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GIH

CRITICAL SERVICES FOR OUR CHILDREN:

Integrating Mental and Oral Health into Primary Care

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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 health services researchers on April 17, 2007, for an informative discussion about improving the children's health care system by better integrating oral and mental health services into primary care. The program focused on strategies for reducing fragmentation of services and explored opportunities for health funders.

This Issue Brief synthesizes key points from the day's discussion with a background paper previously prepared for Issue Dialogue participants. It includes information describing the challenges to an integrated children's health system and provides examples of how health funders are addressing these problems.

Special thanks are due to those who participated in the Issue Dialogue, but especially to the presenters and discussants: Melinda Abrams, The Commonwealth Fund; Christine Ferguson, School of Public Health and Health Sciences, The George Washington University; Mary Foley, formerly at the Children's Dental Health Project; Shelly Gehshan, National Academy for State Health Policy; David Grossman, Group Health Permanente Center for Health Studies; Lisa Honigfeld, Children's Fund of Connecticut; Ellen Kagen, Communities Can at Georgetown University; Judith Meyers, Children's Fund of Connecticut; Deb Perry, Women's and Children's Health Policy Center at Johns Hopkins Bloomberg School of Public Health; and Ed Schor, The Commonwealth Fund.

Lauren LeRoy, president and CEO of GIH, moderated the Issue Dialogue. Elise Desjardins, program associate at GIH, planned the program, wrote the background paper, and synthesized key points from the Issue Dialogue into this report. Editorial support was provided by Anne Schwartz, former vice president of GIH, and Eileen Salinsky, vice president for program and strategy. Larry Stepnick of The Severyn Group, Inc. assisted in documenting the topics discussed during the Issue Dialogue meeting.

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EXECUTIVE SUMMARY

CRITICAL SERVICES FOR OUR CHILDREN:

Integrating Mental and Oral Health into Primary Care

Grantmakers have long been interested in improving children's access to health care. Yet, a number of services critical to children's healthy growth and development—such as mental health and oral health services—fall outside the traditional primary care model. This fragmentation of services has contributed to access barriers and has compromised the quality of pediatric care. Growing awareness of the importance of mental health and oral health has resulted in a variety of innovative efforts to integrate these services into children's health care.

Both mental health and oral health are integral parts of effective pediatric primary care, yet these crucial services are not typically delivered by primary care providers, and they remain significantly underutilized. Low rates of service utilization do not reflect the significant prevalence of mental health and oral health problems. Over 50 percent of six- to eight-year-olds have experienced tooth decay, and an estimated 20 percent of children have some type of mental health disorder (Crall and Edelstein 2001; HHS 1999). Left untreated, these conditions can result in a range of functional impairments and have serious implications for growth, development, school performance, and peer relationships.

Although many of the factors that undermine access to these services are similar, the mental health and oral health delivery systems differ substantially. Dental services are largely delivered by private, independent practitioners who provide care in their own offices. A small number (fewer than three percent) of dentists have completed the training required to specialize in pediatrics. The mental health workforce, by contrast, is composed of a wide variety of professionals who have had different training and practice in a range of settings such as inpatient psychiatric facilities, school systems, and child protective service agencies.

Both oral and mental health face constrained workforce capacity, which has historically been influenced by weak third-party financing. Private health insurance often excludes or significantly restricts coverage for these services. Even with parity legislation at the state and federal levels, mental health services are often subject to limitations in types of services and providers eligible

for coverage. Dental benefits, if available, are routinely provided through separate, stand-alone insurance plans. In public programs, such as Medicaid and the State Children's Health Insurance Program (SCHIP), benefits are nominally more generous, but low reimbursement rates and administrative barriers, such as unique claim forms and prior authorization requirements, hinder providers' willingness to participate.

Constrained resources for oral and mental health services have contributed to an underappreciation of the pivotal role these services can play in children's health by providers, families, and the communities in which they live. Parents, primary care providers, and child-serving organizations, such as schools, child care agencies, and juvenile justice systems, could be empowered to play a much more active role in the detection of mental health and oral health problems. Raising awareness of the impact that untreated oral and mental health disorders can have on children's development and well-being and providing tools to facilitate early identification of and response to these problems are key to both minimizing disease burden and stimulating appropriate levels of demand.

