex structure, and formal process have all been linked to partnership effectiveness. A focus on evaluation is critical. Collecting data and concentrating on outcomes is a significant indicator of partnership success, both in terms of member satisfaction and goal achievement. Concretely, focusing on outcomes entails setting intermediate goals, collecting data, evaluating progress against the intermediate goals, making reports to stakeholders, and constantly soliciting feedback. Rigorous program evaluation is a key instrument of accountability.

The diversity of the coalition is also significant, and research shows that including members from a variety of sectors contributes to coalition success. For example, one study found that

17 Id. at 374.
18 Id.
20 Roussos and Fawcett, supra note 11, at 387.
21 Id.
22 Id.
drawing members from a larger number of health sectors positively impacted an organization’s ability to come up with a logical, comprehensive research-based substance abuse prevention plan.\textsuperscript{25} The coalition should encourage members to participate as actively as possible in the planning process, as active participation and strong leadership are also correlated with success.\textsuperscript{26}

The nature of the relationships among members is also significant, as complex coalition structure is also correlated with success.\textsuperscript{27} That is, coalitions with many interconnections among members, promoting collaboration and facilitating group cohesion, see greater success.\textsuperscript{28} Generally speaking, coalitions need collaborative capacity along multiple dimensions: “within members, within relationships, within the overall organizational structure, and within the programs they sponsor.”\textsuperscript{29} One aggregation study found that complex structures were associated with strong resource mobilization and high levels of plan implementation.\textsuperscript{30} In another study, mentioned above, coalitions working to combat substance abuse were more likely to produce a high-quality prevention plan (as assessed by independent evaluators) when members had more frequent, collaborative interactions with one another.

Substantively, process is also extremely important. Formal procedures for governance and decision-making are related to effectiveness,\textsuperscript{31} as is having a clear vision and mission. One study found that partnerships with a targeted mission (e.g. reducing teen pregnancy) were five to six times more effective than more generic “healthy communities” initiatives.\textsuperscript{32} Relatedly, successful partnerships invest time and resources in concrete action planning: identifying what changes to aim for, who will produce them and by when, and how to gain support and minimize opposition.\textsuperscript{33} Action planning leads to increased membership and participation, sustainability, and broader impact, though taking strong positions can also lead to internal conflict.\textsuperscript{34}

### III. Coalitions in other states


\textsuperscript{26} Zakocs and Edwards, \textit{supra} note 24, at 357–58; Roussos and Fawcett, \textit{supra} note 12 at 385.

\textsuperscript{27} Hays, \textit{supra} note 25, at 376.

\textsuperscript{28} Zakocs and Edwards, \textit{supra} note 24, at 358.


\textsuperscript{31} Foster-Fishman, \textit{supra} note 29 at 254; Zakocs and Edwards, \textit{supra} note 24 at 357.

\textsuperscript{32} Roussos, \textit{supra} note 12, at 384

\textsuperscript{33} \textit{Id}.

\textsuperscript{34} \textit{Id}.
A. Methodology

This section describes the similarities and differences of eight statewide child health coalitions on several dimensions: structure/membership, process, and successes. A 50-state survey was conducted to identify existing health entities around the country. A broad range of entities was found, including broad coalitions that do policy advocacy, or care coordination, or both; centralized organizations that have delegated action to local or issue-centered subcommittees; government backed councils that work on legislation, and more.

From this set, a short list was compiled of organizations that most resemble the currently proposed Child Health Coalition: coalitions composed of several organizations that operate statewide and tackle a number of issues relating to health, children, or both. For the purposes of this research, purely governmental councils were excluded, as they require a clear legislative mandate and generally seem less effective. Briefly, the organizations analyzed in the next few subsections are:

California Adolescent Health Collaborative
The California Health Collaborative (CAHC) works to “ensure that all of California’s teens have the support they need for healthy development and a smooth transition to adulthood.” A steering committee of experts guides the work of the over 2,000 professionals from a variety of fields who make up the Collaborative’s network. CAHC conducts four main types of activities: “convening” (hosting meetings on specific issues so that members can share knowledge and resources); training, technical assistance and education; resource and data dissemination (including a quarterly newsletter and official publications); and legislative advocacy.

EverThrive Illinois
EverThrive Illinois is a partnership of over 90 organizations that aims “to improve the health of women, children, and families through community engagement, partnerships, policy analysis, education, and advocacy.” Led by a program staff and a Board of Directors, EverThrive works on policy advocacy as well as a number of direct service programs, including the Illinois Premature Infant Health Network and the Chicago Area Immunization Campaign.

