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A Systems and Innovation Approach to Attune Grantmaking for Early Childhood to What Matters Most at the Point of Service

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Introduction

The JPB Foundation was established in 2011 with a commitment to catalyze impact on pressing societal issues in the United States. From the outset, it pursued a multistakeholder path, combining support for medical research, a healthy environment, and the transformation of social systems that underlie and reinforce poverty. This article discusses how and why JPB promoted the pursuit and application of multistakeholder innovations as it evolved its strategy for early childhood health equity to help families burdened by poverty and hardship.

As used here, 'multistakeholder innovation' refers to the use and development of new technical, technological, or organizational capabilities to create public and private value benefiting participating stakeholders through the transformation of existing economic constraints that determine trade-offs between equity, quality, cost efficiency, and other domains of performance (Lazonick, 2002; Mazzucato, 2018).

Such innovations enabled JPB's cross-sector partnerships over the past decade to shift the science, clinical practice, and public discourse on early life stress. These successes — and the obstacles encountered — led JPB and its partners to identify a path toward a reimagined paradigm of care beyond the traditional top-down view of quality improvement, which omits the subjective perspectives of individual parents and providers. With investments in staff capacity and the addition of subject matter experts, JPB came to reimagine quality improvement as a function of the care continuum's incentives, abilities, and

Key Points

- This article discusses how and why The JPB Foundation, a nationally focused private philanthropy in the United States, promoted multistakeholder innovations as it evolved its strategy for early childhood health equity. Through coordinated grantmaking, its cross-sector partnerships over the past decade shifted the science, clinical practice, and public discourse on early life stress.
- Building on field learning and trusted relationships, JPB and its partners paved the way for a reimagined paradigm of care that brings ecosystem stakeholders together to overcome competing frictions inhibiting their mutual flourishing. Working collaboratively with grantees as their champion and thought partner, JPB formulated an agenda to facilitate stakeholders' codependent functioning to make tailored care of higher quality feasible at a greater scale and scope than currently exists. This change in working with grantees resulted from a shift in JPB's beliefs and thinking, which led to a more ambitious attempt to transform both equity and performance at the scale of full populations.
- Promising results from proof-of-concept studies show that feedback loops built into the new paradigm of care can support more enlightened decision-making by stakeholders, including foundations and evaluators. New, explicit information flows can, moreover, dissolve the tension between the management of aggregate performance benchmarks and uniquely tailored care for

(continued on next page)

decision-making workflows. This led it to shift its focus from the pursuit of "point solutions" to the design of an ecosystem to support "what matters most" to and for the family. In this paradigm, the experiences of individual families and providers motivate the design, funding, and governance of programs and services. The ecosystem is positioned to overcome challenges by learning-to-learn to make custom, individualized care of higher quality feasible at a greater scale and scope than currently exists.

Initially, however, the notion of tailored care for the individual child and family had not been formally codified and implemented as an ecosystemwide quality improvement and health equity strategy. To achieve this, JPB took stock of insights from prior whole-of-community efforts on poverty and stress. Alongside partners, it formulated a new agenda to facilitate stakeholders' codependent functioning and to build collective intelligence from the experiences of individual families and providers at the point of service. Through the author, JPB contributed expertise in health policy and management, systems and innovation thinking, and human-centered design.

As a starting point, this new agenda explored (1) how POS care objectives could be jointly determined and (2) how the measurement of progress could be embedded in new workflows to catalyze improvement. By presenting the evolution of JPB's strategy, the author hopes to encourage grantmakers to integrate systems and innovation thinking not only to overcome poverty and inequity, but also to transcend adversarial polarization and elevate the standard of human flourishing.

Introduction and Background

With fundamental commitments to inclusive diversity, social justice, and interdependence at its core, JPB sought from its origin to enable future generations to flourish. This mission led it early in its history to join emerging work on the interrelated issues of adverse childhood experiences and toxic stress as a strategy to prevent future illness, reduced life expectancy, and sacrificed educational and professional attainment.

Key Points (continued)

the individual family. These new flows also position the public, private, and social sectors to push and enable one another to improve equity and performance simultaneously.

- Foundations seeking to apply systems, innovation, and design thinking to challenge existing assumptions about the scope of their learning and impact will benefit from this case study.

Landmark epidemiological research by the Centers for Disease Control and Prevention and Kaiser Permanente in the 1990s had established a strong association between ACEs (i.e., severe traumatic events, such as abuse and neglect, where caregiving fails to buffer stress) and poor health outcomes in adulthood, including cancer, chronic disease, mental and behavioral disorders, and substance use (Felitti et al., 1998). It also showed that ACEs occur widely, regardless of income or geography. Subsequent studies estimated that ACEs affected nearly 35 million children nationwide (Child and Adolescent Health Measurement Initiative, 2013).