Possible Solutions

Foundations across the country have supported innovative efforts to improve access to oral and mental health services and better integrate these services into primary care practice. These efforts include:

Improving oral and mental health workforce capacity. To address workforce constraints in mental health and oral health, several promising efforts are underway. Foundations have supported policy analyses and other analytic studies to assess and publicize the adequacy of the existing workforce available to provide mental health and oral health services. Some funders have focused on expanding and improving pipeline training programs for mental health and oral health providers.

Strengthening prevention, early diagnosis, and referral services. A number of funders have sought to help clinicians, schools, public health agencies, and families implement evidence-based prevention strategies and intervene early on in the disease process. Several grantmakers have worked to infuse the preparatory training of pediatricians with a more rigorous exposure to mental health and oral health issues. Other programs focus on improving the awareness and skills of practicing physicians by providing screening tools and educating pediatricians about preventive oral health services. Others have supported community-based water fluoridation and nutrition education.

Supporting the provision of oral and mental health services. Expansion of specialty services may be necessary to tackle the unmet treatment needs in children's mental health and oral health. Funders have successfully funded service expansions, such as mobile vans and volunteer-based clinics, and have helped primary care safety net clinics add oral and mental health services to their service portfolios. To ensure sustainability of these expansions, several health funders are working toward policy change that will improve the payment incentives of Medicaid programs. For oral health services, these changes largely seek to expand the role of primary care providers in delivering preventive dental services and increase reimbursement rates for restorative treatments to improve dentists' willingness to serve Medicaid patients. For mental health services, these changes focus on allowing greater flexibility in payment policy to facilitate blended funding streams and reduce fragmentation across silos of service.

Several factors have led to inadequate, poorly integrated oral and mental health services: limited private, third-party insurance for these services; inadequate public funding; workforce capacity constraints; and a historical belief that oral and mental health are somehow secondary to overall health status. Reformed funding mechanisms, innovative approaches to workforce development, and a greater emphasis on both population-based and clinical preventive services promise to address the oral and mental health problems that too often rob children of their lifelong potential.

TABLE OF CONTENTS

OVERVIEW OF THE ISSUE

Both mental and oral health care are integral to effective pediatric primary care, yet these critical services remain significantly underutilized, resulting in unnecessary disease, disability, and even death. Nearly half of all children (under the age of 18) do not receive appropriate oral health services, and over two-thirds of adolescents (ages 12 to 18) with mental health needs fail to receive diagnostic or treatment services (Halfon et al. 2007).

Children living in poverty suffer twice as much tooth decay as their more affluent peers, and their disease is more likely to go untreated.

Low rates of service utilization obfuscate the prevalence of mental and oral health problems. Over 50 percent of six- to eight-year-olds have experienced tooth decay making dental caries the most prevalent chronic illness among children (Crall and Edelstein 2001). Among 5- to 17-year-olds, tooth decay is more than five times as common as asthma and seven times as common as hay fever (HHS 2000). An estimated 20 percent of children have some type of mental health disorder; approximately half of these children suffer from serious disorders that cause significant functional impairment in their day-to-day lives at home, in school, and with peers (HHS 1999).

While oral disease and mental illness cut across socioeconomic classes, poor and marginalized children suffer more. For example, children living in poverty suffer twice as much tooth decay as their more affluent peers, and their disease is more likely to go untreated (HHS 2000). Similarly, racial and ethnic minority children are less likely to receive care for a mental health disorder; when they do, the service is often of poorer quality (HHS 2001).

High levels of unmet need have compromised children's health, academic success, and social well-being, particularly for low-income and minority children. Left untreated, mental and oral health disorders can result in a broad range of functional impairments such as difficulty eating, speaking, maintaining cognitive focus, or controlling behavior. These problems have far-reaching implications for growth, development, school performance, and peer relationships (HHS 2000). The disease burden of oral and mental disorders also has financial repercussions, which affect families who may struggle to afford health care costs or who need to take unpaid time off to care for a child. It also extends to society in the way of decreased productivity and increased health care costs.

