GRANT
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HEALTH

CONNECTING THE DOTS:

Developing a Holistic Picture of Children's Health

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FOREWORD

As part of its continuing mission to serve trustees and staff of health foundations and corporate giving programs, Grantmakers In Health (GIH) convened a group of grantmakers and child health experts on June 12, 2008, for an informative discussion about integrative approaches to improve the health and development of young children. The discussion considered innovative models for encouraging collaboration across child-serving sectors, including health care, early childhood education, child welfare, and social services, and explored roles for health funders in advancing these promising practices. The Issue Dialogue meeting, entitled **Connecting the Dots: Developing a Holistic Picture of Children's Health,** *reviewed efforts to encourage health care providers to adopt a broad vision of children's health; discussed attempts to improve linkages between the health care system and other child-serving sectors; examined cross-sectoral reform initiatives in the public sector; and explored strategies grantmakers are pursuing to influence public policies that support a comprehensive, holistic view of children's health. This Issue Brief summarizes background materials compiled for the meeting and highlights key themes and findings that emerged from the day's discussion.*

Special thanks are due to those who participated in the Issue Dialogue, especially the presenters: Charles Bruner, executive director, Child and Family Policy Center; Janice Cooper, senior research associate for children's mental health, National Center for Children in Poverty; Barry Zuckerman, professor, School of Medicine, and chair, Department of Pediatrics, Boston Medical Center; Richard Antonelli, chief, Division of Primary Care, and director, Department of General Pediatrics, Connecticut Children's Medical Center; Marihelen Barrett, director, Center for Children's Health Innovation, Nemours Health and Prevention Services; Gena O'Keefe, senior associate, The Annie E. Casey Foundation; Ed Schor, vice president for child development and preventive care, The Commonwealth Fund; Peter Gorski, director of research and innovation, The Children's Board of Hillsborough County; Judy Langford, senior fellow, Strengthening Families; Ann Kirwan, vice president for national policy consultation, Ounce of Prevention Fund; Debbie Chang, executive director, Nemours Health and Prevention Services; Marcia Egbert, senior program officer, The George Gund Foundation; Judith Meyers, president and CEO, Children's Fund of Connecticut; and Ann Segal, senior philanthropic advisor for disadvantaged children and families, Wellspring Advisors, LLC.

Lauren LeRoy, president and CEO of GIH, moderated the Issue Dialogue. Eileen Salinsky, program advisor at GIH, planned the meeting and

synthesized key points from the Issue Dialogue into this report. Faith Mitchell, vice president of GIH, and Leila Polintan, communications manager at GIH, also contributed to this report.

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EXECUTIVE SUMMARY

CONNECTING THE DOTS:

Developing a Holistic Picture of Children's Health

Current definitions of child health transcend the historical biomedical model, which largely equated health with the absence of disease. Scientific evidence indicates that child health is best defined as the optimization of a child's developmental potential and functional capacity with interventions focused on maximizing protective factors and minimizing risk factors. This approach to child health recognizes the interplay among physical, cognitive, social, and emotional development and stresses the lifelong consequences of deficits in these developmental areas.

A comprehensive view of child health suggests that health care services are one of many supports and resources needed to promote healthy children. Many of the health threats facing children today, such as obesity and social, emotional, and behavioral disorders, are, in fact, poorly addressed by traditional health care services. Public programs to support children's broader health and developmental needs exist but are highly fragmented and often under-resourced. A variety of sectors such as early childhood education, child welfare, social services, and family and juvenile justice systems all provide services for young children, yet significant service gaps remain and communication across sectors is poor. In short, existing systems typically fail to meet the health and developmental needs of the "whole" child because all service sectors are incomplete, some sectors are woefully incomplete, and coordination across sectors is inadequate.

In order to promote a more comprehensive vision of child health and reduce fragmentation of child-oriented services, health funders are being challenged to work in areas that may be outside their comfort zone. A number of health philanthropies have taken on this challenge and are pursuing innovative models for child health promotion. The GIH Issue Dialogue *Connecting the Dots: Developing a Holistic Picture of Children's Health,* convened on June 12, 2008, brought together private and public health funders actively engaged in maternal and child health improvement efforts, along with experts in child health and development, to explore the successes, challenges, and opportunities inherent in this work.

A wide variety of grantmaking strategies was discussed to develop more comprehensive and better integrated services for children. These initiatives fall into three major categories:

- **Improving the quality and coordination of pediatric health care services**
  - facilitating the adoption of prevention-oriented practice standards through program and policy support (such as promoting the use of standardized developmental screening tools and advancing policy change to ensure adequate reimbursement for these services)
  - establishing referral support resources for early intervention services and other community-based services that fall outside the traditional health care silo
  - increasing access to underutilized specialty services (such as dental and mental health care)
  - promoting care coordination services by supporting analytic research, sponsoring demonstration projects, and advocating for supportive public policies

- **Addressing social and environmental determinants of health**
  - advancing health priorities in other child-serving sectors (such as incorporating health-related measures in child care licensure standards and quality rating systems)
  - bolstering social support networks (such as home visitation programs for new mothers)
  - improving environmental conditions (such as reducing exposure to lead and other environmental threats)

- **Supporting cross-sectoral reform initiatives**
  - encouraging, participating in, and monitoring the progress of state and local planning initiatives to integrate child services, reduce duplication, and promote interagency collaboration

Issue Dialogue participants explored many of the key lessons learned from these endeavors. Critical roles for health funders were highlighted and remaining challenges were discussed. The following briefly synthesizes major issues that emerged from this rich discussion.

- **Much work remains to be done *within* the health care silo in order to ensure that all children have access to comprehensive, coordinated services.** Health funders do not have to venture beyond the boundaries of the traditional health care system to find opportunities for developing a more supportive, enriching approach to child health. Expansions in health insurance coverage and access to care, as well as improvements in the breadth, depth, and quality of services offered, are critically needed. Health funders play a pivotal role in stimulating and supporting innovative clinical practice.

- **The diffusion of innovation from innovator sites to widespread adoption of new practices represents a tremendous challenge.** A transformation of pediatric health care services is unlikely to occur absent significant evolution in professional standards, financing policies, and workforce training programs dictating practice norms. Health funders can support states and localities in piloting these innovations, replicating evidence-based models, and pursuing policy change to incorporate these models into normative expectations. The "medical home" concept offers a coherent frame for defining the vision of a holistic approach to children's health and is viewed as a promising model by many funders. It is important to note, however, that most current efforts to reform coverage and payment policies, including implementation of the medical home, have largely focused on practices that fall within the traditional health care domain.

- **Opportunities abound for forging stronger linkages between the health care sector and other systems that serve young children.** Connections between health professionals and those working in early childhood education, social services, early intervention, child welfare, and family courts are weak and, sometimes, completely absent. These missed connections are seen at the individual level when children fail to receive needed services due to poor coordination among sectors. Missed opportunities are also seen at the strategic level, both when health objectives fail to be addressed in other child-serving sectors and when education, child protection, security, and wellness goals go unrecognized by health care professionals. Health funders can help address many of the barriers that prevent cross-sectoral collaboration by convening stakeholders and giving support and visibility to effective leaders and strategies.

- **Health philanthropy can promote accountability for public sector policies and programs.** Closely monitoring progress and opportunities for improvement in the public sector can be done in a way that does not undermine collaborative relationships. Advocacy activities, such as providing policy-relevant information and building the capacity of advocacy organizations, can play a pivotal role in creating a sustainable, secure "system of systems" for the promotion of children's well-being.

Perhaps the most important lesson gleaned from over four decades of efforts to improve systems integration for children is that this work is incredibly hard— and incredibly important. Health funders are well positioned to learn from lessons of the past and are carrying this work into the future with new tools, technologies, evidence, and strategic allies.

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BACKGROUND

Children need a wide variety of resources and supports to grow up healthy and happy. Stable relationships with caring adults, nutritious food, safe homes and neighborhoods, time and space to play and exercise growing bodies, opportunities to learn and challenge growing brains, and access to high-quality health care services all contribute to optimal growth and development. These factors come together in complex, inter-related ways. Deficits in some resources can be offset by strengths in others while multiple deficiencies can compound each other, leading to illness, developmental delays, academic failure, disability, and—in the most severe cases—death.

Research increasingly demonstrates the intersecting and reinforcing nature of children's physical, mental, emotional, cognitive, and social development and underscores the importance of early intervention to mitigate risks, maximize protective influences, and minimize societal costs (Halfon et al. 2007). Early childhood represents a critically sensitive period in life during which early experiences and exposures set the stage for future health outcomes. An ever-expanding evidence base supports a "life course" approach to children's health grounded in an inclusive definition, which recognizes children's unique developmental needs.

Early childhood represents a critically sensitive period in life during which early experiences and exposures set the stage for future health outcomes.

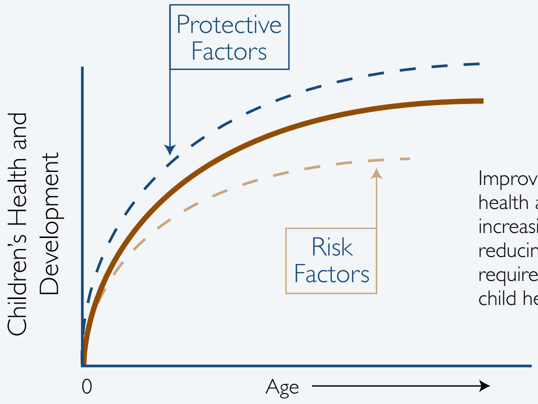
The Institute of Medicine (IOM) defines children's health as the extent to which individual children or groups of children are able or enabled to (1) develop and realize their potential; (2) satisfy their needs; and (3) develop the capacities that allow them to interact successfully with their biological, physical, and social environments (IOM 2004). This developmental framework acknowledges that every child's lifelong health trajectory is profoundly influenced by early childhood experiences (see Figure 1). Efforts to improve children's health cannot focus solely on the prevention and treatment of disease or disorders but must also seek to optimize children's developmental capacities.

As the 2004 IOM report *Children's Health, Nation's Wealth: Assessing and Improving Children's Health* clarifies, existing data monitoring systems and analytic approaches do not provide a comprehensive, cohesive perspective on children's health and well-being. Some aspects of children's health have improved dramatically over the last several decades. Reductions in infant mortality, morbidity and mortality due to infectious diseases, mortality related to accidents, teen pregnancy rates, and blood lead levels represent significant progress in protecting children from serious threats to health.

But children are also facing previously unrecognized and more ambiguous health risks that threaten to compromise development and portend

Figure 1

Altering Outcomes for Children



Improving the trajectory of child health and development involves increasing protective factors and reducing risk factors—which requires a broad definition of child health services.

Source: Bruner 2007

long-term disease and disability.