Adverse childhood experiences can harm optimal child development and lifelong health through the chronic activation of stress hormones in the body and the brain (Center on the Developing Child, 2020). When JPB entered this field, several challenges impeded the implementation of clinical, community, and public policy interventions to address toxic stress. First, public awareness lagged behind other health priorities; only a few states at the time conducted ACEs surveillance and reporting. Second, the task of clinical identification was complicated by age, exposure, and individual child; babies, school-age children, and adolescents all presented differently. Third, clinicians lacked the technical means to measure excessive stress activation. Fourth, the evidence base to specify tailored intervention had yet to be developed through

Although challenges remain, JPB's support of constructive risk-taking as a funder, champion, connector, and strategy consultant has improved the child life course trajectory.

scientific research. These challenges called for philanthropic commitment.

Coordinated Grantmaking for Cross-Sector Mobilization

To equip clinical and service providers to target ACEs and toxic stress, JPB initiated funding in 2013 to develop and diffuse new technical, technological, and organizational capabilities focused on populationwide developmental promotion and early detection, as well as on individual risk assessment, intervention, and treatment. With stakeholders, JPB co-designed a diversified portfolio of projects to generate synergies between scientific research, clinical practice, service referral and linkage, and payment reform. It disbursed consecutive multiyear grants to enable basic and translational research, public communications and grassroots engagement, early childhood system building, and workforce training and retooling. Its partners included local, regional, and national stakeholder networks organized through the American Academy of Pediatrics, Center for the Study of Social Policy, Center for Youth Wellness, Chapin Hall, Connecticut Children's Medical Center, Harvard University's Center on the Developing Child, Help Me Grow National Center, MLPB, and Tufts Medical Center. By facilitating cross-disciplinary learning and cross-pollinated strategy, JPB promoted synergistic collaboration.

As reported below, JPB's cross-sector partnerships successfully advanced (1) scientific and public understanding of the biology of adversity, resilience, and developmental plasticity; (2) pediatric practice, public health surveillance, and whole-of-community care; and (3) public policy discussions on payer coverage and reimbursement. Although challenges remain, JPB's support of constructive risk-taking as a funder, champion, connector, and strategy consultant has improved the child life course trajectory.

In California, for instance, ACEs screening became standard patient care, incentivized by the state's investment in practice and payment reform (Underwood, 2020). Nationally, greater awareness of toxic stress led to calls for trauma-informed teams, integrated medical and behavioral health, and coordinated services (Garner et al., 2022). Public health surveillance also grew; since 2014, 21 states began reporting ACEs to the CDC (2020). By 2020, 27 states had enacted ACEs-related legislation and at least 37 planned statewide community-based collaboratives for trauma-informed policy and practice (Novoa, 2020).

On the scientific front, a battery of biomarkers of stress activation, developed with state-of-the-art techniques, is being validated to strengthen measurement capacity in pediatric primary care (Shonkoff et al., 2021). These measures will enable early identification of relative risk at the individual, rather than population, level. They will also lay the groundwork for individualized guidance for parents and care tailored to their child's specific needs. Additionally, laboratory and clinical studies are expanding the field's understanding of the reversibility of stress effects as well as what treatments work best for whom, why, and in what contexts (Shonkoff et al., 2021). These technical innovations will provide a fuller, more biologically informed explanation of how individual children respond differently to adversity, how excessive stress activation may vary by age and sex, and ultimately how early life stress can increase risk for long-term health impairments (Shonkoff et al., 2022). Simply stated, neither "nature" nor "nurture" alone determines life outcomes.

Altogether, these advances have set the stage for a future of individualized care to improve

outcomes stemming from the complex interactions between poverty, hardship, and stress-related disease. However, while therapeutic innovations are essential, foundations are also obliged to counterbalance the limitations of "medicalizing" poverty (Shepherd & Fretwell, 2018; Tyler & Teitelbaum, 2019) by dismantling the socially determined roots of adversity, which leave lasting biological effects on future generations.

Systemic Constraints on Philanthropic Impact

As these projects approached their sixth year, JPB's board asked staff and leadership to assess results and consider future options. JPB had by this time hired more subject matter experts (including the author) with cross-functional and cross-sector experience who could conduct a holistic evaluation. Despite satisfaction with its partners' early adoption and diffusion of innovations, JPB found its impact constrained by ecosystem-design issues which hindered comprehensive practice transformation.

To identify the actors and factors involved, JPB conducted site visits, broad literature reviews, key informant interviews, and focus group discussions. Insights from these accounts pointed to three interrelated constraints on advancing both equity and performance: (1) the fragmentation of programs and services; (2) the coordination and compatibility of public and private funder agendas; and (3) the reliance on aggregate measures of quality for payment and accountability.