In extreme cases, the failure to treat mental illness or oral disease can be fatal. In February 2007, a 12-year-old boy from Maryland died from an infection that started in his tooth and spread to his brain. Because his

family was unable to locate an oral surgeon who would accept Medicaid, the boy was unable to have a simple tooth extraction that could have saved his life. Childhood mortality related to untreated mental disorders is even more common, with nearly 1,500 suicides committed each year by persons 18 years old and younger (CDC 2008). In 2004 the youth suicide rate rose for the first time in more than a decade, increasing by 11 percent for youth aged 14-19 and by 8 percent for youth aged 10-14 (Hamilton et al. 2007). As the tragic events at Virginia Tech in April 2007 illustrated, in rare instances untreated mental illness can also lead to violence toward others.

The intersecting factors that undermine access to care and perpetuate the under use of services are, in many ways, similar for both oral and mental health. The delivery systems for these two types of services, however, are very different, leading to some important distinctions. The following summarizes the key challenges to ensuring that oral and mental health are appropriately integrated into children's health care services.

Constrained Capacity for Specialty Services

Most oral and mental health services are delivered outside of the traditional, primary care setting by separate systems of care. Although both service types are believed to be experiencing workforce shortages, the delivery systems that have evolved to provide these specialty services are very dissimilar, resulting in differences in the nature of service capacity inadequacies.

Dental services in the United States are largely delivered by private, independent dental practitioners who provide care in their own offices. Dentists complete a four-year doctoral training program post-baccalaureate and are state licensed. According to the American Dental Association (ADA), 94 percent of all practitioners are in the private sector, 92 percent practice either alone or with one other dentist, and 80 percent are generalists. Fewer than 3 percent of dentists have completed the two-year training required for a pediatric specialty. Dental services are largely surgical in nature, and establishing a practice requires a significant capital investment to procure the equipment and facilities needed for a dental operatory. The average staff of a dental office consists of a dentist with the support of two to three staff members, including hygienists, dental assistants, and office assistants or managers. Dentistry has slowed in supporting the use of allied health professionals, with only a handful of states allowing for mid-level providers known as expanded function dental assistants.

Although there is some disagreement regarding whether or not the oral health workforce is currently experiencing an overall shortage, there is a geographic maldistribution of dentists, and workforce levels nationally have diminished over time. The ADA reports that in 1999 the population to

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primary care dentist ratio was 2,200 to 1, approximately twice the population to primary care physician ratio (HHS 2006). The number of persons per dentist has risen consistently since the mid-1990s and is expected to increase rapidly in 2010 as a large cohort of practicing dentists begins to retire. The U.S. Department of Health and Human Services has identified 1,700 dental health professional shortage areas, and the population living in these areas is currently over 25 million (Children's Dental Health Project 2007).

More communities are likely to face dentist shortages in the future.

More communities are likely to face dentist shortages in the future. The average dentist is now 49 years old, according to the ADA, and for the next decade retiring dentists will likely outnumber new ones. The number of dentists in the training pipeline has declined significantly over the past 15 years. The size of the entering first-year class of students has been reduced by nearly 40 percent between 1986 and 2000. Even if more students wanted to become dentists, several large dental schools have closed, and states are not actively seeking to reopen them (Berenson 2007).

In sharp contrast to the oral health system, the mental health workforce is composed of a wide variety of different types of professionals who practice in a range of service settings. Children's mental health providers include psychiatrists, psychologists, psychiatric nurses, counselors, therapists, and licensed clinical social workers. The scope of practice for these various disciplines is defined by state law, with significant differences across states. These professionals may be in private practice, working in inpatient psychiatric facilities, school systems, child protective services agencies, or juvenile justice organizations. Services across providers are not typically coordinated, and a single child may be accessing mental health treatment and behavioral modification therapy from multiple sources. The diversity of mental health services for children makes it difficult to gauge service capacity levels, but available services are believed to be inadequate, due in part to fragmentation and diffusion of resources.