The prevalence of chronic health conditions during childhood, such as obesity, asthma, diabetes, and mental disorders, is on the rise. A growing number of children have intensive medical and other service needs due in part to increasing survival rates for preterm and low-birth weight infants. Environmental exposure to toxins and pollutants is becoming a more pervasive concern. Furthermore, racial, ethnic, and socioeconomic disparities in children's health outcomes are alarmingly high, both for these "emergent" health concerns and for more traditional measures of morbidity and mortality. Trends and demographic variations in developmental capacities related to cognitive, social, and emotional outcomes are less well documented and more poorly understood. Unmet needs in these areas, however, are apparent, and currently the health care system is not well positioned to address these needs. As Janice Cooper underscored in her opening remarks at the Issue Dialogue, "Most children in the United States live in families with incomes below 200 percent of the federal poverty level, and this is particularly the case for very young children…very few young children live in communities where less than 30 percent of them are in households with incomes above 200 percent of poverty."

Strides that have been made in reducing childhood mortality and some traditional forms of morbidity likely owe much of their success to a significant increase in public investment in children over the last half century. Federal spending on children increased from $53 billion in 1960 to $333 billion in 2006 (in inflation-adjusted dollars and including tax credits and exemptions) (Carasso et al. 2007). Nearly half of this total increase can be attributed to growth in health-related programs, including Medicaid. Yet despite this substantial increase, in 2006 federal spending on children represented only 2.55 percent of the gross national product and 16 percent of domestic federal spending (excluding defense and international expenditures).

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Federal dollars support a wide range of services that contribute to young children's health and well-being. The Early Childhood Comprehensive Systems Initiative (ECCS), supported by the Health Resources and Services Administration within the U.S. Department of Health and Human Services, has identified five domains needed to support young children's health and development, including:

- access to health insurance and a medical home;
- social, emotional, and mental health;
- early care and education;
- parenting education; and
- family support.

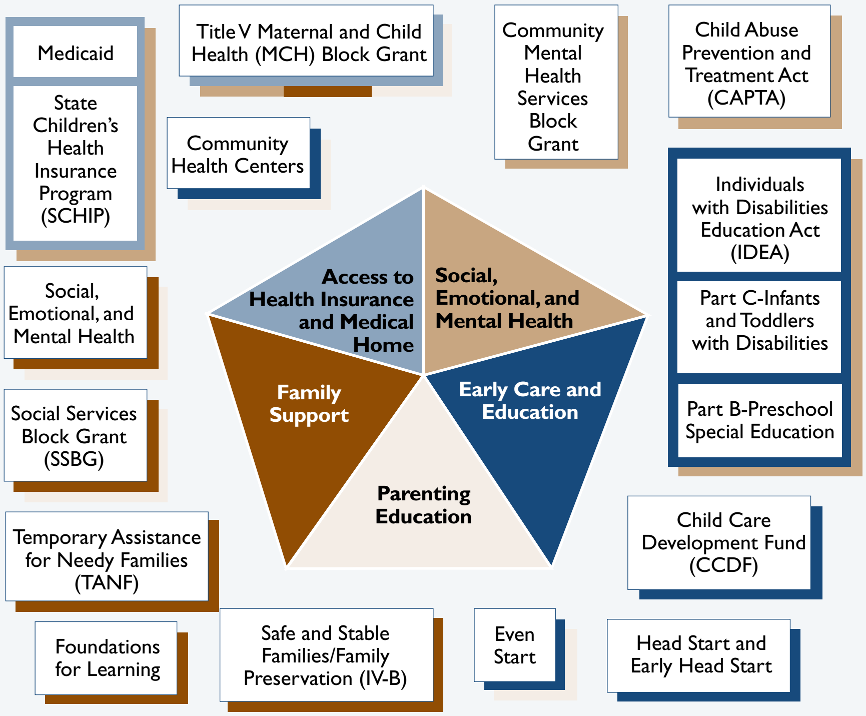
Federal funds flow through myriad programs to support services in these domains (see Figure 2). This fragmentation in funding streams is further reflected in the diversity of public agencies at the state and local level that touch the lives of young children. Organizational structures vary by state and local jurisdiction, but agencies responsible for health, mental health, education, child care, child protective services, income supports, social services, juvenile justice, labor, and youth development may all offer services for young children.

Despite the variety of programs focused on the needs of young children, numerous deficiencies exist. These shortcomings include suboptimal performance within individual service sectors, as well as poor coordination and communication across sectors. Funding restrictions, differences in eligibility criteria across programs, and administrative barriers result in service gaps for children. These gaps can be described in terms of both *who* is unable to access available services and *which* resources and supports are in short supply regardless of eligibility status. In short, existing systems typically fail to meet the health and developmental needs of the "whole" child because all service sectors are incomplete, some sectors are woefully incomplete, and coordination across sectors is inadequate.

Health funders in both public and private sectors have long recognized that children's services are highly fragmented and under-resourced. Although service integration efforts predate the Great Society movement, such endeavors intensified in the 1960s and have become a perennial ambition for policymakers and philanthropy (Kagan and Neville 1993). In 1991 the Robert Wood Johnson Foundation launched a major demonstration project, the Child Health Initiative, focused on reducing fragmentation through the creation of flexible funding pools at the local level. Foundation project staffers were quite mindful of the dismal history of service integration and undertook this project in large part because of the scarcity

Figure 2

Federal Funding Streams to Link the Five Components of ECCS



Source: Johnson and Knitzer 2006

of successful precedents. The project involved nine community demonstration sites and focused on helping local governments consolidate funds derived from categorical programs to enhance flexibility in services and improve care coordination.

Although many sites were successful in both developing local-level monitoring systems to assess child health and improving their care coordination services, only one site was able to make progress in de-categorizing funds (Newacheck et al. 1995). Sites struggled to integrate funding streams due to prevailing state and federal restrictions and, to some extent, interagency tensions. The project did, however, demonstrate the feasibility of interagency cooperation and the utility of flexible funding sources (although these funds were not derived from de-categorized dollars).

Current efforts to improve service integration for children have built on lessons of the past, emphasizing practical strategies to enhance cross-sectoral coordination, as well as policy advocacy to relax funding restrictions. As Charles Bruner clarified in his opening remarks, which launched the day's discussion, "Seamlessness, not consolidation, is [the] goal. It is the idea of no wrong door rather than

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trying to integrate everything in terms of a one-stop perspective."

This report describes three major strategies health funders have pursued in recent years to develop a more comprehensive, coherent approach to children's health:

- improving quality and coordination of health care services,
- addressing social and environmental determinants of health, and
- supporting cross-sectoral reform initiatives.

Illustrative examples of these strategies are provided, many of which were highlighted during the meeting. The efforts profiled, however, represent only a small proportion of philanthropic activity in these areas. The report concludes with a brief summary of key messages that emerged during the Issue Dialogue discussion.

INSIDE THE BOX: IMPROVING THE QUALITY OF CHILDREN'S HEALTH CARE SERVICES

Although the health care system is arguably better resourced relative to other child-serving sectors, health care services for children remain inadequate in terms of accessibility, quality, efficiency, and equity. A recent study conducted by RAND and sponsored in part by the Robert Wood Johnson Foundation revealed that children receive only 46.5 percent of recommended care (Mangione-Smith et al. 2007). Conformance to pediatric practice standards was highest for acute medical problems and lowest for preventive care. The delivery rate for appropriate screening services (such as developmental, psychosocial, lead, vision, and hearing screenings) was particularly low.

PEDIATRIC = HEALTH CARE FOR CHILDREN

For the sake of simplicity, this paper frequently refers to health care services for children as *pediatric* services, care, or treatment. This should not be interpreted, however, to suggest that all health care services for children are (or should be) delivered by pediatricians. The contributions of other medical specialties and nonphysician providers to the child health system are significant and important.

As Ed Schor observed after the RAND research findings were presented at the Issue Dialogue, "That poor quality is a reflection of trying to…squeeze into [a well child visit lasting] 18 minutes, way too much with overburdened people who tend to be just making it financially. So we really have to think about changing the system."

Pediatric care bears improvement nationwide, but concerns are particularly pronounced in southern and western states. A recent report by The Commonwealth Fund found wide variation in the performance of child health systems across states based on 13 indicators of access, quality, costs, equity, and the potential to lead healthy lives (Shea et al. 2008). Performance across measures appears highly inter-related; leading states consistently outperformed lagging states on multiple indicators and domains. The correlation between access to care and quality of care was found to be very strong, highlighting that access is an essential first step in ensuring quality.

Health funders have focused significant resources on improving access to high-quality pediatric health care services. Many of these efforts emphasize expanding health insurance coverage among children or

…children receive only 46.5 percent of recommended care.

Adherence to Quality Indicators

Overall Care	46.5 percent
Type of Care	
Preventive	40.7 percent
For Acute Conditions	67.6 percent
For Chronic Conditions	53.4 percent
Function	
Screening	37.8 percent
Diagnosis	47.2 percent
Treatment	65.9 percent
Follow-up	44.7 percent

Source: Mangione-Smith et al. 2007

increasing the capacity of safety net providers who provide primary care to low-income families and other vulnerable populations. These efforts clearly represent crucial elements in a comprehensive approach to children's health. (The achievements and challenges associated with these types of activities have been more fully documented in previous Grantmakers In Health (GIH) publications, including *More Coverage, Better Care: Improving Children's Access to Health Care Services*, February 2006).

Some funders have sought to build upon expansions in coverage and service capacity by simultaneously addressing the nature and content of health care services provided to children.

Some funders have sought to build upon expansions in coverage and service capacity by simultaneously addressing the nature and content of health care services provided to children. These efforts seek to monitor variations in quality; promote more comprehensive, integrative practice standards; and assist health care providers in developing and sustaining innovative operating structures and care practices.

The Commonwealth Fund has identified improvements in pediatric preventive care as a major strategic focus and has invested in a coordinated set of strategies that seeks to transform the way care is delivered to children. In addition to supporting the scorecard of state child health systems described above, Commonwealth has initiated a broad range of grants to nurture innovative clinical care models and cultivate a public policy atmosphere that supports and sustains these innovations. The following highlights examples of activities that Commonwealth and other health funders have supported to improve the quality of pediatric care.

Facilitating the Adoption of Prevention-Oriented Practice Standards

Bright Futures is a set of health supervision guidelines, tools, and resources developed by the American Academy of Pediatrics under the leadership of the Maternal and Child Health Bureau (MCHB) within the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services. Bright Futures is designed to improve child health and standardize care by clearly identifying the types and timing of preventive screens and services that children should receive, making screening tools and family education materials readily available to providers, and encouraging a developmental approach to health that is patient-centered and draws on community resources.

Bright Futures summarizes *what* and *when* preventive services for children should be delivered by primary care providers but also gives guidance on *how* those services should be delivered. The guidelines address key disease detection, disease prevention, and health promotion activities for primary care in infancy, early childhood, middle childhood, and adolescence.