Florida Children’s Council
The Florida Children’s Council (FCC) is a non-profit umbrella organization that oversees regional,
governmentally-authorized councils that focus on children’s services.42 The FCC’s “mission is to promote policies that build effective primary prevention and early intervention systems of supports for Florida’s children and families by engaging and enhancing the collective strengths of the individual Children’s Services Councils of Florida.”43 A Board of Directors creates and implements a strategic plan and coordinates the efforts of the regional councils.44

Louisiana Public Health Initiative
The Louisiana Public Health Initiative (LPHI), through the efforts of its staff and Board of Directors, endeavors to “promote and improve health and quality of life through diverse public-private partnerships with government, foundations, academia, community groups and private businesses at the community, parish and state levels.”45 Members come from a range of fields46, and administer a diverse portfolio of programs in communities throughout the state, including ones on maternal and child health.47

Massachusetts Child Health Quality Coalition
The Massachusetts Child Health Quality Coalition (MCHQC) is a public-private partnership that brings together a broad range of stakeholders to work on improving child health quality and measurement.48 A steering committee and various task forces work on policy advocacy as well as substantive projects (including, for example, care coordination).49

Nevada Early Childhood Advisory Council
The Nevada Early Childhood Advisory Council (NECAC), established by state executive order, “works to strengthen state-level coordination and collaboration among the various sectors and settings of early childhood programs.”50 Members are appointed by the government and come from the business, community, education, government and nonprofit sectors.51 NECAC oversees eight regional advisory councils that plan and implement local strategies to serve
children pursuant to the state’s priorities.\textsuperscript{52} In 2012, for example, the Churchill County ECAC designed pamphlets on early childhood care and education for parents in the community.\textsuperscript{53}

**North Carolina Institute of Medicine**

The North Carolina Institute of Medicine (NCIOM) is an independent agency chartered by the state legislature whose mission is twofold: “To seek constructive solutions to statewide problems that impede the improvement of health and efficient and effective delivery of healthcare for all North Carolina citizens,” and to advise government entities on public policy relating to complex public health issues.\textsuperscript{54} NCIOM employs a program staff and convenes task forces around specific health issues to develop reports and recommendations.\textsuperscript{55}

**Texans Care for Children/Infant Health Alliance**

Texans Care for Children (TCC) is a coalition of subordinate coalitions that advocates for policy change to improve the lives of children throughout the state.\textsuperscript{56} It pursues a number of substantive priorities through its various coalitions, including child health, and supports networks of organizations around each priority.\textsuperscript{57} One such network is the Infant Health Alliance (IHA).\textsuperscript{58} IHA members include community and health organizations, care providers, parents, elected leaders and legislative staff, who exchange information and resources and put together reports on particular health topics.\textsuperscript{59}

### B. Structure

Most of the coalitions employ a structure similar to that proposed for Mississippi’s Child Health Council: a leadership committee of some sort (such as a board of directors or a steering committee), with smaller subcommittees that address specific issues.

The coalitions surveyed adhere to this structure to varying degrees. The Massachusetts Child Health Quality Coalition and the Infant Care Alliance in Texas have a strong leadership committee with issue-centered subcommittees. The Nevada Early Childhood Advisory Council and the Florida Children’s Council are similarly governed by a larger leadership committee, but delegate significant decision-making authority to regional committees. EverThrive Illinois and

\textsuperscript{54} North Carolina Institute of Medicine, About Us, http://www.nciom.org/about-us/ (last visited Dec. 29, 2013).
\textsuperscript{55} Id.
the North Carolina Institute of Medicine are more loosely structured, with very strong, independent task forces facilitated by a more administrative leadership committee.

The Massachusetts Child Health Quality Coalition brings together stakeholders from the public and private sectors in order to improve child health outcomes in Massachusetts.60 Smaller task forces work on the substantive issues, facilitated by MCQHC’s executive committee and a six-person program staff.61

Infant Health Alliance operates differently. A member of Texans Care for Children, which administers a range of coalitions focusing on children’s issues,62 IHA is a network of community and health organizations, healthcare providers, parents, elected leaders, legislative staff, and other citizens who promote children’s health through policy efforts, education and information sharing.63 Specifically, IHA advocates for public funding of family planning as well as prenatal care for mothers and preventative care for infants.64

The Nevada Early Childhood Advisory Council has a statewide council as well as eight subordinate councils that represent the state’s seven counties and its tribal population and participate in local health collaborations.65 Similarly, the Florida Children’s Council focuses on overarching state policy and legislation through its Board of Directors. The board also oversees local Children’s Services Councils (CSC), which are local government bodies that focus on improving the health and wellness of each region’s children and families.66 The eight existing councils are created by county ballot initiatives, authorized by Ch. 125 of the Florida Statutes, and funded by the state government.67 The chief executive officer or board chair of each CSC serves on the FCC’s Board of Directors, which also has an elected CEO and a Director of Research and Development.68

Other coalitions, such as EverThrive Illinois and the North Carolina Institute of Medicine employ a more horizontal administrative structure, though they are made up of multiple task forces. A

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61 Id.
66 Id.
67 Id.
68 Id.
quasi-governmental agency created by the state legislature, NCIOM focuses on conducting research on specific health issues, including child health issues, and promulgating policy recommendations for policymakers as well as advocates, healthcare providers and communities.69 NCIOM is directed by a President/CEO and a Board of Directors, who oversee a program staff of health researchers and administrative personnel.70 To carry out its substantive work, NCIOM convenes task forces on different health issues, each led by a steering committee.71 Currently, NICOM has task forces working on healthcare reform, rural health, and early childhood obesity prevention.72

EverThrive Illinois is the most loosely structured of the coalitions examined. A small program staff, including an executive director, and a Board of Directors, oversee the organization’s five “signature projects”: The Chicago Area Immunization Clinic, The Illinois Coalition for School Health Centers, The Illinois Premature Infant Health Network, The Campaign to Save Mothers and Babies, and The Health Reform Implementation and Education Initiative.73 Communication among the task forces is limited.

