GRANT MAKERS IN HEALTH

Forging Stronger Relationships with State Title V Agencies

Although philanthropy has a long history of working with state government to advance health goals, partnerships with Title V agencies appear to be relatively uncommon. These untapped relationships may stem, in part, from an incomplete understanding of the role and contributions of state Title V programs. Unlike state Medicaid and state children's health insurance programs, which are prominent fixtures in state health policy debates, Title V programs typically play a more interstitial, gap-filling role that can be difficult to clearly define and characterize.

As charged by Title V of the federal Social Security Act, public sector MCH programs have the unique mission of broadly addressing the health needs of *all* mothers and children. States have broad latitude in defining the scope and structure of their Title V programs (see box) (AMCHP 2010). Within any given state, policy decisions regarding the allocation of Title V resources are strongly influenced by the nature of existing health insurance programs, the adequacy of health care delivery systems, and unmet maternal and child health needs. Yet, despite this variability, Title V programs are alike in their strategic intent—facilitating a comprehensive *system of care* that improves the health of children and their parents.

Philanthropic organizations often share this strategic vision and have the potential to play a synergistic role working collaboratively with Title V programs to improve the health of women, children, and families. Both health funders and Title V agencies have embraced a holistic vision of community health that recognizes the wide range of factors that determine health outcomes for families, including access to health care services, environmental conditions, economic circumstances, educational opportunities, and social supports. By joining forces, philanthropy and Title V programs may be able to better leverage their own investments to address these deeply entrenched social determinants of health.

In order to help cultivate such partnerships, Grantmakers In Health (GIH) convened the strategy session *Promoting Public-Private Collaboration to Improve Maternal and Child Health* on November 14, 2011, in Dallas, Texas. Sponsored by the Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau within the U.S. Department of Health and Human Services (HHS), this strategy session brought representatives of healthy philanthropy together with state Title V maternal and child health program administrators. Focused on the states within HHS Region VI (Arkansas, Louisiana, New Mexico, Oklahoma, and Texas), the strategy session sought to foster better communication and explore opportunities for enhancing strategic relationships.

Prior to the GIH strategy session, few of the philanthropic participants had met their state's Title V director and many were not fully aware of the initiatives and activities spearheaded by the Title V program. Similarly, the Title V directors

WHAT IS TITLE V?

Since its enactment in 1935, Title V of the Social Security Act has provided federal support for state efforts to improve the health of women, children, and families. Title V is currently structured as a federal block grant with a 4:3 state match requirement. In fiscal year 2011, $656 million in federal funds flowed to states through Title V, leveraging over $492 million in state and local investments.

The federal government places few restrictions on states' use of Title V funds. Approximately one-third of funds must be used to address the needs of children with special health care needs, one-third must be used to support preventive and primary health care services for children, and no more than 10 percent of funding can be used for administrative costs. Within these broad parameters, states have great flexibility in determining how block grant funds will be utilized to address maternal and child health needs. As a result, Title V programs vary significantly across states in terms of both organizational structure and nature of funded services.

In general, states use Title V funds to support:

- infrastructure development (such as planning, quality assurance, workforce training);
- population-based services (such as newborn screening, injury prevention);
- enabling services (such as transportation, respite care, case management); and
- direct health care services.

The mix, breadth, and depth of activities, however, can vary substantially from state to state. For more information on state Title V programs, refer to HRSA's Title V Information System at https://perfdata.hrsa.gov/MCHB/TVISReports/default.aspx.

acknowledged their limited experience with health foundations. Despite this initial lack of familiarity, both public and private sector participants came to the meeting with the belief that stronger relationships would enhance the strategic effectiveness of their respective organizations, and left the strategy session with a renewed commitment to ongoing communication and collaboration.

Although the strategic priorities identified by meeting participants were not perfectly aligned, interests did coalesce around a shared set of goals to a remarkable extent. Maternal and child health priorities discussed during the strategy session included:

- reductions in infant mortality and preterm birth,
- obesity prevention,
- improvements in mental health and substance abuse services and outcomes,
- expanded access to oral health services,
- reductions in tobacco use,
- enhancements in preconception care for women, and
- the prevention of unintended pregnancies and sexually transmitted diseases (particularly among adolescents).

Health funders typically focused more selectively on one or two of these goals, while Title V directors identified a broader range of strategic priorities.

In reflecting on the challenges of maintaining vibrant relationships between philanthropy and government agencies, strategy session participants echoed many of the difficulties known to undermine public-private collaboration, including differences in scope and scale of responsibilities, asymmetries in operational flexibility, disparate time horizons for planning and implementation, incongruent cultures and decisionmaking processes, and incompatible attitudes toward risk-tolerance (MacKinnon and Gibson 2010). Public sector participants cautioned that recent state budget shortfalls have compounded these longstanding issues, with government workforce reductions leaving state agencies understaffed and overwhelmed. While resource constraints have increased the urgency of better coordination with partners, budget cuts have also decreased staff capacity to initiate and engage in collaborative relationships.

Despite these challenges, participants agreed that the benefits of collaboration outweigh the difficulties of forging and sustaining relationships if strategic goals are sufficiently in sync and partners are able to maintain open channels for candid dialogue. Strategy session participants identified a number of concrete opportunities for strengthening working relationships between Title V agencies and health philanthropies. First and foremost, they cited the need for improved communication between Title V programs and health funders. Title V directors acknowledged that they do not routinely include health funders when disseminating information regarding maternal and child health programs, but realize that philanthropy can be a strong ally in advancing state initiatives. Similarly, health funders are often well "plugged-in" to system dynamics and emerging needs at the local level and recognized the utility of sharing these insights with state maternal and child health officials.

Collaboration is perhaps most powerful when partners can provide complementary capabilities that balance the respective strengths and weaknesses of each other's organizations. While the scale of government funding typically eclipses philanthropic investments, health foundations often have latitude to invest in activities and innovations that the public sector cannot fund. Participants noted that public and private funders often share grantees and may be able to plan more strategically regarding the collective impact of joint funding. For example, organizational capacity development, media communications, information technology, family planning services, and policy advocacy were cited as areas where philanthropic engagement could be particularly constructive.

Both public and private sector participants found the strategy session to be an extremely valuable experience that broadened their appreciation for potential partnerships between health philanthropy and state Title V programs. As one participant remarked, "So many times we get locked into our cocoons and forget that there are other people and organizations all striving for the same thing. This opened my eyes to the possibilities of reaching out and connecting with these people to meet the needs of our state."

Based on this successful pilot, GIH plans to replicate this strategy session in other regions of the country. On March 9, 2012, immediately following the conclusion of the GIH Annual Meeting on Health Philanthropy in Baltimore, we will convene leaders of health philanthropy and Title V MCH program directors from HHS Region III (Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, and West Virginia). If you are a grantmaker who funds within these states and are interested in participating, please contact Sumintra Jonas (sjonas@gih.org).

SOURCES

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