- **Disease detection** activities include both surveillance (skilled observation based on physical examination, patient history, and interaction with the child and parents) and screening (a formal assessment using standardized tools and instruments). Bright Futures provides recommendations for universal screenings (tests that should be performed for all children at particular times), as well as selective screenings based on risk assessment information gleaned through surveillance activities. Traditionally health care professionals have relied heavily on surveillance to identify delays in child development, yet this technique has been shown to detect less than 30 percent of developmental problems (Hagan et al. 2008). Bright Futures recommends the use of structured developmental assessment tools at 9 months, 18 months, and 30 months of age. Such tools have been found to identify up to 90 percent of developmental delays in young children.

- **Disease prevention** activities focus on eliminating or reducing specific threats to health and include clinical interventions (such as immunizations), as well as parental education. Bright Futures assists providers in selecting appropriate disease prevention strategies for individual patients, their broader patient population, and the community as a whole.

- **Health promotion** activities focus on wellness and emphasize a strengths-based approach. Rather than addressing disease-specific risks, health promotion activities allow the provider to more broadly engage with parents and the community to create conditions conducive to child health. Bright Futures identifies five priorities for each well child visit and provides anticipatory guidance that providers can offer parents and children to promote wellness.

> An example of an evidence-based health promotion activity highlighted in Bright Futures is the Reach Out and Read model, which incorporates anticipatory guidance emphasizing the importance of reading, volunteers reading aloud in patient waiting areas, and the distribution of developmentally appropriate books at well child visits.

Of the estimated 15 percent of children who experience developmental, emotional, or behavioral disorders, fewer than half are identified prior to school entry.

The Commonwealth Fund supported 15 pediatric practices in nine states to implement Bright Futures guidelines and evaluated these experiences. The study offered participating practices six types of practice-support tools (preventive services prompting systems, structured developmental assessments, recall/reminder systems, a checklist of community linkages, systematic identification of children with special health care needs, and assessment of parental strengths and needs) to facilitate the uptake of Bright Futures practice guidelines. All of the supports studied improved adherence to Bright Futures, but participating practices found that the preventive service prompting system and the checklist of community linkages were most valuable in their initial efforts.

Recognizing the critical role that state policies and leadership play in the adoption of developmental screening protocols by health care providers, Commonwealth launched the Assuring Better Child Health and Development (ABCD) initiative in 1999. Now in its third phase of working with state Medicaid agencies, ABCD has helped over 25 states develop policies that support developmental screening, referral, and intervention services. ABCD states pursued a variety of implementation strategies; common approaches include addressing barriers in existing Medicaid policies that prevent or hinder reimbursement for developmental services, educating participating health care providers about policies and recommended screening tools, and reducing policy disconnects with other state agencies.

Some policy fixes that help increase developmental screening included allowing providers to bill separately for developmental screenings rather than bundling reimbursement into the well child visit; allowing providers to bill for developmental screens and other Early and Periodic Screening, Diagnostic, and Treatment preventive services on the same day as a sick visit; and highlighting recommended screening tools in Medicaid provider manuals. Some ABCD-initiated efforts did not involve policy changes per se but involved educating providers about how to maximize developmental services under existing policies. Ed Schor (2008) summarized the strategic benefits of this initiative: "The bonus, kind of one plus one equals three, is when you get the doctors and the payers' policy people to start talking to one another, the policies get better. The policies have rarely been informed by either the parents who are being affected or the providers who are supposed to be providing the services."

Establishing Referral Support Resources for Early Intervention Services

The perceived scarcity of community resources to address identified developmental needs has been cited as a major barrier to increasing screening rates (Fine and Mayer 2006). Of the estimated 15 percent of children who experience developmental, emotional, or behavioral disorders, fewer than half are identified prior to school entry. Providers have expressed ethical concerns about identifying developmental delays if they cannot provide appropriate therapies themselves or are unable to secure an appropriate referral resource.

Given the need for better referral mechanisms, The Commonwealth Fund has funded the Connecticut Children's Medical Center to help five states replicate Help Me Grow, a highly regarded program sponsored by the Connecticut Children's Trust that links families to community resources. In addition to training health care providers in effective developmental screening techniques, Help Me Grow maintains an inventory of community-based referral resources; offers a telephone hotline for parents and providers seeking support; administers a coordinated, centralized referral service to ensure children in need are connected to existing early intervention services and other community resources; and collects surveillance data on the developmental status of children in the state.

Barry Zuckerman (2008) applauded the impact Help Me Grow has had on increasing developmental screening and referrals and raised a provocative question: "Help Me Grow…is a wonderful innovation. And I know a number of states are thinking about it. Why 10 years later are there no other states doing it?" Commonwealth hopes to jump start this replication by providing targeted technical assistance and support to states interested in adopting this model.

Increasing Access to Specialty Services

Constrained access to certain specialty services, such as mental health and dental care, is widespread. These services are usually not integrated into traditional pediatric practices, and the number of specialty providers willing to treat young children is limited. Poor children who are typically covered through public insurance programs or lack health insurance entirely face the greatest access challenges.

Many states participating in The Commonwealth Fund's ABCD initiative created financial incentives to increase the availability of follow-on treatment resources, with several states targeting mental health service capacity for expansion. For example, the state of Minnesota pursued a multipronged strategy to improve access to treatment for young children with social and emotional problems. Important components of this strategy were changes to the state's Medicaid

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policies to more broadly support reimbursement for mental health services (Kaye and Rosenthal 2008). The state created a new benefit called Children's Therapeutic Services and Supports, which authorizes Medicaid reimbursement for providers and social service agencies (such as Head Start) that provide skill-building and treatment services to eligible children with emotional disturbances and their families.

A related policy change addressed concerns that existing diagnostic criteria do not adequately reflect social and emotional disorders in infancy and early childhood. Because most Medicaid programs require providers to submit diagnostic codes using either the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD) for reimbursement purposes, the lack of suitable codes for young children may discourage mental health providers from serving this population. Minnesota's Medicaid agency allowed providers to use a diagnostic coding system developed by the ZERO TO THREE organization (DC-0-3) and cross walked these codes into the DSM and ICD coding systems. The state's mental health agency reinforced this policy change by training providers in the new coding system and the crosswalk. Similar policies related to diagnostic coding were ultimately adopted by all of the states participating in ABCD.

In addition to these policy changes, the state of Minnesota also funded pilots to colocate a mental health provider (either a psychiatric nurse or a licensed mental health professional) at two primary care practice sites. This allowed children, whose social or behavioral problems had been identified through an initial screen, to see a mental health professional for follow-up on the same day as their well child visit. Colocation of services also facilitated consultations between the primary care provider and the mental health specialist for children with less intense needs.

A detailed analysis of what is currently known about the use and benefits of colocation of services, sponsored by The Commonwealth Fund, indicates that a variety of colocation models appears promising. Beyond the sharing of physical space, colocation appears to enhance communication among providers, as demonstrated in the Minnesota experience described above. The analysis, however, cautions pediatric practices to carefully consider varying organizational structures and other implementation options before committing to colocation arrangements, as colocation strategies can differ significantly (Ginsburg 2008).

New federal resources are now available to promote integration of behavioral health services into primary care. The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services has solicited applications from state governments for a new cooperative agreement program named Linking Actions for Unmet Needs in Children's Health (Project LAUNCH). Funds

MCHB DEFINITION OF CHILDREN WITH SPECIAL HEALTH CARE NEEDS

The Maternal and Child Health Bureau defines children with special health care needs as children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

totaling $5.5 million are expected to be distributed to six states through a competitive process to support the implementation of evidence-based practices promoting the wellness of children, birth to age 8. States are being asked to build on existing health, behavioral health, and social service capacity to improve the effectiveness of children's services and enhance the coordination of physical and behavioral health services. States have flexibility in determining how to achieve these goals, but SAMHSA has highlighted integration of behavioral health services into primary care settings as an essential program component.

A number of health funders have made substantial commitments to increase the availability of mental health, dental services, and other scarce specialty health care services for children. (Developing innovative service delivery models, supporting workforce development programs, and advocating for more supportive public policies are among the strategies profiled in the recent GIH publication *Critical Services For Our Children: Integrating Mental and Oral Health Into Primary Care*, February 2008.)

Promoting Care Coordination

It can be tempting to focus on pieces that are missing from the children's health care services puzzle—but even when all the pieces are on the table, someone needs to put them together. Too often parents are tasked with both finding the missing pieces and figuring out how all the pieces relate to each other. Care coordination can be extremely challenging, particularly for the 13 percent of children with special health care needs. While coordinating care for medically vulnerable children is especially daunting, *all* children are likely to require care coordination services at some point in time. Even relatively simple, routine referrals (such as those for dental care) can require significant effort to identify an appropriate and available service provider, verify that services are actually secured, and incorporate pertinent information into the child's medical record.

A number of organizations and programs provide care coordination services for children, but these services are often limited both in terms of eligibility for participation and the scope of services to be coordinated.

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CARE COORDINATION ACTIVITIES

- Contact via phone or face-to-face
- Face-to-face meetings with community-based agencies and organizations (such as state child welfare agencies and schools systems) in which children receive services
- Formal telephone conferences with organizations and agencies serving children
- Assessment/intake with family and/or children
- Review of assessment/intake with other treatment providers
- Addressing barriers to services, including:
    - scheduling appointments
    - exploring payment and reimbursement options
    - securing referrals (shelters, health care, educational, mental health, and early intervention)
    - arranging transportation, interpreters, and special equipment that children and families need to access health and community-based services
- Meeting with agencies and organizations to review resources for addressing children's functioning
- Written reports/evaluation of reports that contribute to children's treatment plans
- Follow-up contacts with family, school, and treatment interventions

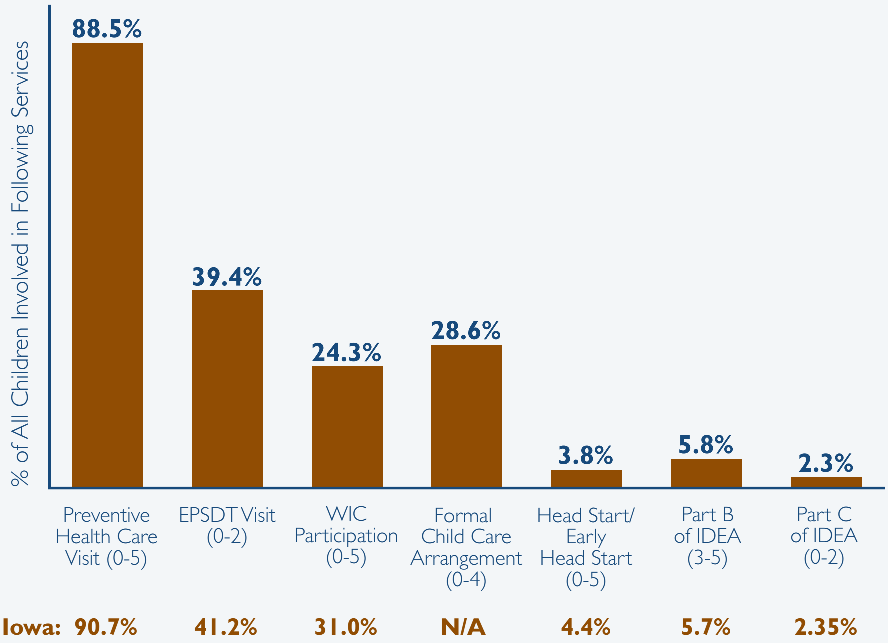
Only 11 percent of children with special health care needs are estimated to receive care coordination services through their primary health insurance plan.