Finally, California Adolescent Health Collaborative and the Louisiana Public Health Institute are health coalitions that use a unitary structure. CAHC has a steering committee composed of sixteen stakeholders from across the state who are involved in different areas of teen health, including representatives from government and community based organizations. CAHC also employs three staff members: a Director, an Analyst, and a Program Assistant. LPHI in Louisiana is an independent non-profit with a full staff of ninety74 and a board of directors75, and it facilitates collaboration among local organizations to achieve specific health goals.76

C. Membership

Although not every coalition provides information on how it selects its members, their websites nevertheless shed light on some of their priorities. Many organizations, including LPHI,

72 Id.
73 Id.
76 See, e.g., Louisiana Public Health Institute, Orleans Teen Pregnancy Prevention Project, http://www.lphi.org/home2/section/3-367/orleans-teen-pregnancy-prevention-project (last visited Oct. 28, 2013). LPHI’s Orleans Teen Pregnancy Prevention Project is a collaborative project to prevent teen pregnancy in Orleans Parish, funded by the U.S. Department of Health and Human Services. LPHI brings together partners including the City of New Orleans, Goodwill, Communities in Schools, and clinics at both Tulane and LSU.
CHQC and Texans Care for Children emphasize the importance of public-private partnership as a way to leverage the financial resources of the private sector in pursuit of public health prerogatives. More generally, and even more importantly, all eight coalitions have convened a diverse membership, drawn from a broad range of organizations: service providers such as hospitals and community centers, governmental entities, educational institutions, and policy groups (involved with child advocacy and health care) in various configurations.

EverThrive supports a network of over ninety member organizations across the state, including hospitals, community centers, government departments, universities, and child advocacy groups. Its Board of Directors comprises eighteen individuals from these various organizations, including representatives from both the public and private sectors. The Massachusetts Child Health Quality Coalition’s partnership includes over sixty doctors, insurance providers, professional organizations, hospitals, and policy experts. Louisiana Public Health Institute has a full time staff of ninety, and works with local level non-profit organizations. Texans Care for Children is composed of issue networks made up of nonprofit organizations and coalitions, hospital associations, schools, universities, doctors, nurses, and concerned citizens. The Nevada Early Childhood Advisory Council includes a number of government members, educators, and health care professionals (as determined by statute). California Adolescent Health Collaborative (CAHC) counts among its members over 2,000 professionals involved with clinical care, policy development, research, public health, youth development, advocacy, legal aid, schools and youth services. They are affiliated with the Public Health Institute, an international public health support entity located in California. The North Carolina Institute of Medicine draws its task force members primarily from public health fields.

**D. Process**

Process is integral to the success of a health coalition. Process encompasses various areas of procedure, including the way that coalitions achieve their substantive goals, how committees operate, how they relate to one another, and how they relate to their steering committee. As the research discussed in Part II shows, process is critical to how a public health coalition functions. Of the organizations surveyed, the North Carolina Institute of Medicine, the Massachusetts Child Health Quality Coalition and Texans Care for Children have the most formally structured processes. NCIOM, which produces research and recommendations,

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77 See, e.g., Michael R. Reich, *Public-private partnerships for public health*, 6 NATURE MED. 617, 617 (June 2000).
81 E-Mail from Eric Baumgartner, *supra* note 74.
employs fairly independent task forces; CHQC, which does advocacy and project development, uses task forces that report to a centralized committee authority; and TCC, which exclusively does policy advocacy, uses an interconnected, fairly horizontal structure.

NCIOM conducts research and makes recommendations on health issues through discrete, ad hoc task forces that meet for between six to nine months, while its Board of Directors meets quarterly. NCIOM has selected a public health issue and convened a task force, work proceeds in two phases. First, in the fact finding stage, the task force gathers perspectives on the issue from in-state experts. The steering committee sets meeting agendas and does substantive research planning, inviting speakers – including committee members, researchers, leaders and NCIOM staff – to provide information, insight and opinions on the task force’s issue. The currently convened task force on rural health, for example, has made it a priority to gather input from residents of rural areas. It held public forums in eight communities, asking locals to identify their needs and priorities, suggest strategies, and provide feedback on the work of the task force thus far. Throughout the process, NCIOM staff members handle logistics, organize and report on meetings, and gather information. Task force members rarely, if ever, are assigned work outside of the regular meetings.

In the second phase, the task force converts its factual findings into a slate of policy recommendations, on which task force members vote at the final meeting. NCIOM staff then draft a report presenting the task force’s findings and recommendations. The final report is widely circulated throughout the government and to advocates.

MCHQC has adopted a slightly more centralized approach, perhaps in part because of frequent requests by members to have more opportunities to network. MCHQC’s full membership meets quarterly, rotating meeting places throughout the state. Because of the difficulties in scheduling, they try to alert members a year in advance of meeting dates to achieve maximum attendance. The meetings last for about 2 ½ hours, focusing on three topics selected by the executive committee at each meeting.