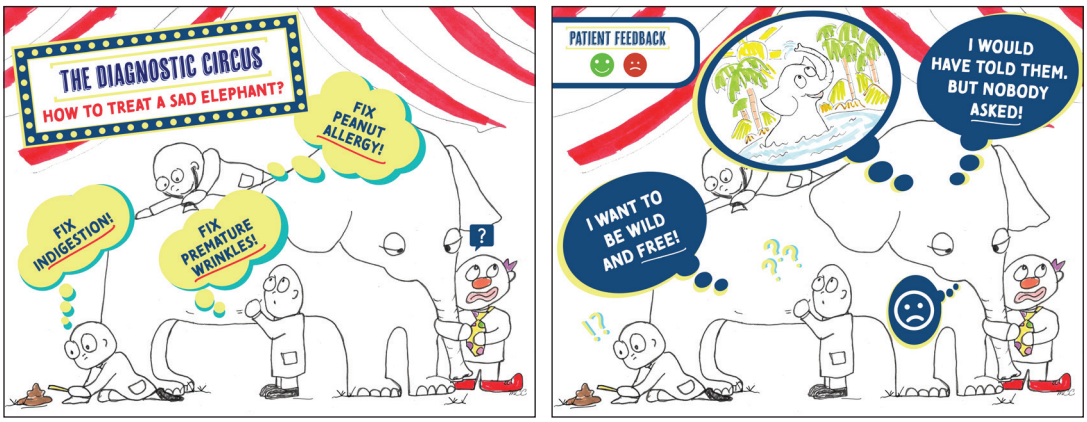
First, fragmented care gave rise to gaps and unnecessary duplicated effort, as well as access and coordination pain-points for families and providers. Prevailing workflows and protocols were byproducts of a complex web of local funding and governance, where state agencies manage different programs and services operated by a range of public and private actors (Dichter, 2015). Piecemeal policy directives and siloed payment mechanisms (Kauerz & Kagan, 2012) compounded the fragmentation by offering weak incentives to link services or to integrate POS feedback in the design and governance of the care continuum. Despite improved cross-sector coordination over the past two decades, the care continuum remained cumbersome and inadequate for families with complex health and health-related social needs such as housing, food, employment, and financial stability (RTI International, 2021).

Second, against this backdrop, uncoordinated and incompatible public- and private-funder agendas exacerbated the challenges faced by families and providers while stifling nascent innovations reliant on effective coordination. However well-meaning, individual philanthropic goals that omit consideration of the systemic effects of single interventions can lead to indirect contests among stakeholders while reinforcing antiquated paradigms of care. Strategic adaptations to piecemeal public policies or siloed public budgeting have the potential, moreover, to sow unintentional discord among stakeholders when select groups are privileged over others. For instance, a proposed funding increase for the child care workforce may engender resistance from threatened stakeholders and their allied donors.

Third, within the care continuum, workflows and protocols favored families with routine cases anticipated by service delivery. The reliance on aggregate measures of quality, which assess average case outcomes and effects to manage accountability and to optimize payment and reimbursement, sidelined families with exceptional or statistically atypical care needs and priorities. Apart from inducing "cherry picking," static optimization of cost and quality obscured how families and their providers might inform the development of higher standards of both equity and performance.

As an example, payment and policy concerns about population-based risks and deficits dictate the choice of items prioritized by conventional health and health-related social needs intake-screening. Such protocols count people as being at risk of hunger, eviction, physical violence, and so on; no space is made for personal aspirations or for personal trade-offs to avoid "bad" states. As such, a family that eats nothing

FIGURE 1 What Matters Most?



Multiple siloed perspectives, such as those represented at left, may exist regarding "what matters most" to and for the beneficiary of care. A new, shared perspective may arise if and when one enters into the world of the other — in this case, the patient's — as a trusted partner, although they may not be of that world.

Source: Illustrations © Mona Chiang

but instant noodles to avoid hunger is considered fed. They are left out, even though they would prefer and benefit from a better diet. Unless the provider has both the means and the authority to exercise discretionary power, families with an uncommon agenda could be sidelined.

The Problem of Goal-Discordance

A further constraint identified by JPB's analysis arose endogenously from routinized POS protocols and inflexible service workflows, which had the potential to cause waste and harm through oversight and inattention to the family's perceived "goals of care" — for example, where siloed health providers struggle to ascertain "what matters most" from their patient's perspective. (See Figure 1.) As used here, the term GOC refers to the desired state of biopsychosocial functioning that defines the purpose and intention of service or therapy.

Disparate perspectives between the parent and the provider may arise regarding what matters most to and for the family, given both sides' unique roles and lived experiences. Poverty and stress may impose on families conflicting or ambiguous demands, which complicate how GOC are formulated, by whom, and for what reasons. Point-of-service providers then risk faulty assumptions and false predictions about care objectives, service needs and utilization, and a family's desire and ability to engage or follow through on recommendations.