Although overall estimates of mental health service capacity are elusive, the current shortage of pediatric psychiatrists and psychiatric nurses is fairly well documented. In 2000 there was a projected need for 30,000 child psychiatrists; currently, there are only 6,300, many of whom do not accept public insurance. Enrollment of nurses in graduate psychiatric training programs has decreased (National Technical Assistance Center for Children's Mental Health 2005).

Public investments for building the pediatric workforce are limited but have yielded promising models. Training grants and opportunities for loan repayment are administered by the Health Resources and Services Administration (HRSA) under the authority of Title VII of the Public Health Service Act. These grants provide for innovative training, faculty development, and post-

doctoral programs. In particular, these grants support the training of physicians and other health professionals in non-hospital settings such as child care centers, juvenile detention centers, and community health clinics. For example, Nebraska uses Title VII funds to address mental health professional shortages, particularly in rural areas, by training doctoral-level psychologists in primary care practice settings. Many states use Title VII funding for Residency Training in General and Pediatric Dentistry, which ensures that dentists are trained to provide quality care in underserved areas and also represent the diverse makeup of the general population.

Financing Challenges

Historically, insurance coverage and reimbursement policies have hindered the development of more robust service capacity in both mental and oral health services. Private health insurance often excludes or significantly restricts coverage for mental and oral health services. Even with mental health parity laws enacted at the state and federal level, mental health services are often subjected to exclusions, restrictions, and administrative requirements that are not imposed on other types of medical services. If available, dental benefits are routinely provided through separate, stand-alone insurance plans. When included as covered benefits within health insurance plans, mental and oral health services are often administered separately or "carved out" of managed-care contracts. Poor coverage and reimbursement by third-party payers have led to high out-of-pocket payment obligations for patients seeking oral and mental health services—reducing access for those without the financial means to

Historically, insurance coverage and reimbursement policies have hindered the development of more robust service capacity in both mental and oral health services.

The National Business Group's *Investing in Maternal and Child Health: An Employer's Toolkit* provides concrete recommendations on employer-sponsored benefits and related programs for children, adolescents, and pregnant women. The model recommends zero cost sharing for preventive services, encourages the delivery of services by a "health care team" to promote coordination of care, and proposes that employers streamline care when using multiple plan administrators (e.g., vision, dental, behavioral health). The recommendations also suggest that preventive dental services, such as dental sealants and fluoride varnish, are cost effective for high-risk populations and that early intervention mental health services are also likely to save costs to employers. The plan allows for primary care providers to deliver oral health risk assessments, apply fluoride varnish, and furnish or coordinate early intervention mental health services.

Source: Campbell 2007

Although oral and mental health services are included in the benefit designs of public insurance programs, administrative hurdles suppress utilization and control public sector spending.

shoulder these costs, limiting the pool of paying patients, and ultimately constraining provider supply.

The benefit designs of public insurance programs, such as the State Children's Health Insurance Program (SCHIP) and Medicaid, are nominally more generous than those of private payers, but low reimbursement rates and administrative barriers hinder providers' willingness to participate in these programs. The majority of SCHIP programs include some level of dental coverage, although states continually re-evaluate this in light of increasing budgetary pressures.

Medicaid provides fairly comprehensive coverage for children's oral and mental health services through the federally mandated Early Periodic Screening, Diagnostic, and Treatment provisions. Participation, however, in Medicaid programs often places administrative burdens on providers, including the use of unique claim forms, prior authorization requirements, cumbersome eligibility verification processes, and requirements to document medical necessity. In general, low participation by private dentists in publicly funded programs has been well documented. Dentists characterize these programs as underfinanced, burdensome, and at variance with contemporary dental practice guidelines. Mental health providers face similar, as well as additional, challenges. Some types of mental health providers may not be eligible for reimbursement under Medicaid or SCHIP, further constricting the availability of services. For example, at least 20 states do not allow direct billing from psychologists, although they may reimburse community mental health centers or outpatient facilities that employ psychologists.