State Title V agencies provide care coordination services for children with highly complex medical and developmental needs, child protective services agencies coordinate care for children living in out-of-home placements (such as foster care), and service coordination is federally mandated for children receiving early intervention services under Part C of the Individuals with Disabilities Act. Yet these public programs are limited to children who meet the respective eligibility tests, and these requirements vary across states. Similarly a number of public and private health insurers provide or pay for care coordination benefits, but eligibility is typically limited to carefully defined patient populations, such as those who need services from three or more providers or levels of care. Only 11 percent of children with special health care needs are estimated to receive care coordination services through their primary health insurance plan (Honigfeld 2007).

Primary health care settings represent a logical locus for care coordination services. The health care system is almost universally the first service sector that engages with an infant and his or her family at birth. Children are more likely to come into contact with a health care provider than with

Figure 3

Children's Healthy Development: Who Sees Young Children?



Source: Bruner 2007

any other social or educational service provider during their early years of life. Primary care providers play a critical role in identifying children's diverse medical needs and have the potential to play a more proactive role in assuring these needs are addressed, as well as attending to their nonmedical developmental needs.

Care coordination represents an important component of the "medical home" model for primary care. This vision of accessible, family-centered, continuous, comprehensive, culturally competent primary care, however, is far from reality for most children today. Recent research focused on the needs of adults with chronic illness suggests that few primary care practices have adopted the infrastructure required to support a medical home (such as electronic medical records and multidisciplinary care teams)(Rittenhouse et al. 2008). Even in large physician practices, only a small proportion of providers have implemented the types of practice innovations required to realize the medical home concept. Available evidence suggests that the status of medical home development in pediatric practices is similarly nascent (Honigfeld et al. 2006).

Health philanthropy has been pivotal in seeding the development and broader adoption of true medical homes for children. For example, the Children's Fund of Connecticut has worked closely with the Connecticut Department of Social Services, the Hartford Foundation for Public Giving, and the Connecticut Children's Medical Center to jointly fund a demonstration project called Health Outreach for Medical Equity (HOME). Facilitated by the Hispanic Health Council, this project at the Charter Oak Health Care Center at Connecticut Children's Medical Center provides care coordination and outreach services to more than 1,200 children and their families in Hartford, many of whom represent minority groups. The program targets children who miss primary care appointments, transfer care among provider sites, use emergency room services for nonurgent conditions, and miss appointments for follow-on care. A project evaluation of the HOME program is assessing the extent to which care coordination services provided from a health care site achieve the medical home goals of access, coordination, continuity, and family-centeredness. In addition to this demonstration project, the Children's Fund of Connecticut is collaborating with a variety of state agencies and advisory councils to assess broader policy reforms to support the financial sustainability of medical home services.

Highlighting disconnects between current policy and desired evidence-based practice models, Richard Antonelli (2008) observed:

> What happens in a medical home setting when nonreimbursable care coordination activities are performed? Well, in fact, 62 percent of nurse encounters in care coordination transactions—that is almost two-thirds—prevented something. And what were some of those 'somethings'? Fifty-eight percent of the time, because a nurse spent nonreimbursed time on the telephone working with the family, that family didn't have to come into the office that day, didn't have to pull the child from school or daycare, didn't have to leave work. And about a quarter of the time, emergency department visits were prevented… But this is really the take-home message…for folks that think at

DENTAL HOMES

The American Academy of Pediatric Dentistry has partnered with the Office of Head Start to launch a Head Start Dental Home Initiative to ensure that all children in Head Start will have an ongoing source of comprehensive, continuously accessible, coordinated, and family-centered dental care. This network of both pediatric and general dentists will be organized and trained to work effectively with Head Start programs and participating families and has begun to recruit interested providers.

policy levels—non-revenue generating office nurses drive the most system-level cost savings…So is a medical home enough? A medical home demands system redesign, financing quality measurement, performance improvement, regulatory support, state and federal policy support.

BEYOND THE CLINIC DOOR: ADDRESSING SOCIAL AND ENVIRONMENTAL DETERMINANTS OF HEALTH

While the activities described previously focus on expanding the scope and improving the effectiveness of health care services, philanthropy has also worked to create environments that support healthy growth and development well beyond the clinic door. Some of these efforts seek to leverage the expertise and influence of the health care system to strengthen other child-serving sectors, while others focus more directly on improving social and environmental conditions. The following narrative highlights illustrative examples of these types of philanthropic interventions.

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Advancing Health Priorities in Other Child-Serving Sectors

Child care facilities, preschools, early intervention services, and social welfare agencies are concerned about children's general health status but may lack the time, resources, and expertise to give priority to health-related issues. Some health funders have worked closely with organizations outside the traditional health domain to ensure that children's health concerns are addressed in these settings. For example, Nemours Health and Prevention Services, an operating foundation of one of the nation's largest pediatric health systems, is working to ensure that healthy eating and physical activity are integral components of high-quality child care. At the practice level, Nemours has provided training, resources, and technical assistance to child care facilities across the state of Delaware to promote healthy behaviors for young children. This work has included collaborating with Sesame Workshop, the creators of Sesame Street, to produce *Healthy Habits for Life* (a resource kit for prekindergarten teachers); creating original videos for statewide distribution that demonstrate ways to promote healthy behaviors in child care facilities and at home; sponsoring a learning series involving 28 child care centers statewide; and offering ongoing technical assistance from Nemours to participating facilities.

At the policy level, Nemours has been a strong voice for integrating health objectives in early childhood care and education services. Nemours has worked closely with the Delaware Department of Education/Child and Adult Care Food Program to develop a *Best Practices for Healthy Eating* guide that details nutrition standards, which all licensed child care providers are required to follow. Nemours successfully advocated for the Delaware Office of Child Care Licensing to adopt licensing regulations in child care centers and family-based child care provider sites that limit daily screen time and increase the amount of moderate to vigorous physical activity required. Current advocacy efforts focus on Delaware Stars for Early Success, a voluntary quality rating system for child care facilities seeking to incorporate specific criteria related to nutrition and physical activity.

Commenting on this work during the Issue Dialogue, Debbie Chang remarked:

> We really worked very hard to work with the other sectors and have health be something they care about. And that work took a little while. But we actually made a lot of progress in our child care sector as well as our school sector. In child care we were successful in getting the legislature and the different interested parties to include health, both physical and emotional, in the quality rating. So I think policy can be so effective because if the legislation passes and if the governor changes, it's still there. You still need to have the people involved. Policy is so important.

A number of public agencies assist child care facilities in obtaining health-related expertise and guidance through both health and mental health consultations. These consultations provide technical assistance to staff and administrators at child care and early childhood education centers on a wide range of health and safety topics, such as infection control, first aid, sanitation, nutrition, and concerns related to children with special health care needs. Health and mental health consultants, such as nurses, nurse practitioners, licensed mental health professionals, and physicians, help child care centers review their centerwide policies and programs and may also consult on the needs of an individual child. Consultations may include assisting child care providers in teaching children healthy behaviors, ensuring the safety of child care facilities, and identifying developmental or emotional health needs in children.

Although the model is promising, a substantial number of centers do not have access to health or mental health consultants. Developmental surveillance, oral health, and nutrition were identified as issue areas for which centers have significant unmet needs for consultative guidance (Ramler et al. 2006). While at least 24 states require health consultations for some types of licensed facilities, public funding for these services is limited. Over half of child care providers cite difficulty finding qualified, affordable health consultants.

The Health Resources and Services Administration's Maternal and Child Health Bureau has funded the National Resource Center for Health and Safety in Child Care and Early Education to develop national performance standards for child care facilities and also funds the Healthy Child Care Consultant Network Support Center (NSC) to build the capacity of states to support and sustain the professional developments of child care health consultants (American Academy of Pediatrics et al. 2002). While philanthropic support for such consultations has not been widespread, some examples of public-private partnerships have helped extend the reach of this service. For example, The Irving B. Harris Foundation challenged the Illinois State Board of Education to cofund a significant training effort for early childhood mental health consultants at the Erikson Institute. The United Way of Tucson and Southern Arizona solicited support from private foundations in 2006 to expand the number of available child care health consultants as part of a broader effort to improve the quality of early childhood education in Pima County. These funds, combined with funds from the state Department of Health Services and county tax dollars, fund a comprehensive system of health consultants for child care facilities.

Janice Cooper (2008) stressed the value of incorporating mental health consultations into high-quality early childhood education:

> Ensuring that some of the efforts at universal pre-K don't end up being counterproductive [involves] making sure that those efforts include comprehensive mental health and health care so that we are not kicking kids out and expelling kids from preschool settings because of their behaviors.

Ann Kirwan (2008) echoed this concern:

> This was an issue where we knew there was a dearth of resources, whether those were dealing with children with fairly mild social/emotional issues or the sort of much more severe stuff that would require some treatment by clinicians. We did a statewide survey in Illinois in the late 1990s, and 42 percent of the child care programs had talked to parents about needing to remove their infant or toddler from the program. And that really sent a chill up people's spine, and we really realized that we wanted to focus significantly on this.

Similar efforts have sought to better integrate health care services into the child welfare system. For example, the state of Florida's Infant and Young Child Health pilot project fosters collaboration between mental health service providers and juvenile and family courts. The model seeks to break the cycle of intergenerational abuse and neglect by providing early identification and treatment services for children deemed at high risk for maltreatment. Nationally, approximately 1 million cases of child abuse and neglect are documented each year, and nearly half of these cases involve children under the age of five. Florida noted that many of these cases involved parents who were themselves abused and neglected as children.

The Florida pilot, funded by the state government, focuses on referring parent-child dyads involved with the child welfare system (both those identified at risk for abuse and neglect by child protective services and those who had been adjudicated by juvenile courts and deemed dependent) to mental health assessment and therapy, as well as other social service and educational programs that exist in the local community. Therapy is specifically designed to intervene in the nature of the parent-child relationship and address the child's trauma through a rebuilding of trust and attachment in this relationship. The form of child-parent psychotherapy is an evidence-based approach that has been shown to be highly effective for those completing treatment (Osofsky et al. 2007).