Unless harmonized, these disparate perspectives may produce goal-discordant care. For example, a single parent balancing multiple obligations may lack the time and means to navigate care, explore service options, or deal with multiple referrals, especially if gated by terms that outweigh benefits. Barriers such as child care and public transportation could interfere with care recommendations by rendering participation unworkable.

For philanthropy, goal-discordance across the care continuum poses a systemic minefield. Grantmaking by separate foundations may produce mutually incompatible goals when linear mechanical theories of change target single reforms and point-solutions. Collectively, such grantmaking may unknowingly mask pain-points, reinforce the risk of waste and harm, or compound the choices made by payers, professional societies, and other stakeholders that indirectly aggravate goal-discordance.

For example, a grant that adapts to the design of eligibility rules for food and other needs-based

programs may overlook a family's preferred objectives, such as a diet superior to supplemental food access; or, conversely, overlook painful trade-offs that deny the family access, such as an inferior diet maintained to avoid hunger. Similarly, a grant that adapts to existing measures of program-effectiveness may define "success" antithetical to goal attainment. Organizational pay-for-performance and volume-driven reimbursement tied to recruitment, retention, or model-adherence may favor enrollment of families with slower progress, while families who progressed too quickly are "failures." Unless averted, goal discordance may distort resource allocation by public and private actors, conceal gaps in care, or subordinate the family's agenda.

Internal Shifts in Thinking

These findings, combined with further insights across JPB's programs and portfolios, led staff and leadership to seek deeper impact through a more active and inclusive style of grantmaking. Although untested and risky, we sought to identify partners willing and able to co-create interdependent EC strategies. While some grantees exited, a critical core continued forward with new stakeholders.

Concurrent with these discussions, JPB refined its own capabilities and awareness. Staff tutorials on Trust-Based Philanthropy (Trust-Based Philanthropy Project, 2024), an internal task force on diversity, equity, and inclusion, and a regular teach-in series on topics such as narrative storytelling and feedback loops to capture stakeholder experiences, all contributed to a shift in beliefs and thinking. Additionally, contemplative techniques such as mindfulness and compassion were introduced as resources to reframe relational perspectives, to cultivate empathy and interdependent awareness, and to establish conditions for "psychological safety" and "authentic, transformational leadership." (These techniques were subsequently expanded into a program manual called Embodied Leadership for Innovation™ and disseminated by the author.)

As JPB came to recognize, the foundation's role in this conception is not to be a "savior," a "cheerleader," or a "bystander," but rather to be a "catalytic ally," whose care, skill, judgment, patience, and wisdom invite co-created boundaries and practices with and among the ecosystem's multiple stakeholders to manifest anew. From this standpoint, problems and their solutions are jointly "owned."

These internal investments helped inspire JPB's idea to initiate and institutionalize a similar shift in the early childhood ecosystem: namely, to tackle underperformance by embodying DEI principles in feedback loops to give value and voice to the family, the provider, and all who supported the child's well-being. As JPB came to recognize, the foundation's role in this conception is not to be a "savior," a "cheerleader," or a "bystander," but rather to be a "catalytic ally," whose care, skill, judgment, patience, and wisdom invite co-created boundaries and practices with and among the ecosystem's multiple stakeholders to manifest anew. From this standpoint, problems and their solutions are jointly "owned." For philanthropy to succeed — and graduate to more evolved, complex challenges — it would first have to help stakeholders transcend old patterns of cyclical, insular struggles for access, quality, or cost efficiency.

JPB thus prioritized the construction of deeper, more sophisticated feedback loops to manifest and cultivate the functional interdependence and interrelatedness of quality improvement,

JPB formulated the practice to verify and enable prospective partners' incentives and abilities to participate in multistakeholder developmental grantmaking, and to trust front-line decision-making based on a first-hand knowledge of risks and opportunities.

foundation learning, philanthropic strategy writ large, macro- and microinnovation, agency performance, and individual family goals. JPB also recognized the need for such feedback loops to help disparate stakeholders expand their circles of care and empathy for one another as a necessary precondition to "give and receive" each other's time, talent, ties, resources, and connections. By jointly establishing reciprocal commitments, one may then challenge and enable the other to cultivate capacities for mutual benefit. Only then could the conventional preoccupation with narrow, self-interested power imbalances be overcome to enact a more holistic vision where foundations and stakeholders together refine new patterns of thinking, acting, and doing.

Given JPB's prior experience and sunk costs in the early childhood sector, its board and leadership agreed to pursue an experimental approach where it formulated developmental grantmaking through the lens of multistakeholder perspectives. It would incentivize and enable grantees to work with their stakeholders to take constructive risks to transform the technical, economic, and relational constraints that hinder progress on equity and performance at greater scale than currently feasible.