Low payment rates are a further disincentive to provider participation, particularly in dentistry, which relies almost exclusively on private practices for service delivery. In general, Medicaid pays significantly less than other payers for dental services (GIH 2001). A study by the U.S. Government Accountability Office found that prevailing Medicaid rates nationally were equal to fees charged by the lowest 10th percentile of dentists, suggesting that only 10 percent of dentists would find Medicaid reimbursement rates adequate. Increased payment rates under public programs have consistently yielded significant increases in provider participation. For example, when Georgia raised its rates to the 75th percentile of dentist rates, provider participation increased by over 500 percent (Crall and Schneider 2004).

Unlike most dental practices, a variety of mental health service providers do receive direct, public subsidies in addition to reimbursement. Fragmented funding streams, however, can lead to a diffusion of resources and undermine service integration. Blending these funding streams is difficult and requires sorting through a tangled web of public child-serving programs: Title IV (Child Welfare); Title V (Maternal and Child Health); Title XIX (Medicaid); Title XXI (SCHIP); Head

Start; Women, Infants, and Children; education; juvenile justice; and other programs for children. By 1994 nearly 500 federal programs funded services for children (Hughes et al. 1997.) These programs have different missions and different, yet overlapping, clientele and are administered by different federal agencies. State and local agencies add to the administrative complexity, and conflicting rules and restrictions can make service coordination difficult.

Primary Care Practice Standards

For many children, primary care is usually the first point of patient contact. The well-child visit provides an important opportunity for prevention and early intervention for a variety of health problems; yet children receive fewer than half of the recommended exams regardless of financial barriers. Even when children do receive regular check ups, the quality of those visits is often less than ideal. Time limitations constrain the nature and scope of screening and educational services offered within each well-child visit. For example, a national study cited that 36 percent of parents reported not discussing specific child health issues with their pediatricians, and 40 percent of parents of children covered by Medicaid were not asked to share concerns about their child's development or behavior (Schor 2004).

Early detection is critical to treating most mental or oral health problems, yet pediatricians do not screen for these conditions with regularity. When they do, doctors often do not have the tools to treat the child or do not make an appropriate referral to a specialist. There are many reasons a provider may not make a referral, including time constraints, lack of familiarity with mental or oral health services (and therefore a reluctance to refer), and inadequate referral capacity.

Constrained service capacity for mental and oral health services creates a real dilemma for primary care physicians. Many pediatricians believe that they should not screen unless they can treat the problem themselves because referral resources are not available. In addition, even when such services exist, primary care providers may not be able to coordinate care with specialty service systems and may struggle to help children and families navigate fragmented service silos. (Fine and Mayer 2006).

Parental and Community Awareness

Although their role in providing health care is paramount, primary care providers are not the only stakeholders who need to get involved. The notion of "daily dose" intervention suggests that primary care is not the only means of promoting healthy development. Child care settings, schools, the child welfare system, and the juvenile justice system interact with children on a daily basis and, with proper training, can serve as important agents in the

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detection of mental and oral health problems. The federal Early Head Start program, which provides services for low-income, pregnant women and families with children up to age 3, embraces the notion that all child care professionals should be concerned with children's mental health.

Involving families in their children's care is an important piece of service integration, as is providing education to caregivers. Family-driven care is based on the idea that families have a primary decisionmaking role in the care of their children, including choosing services and providers, monitoring outcomes, and assessing health promotion efforts (Hornberger et al. 2006). In an effort to empower families to be effective in this role, family advocacy groups, such as Family Voices, encourage families to work to dispel stigma, promote cultural awareness, and affect policy change.

Parental health status and service use also have important roles to play in their child's health. Parents' own untreated health conditions can cause similar problems in their children. There is evidence that mothers with significant tooth decay may harbor high levels of the cavity-causing bacteria that can be passed to their children through saliva. Anecdotal evidence suggests that parents with untreated dental problems are less likely to bring their children to the dentist. To some degree, mental health conditions can be genetic, but evidence also shows that stressors involved in living with a caregiver suffering from a mental illness can increase the risk of mental health problems in children. Postpartum depression, for instance, bears consequences for infant development, but, if untreated, parental depression can also affect a child's cognitive performance and may be linked to conduct and behavioral problems in school-age children.