86 Id.
87 Telephone Interview with Chris Collins, Co-Chair, NCIOM Task Force on Rural Health (Dec. 13, 2013).
88 Id.
89 Id.
90 Id.
91 Id.
92 Id.
93 E-Mail from Gina Rogers, Consultant and Founding Exec. Dir., Mass. Child Health Quality Coalition, to Matthew Tako, Miss. Delta Proj. (Oct. 18, 2013) (on file with authors). She explained that the Coalition is working on creating these opportunities.
94 Id.
95 Id.
96 Id.
MCQHC’s main substantive work is done on a much smaller level. The coalition splits its efforts into two main tracks: advocacy and project development. A single standing task force is devoted to advocacy; the work is divided up on a case-by-case basis, and a great deal of this work entails reaching out to constituents. By contrast, the project task forces follow a more rigidly defined process. Once MCHQC has selected a priority area (for example, child obesity or teen pregnancy), it populates a task force, with the goal of achieving a balanced representation of all possible stakeholders. The task force then develops objectives and action plans. Monthly meetings of the full task force take place at first, with individual tasks given to smaller working groups. Those working groups are then responsible for bringing recommendations back to the full task force.

Throughout the process, the Steering Committee provides input and helps task forces build consensus. Rather than having members vote yes or no on drafts and proposals, the MCQHC operates by “seeking input, collating that input, and then having members weigh in on the resulting draft” to generate more member buy-in of projects. Furthermore, the Coalition ensures that one co-chair is from the public sector while another is from the private sector.

Texans Care for Children, which focuses on policy advocacy, employs an even more interconnected approach, as part of its philosophy of “cross-pollination.” TCC holds monthly meetings with the coalitions and organizations that form each issue network, in order to facilitate the exchange of ideas and information regarding each network’s legislative agenda. TCC also holds regular events that bring networks from different issue areas together to “cross-pollinate” ideas, and hosts an annual multi-issue conference for the same purpose. Like MCQHC, TCC does not arrive at its policy positions by unanimous consensus, but rather through active dialogue and vetting of issues, without the expectation that all members of the networks will support every position.

In contrast, organizations that have devolved programmatic authority to local organizations operate differently. LPHI does not engage in policy work, but rather works to implement grant-
funded programs through local collaborations. Obstacles are often handled at the local level rather than the coalition level. Similarly, NECAC’s local advisory councils develop their own plans and goals and work on these goals through their own individual processes. The twelve members of main NECAC do meet every two months to discuss state legislation and program proposals, but not local programs. In Florida, the FCC does not coordinate substantive projects. Instead, the regional Children’s Services Councils plan, fund, and administer programs independently. Finally, EverThrive also divides its resources and personnel into fairly discrete task forces that work on direct service provision, but task forces do not necessarily communicate effectively with each other, according to one representative.

E. Successes

The coalitions discussed here have adopted a range of approaches and strategies to achieve their healthcare goals. Unfortunately, as discussed, a coalition’s “success” is incredibly difficult to quantify: outcomes result from complex, interrelated factors, and often cannot be observed for a significant length of time. In addition, many successes (such as changing the vote of an individual legislator) and failures (such as breakdowns in communication) take place behind-the-scenes. Nevertheless, this section considers how coalitions have succeeded according to two different measures: observable impact and implementation.

i. Observable Impact as Success

Policy advocacy is a type of work whose success is relatively simple to evaluate. A bill may be crafted, supported, or opposed by an organization and the success or failure of such activities may be observed in the action taken by the legislature. Given this measurability, it is clear some coalitions that focus on policy advocacy have made strides. EverThrive Illinois shared action alerts about and supported the passage of the federal PREEMIE Reauthorization Act, which will ensure that federal research and education continues to help lower and prevent preterm birth. EverThrive also aided in the passage of Illinois House Bill 4968, the Hospital Infant Feeding Act. This law requires all birthing hospitals in the state to adopt an infant feeding policy that promotes breastfeeding.

109 E-Mail from Eric Baumgartner, supra note 74.
110 Id.
112 Id.
117 Id.
Texans Care for Children’s Infant Health Alliance has been successful in working with other coalitions and organizations to encourage the Texas Legislature to reinstate funding for family planning that was cut in previous legislative sessions.¹¹⁸ IHCA is also hoping to work for increased funding in the future, as well as attempting to establish legislative policies and programs that will more directly affect the availability of prenatal care and other preventative health options for expecting mothers.¹¹⁹

The Florida Children’s Council has seen reasonable success in its legislative lobbying. In 2013, the state allocated $5.1 million to early learning programs, the first funding increase in a decade.¹²⁰ Its efforts to expand health coverage to the children of undocumented immigrants is coming to a head in late 2013, as the organization has helped to push a bill that would repeal a provision in the current code denying coverage to children who have been in the United States for less than five years.¹²¹

The Massachusetts Child Health Quality Coalition advises the Massachusetts legislature and state agencies on the implementation of the state’s various healthcare reform measures. Similarly, the Louisiana Public Health Initiative was engaged by the Louisiana Office of Public Health to facilitate development of a five-year plan for the Maternal and Child Health Bureau 2012 Needs Assessment.¹²² The LPHI conducted a comprehensive statewide needs assessment initiative, targeting the Louisiana Department of Health and Hospitals’ regions.¹²³ That the CHCQ and LPHI play such active roles in administrative governance indicates that their expertise and insights are respected by state entities.

ii. Implementation as success

For some kinds of projects, especially those more focused on direct service or care coordination, it is extremely difficult to determine whether a coalition has “succeeded” or “failed.” Many of the outcomes require long term monitoring and data collection that is not currently available, nor can generally be undertaken during the lifespan of a coalition. Consequently, the fact that such projects have been implemented as planned may in itself be considered a success. Although not all coalitions make information on their projects available online, it is clear that many have succeeded in carrying out their projects to varying degrees.