This approach to "multistakeholder developmental grantmaking" required JPB to work closely with grantees to co-create new patterns for themselves and their partners, including public payers and private funders. It also required JPB to elicit and negotiate calibrated priorities with safety and harm avoidance as equally paramount concerns. For example, JPB took care to understand the incentives and abilities not just to implement new agency practices, but also to transition safely away from antiquated practices.

To further operationalize its approach, JPB transformed testing, psychometrics, and methodology practices to overcome fragmented decision-making within an evolving interdependent ecosystem. JPB formulated the practice to verify and enable prospective partners' incentives and abilities to participate in multistakeholder developmental grantmaking, and to trust front-line decision-making based on a first-hand knowledge of risks and opportunities. As part of this commitment to verify, enable, and trust, or 'VET,' JPB provided technical assistance to grantees and encouraged them to tailor their partners' TA according to their unique developmental baselines and to staff-up or hire consultants they deemed the best fit. This flexible but more expensive option contradicted conventional prescriptions to capture known economies of scale by centralizing and outsourcing group TA. Such flexibility proved valuable during the COVID-19 pandemic and instrumental to the productivity of multiple field experiments with uncertain outcomes.

A Compass for Ecosystem Design and Resilience

As JPB discovered, foundations needed to do more than improve access, utilization, and service coordination within the ecosystem to help parents buffer early life stress. The more ambitious vision is to catalyze a co-designed care continuum with the capacity to respond to challenges by learning-to-learn to make custom, individualized care of higher quality feasible at a greater scale than currently exists. In a rapidly changing world with natural, technological, and socioeconomic shocks such as the COVID-19 pandemic, to cultivate ecosystem resilience is to innovate continuously.

Various case studies reinforced the idea to support this strategy by enabling mutually self-directed, cross-sector learning, where feedback loops traverse multiple nested systems operating at higher levels of governance, management, and control (Marshall, 2008; Human Learning Systems Collaborative, 2021). Integrated connectivity along these lines has been shown to amplify learning across disciplines and boundaries, and to enhance multilevel stakeholder responses to upstream as well as downstream health and social determinants (Carroll & Rudolph, 2006; Rechel et al., 2018; Aragón & Garcia, 2015).

This strategy also requires the ecosystem to push and enable stakeholders to evolve codependently with goal concordance and goal attainment as the moral and practical compass. For philanthropy, the paradigm of goal-concordant care invites stakeholders to rethink systemically how, why, and where to set the fulcrum of planning and decision-making to assure collective inclusion as well as improved buy-in, efficiency, and effectiveness.

While goal-concordant care arose for high-need, high-cost adult patient care (National Committee for Quality Assurance, 2018), it had yet to be formally codified and implemented throughout the early childhood ecosystem as a quality improvement and health equity strategy. To achieve this, JPB convened partners and stakeholders and contributed the author's expertise on GCC workflows. Collectively, it became apparent that new routines needed to be built, as current pediatrics guidelines offered limited advice beyond soliciting "questions and concerns" about learning, development, and behavior (Hagan et al., 2017). New POS decision-making workflows were necessary to elicit preferences and explore care objectives, while encouraging emergent insights and information.

As a promising sign for foundations and evaluators, anecdotal reports from JPB's partnerships indicate that the new informational capabilities deriving from the construction of GCC feedback loops can support more enlightened decision-making by stakeholders. The joint determination, documentation, monitoring, and measurement of goals of care, including the analysis of feasibility and goal attainment, can yield new insights about causal chains and causal mechanisms linking outcomes to the ecosystem's functioning.

Through the use of "process-tracing" techniques (Beach & Pedersen, 2019), management and governance decision-makers can address how and where gaps in goal-attainment appear and discern how desired GOC can be made more feasible and attainable for more families at a greater scale and scope than currently exists. Insights from these techniques can guide more precise reforms in governance, regulation, and financing, and more robust, collective engagement of the public, private, and social sectors. As documented in the example below from a pediatric system, these techniques can illuminate the need for new capabilities, which foundations should support to make feasible the pursuit of new, superior outcomes, as judged by all involved.

Grantmakers and program designers also have more tools to facilitate trusted relations, beginning at the point of service. Systematic analysis of the conduct of shared goal-setting and goal-monitoring can inform operational checks and balances to assure participants' satisfaction and to mitigate bias and infra-humanization,[1] which arise from differences in class, racial, or economic privilege. Provider teams must be trained, for example, to engage families in ways that demonstrate that both sides matter to and for each other.[2] Similar structured interactions have been shown to defeat stigma and discrimination associated with poverty, health, and marginalization (Capozza et al., 2016; Ling et al., 2020).

[1] Infra-humanization by in-group members attributes a lower human status to out-group members; in-group members deny that out-group members share common experiences of human feelings or emotions (Leyens et al., 2007).

[2] Mattering refers to the psychological experience of feeling valued and adding value (Flett, 2018).