The Endowment for Health in New Hampshire is currently working to replicate this model in two pilot sites within the state. Still in the early planning stages, the Endowment for Health has dedicated approximately $30,000 and significant in-kind staff support to prepare for the launch of the program. Leaders in the state's family court system and the mental health profession independently expressed interest in replicating the Florida model. Yet even with this high level of readiness and receptivity, foundation staff recognized the need to improve communications, referral mechanisms, and implementation capacity in the courts, the mental health treatment system, and related community support services.

This preparatory work has bridged cultural divides between mental health services and the courts, addressed data gathering and other oversight needs, laid the groundwork with state Medicaid officials to facilitate supportive reimbursement policies in the future, and allowed professional staff at community mental health centers in the pilot sites to undergo intensive training. This training, which has benefited from additional support from The Irving B. Harris Foundation and the A.L. Mailman Family Foundation, Inc., is intended to ensure that participating mental health professionals can improve their skills working with infants and young children and maintain fidelity to the evidence-based model. The project expects to begin implementation in the pilot sites by spring 2009.

Bolstering Social Supports

A child's family and broader social support network are pivotal in determining his or her developmental trajectory. Families face a variety of challenges in raising happy, healthy children, and the challenges facing low-income families can be especially persistent and difficult to overcome. Strong public support for the financial, emotional, and physical needs of parents is not the norm in American society. Compared to other industrialized countries, in the United States few public resources are available to help families navigate the complex and often stressful decisions they must make regarding their children's safety, nutrition, environment, education, and health care.

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Family-based interventions are typically limited to the most at-risk families, such as those experiencing domestic abuse and neglect, those caring for a disabled child, or those experiencing mental illness. Yet within this context of extreme circumstances, efforts are being made to create more constructive, asset-based approaches to help families create nurturing homes for their children. Many of these innovations are taking place outside the health care system. As Charles Bruner suggested during the Issue Dialogue:

> It doesn't take a medical degree to determine that a mom is really under stress, that she is not interacting very well with her kid, her kid's acting out, and it is not going to lead to a very healthy long-term relationship. It does not take a medical degree to identify that, and it does not take medical interventions to change it. But it does take [connecting] that family to something that can provide the support necessary to aid in the family's reduction of stress and improvement of nurturing and response.

The Center for the Study of Social Policy, with support from the Doris Duke Charitable Foundation, The Annie E. Casey Foundation, and The Edna McConnell Clark Foundation, is engaged in a multistate effort to help early childhood care and education programs prevent child abuse and neglect by reaching out to and supporting families. Launched in 2001, the effort began by studying links between research findings regarding effective ways to prevent abuse and neglect and the evidence base surrounding high-quality early childhood education. The resulting Strengthening Families program is focused on helping families build five protective factors: parental resilience, social connections, knowledge of parenting and child development, support in times of crisis, and interventions to facilitate children's health and development.

EDUCARE

One exemplar program highlighted by Strengthening Families is the Educare Center in Chicago, Illinois, which serves over 150 children and their families and provides a range of interdisciplinary services. Administered by the Ounce of Prevention Fund, a nonprofit organization, Educare provides full-day, full-year child care (Early Head Start), early education (Head Start), and family support. In addition to traditional high-quality early education services, Educare also provides on-site developmental screening; early intervention, such as physical therapy; parenting education; family support; crisis intervention; mental health consultations; referrals to social services; and doula services (community-based staff develop supportive relationships with pregnant teens and assist before, during, and after delivery). Educare works in partnership with the Hayes Family Health Center to provide medical services to qualifying participants. In an effort funded by the Buffett Early Childhood Fund, the Educare model is being documented and replicated through the Bounce Learning Network.

Strengthening Families provides technical assistance to participating early care and education programs and connects participants to exemplary models with a proven track record in building protective factors. In addition to assisting early care and education programs to develop the capacity to offer more supportive services to parents and other primary care givers, Strengthening Families also works with states to create policy environments conducive to the development of the protective factors. Strengthening Families began with a seven-state pilot; by February 2008 the effort had grown to a national network involving 23 states.

Several models for supporting families tap into the skills and credibility of health care providers to strengthen parenting skills and create healthier home environments. The Nurse-Family Partnership (NFP) is an example of a home-visitation program that is backed by an extensive evidence base demonstrating its effectiveness in improving birth outcomes and child health and in reducing maladaptive behaviors, crimes, and child abuse. With support from the Robert Wood Johnson Foundation, the W.K. Kellogg Foundation, The Edna McConnell Clark Foundation, the Picower Foundation, and Google, the NFP model has spread to numerous sites in 26 states. New sites receive in-depth training and technical assistance to ensure fidelity to the evidence base model, which includes home visits for low-income, at-risk, first-time mothers beginning no later than the end of the 28th week of pregnancy and continuing to the baby's second birthday. Home visits are conducted by baccalaureate-level nurses, each of whom maintains an active caseload of no more than 25 mothers. By forging a long-term, trusting relationship, the nurse home visitors help mothers gain self-sufficiency and healthy behaviors.

Colorado, Pennsylvania, Louisiana, and Oklahoma are implementing the model statewide. In 2000 The Colorado Trust and several other private philanthropies helped establish Invest in Kids to educate state and local leaders about NFP. These advocacy efforts contributed to the passage of the Colorado Nurse Home Visitor Act, which calls for gradually scaling up NFP over a 10-year period throughout the state using tobacco settlement dollars. Program sites in 52 of Colorado's 64 counties have been established, and over $300 million in state Tobacco Settlement Funds have been secured to support the program. NFP programs and similar home visitation programs are often supported by a range of public funding sources including Medicaid, Title V, the Child Care Development block grant, Healthy Start, and juvenile justice.

Advocacy efforts to increase public investment in family strengthening and support services extend far beyond those focused on health care service providers. The Bingham Program has committed to a $1 million initiative to focus the state of Maine's attention on the devastating personal and economic

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effects of violence against women and children. Domestic violence causes approximately one-half of the homicides in Maine and costs the state an estimated $1.3 billion each year. In response to this significant health problem and economic drain, The Bingham Program developed an anti-violence initiative that focuses on primary prevention from a statewide perspective and is intended to support broader efforts to develop healthier environments for young children. Bingham had initially planned to focus its efforts on building awareness and referral capacity among health care providers but quickly realized that a more general constituency-building campaign was needed. Working with a former governor committed to reducing domestic abuse and the president of the state's chamber of commerce, Bingham sought to engage business leaders in addressing domestic violence.

Beginning with a convocation that exposed the business community to research on the long-term impact of adverse childhood experiences, Bingham forged a strong link between violence prevention and the state's economic future. The endowment is currently working with the Maine Development Foundation to include a focus on domestic safety in its annual *Growth Council's Measures of Growth* report, which tracks the state's economic prospects. Recognizing that business interests are influential with state legislatures, Bingham believes this advocacy work, though still building, has already bolstered public support for domestic violence prevention and intervention services. When the state faced a $100 million shortfall in its last budget cycle, the legislature restored full funding to domestic violence and sexual assault programs.

Improving Environmental Conditions

Strong and caring families are a key ingredient to child health, but even capable, loving parents may be unable to protect their children from environmental health threats. Low-income families are particularly vulnerable given the risks to health associated with poverty, such as material depravation, inadequate nutrition, substandard housing, impure water, and unsafe neighborhoods. Health philanthropies are increasingly beginning to address the broad range of environmental conditions that can have a profound influence on a child's health and development. These efforts have taken on a wide variety of forms. Some focus on minimizing particular types of environmental threats (such as exposure to lead), others focus on opportunities to promote health (such as increasing the availability of healthy foods), and still others seek to address multiple determinants of health simultaneously.

For example, the Medical-Legal Partnership for Children teams primary care providers with attorneys to help children and their families address a variety of issues that affect health and can be resolved or ameliorated with legal aid.

Immigration status, child support payment, domestic violence, eviction proceedings, disputes with landlords, substandard housing conditions, eligibility for public programs, utility disruptions, and worker compensation claims are examples of legal issues that can influence the economic security, well-being, and, ultimately, health of a child.

First piloted by the Boston Medical Center in 1993, the Medical-Legal Partnership model has spread to at least 80 clinical sites throughout the country. In 2005 the W.K. Kellogg Foundation and the Robert Wood Johnson Foundation funded a national center for medical legal partnership to provide technical assistance to emerging sites and disseminate best practices. Philanthropies nationwide have helped initiate and support replication of the model, which has been successfully piloted in a variety of primary care settings, such as community health centers, hospital outpatient departments, and private practices. Placing legal aid attorneys on-site in primary care clinics has not only increased patients' access to these services, it has also helped expose health care providers to the ways in which legal and social problems influence patients' ability to lead healthy lifestyles and comply with disease-management guidance. In addition to offering valuable, proactive legal advice on a case-by-case basis, the partnership has been effective in addressing broader policy issues at a community level. (A more detailed description of the medical-legal partnerships can be found in the *GIH Bulletin* Views from the Field article "Improving the Health of Vulnerable Children with Medical-Legal Partnerships," January 28, 2008.)

More focused efforts to harness the reach and credibility of health care providers may target a specific determinant of health. For example, the Children's Sentinel Nutritional Assessment Program (C-SNAP) is a multisite network of pediatric and public health professionals who monitor the impact of public policy on the nutrition, food security, and health of young children; advocate for broad policy change; and provide interventions to address food insecurity for individual children. C-SNAP is supported by a broad coalition of private funders, including the W.K. Kellogg Foundation, The Annie E. Casey Foundation, and The Pew Charitable Trusts, and is headquartered at the Boston Medical Center, with additional research sites at the University of Maryland School of Medicine in Baltimore, the University of Arkansas for Medical Science in Little Rock, the Hennepin County Medical Center in Minneapolis, and the St. Christopher's Hospital for Children in Philadelphia. C-SNAP provides direct clinical services for children at risk for growth and nutritional problems; helps link families to community services for food, housing, and child care; and conducts policy-relevant research to advocate for changes in public programs such as Food Stamps and Women, Infants, and Children.

C-SNAP research has demonstrated that infants and toddlers in food insecure households are at increased risk for iron deficiency anemia, deficits in cognitive development, and emotional problems. Furthermore, children receiving Food Stamp benefits are 25 percent more likely to be food secure than eligible children not receiving benefits (Perry et al. 2007). In addition to advocating for more inclusive eligibility and outreach for public nutrition programs, C-SNAP also assesses the adequacy of benefits received through these food assistance programs. A recent C-SNAP research brief, which compared the costs of a healthy diet to Food Stamp benefit levels in Boston and Philadelphia, revealed that food costs were substantially higher than maximum benefit levels in both cities. In Boston the average monthly cost of the Thrifty Food Plan defined by the U.S. Department of Agriculture was $752 or 39 percent higher than the maximum Food Stamp benefit for a family of four. In Philadelphia average monthly costs were found to be $805 or 49 percent higher than the maximum benefit. By carefully tracking children's dietary intake, nutritional status, and health outcomes, C-SNAP researchers help infuse the public policy debate with timely clinical information on children's health and well-being.