¹¹⁹ Telephone Interview with Alice Bufkin, Early Opportunities Policy Associate, Texans Care for Children (October 24, 2013).
¹²³ Id.
EverThrive Illinois has increased statewide enrollment in text4baby, a free mobile information service that promotes maternal and child health for pregnant women and new moms. They also launched the “Protecting Our Infants from Pertussis” campaign in January 2012, responding to a recent pertussis (whooping cough) outbreak in Illinois. In addition, EverThrive developed two statewide pregnancy and birthing social marketing campaigns. EverThrive also finalized a provider toolkit on the Affordable Care Act and educated hundreds of Illinois citizens on the benefits of health reform.

The Louisiana Public Health Initiative helped initiate the 4realhealth.org website and campaign, aimed to reduce the incidence of and behavioral risk factors of teen pregnancy among Orleans Parish youth. The School Health Connection, also an LPHI program, saw success in its sex education efforts. Staff at a school-based health center conducted two sex education/ STD training sessions for high school students. In the five weeks following the training sessions, the center saw an 11% increase in visits and a significant increase in STD screenings, including a 200% increase in chlamydia/gonorrhea testing, a 240% increase in HIV testing, and a 400% increase in syphilis testing.

F. Analysis

A public health coalition needs a strong, centralized leadership committee or backbone organization to take in the bigger picture, promote coordination, and facilitate communication. A genuinely collaborative approach—one that collects and carefully considers the input of its stakeholders—is key.

Despite enjoying some success, EverThrive’s often faces organizational hurdles and communication problems within the coalition, hindering its ability to accomplish its goals. Because most issues related to maternal and child health are multi-factorial and require the coordination of multiple actors and programs, effective communication and organizational cohesion is essential to the successful operation of EverThrive’s projects. Child health advocacy is fragmented in Illinois, an EverThrive representative said, and public and private actors often are siloed in the development and implementation of programs and policies. This failure sometimes stymies EverThrive’s ability to address the mosaic of factors contributing to child welfare across the state.

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125 Id.
126 Id.
127 Louisiana Public Health Institute, supra note 122 at 4.
129 Id.
130 Id.
131 Telephone Conversation with Janine Lewis, supra note 114.
Similarly, a representative of the Massachusetts Child Health Quality Coalition underlined two specific elements of its infrastructure that have been key to its success. First, funding to cover a “backbone organization”—which coordinates meetings and moves the agenda forward—\textsuperscript{132} is absolutely critical.\textsuperscript{133} This backbone organization should be composed of strategic thinkers who are particularly strong with consensus building.\textsuperscript{134} Second, the MCHQC attributes a large part of its success to a strong Executive Committee that values collaboration.\textsuperscript{135} The Executive Committee provides input on emerging issues and guides members toward consensus.\textsuperscript{136}

There are, of course, multiple ways to do this. One of the most successful initiatives, the NCIOM, looks at first glance to be as loosely structured as EverThrive. However, although NCIOM does not have a single overarching steering committee, the taskforce committees, aided by NCIOM’s general program staff, do the same job on a smaller scale. In addition, since NCIOM works on only a small set of projects at any given time (currently three projects), the Board of Directors and program staff can feasibly manage those steering committees. Nevertheless, although strong leadership is important, personal conversations and the academic literature show that coalitions must be genuinely collaborative in order to be effective. MCHQC does not simply ask members vote yes or no on drafts and proposals, but gathers input from members throughout the drafting process.

\textbf{IV. Alternatives to the statewide approach}

Although geographically broad, multi-issue coalitions have the benefit of helping members to see the larger picture, they also face a number of challenges in communicating, coordinating, and prioritizing. Although strong centralized leadership would go a long way to ensuring no stakeholder’s interests fall by the wayside, resource constraints may make this difficult. In response to these concerns, the following subsections examine several alternative collaborative public health organizations, including issue-focused coalitions, regional coalitions, and coalitions focused on implementation of the Affordable Care Act. These other configurations may serve as alternative models for the proposed coalition, or may supply ideas that can be incorporated into the creation of Mississippi’s proposed coalition and/or into the structuring of its subcommittees.

\textit{A. Single-issue coalitions}

A more narrow kind of community health partnership is one that concentrates its efforts on a single health concern. Though these organizations can be structured in myriad ways, the most successful models tend to take a comprehensive view of the targeted issue.