These frameworks are transformed by adding collective accountability for goal-attainment onto their agendas and by integrating process-tracing techniques into their methodologies to assess and redesign stakeholders' relational interactions (e.g., through improved workflows).

Moreover, by introducing reciprocal commitments in service of the other's role as a parent or as a provider, the process transforms role-positional differences into a resource that overcomes a preoccupation with transactional POS power imbalances. That is, care can be more than either "family driven" or "provider driven" (Osher & Osher, 2002) when both sides collaborate interdependently for mutual benefit. These relational insights apply equally to foundation practices.

GOC Transform System Approaches for Quality Improvement

With JPB's technical assistance in the areas of systems evaluation and health informatics, collaborating partners learned how to apply new informational capabilities to transform "system approaches," such as collective impact (Kania & Kramer, 2011) and targeted universalism (Help Me Grow National Center, 2022; Othering & Belonging Institute, 2023), into dynamically innovative equivalents. In their original forms, both frameworks rely on commercial inputs to pursue their agendas but may not necessarily seek to influence how these inputs may be better developed and produced to enable new, superior agendas to emerge.

These frameworks omit the development of new, superior capabilities to reshape a program's quality and cost efficiency and to involve new actors, roles, and functions to improve social welfare at the individual and population levels. New workflows and health-information technologies can, for example, produce higher quality, more efficient information routing at a larger scale and scope than previously possible. Additionally, these frameworks omit new capabilities for endogenous reorganization, where operations, governance, and planning evolve to attain GOC defined by parents' aspirations rather than their needs or deficits.

These frameworks are transformed by adding collective accountability for goal-attainment onto their agendas and by integrating process-tracing techniques into their methodologies to assess and redesign stakeholders' relational interactions (e.g., through improved workflows). With these elements, top-down and bottom-up planning dissolves the tension between the management of aggregate performance benchmarks and uniquely tailored care for the individual family, however statistically routine or atypical.

In their fully dynamic equivalents, the ecosystem's collective engagement improves quality and cost-efficiency standards by shaping and responding to the interaction of public and corporate governance. Commercial, firm-led innovations (e.g., information technology) are required throughout the ecosystem to equip targeted and universal programs to tailor care for individual families. A greater diversity of families benefits from the cultivation of a more resilient, sophisticated ecosystem.

A Grantmaking Agenda to Attune to What Matters Most

To attune POS-care to "what matters most," JPB co-formulated a new agenda drawing on human-centered design principles. This agenda sought to explore how GOC could be jointly determined and how the measurement of progress toward family goal-attainment could catalyze ecosystem improvement.

Comparative multilevel studies conducted with diverse pilot communities used observational and participatory techniques to assess a range of benefits for stakeholders through formative and developmental evaluations. As a starting point, four broad domains of progress were chosen: (1) enhanced equity and inclusion in decision-making, (2) refined resource use and allocation, (3) coordinated management and governance, and (4) ecosystemwide learning.

To elucidate causal chains and causal processes, JPB partners conducted interviews with families, providers, program administrators, and other key informants to map out their experiences and interactions, showing how POS care reflects the strengths and limitations of the care continuum itself. Case studies analyzed the effects of process changes, such as devolving authority to parents and providers, on (1) the subsequent use and deployment of resources, (2) intraagency and interagency cooperation and information sharing, (3) collective accountability for progress toward goal attainment, and (4) further quality and performance improvement.

Promising early results show that families participate in shared goal-setting and affirm its purpose and principles, providers experience greater satisfaction and feelings of effectiveness when utilizing GCC practices, and caregivers experience higher rates of linkage to community-based services, improved responsiveness on referral and intervention, and greater service continuity when engaging with an ecosystem led by goal-concordant care. Moreover, these studies documented how POS information led a regional pediatric health system's management and governance to invest in workforce training and retooling, more sophisticated workflows, new data collection protocols, and more agile, centralized care-coordination routines.

Future proof-of-concept studies will assess other benefits, such as the quality of bottom-up and top-down learning, and its effects on strengthening the individual contributions of organizations as well as the synergies between organizations that contribute to goal attainment.

Philanthropy Reflected and Embodied in the Care Continuum

As reported in this article, JPB's contributions to the early childhood ecosystem were made possible through interdependent partnerships and strategic decision-making. To meet shared challenges, the portfolio enabled and incentivized constructive risk-taking as well as the quality of learning and failure. Moreover, JPB invited and expected dissenting views as a path to clarify priorities and improve buy-in, alignment, and coordination. JPB positioned itself and its grantees to learn from and alongside one another; to cultivate and challenge the ecosystem to make superior family GOC feasible and attainable; and to apply foundation grantmaking, convening, and evaluation and monitoring to help realize a superior standard of health equity.