Parenting practices and community supports can have a significant influence in preventing the need for oral and mental health services. Primary prevention of dental disorders includes effective oral hygiene, fluoride exposure (in toothpaste, varnish, or the water supply), and control of dietary exposures to simple sugars (soft drinks). While primary prevention of mental health disorders is more complex, evidence suggests that reducing environmental and social stress promotes more optimal psychological and psychosocial development in children. Community- and family-based efforts to improve nutrition, ensure safe housing, foster positive parent-child interactions, reduce exposure to violence, treat parental substance abuse, and strengthen social networks can exert protective influences that may prevent mental disorders in children.

POSSIBLE SOLUTIONS

Expanding access to mental health and oral health services for children and integrating these services into the primary care system will require multiple stakeholders, including primary care providers, schools, and other child-serving agencies. Public and private funders have pursued a variety of strategies to engage and sustain the work of these stakeholders. The following summarizes some of the more dominant approaches, including developing the oral and mental health workforce; strengthening prevention, early diagnosis, and referral services; supporting service capacity expansions; and facilitating policy change in public insurance programs. Although each of these strategies is discussed separately, it is important to note that many funders have pursued comprehensive initiatives that have incorporated some or all of these approaches.

Developing the Oral and Mental Health Workforce

Several health funders have supported data and analytic efforts to examine and document the adequacy of the existing workforce to provide oral and mental health services. For example, the Connecticut Health Foundation has funded a comprehensive policy analysis of the actions needed to improve the accessibility and quality of oral health services within Healthcare for UninSured Kids and Youth (HUSKY), the state's Medicaid and SCHIP program. The analysis includes a detailed examination of the overall supply of dental providers within the state and participation rates in HUSKY. As this effort illustrates, attempts to increase the size and improve the quality of the oral and mental workforce available to serve children may not focus exclusively on pediatric programs given that many health providers who serve children do not receive specialty pediatric training, particularly in dentistry.

Some funders have focused on expanding and improving pipeline training programs for oral and mental health providers. In 2001 the Robert Wood Johnson Foundation (RWJF) funded 15 accredited dental schools in the launch of its Pipeline, Professions, and Practice program to increase the number of minority dental students, improve the cultural competence of care delivery, and provide dental services in the community setting. The California Endowment and the W.K. Kellogg Foundation also supported this initiative, which provides opportunities to senior dental students and general dentistry residents to conduct an externship in a community clinic and gain experience and confidence treating underserved patients. Students may work in any number of settings, including county health departments, elementary schools, American Indian reservations, or institutional settings. One grantee used funding to address geographic challenges by expanding bus programs

and other partnerships that treat children living in remote areas.

In some cases, funders have sought to develop innovative provider education models that depart from the traditional training pipeline. For example, there is a growing movement to create a mid-level, allied health professional discipline in dentistry. While masters-level providers serve individuals with mental health problems with minimal medical oversight, there is no equivalent in dentistry. Several potential models exist, however, including the advanced dental hygiene practitioner (ADHP) credential proposed by the American Dental Hygiene Association. This degree program would train masters-level dental hygienists in preventive and minimally invasive therapies and develop skills related to health promotion, case management, and nutrition. Currently, a non-accredited degree program is being piloted at the University of Minnesota, and other universities are seeking resources to develop curricula, recruit faculty, and establish programs.

While increasing the supply of oral and mental health providers is important, improving early diagnostic screening to identify the need for these services is also critical.

Strengthen Prevention, Early Diagnosis, and Referral Services

While increasing the supply of oral and mental health providers is important, improving early diagnostic screening to identify the need for these services is also critical. Health grantmakers have supported programs that seek to infuse the preparatory training of pediatricians with a more rigorous exposure to oral and mental health issues. The Rose Community Foundation in Colorado funded a pilot program to integrate mental health care in the service and curriculum at a major teaching clinic. The Child Health Clinic at The Children's Hospital in Denver provides services to children, most of whom are uninsured or covered by public insurance. Pediatric trainees can opt to take month-long electives as part of their preparation. In Kansas, the Reach Healthcare Foundation has supported a number of provider training programs, including a grant to Children's Mercy Hospitals and Clinics to implement a pilot training program in oral health for pediatric residents. The hospital continues to offer a variety of elective rotation assignments, including developmental behavioral pediatrics and pediatric psychiatry.