\textsuperscript{132} E-Mail from Gina Rogers, \textit{supra} note 96.
\textsuperscript{133} Id.
\textsuperscript{134} Id.
\textsuperscript{135} Id.
\textsuperscript{136} Id.
Research is the foundation of successful issue-focused healthcare nonprofits. Understanding the causes of a certain problem is paramount in understanding how to address it most effectively. Effective research can be tailored to the state and issue in question. For example, the Adolescent Pregnancy Prevention Campaign of North Carolina (APPCNC), an organization that has been very successful in combating teen pregnancy in the state of North Carolina, partners with local schools to build comprehensive maps of teenage girls giving birth across the state, which helps to target certain high risk areas.\textsuperscript{137} APPCNC also employs several staffers that are dedicated specifically to researching teen pregnancy.\textsuperscript{138} The group manages its own resource library, designed to bring the latest knowledge to individual parties dedicated to combating teen pregnancy in North Carolina.\textsuperscript{139} Successful research is translated from legal or academic language into concise, high impact phrasing that is more generally accessible to the population.

Educating individuals is perhaps the most essential aspect to any healthcare focused initiative. People who understand the risks they may be taking or placing upon their children are much more likely to take steps to minimize those risks. There are many avenues to communicate this information. The Georgia Diabetes Coalition (GDC) has been highly successful in instituting what it has coined the 20/20 campaign – designating the 20\textsuperscript{th} of each month to raise awareness of diabetes and its consequences in Georgia.\textsuperscript{140} The GDC provides educational materials and messages to hospitals, churches, and employers across the state on a monthly basis. The organization has also created an ADA-approved program to train laypeople to educate families about the dangers of diabetes and obesity, and organizes various awareness-raising initiatives such as summits, conferences, and health fairs.\textsuperscript{141} Those organizations that are most aggressive in getting materials in front of their target audience – whether students, families, hospitals, clinics, etc. – appear to be the most successful in raising awareness, especially in comparison with those organizations that provide only passive materials, such as only communicating information and outreach through their websites.

Partnerships with local schools, nonprofits, clinics, and other related organizations can provide the most effective way to reach out to the population at large – especially those populations with less healthcare and health risk competency who are often at the highest risk. North East Florida Health Start has organized task forces that are designed to go directly into communities to discuss infant mortality with practitioners at hospitals and volunteers at family healthcare clinics to discuss and promote education about infant mortality rates and its causes in

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Florida. The South Carolina Campaign to Combat Teen Pregnancy (SC Campaign) has partnered with the federal Office of the Assistant Secretary of Health to institute a Community Mobilization Project. The project is focused on ensuring that teens in communities across the state have the opportunity to participate in programs demonstrated to reduce teen pregnancy, ensuring access to reproductive health services, and increasing community awareness of teen pregnancy issues. Some concrete steps the SC Campaign has taken include conducting community surveys of over 800 adults and students to help assess the current state of awareness of issues related to teen pregnancy is across different counties, contacting local media to ensure Community Mobilization Project receives publicity, and acquiring performance-based contracts that have provided $200,000 in funding for proven programs that educate students about teen pregnancy.

Successful advocacy can help to institute statewide policies that provide funding or support for an organization’s selected cause. The Georgia Campaign for Adolescent Power and Potential (GCAAP) has made this a central part of their mission. They organize adolescent services network meetings, where various nonprofit and service representatives convene to discuss the major policy issues of the day and coordinate efforts to advocate effectively for policies designed to limit teen pregnancy. They also write targeted policy briefs, sometimes in tandem with these other organizations, which are designed to crystallize and solidify the arguments around teen pregnancy that they are advancing at any given time.

**B. Regional coalitions**

A local coalition operates by bringing together numerous private, public, and nonprofit actors working within a single region in order to coordinate their efforts around a key health issue. An example of such an arrangement could include individual doctors, local medical schools, national nonprofits with local offices like March of Dimes, local nonprofits with one office, and state agencies for child and family services working together on a single health issue – for example, diabetes. The geographic area covered by a local or regional coalition varies greatly depending on the state and context of the issues it addresses. Geographic coalitions below the state level tend to be organized by region, or by county/city. As a result, there are

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144 Id.
countless such coalitions nationwide. This report therefore looks briefly at two examples—Growing Healthy Kids Columbus and Nevada’s Maternal and Child Health Coalitions—to draw some general conclusions.

Growing Healthy Kids Columbus is a city-based coalition that was originally funded by the state of Ohio and is now funded by the city of Columbus.\(^{150}\) The coalition aims to reduce childhood obesity through substantive interventions, which it subdivides into four achievable goals: increasing breastfeeding, increasing access to healthy foods, increasing opportunities for daily activity for children, and increasing health screenings and referrals.\(^{151}\) Member organizations meet monthly, a schedule that is feasible because they are located so close to one another.\(^{152}\) At these meetings, members report updates on their ongoing programs\(^{153}\) and work to develop further developing initiatives that supports these four core efforts.\(^{154}\) For example, Growing Healthy Kids Columbus Coalition is developing a Water First for Thirst public awareness campaign focused on teaching children to drink water as their first option ahead of soda or other sugary drinks.\(^{155}\) Coalition meetings then go in-depth on these action plans and create next steps to be revisited at the following month’s meeting.\(^{156}\)

In Nevada, a group of regional coalitions operate under the umbrella of the statewide Maternal and Child Health Coalition (distinct from the previously discussed Nevada Early Childhood Advisory Council).\(^{157}\) These regional coalitions were, in fact, formed first, and the statewide coalition was later established as a way to provide further infrastructure, support, and coordination for these regional efforts in the state.\(^{158}\)

Among these regional coalitions is the Maternal and Child Health Coalition of Northern Nevada, which, like the city-based coalition in Columbus, holds meetings each month at the same central location in Washoe County, the most populous county in the region.\(^{159}\) The regional


\(^{150}\) Id.