That the ecosystem itself might one day stimulate and advance multistakeholder innovations through productive cross-sector collaboration may depend, however, on the emergence of an interconnected philanthropy that recognizes the need for systems change at the scale of markets and populations. Philanthropy writ large, however, has been molded by a sociopolitical and economic paradigm that excludes stakeholder leadership and participation in the creation or discovery of new capabilities to overcome the constraints on prevailing standards of equity and organizational performance. Philanthropy's own fragmentation can, furthermore, undermine itself through uncoordinated decision-making that puts ecosystem stakeholders at odds collectively with one another, as demonstrated by the tension between population and individual impact manifesting as POS goal discordance. Earnest, well-meaning attempts by foundations and other institutions seeking to solve poverty and health inequity by "balancing" stakeholder interests fail to recognize the dynamic stasis left intact when the cycling of new rules, regulations, and cultural norms preserves the underlying trade-offs inhibiting greater flourishing for more groups and individuals. The intended beneficiaries might reasonably come to see their frustrations weaponized by philanthropy.

The shared human experience of climate change, the COVID-19 pandemic, and countless social injustices is a reminder that foundations, as individual agents, are all bound together and implicated as members of the social systems that produce such effects.

The goal-concordant care paradigm described here offers philanthropy a path to reverse these dysfunctions while simultaneously enhancing ecosystem resilience: specifically, by establishing intentional workflows and feedback loops to learn from the most marginalized families, who lack the clout, means, or resources as individuals or as a group to wield sanctions or barter for gains. By including their perspectives and experiences in the design and reform of the care continuum, the ecosystem as a whole confronts opportunities for further innovation to address more complex challenges.

The manner and quality of philanthropy's interdependent functioning can either impede or advance systemic, multistakeholder innovation to overcome poverty and health inequities. The latter requires sustained commitment across two distinct, interrelated spheres of improvement: job-related skills and mindsets, and relational trust and collaborative engagement. The first, more familiar, approach leverages conventional grantmaking. The second, less utilized, approach facilitates the co-creation of systematic feedback loops to link cross-sector stakeholders to enlarge their focal view of concerns and opportunities, and to expand the ecosystem's collective intelligence and depth of strategic consensus and coordination. Both are necessary to help the care continuum evolve to fulfill its purpose and mission for individual families and for the ecosystem.

The shared human experience of climate change, the COVID-19 pandemic, and countless social injustices is a reminder that foundations, as individual agents, are all bound together and implicated as members of the social systems that produce such effects. Society as a whole creates and enacts its own realities. This reminder invites foundations to re-envision how cross-sector stakeholders might "connect, understand, relate, and engage" with one another. Foundations can do more than seek to maintain human survival or repair and attenuate human injury; they can also confer a legacy of ever-higher standards of child and family flourishing.

References

Aragón, T. J., & Garcia, B. A. (2015). Designing a learning health organization for collective impact. *Journal of Public Health Management and Practice, 21*(Suppl 1), S24-33. https://doi.org/10.1097/phh.0000000000000154

Beach, D., & Pedersen, B. P. (2019). *Process-tracing methods: Foundations and guidelines*. University of Michigan Press.

Capozza, D., Falvo, R., Boin, J., & Colledani, D. (2016). Dehumanization in medical contexts: An expanding research field. *TPM — Testing, Psychometrics, Methodology in Applied Psychology, 23*(4), 545–559. https://doi.org/10.4473/TPM23.4.8

Carroll, J. S., & Rudolph, J. W. (2006). Design of high reliability organizations in health care. *BMJ Quality & Safety.* 15(Suppl 1), i4-9. https://doi.org/10.1136/qshc.2005.015867

Center on the Developing Child. (2020). *ACEs and toxic stress: Frequently asked questions*. Harvard University. https://developingchild.harvard.edu/resources/aces-and-toxic-stress-frequently-asked-questions/

Centers for Disease Control and Prevention. (2020). *Behavioral Risk Factor Surveillance ACE Data*. https://www.cdc.gov/violenceprevention/aces/ace-brfss.html

Child and Adolescent Health Measurement Initiative. (2013). *Overview of adverse child and family experiences among US children*. Data Resource Center for Child and Adolescent Health, U.S. Health Resources and Services Administration. https://www.childhealthdata.org/docs/drc/aces-data-brief_version-1-0.pdf

Dichter, H. (Ed.). (2015). *Rising to the challenge: Building effective systems for young children and families, a Build e-book*. Build Initiative.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., et al. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine, 14*(4), 245–58. https://doi.org/10.1016/s0749-3797(98)00017-8

Flett, G. (2018). *The psychology of mattering: Understanding the human need to be significant*. Academic Press. https://doi.org/10.1016/B978-0-12-809415-0.00016-5

Garner, A., Yogman, M., & Committee on Psychosocial Aspects of Child and Family Health, Section on Developmental and Behavioral Pediatrics, Council on Early Childhood. (2021). Preventing childhood toxic stress: Partnering with families and communities to promote relational health. *Pediatrics, 148*(2), e2021052582. https://doi.org/10.1542/peds.2021-052582

Hagan, J. F., Shaw J. S., & Duncan, P. (2017). *Bright futures: Guidelines for health supervision of infants, children and adolescents* (4th ed.). American Academy of Pediatrics.