Other programs focus on improving the awareness and skills of practicing physicians and other professionals. For example, the federal Bright Futures in Mental Health strengthens the ability of practicing pediatricians and other key stakeholders to provide mental health assessments and screenings. In addition to producing written training materials, Bright Futures provides hands-on training to pediatricians and school personnel on how to identify and help children with mental health disorders. The program, however, seeks to go beyond training professionals—the goal is to change the mindset of entire communities to identify and support children with mental disorders, as well as create environments that foster mental health wellness.

Through this program, the state of Missouri conducted a survey of school-based counselors and identified social and emotional difficulties as the most prevalent issues addressed. State representatives asked Bright Futures staff to train guidance counselors, school nurses, and others on how to identify and care for children with these problems. Bright Futures leaders agreed to do the training but also insisted on including systems-based strategies to help teachers, school nurses, guidance counselors, principals, family members, and other individuals involved in children's lives to create positive environments conducive to mental health development.

Into the Mouths of Babes is a statewide program in North Carolina that provides training for primary care providers on oral health prevention. The state's Medicaid program will reimburse primary care providers to deliver oral health risk assessment, screening, referrals, fluoride varnish application for Medicaid-eligible children ages 0-3, and oral health education to caregivers if those providers have been trained in these services. Into the Mouths of Babes works to develop relationships with providers by offering continuing medical education seminars, screening tools, practical strategies for implementation, and follow-up training. Into the Mouths of Babes has increased access to preventive dental services for Medicaid children (Rozier et al. 2003). In April 2007 Maine adopted a model based on Into the Mouths of Babes that will integrate oral health care into medical and social services for very young children.

South Carolina has created a similar statewide partnership, More Smiling Faces in Beautiful Places, which seeks to improve oral health care for young children and those with special needs served by Medicaid. With a three-year, $960,000 grant from RWJF, the partnership works with several counties to develop an integrated oral health network of public and private health providers. These providers receive training in pediatric oral health and learn how to educate and empower families. The partnership also offers links to providers for patients who need referrals. Faith communities also worked to deliver the message; some churches incorporated oral health education into worship services, offered oral health screenings, and, as such, provided models for other religious groups.

The Washington Dental Service Foundation (WDSF) is working with Group Health Cooperative, an integrated health plan and delivery system in the Pacific Northwest, to train primary care providers to detect and treat oral disease. Providers are trained to detect oral pathology in children, apply varnish as a preventive measure against dental decay, and make appropriate referrals. These oral health services are routinely provided to all children enrolled in Group Health during well-child visits. WDSF pays an incremental $25 for each Group Health child member who receives the services and is not covered by Washington Dental

Services—a private insurer affiliated with WDSF—or the state Medicaid program. The foundation has committed to providing this funding for three years. During this time, Group Health will upgrade its information systems to determine whether its uninsured members are eligible for some type of payment assistance. The incremental funding was critical to Group Health's decision to continue to provide oral health services during routine well-child visits.

Some strategies have worked to develop collaborative care models that improve care coordination across primary and specialty care providers. The Hogg Foundation for Mental Health in Texas is committed to breaking down the barriers to integrated health care at all levels of the service delivery system. The foundation's Integrated Health Care Initiative began in 2006 with over $2.6 million awarded to five organizations over three years. The grantees have adopted a collaborative care model with the goal of providing primary care clinicians with the necessary training to partner with mental health providers to manage patients' mental and physical health problems holistically. One grantee has used funding to hire a care manager to track patients' progress; educate families about a child's condition; and, in some cases, provide therapy services to the child. The primary care provider consults with a psychiatrist for advice on medication management and treatment progress. This arrangement allows the clinic to tap into specialty expertise without incurring the high cost of having that provider on staff. The foundation is dedicated to continuing this important work and hopes to use lessons learned from its first wave of funding to inform future grantmaking.