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In describing the C-SNAP effort, Gena O'Keefe (2008) remarked:

> [C-SNAP has] collected data on approximately 28,000 low-income families with young children ages zero to three. And why under three? This is a period of rapid brain development and they have the data collection structured so that they can really rapidly assess how evolving forces are affecting the health of kids in this age range…everything from access to Food Stamp benefits to increasing energy costs to housing subsidies and instability due to the subprime mortgage crisis… It really takes nutrition out of a specific health silo and demonstrates how it's essential to understanding school readiness, early childhood development, and family economic success—it really sits at the nexus of all of those things.

A variety of philanthropic efforts has focused on reducing children's exposure to polluted air and water and other toxic substances that can impair growth and development. For example, Pacoima Beautiful is a multicultural nonprofit organization located in Los Angeles that provides environmental education, advocacy, and leadership. Funded by a variety of funders, including private donors, The California Wellness Foundation, the U.S. Environmental Protection Agency, and the Los Angeles County Department of Public Health, Pacoima Beautiful was established in 1995 and initially focused on empowering community residents to identify and address environmental health hazards such as lead and diesel fuel emissions. The organization recently launched a planning initiative to develop a network of parks and trails within the community to promote physical activity.

SUPPORTING CROSS-SECTORAL INITIATIVES

In recent years a number of states and communities have undertaken broad system reform efforts that seek to strategically realign public sector systems and programs that serve young children (Floyd 2004). Initially many of these cross-sectoral transformation efforts were catalyzed by school readiness or child abuse prevention objectives, but these initiatives typically embrace a broad vision that extends far beyond early childhood education or child protective services. Although these initiatives inherently represent a reform of public financing streams and operating policies, philanthropy has often been instrumental in catalyzing or reinvigorating these efforts.

State-Level Initiatives

Cross-sectoral initiatives to improve child health and well-being have taken on a variety of forms and organizational structures. At the state level, at least 20 states and the District of Columbia have established "children's cabinets" or other types of high-level councils, collaboratives, or commissions to improve coordination across agencies (Gaines et al. 2008). Established through legislative action or executive order, these cross-agency coordinating bodies seek to ensure that children and their families are a public policy priority, foster a shared vision for improving child and family outcomes, and engage new partners in public efforts to serve children and their families.

Philanthropy has often played a pivotal role in shaping these cross-sectoral reform efforts. For example, the Build Initiative, a nine-state effort to build comprehensive systems for children, is funded by a group of foundations that participate in the Early Childhood Funder's Collaborative, a consortium of national and local funders with substantial grantmaking programs in child care and early education. The Build Initiative was launched in 2002 by The George Gund Foundation, The Irving B. Harris Foundation, Ewing Marion Kauffman Foundation, the W.K. Kellogg Foundation, the Lucent Technologies Foundation, the A.L. Mailman Family Foundation, the McKnight Foundation, the Robert R. McCormick Tribune Foundation, The David and Lucile Packard Foundation, the Rockefeller Brothers Fund, the Caroline and Sigmund Schott Foundation, and The Schumann Fund for New Jersey. The initiative supports systems building within individual states and fosters peer learning across states.

Since its inception, the initiative has given participating states a high degree of flexibility in designing an integrative approach to early childhood development. Five states (Illinois, Ohio, Pennsylvania,

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Minnesota, and New Jersey) received funding to construct comprehensive systems for early childhood care and education, and four additional states (Hawaii, Michigan, Oklahoma, and Washington) were invited to participate in learning collaborative opportunities. Each state pursued different strategies and governance structures in order to maximize the utility of existing resources and policies.

The Early Childhood Comprehensive Systems Initiative (ECCS), supported by the Maternal and Child Health Bureau (MCHB) within the Health Resources and Services Administration, seeks to support systematic reform efforts across the country. Launched in 2002, ECCS has provided small planning grants to 49 states to support the creation of state plans for building and integrating early childhood service systems (Johnson and Theberge 2007). In some states, ECCS has helped catalyze the creation of systemic reform plans. More commonly, the effort has helped state maternal and child health agencies fully participate in ongoing reform efforts that had their genesis in educationally oriented, school readiness initiatives. In Illinois, Minnesota, Michigan, and Washington, the ECCS project has been absorbed into the Build Initiative. In other cases, such as Kentucky, Ohio, and Vermont, ECCS has been used to fund cabinet-level planning efforts.

The National Center for Children in Poverty's Project Thrive initiative, which is funded by MCHB to provide analytic and technical support to ECCS, indicates that significant progress has been made in integrating early childhood systems, but challenges remain. While most states strive to create a "system of systems" for early childhood, less than half of all states (22) have meaningful evidence of such an approach in their plans. Low-performing states struggle to create routine mechanisms for cross-system coordination, are often health-centric in the orientation of their plans and in the structure of their governance bodies, are more likely to have state leadership focused narrowly on improving early childhood education and prekindergarten programs, have been unable to develop supports for local systems work, and have not established accountability mechanisms.

The state of Illinois has made considerable progress in incorporating health objectives in its early childhood reform efforts and provides an instructive example of how many of the initiatives and programs referenced throughout this brief intersect and interact. This systems building work in Illinois has been spearheaded by the Ounce of Prevention Fund, a nonprofit agency founded in Chicago in 1982 by Irving B. Harris. In 1998 the fund established a Birth to Three project with support from the Robert Wood Johnson Foundation, which sought to develop a more coordinated system of services for young children and their parents. This effort was expanded to Birth to Five in 2002 with support from the Build Initiative and evolved to include a more explicit focus on school readiness.

The Birth to Five project involves a broad group of public and private stakeholders and has yielded results in multiple areas including (1) the development of systems change plans to guide policy efforts, (2) numerous pilot activities (such as health and mental health consultation pilots and professional training related to perinatal depression screening), (3) a government interagency coordinating team that also receives support from ECCS, (4) a variety of more focused public-private "spin-off" committees to address specific goals and objectives (such as a group focused on Medicaid policies and developmental services that receives funding through The Commonwealth Fund's Assuring Better Child Health and Development initiative), and (5) concrete policy changes related to Medicaid and other service systems.

In identifying some of the key features of the Birth to Five project that contributed to its success in Illinois, Ann Kirwan stressed the importance of reciprocal relationships between public and private partners. "I think we can sometimes get caught in [having both] the outside government and the government folks [being] more adversarial, but this was a reciprocal thing. There were things that advocates could do to advance the state government's priorities that they couldn't do [themselves] and vice versa" (Kirwan 2008). She also remarked on the key role private funders played in supporting the effort and the value of having "private funders who understand the long-term nature of advocacy and policy and systems work."

States have many opportunities to facilitate cross-sectoral integration in child-serving systems. The National Academy of State Health Policy (NASHP) has recently released a report that examines important ways that state health policy can influence multisector service and system linkages for young children, with a particular emphasis on optimizing the role of the health sector (Rosenthal et al. 2008). Funded by the W.K. Kellogg Foundation, the study analyzed relevant policies in 12 leading states, summarized helping and hindering factors in both policy development and implementation, and identified promising policy change opportunities that have emerged.

Policy change strategies commonly pursued by leading states and highlighted for wider adoption include:

- Coordinate eligibility policies and intake processes across sectors (such as merged electronic application systems for Medicaid; the State Children's Health Insurance Program; Women, Infants, and Children; and Head Start).

- Coordinate cross-sectoral needs assessment and identification (such as training and reimbursing child care providers in developmental screening).

- Establish shared resources across sectors for communication, coordination, and referrals (such as centralized referral centers, unified case management services, and joint home visiting programs).
- Promote or provide cross-sector consultation or training to connect professionals and enhance skills.
- Encourage cross-agency and public/private planning (through revised organizational structures or less formal coordinating mechanisms).
- Share data to develop comprehensive population-based assessments, resource planning decisions, and service coordination.
- Promote local initiatives that balance flexibility and accountability.

The authors noted that while these strategies are promising, significant barriers to successful implementation remain. Limited capacity across sectors, differences in priorities, federal restrictions, and technological and political hurdles can slow the adoption and realization of these policy changes. An overzealous focus on agency reorganization and other structural features of interagency collaboration can detract from meaningful efforts to integrate programs and policies. Furthermore, support to local jurisdictions to help them understand the latitude and opportunities they have for integrating services on the ground is crucial.

Local-Level Initiatives

Numerous efforts to integrate child-serving systems have also taken place at the local level. However, as the NASHP study recognized and the Robert Wood Johnson Foundation's Child Health Initiative demonstrated, local-level reforms can be very challenging absent state-level policy reforms. Still some communities have made substantial progress in rationalizing their early childhood systems, often relying on dedicated, locally based funding sources to enhance service flexibility. An exemplary model for local-level systems integration is The Children's Board of Hillsborough County in Florida, which seeks to develop an effective system of care for all children living in the county (birth to eight) by monitoring children's outcomes, ensuring access to adequate services, and adhering to best practice models.

The Children's Board is a local tax district funded through a property tax assessment with annual tax revenues of approximately $30 million. These noncategorical funds are used to supplement and enhance services supported through other funding streams to ensure a broad spectrum of prevention and early intervention services for young children, as well as prenatal services. A pool of flexible funding has allowed the board to build service capacity in existing providers, engage in robust research and analytic activities, and engage in policy advocacy to maximize the utility of local resources.

The Children's Board has played a leadership role in assessing the needs of young children in the county, evaluating existing service systems, and identifying opportunities for improved coordination across service providers. For example, The Children's Board conducted an extensive study of the county's child welfare services (including assessments of interagency collaboration, in-home and community-based supports for families, and health screenings for children entering shelters), developed a comprehensive plan to improve services, and monitors implementation progress and child outcomes.

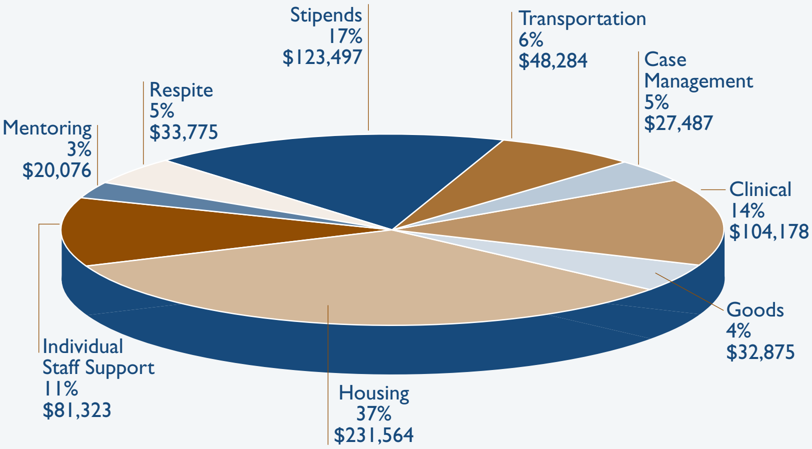
Technical assistance and capacity-building grants to providers and other community organizations are another important way that The Children's Board supports systems building for young children. A dedicated matching grant fund has been in place since 1998 to attract additional public and private funds to the community. An early example of a matching grant program was the development of the Tampa-Hillsborough Integrated Network for Kids (THINK), which serves children with severe mental health disorders. The program received match dollars from the federal Center for Mental Health Services within the Substance Abuse and Mental Health Services Administration, and over a six-year period resulted in a more than $13 million combined investment in the county's mental health service infrastructure.