Help Me Grow National Center. (2022). *Targeted universalism: Help Me Grow's approach to advancing equity*. Connecticut Children's. https://helpmegrownational.org/wp-content/uploads/2022/11/Targeted-Universalism-Help-Me-Grows-Approach-to-Advancing-Equity_HMG-National-Center-2023.pdf

Human Learning Systems Collaborative. (2021). *Human learning systems: Public service for the real world*. ThemPra Social Pedagogy.

Kania, J., & Kramer, M. (2011). Collective impact. *Stanford Social Innovation Review, 9*(1), 36–41. https://doi.org/10.48558/5900-KN19

Kauerz, K. & Kagan, S. L. (2012). Governance and early childhood systems: Different forms, similar goals. In S. L. Kagan & K. Kauerz (Eds.), *Early childhood systems: Transforming early learning* (pp. 87-103). Teachers College Press.

Lazonick, W. (2002). Innovative enterprise and historical transformation. *Enterprise & Society, 3*(1), 3–47. https://doi.org/10.1093/es/3.1.3

Leyens, J.-P., Demoulin, S., Vaes, J., Gaunt, R., & Paladino, M. P. (2007). Infra-humanization: The wall of group differences. *Social Issues and Policy Review, 1*(1), 139–172. https://doi.org/10.1111/j.1751-2409.2007.00006.x

Ling, D., Petrakis, M., & Olver, J. H. (2020). The use of common humanity scenarios to promote compassion in healthcare workers. *Australian Social Work, 74*(1), 110–121. https://doi.org/10.1080/0312407X.2020.1808031

Marshall, G. R. (2008). Nesting, subsidiarity, and community-based environmental governance beyond the local level. *International Journal of the Commons, 2*(1), 75–97. https://www.jstor.org/stable/26522991

Mazzucato, M. (2018). *The value of everything: Making and taking in the global economy*. PublicAffairs.

National Committee for Quality Assurance.(2018). *Goals to care: How to keep the person in "person-centered."* https://www.ncqa.org/wp-content/uploads/2018/07/20180531_Report_Goals_to_Care_Spotlight_.pdf

Novoa, C. (2020, August 27). *Adversity in early childhood*. Center for American Progress. https://www.americanprogress.org/article/adversity-early-childhood/

Osher, T. W., & Osher, D. M. (2002). The paradigm shift to true collaboration with families. *Journal of Child and Family Studies, 11*(1), 47–60. https://doi.org/10.1023/A:1014715527823

Othering & Belonging Institute. (2023). *Targeted universalism*. University of California, Berkeley. https://belonging.berkeley.edu/targeted-universalism

Rechel, B., Maresso, A., Sagan, A., Hernández-Quevedo, C., Williams, G., Richardson, E., et al. (Eds.) (2018). *Organization and financing of public health services in Europe: Country reports*. European Observatory on Health Systems and Policies.

RTI International. (2020). *Accountable Health Communities (AHC) Model evaluation*. Centers for Medicare and Medicaid Services. https://innovation.cms.gov/data-and-reports/2020/ahc-first-eval-rpt

Shepherd, L., & Wilson, R. F. (2018). Introduction: The medicalization of poverty. *Journal of Law, Medicine & Ethics: A Journal of the American Society of Law, Medicine & Ethics, 46*(3), 563–566. https://doi.org/10.1177/1073110518804197

Shonkoff, J. P., Boyce, W. T., Levitt, P., Martinez, F. D., & McEwen, B. (2021). Leveraging the biology of adversity and resilience to transform pediatric practice. *Pediatrics, 147*(2), e20193845. https://doi.org/10.1542/peds.2019-3845

Shonkoff, J. P., Boyce, W. T., Bush, N. R., Gunnar, M. R., Hensch, T. K., Levitt, P., et al. (2022). Translating the biology of adversity and resilience into new measures for pediatric practice. *Pediatrics, 149*(6), e2021054493. https://doi.org/10.1542/peds.2021-054493

Trust-Based Philanthropy Project. (2024). *A trust-based approach*. https://www.trustbasedphilanthropy.org/overview

Tyler, E. T., & Teitelbaum, J. B. (2019). *Essentials of health justice: A primer*. Jones & Bartlett Learning.

Underwood, E. (2020, January 19). California has begun screening for early childhood trauma, but critics urge caution. *Science*. https://www.science.org/content/article/california-has-begun-screening-early-childhood-trauma-critics-urge-caution

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