\(^{152}\) Id.


\(^{154}\) Id.

\(^{155}\) Id.

\(^{156}\) Id.


\(^{158}\) Id.

coalition advocates for policies that further maternal and child health and works on promoting breastfeeding.\textsuperscript{160} It hosts public health conferences\textsuperscript{161}, as well as an annual reception for state legislators at which coalition members present on the coalition’s efforts.\textsuperscript{162}

Juxtaposing these two coalitions highlights some important variation within the concept of the regional coalition, because although they share a narrow geographical focus, they are different in important respects. Growing Healthy Kids Columbus has adopted a direct service/program implementation approach, while the Maternal and Child Health Coalition of Northern Nevada seems to devote its energies to legislative advocacy. Further, and perhaps relatedly, the Columbus coalition hones in on a single public health issue, childhood obesity, while the Maternal and Child Health Coalition of Northern Nevada addresses a range of public health issues. This suggests that different goals may demand different approaches, and vice versa. That is, a direct service approach may be better suited to narrow goals, and an advocacy approach may be better suited to broad goals.

\textbf{C. Affordable Care Act implementation}

Finally, any Mississippi Child Health Council should consider devoting some of its resources to facilitating the implementation of the Affordable Care Act (ACA), which has dramatically expanded health insurance eligibility. Although this is a positive development for countless low income families in Mississippi, including children, the expansion also poses administrative challenges such as ensuring that low income individuals are actually enrolled in health plans, and working to strengthen healthcare infrastructure to meet increased demand for services. In bringing together healthcare providers from throughout the state, the Mississippi Child Health Council will be uniquely able to facilitate the expansion of health coverage in a coordinated fashion that would benefit children as well as adults. However, the attendant administrative challenges require a carefully considered strategy. The following paragraphs consider other states’ collaborative approaches to connecting low-income people with health coverage and services in order to provide guidance to the proposed child health council in addressing ACA implementation.

Organizations in other states have designed education and enrollment strategies aimed at reaching families where they “live, play, work and pray.”\textsuperscript{163} In Washington State, for example, ten lead organizations are collaborating with over 60 partner organizations across the state—ranging from libraries, Boys and Girls Clubs, health clinics, and religious organizations—to

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distribute information about the ACA and steer families toward the statewide exchanges. Similarly, California’s Community Outreach Network collaborates with health centers, youth programs, libraries, and other community organizations to educate families about the ACA and facilitate enrollment.

This emphasis on using preexisting community partnerships as a conduit to reach eligible children and families closely tracks the strategies already employed by state organizations to expand enrollment for children under Medicaid and the Children’s Health Insurance Program (“CHIP”). The ACA provides funding for the federal government’s Connecting Kids to Coverage Outreach and Enrollment Grants, which support organizations that design effective strategies to enroll children under Medicaid and CHIP. In July 2013, 41 organizations in 22 states received grants totaling almost $32 million. The majority of these organizations use local schools as a hub for their education and enrollment activities. United Way of Greater Atlanta, for example, partners with Atlanta Public Schools to conduct screening and enrollment events on school campuses. Outreach teams also educate school staff about working with children and families to increase enrollment. Organizations can identify eligible students by reviewing rosters of those eligible for free and reduced-price school lunches.

In addition to schools, grantees also frequently reach out to members of other community groups that typically engage with low-income families, such as medical centers, faith-based organizations, and re-entry programs. Grantees educate members of these groups about the coverage options available to eligible families and the process of applying for coverage. Some organizations supplement these efforts by encouraging families to contact central call centers, where trained staff members conduct enrollment and referrals over the telephone. Although the organizations funded by these grants focus primarily on expanding coverage under Medicaid and CHIP, the strategies they utilize may be equally effective when employed to expand coverage under the ACA. Moreover, because many uninsured children are already eligible for coverage under Medicaid and CHIP, outreach efforts in Mississippi should also consider children’s eligibility under these preexisting programs.

Organizations in Mississippi are already using some of the aforementioned strategies to expand enrollment under the ACA. In particular, Dr. Michael Minor, pastor of Oak Hill Missionary Baptist Church in Hernando, Mississippi, has begun to assemble a network of churches, patient-

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164 Id.
167 Id.
168 Id. at 1–2.
169 Id. at 1.
170 Id.
171 Id. at 9.
172 Id.
173 Id. at 1.
advocacy groups, and community health centers aimed at increasing face-to-face enrollment assistance. Dr. Minor is helping members of other groups receive the training required by the Department of Health and Human Services to become navigators or certified application counselors. As of October 2013, Martin and his partners had assembled a team of almost 100 federally-funded navigators and counselors. However, Dr. Minor’s Oak Hill church remains one of only two organizations in the state to receive a federal “navigator” grant. More organizational involvement and a greater number of navigators and counselors will be necessary to implement the ACA effectively.