Families rely on The Children's Board in much the same way child-serving agencies look to the organization for policy advocacy, oversight, and support. Functioning as an administrative services organization (ASO), The Children's Board supports individual families in identifying and managing their service needs, facilitates system navigation, reimburses for services that cannot be paid for with other funds, and manages an inclusive network of service providers. The Children's Board offers a wide variety of services, including medication monitoring and management, mentoring programs, respite care, housing assistance (such as financial help with rent/mortgage, utility bills, and furniture costs), clothing stipends, and transportation support. Figure 4 illustrates The Children's Board's ASO expenditures by service type in fiscal year 2006. A range of $20 to $20,000 is spent per family (median $500). By providing individual families with highly customized support and wrap-around services, The Children's Board strives to prevent crises, trauma, and family destabilization.

In summarizing The Children's Board's strategic vision, Peter Gorski (2008a) indicated, "The ultimate goal is that every public and private decision in our county will consider the well-being of children and indeed feel compelled, if not actually be coerced, into filing Child Impact Statements the way today we file Environmental Impact Statements."

Figure 4

The Children's Board of Hillsborough County, Administrative Service Organization Expenditures by Service Type, FY 2006



Source: Gorski 2008b

LESSONS LEARNED

The following discussion is by no means an exhaustive review of the varied ways that health funders are working to develop a more comprehensive, integrative approach to children's health. It is meant solely to provide a flavor for the range and type of activities currently being pursued. In discussing these and related grantmaking strategies, funders noted common themes, messages, and cautions that permeate this work.

Physician Heal Thyself

Much work remains to be done within the health care silo in order to ensure that all children have access to comprehensive, coordinated services. Health funders do not have to venture beyond the boundaries of the traditional health care system to find opportunities for developing a more supportive, enriching approach to child health. Expansions in health insurance coverage and access to care, as well as improvements in the breadth, depth, and quality of services offered, are critically needed.

Some types of services that fall inside the traditional health care domain, such as clinical preventive services, developmental screening, early intervention, and dental and mental health care, are very commonly underutilized due to capacity limitations and financing barriers. As Ed Schor noted at the Issue Dialogue:

> All of these multiple services happen in pediatric practice in the context of roughly, on average, an 18-minute visit. So you're supposed to do a history and a physical examination and draw blood for lead screening; give shots; do height and weight measurements; check vision and hearing; do a family psychosocial screen, developmental assessment, anticipatory guidance, parent education; and make a referral in care coordination in 18 minutes. It obviously cannot be done. It certainly can't be done well.

A reform of the pediatric practice model is clearly needed, with movement toward multidisciplinary care teams; expanded use of health information systems; centralized referral and care coordination resources; customized services that recognize an individual patient's risks and developmental needs; enhanced support for families and caregivers; and increased access to specialty services, such as dental and mental health care.

Health funders play a pivotal role in stimulating and supporting innovative clinical practice. As Lauren LeRoy summarized in her synthesis of the day's discussions at the close of the Issue Dialogue: "That kind of work needs leadership, and it needs champions. And that's an area where foundations actually can play a role in

Evaluation and research activities that test and document the effectiveness of innovative practices are also needed and represent a critical opportunity for philanthropic involvement.

terms of nurturing those leaders and nurturing champions, giving them the stature within their organizations to be able to move things forward."

Evaluation and research activities that test and document the effectiveness of innovative practices are also needed and represent a critical opportunity for philanthropic involvement. Throughout the day's discussion, the importance of a robust evidence base—documenting what works and assessing return on investment—was stressed repeatedly. LeRoy urged participants to consider the role health funders, both big and small, can play in developing the evidence base. The Robert Wood Johnson Foundation's Clinical Scholars Program was cited as an influential driver in creating the cadre of health professionals trained in health services research, but LeRoy noted that similar versions of this work can be done at the state and local level.

Diffusion of Innovation

In her opening remarks at the outset of the Issue Dialogue, Janice Cooper noted, "We have some pockets where research-informed practices are going on in many states where they are toying with either pilots or in limited geographic areas doing some evidence-based practices like parent-child interactive therapy, for example. But it is quite clear that these initiatives need to be taken to scale." The diffusion of innovation from innovator sites to the widespread adoption of new practices represents a tremendous challenge. A transformation of pediatric health care services is unlikely to occur absent significant evolution in professional standards, financing policies, and workforce training programs that dictate practice norms.

The "medical home" concept offers a coherent frame for defining the vision of a holistic approach to children's health, but its realization represents something of a "chicken or the egg" dilemma. Does clinical practice need to reflect the medical home standard before payers are willing to pay for this level of performance? Or are changes first needed in reimbursement policy to motivate providers to elevate the prevailing standard of care? The answer may be that incremental and mutually reinforcing changes are needed in both clinical practice and financing policies until each evolves into something that bears little resemblance to today's reality.

Barry Zuckerman (2008) commented:

> When we think about dissemination and diffusion of innovation nationally, go with the early adopters, wherever they are, because they, over time, will make a critical mass. At the point that you have to start talking people into doing things or instructing them in detail and they do not have any passion for it, you will get what you're seeing [now]. It is just not going to necessarily work that well.

Even early adopters who are ready and eager to adopt clinical innovations, however, may need help in the form of financial support and technical assistance to develop their capacity to implement new approaches to patient care and ensure fidelity to the evidence-based model.

Once a "critical mass" of early adopters is achieved, changes to practice standards, training curricula, and finance policy become more feasible and realistic. Reforms in these areas are likely to be gradual as emergent practices increasingly reflect a departure from "business-as-usual" approaches. But these reforms will not necessarily occur as a matter of course. Advocacy work is typically needed to argue that the practices of early adopters should become the new normative expectation and need to be reflected in the standards and policies that "institutionalize" these practices.

Debbie Chang (2008) observed, "This concept that many of you have talked about today of promoting child development and the content of care… it's not something that [policymakers] understand. If you go to the Hill, people will look at you with glazed eyes." Many policymakers are so accustomed to thinking about child health purely through the lens of insurance coverage that many are not prepared to consider policy levers to improve quality of care. Charles Bruner hoped that the time may be ripe to develop policies that broadly support a comprehensive approach to child health. "I think we have an opportunity of having policies that speak to the content of care. They may be framed around quality. They may be framed around developmental health. They certainly have to be framed around what kids need for their healthy development" (Bruner 2008).

Pay-for-performance incentives and separate reimbursement for care coordination services are becoming increasingly popular with public and private health insurers. These payment models seek to reward early adopters while recognizing that superior performance may not yet be widespread. Such approaches raise concerns, however, for providers and advocates focused on the needs of people living in poverty, the disabled, and other high-risk populations. These additive payment incentives implicitly assume adequate reimbursement in base payment rates and fail to address the differential needs of high-risk patients. Ed Schor (2008) observed, "Medicaid pays less for high-risk families than the private sector does for low-risk families. I think we have to be dealing with that."

Current efforts to reform coverage and payment policies, including emerging medical home standards, have largely focused on practices that fall within the traditional health care domain. The cohort of innovators who are rethinking the role of health care providers relative to the broader social determinants of health has not yet reached the "critical mass" necessary to trigger broad policy reforms. Several participants expressed the need to be mindful of this more expansive vision and noted the unique aspects of pediatric needs that necessitate a more inclusive view of care coordination. Richard Antonelli (2008) remarked,

Many policymakers are so accustomed to thinking about child health purely through the lens of insurance coverage that many are not prepared to consider policy levers to improve quality of care.

"Two-thirds of the time, care coordination needs [are] actually what you would consider to be typically medical. The other third [are] taken up with managing referrals; social services; educational issues; mental health, legal, and nutrition issues."

A developmental approach to children's health, as opposed to the disease model prevalent in adult medicine, suggests that these broader linkages are critical. Barry Zuckerman (2008) crystallized this challenge in raising the question: "How do we use the health care system to, if you will, give it more muscle to further disrupt that link between poverty and poor health and poor development?" He went on to suggest that innovations within the health care system help open the door for improved connections with other service sectors.

Issue Dialogue participant Cathy Hess summarized this point succinctly when she said:

> Part of the problem is we kept wanting to talk about the challenges within the health sector because those are so daunting to begin with. Public health and the medical sector don't effectively work together. Oral health, mental health, all those pieces. We don't want to stop working on cross-sector linkages because of that…I think any efforts we make and you make to help the health system get its act together will help it be more effective in working with the other sectors.

Cross-Sectoral Collaboration

Opportunities abound for forging stronger linkages between the health care sector and other systems that serve young children. Connections between health professionals and those working in early childhood education, social services, early intervention, child welfare, and family courts are weak and, sometimes, completely absent. These missed connections are seen at the individual level when children fail to receive needed services due to poor coordination between sectors. But they are also seen at the system level, both when health objectives fail to be addressed in other child-serving sectors and when education, child protection, security, and wellness goals go unrecognized by health care professionals.

As Richard Antonelli expressed during the Issue Dialogue, "The answer here is not to make primary care providers become surrogate social workers and education specialists, but we have to figure out how to connect these different silos." Helping build functional relationships across the different service sectors is an important role for health philanthropy. Barry Zuckerman noted the utility of enabling capacities, like information systems. "What would happen if you had Head Start connected to a pediatric office, connected to the parents by information technology, or to an EI [early intervention] program? I mean, we could actually share information" (Zuckerman 2008).

He also suggested that relationship building is facilitated by clear, immediate, and mutually recognized goals. "If we're going to start implementing something, we should really pick something where both the doctor and the other site or two need to talk, where it is imperative for that child's well-being… you have got to use the models that will push people. And once they get used to talking, then you can expand it."

Working on concrete projects can support relationship building, but more strategic efforts to foster a shared vision of and priorities for early childhood may also be needed. As Ann Kirwan (2008) remarked, "We need to begin to infuse more early childhood development into the health system; by the same token, we need to bring health and mental health into [the places] where children are."

Health funders can help address many of the barriers that can prevent this from happening. Ann Segal (2008) pointed out, "The language across these communities is sometimes the same but means different things… And so you have to be aware that the language is different, case management is different, all kinds of things are different between these sectors." She also noted, "The fact that [the health sector is] at the table is kind of intimidating to some people…the immediate thing has to be respect for each other at the table and showing it very clearly and listening to the other sides in this arena and try to make it a real collaborative, not just try to attach health onto something."

Health funders need to frame their efforts in ways that are seen as contributing to, rather than detracting from, the mission of nonhealth organizations. Inadequate resources and capacity in other child-serving systems can impede integration efforts. By clarifying how improvements in health will also advance child education or child welfare goals, health funders and health care service organizations can help build support for collaborative endeavors. Judy Langford of the Strengthening Families initiative stressed that even small changes in operating procedures can yield big results. "We need to be looking at where those leverage points are in all of our systems" (Langford 2008).

The dominant role that public sector agencies play in many child-serving systems underscores the importance of forging public-private partnerships in both program and policy work. As Ann Kirwan noted, this often involves building capacity within public sector organizations. "What we really wanted was leadership to grow up in the public agencies, to carry this work further over time. And private philanthropy played a critical role in both incentivizing some efforts and really challenging the public sector to do things a little bit differently" (Kirwan 2008). Successful integration of child-serving sectors is unlikely to result from the creation of some mega, consolidated agency or a single, merged funding stream. Rather, ensuring seamless transitions for children and families will rely on practical measures to foster communication and reinforce common goals.

Developing relationships with public sector health agencies is a challenge unto itself, but forging such partnerships with government organizations that do not have health as a core part of their mission raises that challenge to a new level.

Developing relationships with public sector health agencies is a challenge unto itself, but forging such partnerships with government organizations that do not have health as a core part of their mission raises that challenge to a new level. Partnering with philanthropic organizations that have a history of grantmaking in these sectors and have relationships with public and private stakeholders can be invaluable. Ann Segal (2008) suggested, "I think there is a big need for funders to work together, and by that I don't mean just health funders with health funders. I think it means working with Grantmakers for Children, Youth and Families; the early childhood funders especially, and with Grantmakers for Income Security Task Force."

Judith Meyers (2008) reinforced the need for philanthropic collaboration:

> As philanthropists, we are going to figure out how we might pool our resources and our individual efforts…We don't often collaborate among ourselves, whether it's nationally or at the state level or at the local level. We're trying in a fairly small state to do that better, so we do have an affinity group, basically, of early childhood funders who are coming together to have these conversations."

Meyers described an effort in Connecticut to develop local early childhood plans that was initiated by the state and supplemented by another private funder to address a shortfall in the state appropriation. The Children's Fund of Connecticut provided additional funds for this initiative to ensure that health partners would be brought to the table in these discussions.

Deciding what role they want to play in reforming the early childhood system is a threshold question for health funders. The mission, relationships, history, policy context, and needs of the target population will shape the outcome of this decision. Judith Meyers (2008) observed:

> Sometimes it is hard for funders to figure out what their role is and how much of it's operational and how much of it's funding, and everything in between. How much do we move beyond funding to being conveners, to being facilitators, to being researchers, as well as supporting others to do that work? I think…that philanthropy has a role at the table.

Whether or not philanthropic organizations choose to actively engage in system-reform efforts, supporting neutral forums for advancing this work helps catalyze and guide public sector decisionmaking. In describing the Birth to Five initiative in Illinois, Ann Kirwan (2008) remarked, "Being able to drive the systems work and staff it from outside of government was helpful in bringing people to the table. It also made it easier for state government to participate in a real way in cross-sector efforts because we were able to drive and move the work along." Charles Bruner (2008) echoed this sentiment, "Often there are a lot of people who…want to do things within state government that they may be constrained by what their governor is making in the way of public statements, what they are able to do." While stressing the necessity of convening public and private stakeholders to assess needs, develop plans, and maximize public sector capacity, he concluded his statement with the caution: "You do need an inside and an outside strategy."

Advocacy Efforts

The notion of an "outside" strategy implies that health philanthropy can help hold the public sector accountable for its policies and programs and can do this in a way that does not undermine "inside" movement building (such as collaborative activities and relationships). Some funders feel that an advocacy-oriented approach is essential. As Marcia Egbert (2008) explained:

> Times are tough in our backyard and in our state, really tough. And so while certainly the leveraging motivation remains primary, this notion of the nature of the times calls for all hands on deck, every quiver in the bow, every tool in the box—use your analogy—is such that our board is actually at the point of feeling that if we weren't engaged in policy work, we would be leaving an enormous strategy in a tough, tough time off the table.

The right kind of information can prove instrumental in moving policy debates forward. Many health funders have sought to monitor child health needs and outcomes at local, state, and national levels in order to inform the public and policymakers. Several of these objective analyses were highlighted earlier in this report. Other prominent examples include The Annie E. Casey Foundation's Kids Count initiative that tracks the status of and trends in children's well-being and the Foundation for Child Development's Child Well-Being Index.

Health funders are also exploring a variety of new information resources and tools to raise the visibility of children's health issues. For example, multiple funders are working with James Heckman, a labor economist at the University of Chicago, to incorporate health-related information into an econometric model he has developed to assess returns on investment in children's cognitive, social, and emotional development. Others are examining the need for newer, more inclusive measures of child health and well-being, such as the Early Development Index that was developed in Canada to measure school readiness at the population level.

Some funders have also sought to support and build the capacity of advocacy organizations to ensure they have a strong voice in the policy process. Marcia Egbert (2008) noted:

> We've got people with incredible policy and issue expertise that were really quite effective at being advocacy voices on a variety of debates, but they couldn't find

Some funders have also sought to support and build the capacity of advocacy organizations to ensure they have a strong voice in the policy process.

their way around a state or local or federal budget process to save their lives. So we've basically paid them to go to boot camp on the county budget process, the state budget process, the federal budget process. [Now we can] bring all of that remarkable issue expertise to the table around the most important policy documents in any level of government. And, boy, it has really changed the way these folks engage around the policymaking process, and it's been the best small amount of money, I think, that we've spent in a long time.

Egbert went on to stress that advocacy must extend beyond formal policy actions like legislation, regulations, and appropriations by "funding people to stay at the table deep in the implementation process on public policy, far beyond the public victory on an issue but well into the muck and mire of getting it actually implemented on the ground. And that's been a hugely eye-opening and helpful set of engagements for us" (Egbert 2008). These experiences suggest that support for advocacy can occur in a variety of ways and funders may wish to form strategic alliances to ensure that all advocacy bases are covered.

CONCLUSION

Regardless of how they seek to develop a more comprehensive, coordinated approach to child health and well-being, health funders engaged in or contemplating this integrative work must be prepared to commit for the long haul. Ann Segal (2008) remarked, "I saw flashbacks of having worked on this since the 1960s and we're still where we are. We're having some of the same discussions. So there are a lot of cautions. That it's hard work, absolutely hard work."

Peter Gorski (2008a) offered an analogy to the sea-change that took place regarding tobacco control:

> Just like it took smoking cessation in this country about 45 years to move from the science basis of disease causation from smoking to public acceptance of a smoker as a pariah, we also trust that in moving our own county toward a healthy community for children and families, we are undertaking a similar diffusion of innovation and expect that this is going to be a period of time beyond even the longest imagination of a strategic plan.

Perhaps Ann Kirwan (2008) summed it up best:

> In terms of making this cross-sectoral stuff work, I would say "just start somewhere." We were kind of overwhelmed when we first started…we needed to have the perfect model and theory of change, and we finally just decided let's just bring people together and something will happen out this. Instead of having the perfect plan, just start the hard work.

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ABOUT GIH

With a mission to help grantmakers improve the health of all people, Grantmakers In Health (GIH) seeks to build the knowledge and skills of health funders, strengthen organizational effectiveness, and connect grantmakers with peers and potential partners. We help funders learn about contemporary health issues, the implications of changes in the health sector and health policy, and how grantmakers can make a difference. We generate and disseminate information through meetings, publications, and on-line; provide training and technical assistance; offer strategic advice on programmatic and operational issues; and conduct studies of the field. As the professional home for health grantmakers, GIH looks at health issues through a philanthropic lens and takes on operational issues in ways that are meaningful to those in the health field.

Expertise on Health Issues

GIH's Resource Center on Health Philanthropy maintains descriptive data about foundations and corporate giving programs that fund in health and information on their grants and initiatives. Drawing on their expertise in health and philanthropy, GIH staff advise grantmakers on key health issues and synthesizes lessons learned from their work. The Resource Center database, which contains information on thousands of grants and initiatives, is available on-line on a password-protected basis to GIH Funding Partners (health grantmaking organizations that provide annual financial support to the organization).

Advice on Foundation Operations

GIH focuses on operational issues confronting both new and established foundations through the work of its Support Center for Health Foundations. The Support Center offers an annual two-day meeting, The Art & Science of Health Grantmaking, with introductory and advanced courses on board development, grantmaking, evaluation, communications, and finance and investments. It also provides sessions focusing on operational issues at the GIH annual meeting, individualized technical assistance, and a frequently asked questions (FAQ) feature on the GIH Web site.

Connecting Health Funders

GIH creates opportunities to connect colleagues, experts, and practitioners to one another through its Annual Meeting on Health Philanthropy, the Fall Forum (which focuses on policy issues), and day-long Issue Dialogues, as well as several audioconference series for grantmakers working on issues such as access to care, obesity, public policy, racial and ethnic health disparities, and health care quality.

Fostering Partnerships

Grantmakers recognize both the value of collaboration and the challenges of working effectively with colleagues. Although successful collaborations cannot be forced, GIH works to facilitate those relationships where we see mutual interest. We bring together national funders with those working at the state and local levels, link with other affinity groups within philanthropy, and connect grantmakers to organizations that can help further their goals.

To bridge the worlds of health philanthropy and health policy, we help grantmakers understand the importance of public policy to their work and the roles they can play in informing and shaping policy. We also work to help policymakers become more aware of the contributions made by health philanthropy. When there is synergy, we work to strengthen collaborative relationships between philanthropy and government.

Educating and Informing the Field

GIH publications inform funders through both in-depth reports and quick reads. Issue Briefs delve into a single health topic, providing the most recent data and sketching out roles funders can and do play. The GIH Bulletin, published 22 times each year, keeps funders up to date on new grants, studies, and people. GIH's Web site, www.gih.org, is a one-stop information resource for health grantmakers and those interested in the field. The site includes all of GIH's publications, the Resource Center database (available only to GIH Funding Partners), and the Support Center's FAQs. Key health issue pages provide grantmakers with quick access to new studies, GIH publications, information on audioconferences, and the work of their peers.

DIVERSITY STATEMENT

GIH is committed to promoting diversity and cultural competency in its programming, personnel and employment practices, and governance. It views diversity as a fundamental element of social justice and integral to its mission of helping grantmakers improve the health of all people. Diverse voices and viewpoints deepen our understanding of differences in health outcomes and health care delivery, and strengthen our ability to fashion just solutions. GIH uses the term, diversity, broadly to encompass differences in the attributes of both individuals (such as race, ethnicity, age, gender, sexual orientation, physical ability, religion, and socioeconomic status) and organizations (foundations and giving programs of differing sizes, missions, geographic locations, and approaches to grantmaking).

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