If these organizations are successful in increasing the number of children and families enrolled under the ACA, their achievements may lead to a secondary set of challenges. Increased coverage will expand the pool of patients in need of primary and preventive care, and more medical professionals will be needed to accommodate this expansion. Mississippi is already suffering from a dire shortage of physicians. In 2012, the state had 159 doctors per 100,000 people, ranking last in the nation. Additionally, a disproportionate number of the existing doctors in Mississippi practice in urban areas, leaving the Delta region with an even greater shortage. Although recruiting more primary care physicians to the region would be ideal, the feasibility of such an effort is low. Because the salaries of primary care physicians are considerably lower than those of specialists, states across the country are struggling to maintain an adequate supply of primary care doctors. Even in desirable locations like Santa Barbara, California, medical professionals fear that increased patient numbers under the ACA will place an unmanageable strain on the patient load of primary care physicians.

In response to these concerns, some states have shifted their focus toward increasing the number of nurse practitioners, nurses, and physician’s assistants available to underserved communities. However, Mississippi law currently requires nurse practitioners to practice

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175 Id.
176 Id.
177 Id.
179 Id.
181 Id.
under the guidance of a physician.\textsuperscript{183} Because physicians are not readily available in many Mississippi communities, particularly in the Delta region, this requirement constrains the ability of nurse practitioners to fill in the gaps in primary care present throughout the state. As of 2012, 18 states and the District of Columbia had amended their laws to allow nurse practitioners to perform primary care services without the supervision of a physician.\textsuperscript{184} Some states have also relaxed the law requiring nurse practitioners and physicians to operate in the same location, opting instead to allow nurse practitioners to teleconference periodically with physicians in separate locations.\textsuperscript{185} Some combination of these policies would substantially lighten the burden placed on primary care physicians in the wake of the ACA’s expansion of the patient population. More importantly, these reforms would provide newly insured Mississippians a practical opportunity to receive essential primary care and preventive services.

V. Conclusion

As this brief has shown, Mississippi faces a range of options in structuring its child health council. However, because of the difficulty of measuring long term public health change and the interrelated factors that can influence outcomes, it is hard to draw conclusions about which approaches are most effective. The academic literature provides some general guidance on smaller scale collaborations from which we may draw conclusions: successful partnerships adopt a collaborative approach with open channels of communication and pay great attention to evaluation. The most successful coalitions also seem to share certain qualities that provide some guidance. In keeping with these findings, the Mississippi Delta Project makes the following recommendations.

1) **Complex top-down and tightly networked structure.**

Academic research has found that a complex structure, with strong and numerous inter-member connections, is closely correlated with coalition success. This conclusion is supported by the anecdotal evidence: the coalitions that are both broad and deep (that is, that have a hierarchical structure as well as a number of subcommittees) seem to be more successful. Interviews with coalition members indicate also that a strong backbone or anchor organization devoted to facilitation is critical. Consequently, a Mississippi Child Health Council should have a steering committee that handles substantive planning, as well as a backbone organization devoted to administrative planning. The Council should also have several subcommittees. In addition to the currently planned issue-centered subcommittees, the Council might also consider a subcommittee focused on implementing the Affordable Care Act or regionally focused localized subcommittees. In particular, if the Council hopes to implement direct

\textsuperscript{183} Christensen, supra note 183.
services programs, it should charge its subcommittees with narrow, highly focused substantive mandates.

If more localized subcommittees are contemplated, Mississippi would be wise to avoid establishing coalitions on the city or county level, as resources and people are too spread out to make such an approach effective. Instead, coalitions could be regional and organized around potential partner universities. For example, a five region approach centered around Jackson/Jackson State University’s public health program, Hattiesburg/Southern Miss’s public health program, Gulfport/Biloxi, Northeast Mississippi and Mississippi State University, and the Delta/Ole Miss School of Medicine/Mississippi Valley State’s public health program could provide a base of operations in each region to then bring together interested parties and form a coalition. Any smaller division runs a strong risk of cutting out large portions of the state from any significant resources.

2) **Diverse membership.**

The Council and its subcommittees should draw a diverse membership. If an issue-centered subcommittee approach is adopted, then each subcommittee should have representatives from each of the geographic regions, tasked with giving special attention to regional variation. Membership should also be professionally diverse, and should include healthcare providers, researchers, community members, nonprofit organizations, policy advocates, elected leaders and agency workers. However, healthcare providers should feature prominently on such committees, as they have first-hand understanding of the specific challenges facing Mississippi’s children.

3) **Collaborative process.**

A Mississippi Child Health Council should invest time and resources into ensuring the council adopts a truly collaborative process in order to make the best use of state resources and human capital. This entails action planning, establishing formal procedures to ensure all voices are heard, and perhaps making use of innovative tools like concept mapping. The Council should also strive to involve communities to identify the health priorities that are most important to those affected, to incorporate local input on program implementation, and to generate local buy-in. Council members should also have ample professional opportunities to interact and network in order to promote cross-pollination of ideas and collaborative solutions.

4) **Focus on outcomes.**

Finally, public health research has found unequivocally that a commitment to rigorous self-evaluation leads to greater success. Prior to any implementation, the Council should have evaluative measures and intermediate goals in place to continue improving.