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Support Service Capacity Expansions

Enhancing the role of primary care providers and other community-based professionals can decrease the need for specialty services, but the expansion of specialty oral and mental health services may also be required to address unmet treatment needs. Many funders have helped expand the availability of oral and mental health services. Mobile vans, volunteer-based clinics, and other creative service delivery models have been pursued to fill service gaps within communities. For example, the Endowment for Health in New Hampshire funds the Molar Express, a 40-foot dental office on wheels, which works with participating schools and community health centers. One of 20 Care Mobile units developed by the Ronald McDonald House Charities, the Molar Express is staffed by a hygienist, dental assistant, and clinic coordinator who provide diagnostic and preventive oral health services.

Some funders have focused on building the specialty service capacity in existing primary care safety net clinics in order to facilitate integration with other health services. Community health centers, or federally qualified health centers, provide

an important source of care for over 9 million low-income individuals in the United States and can lead the way in integrating children's health services (Starfield and Shi 2004). In 2005 approximately 73 percent of health centers provided preventive dental services, 69 percent offered some type of restorative dental services, and 75 percent offered some level of mental health services.

The Maternal and Child Health Bureau's Integrated Health and Behavioral Health Care initiative began in 2000 with two-year planning grants to four grantees to develop relationships to support the integration of primary care and behavioral health services. In 2002 the bureau awarded four implementation grants to grantees to develop pediatric models of integrated services. Each grantee featured colocated general health and mental health services and found that follow up and consistent interaction among providers were crucial to the functioning of the system. Burrell Behavioral Health in Springfield, Missouri, established integrated behavioral health practices in high-poverty areas. A behavioral specialist worked on site and shared medical records with primary care providers.

In Rochester, New York, behavioral health providers are colocated in the community health center and deliver services alongside the primary care provider. Behavioral health is not indicated by separate signage within the center so patients can avoid potential stigma associated with using mental health care. In eastern Tennessee, Cherokee Health Systems featured an integrated health center with pediatricians, a clinical psychologist, a clinical social worker, and school psychology liaisons. The multidisciplinary team used electronic charts to monitor care, and the health system provided ongoing training to professionals about the integrated model.

Improve Public Financing Policies

Several states are engaged in efforts to change the payment structure of their Medicaid programs in order to create market incentives for service capacity expansions. Some of these efforts focus on increasing reimbursement rates, while others seek to reduce restrictions regarding the types of services or providers that are covered under the program. For example, some states have worked to encourage Medicaid payment for fluoride varnish as a covered preventive service. Others seek to extend billing privileges to non-physician or non-specialty providers. Scope of practice statutes and Medicaid policies can influence the effectiveness and reach of practice innovations. In some instances, state-level policy changes are needed to allow primary care providers to deliver and bill for preventive oral health services. Thirteen states allow physicians to provide limited oral health treatment (Gehshan 2007). Many states allow dental hygienists to perform services under the supervision of a dentist, and 12 Medicaid programs reimburse them directly.

State-level policy changes are needed to allow primary care providers to deliver and bill for preventive oral health services.

SCHOOL-BASED HEALTH CENTERS

Schools are a logical venue to provide children's health care services; most children spend much of their day in schools and may be assessed by teachers, guidance counselors, and school-based health care providers. School-based health centers (SBHCs) are now found in over 1,500 schools across the United States. Like other community-based programs, SBHCs are funded through a patchwork of funding sources, such as Medicaid, state grant support, and the federal Healthy Schools/Healthy Communities program (GIH 2006). Over half of SBHCs screen children for dental problems; a smaller number offers dental care and protective sealants (National Assembly on School-Based Health Care 2000). For mental health services, schools are often seen as the de facto providers for children and adolescents. It is estimated that between 70 and 80 percent of children who receive mental health services do so in a school setting (The Center for Health and Health Care in Schools 2007).

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The W.K. Kellogg Foundation, a strong supporter of SBHCs, launched the School-Based Health Policy Program, a five-year initiative, in 2004. SBHCs provide a range of services, including mental health and oral health services, such as grief and loss therapy, substance abuse treatment, mental health and oral health referrals, oral health education consultations, dental screenings, preventive dental care, and comprehensive dental care, as well as working with mobile dental units.

With Blue Cross Blue Shield of Michigan Foundation, Kellogg also supports the School-Community Health Alliance of Michigan, a coalition of individuals and organizations representing school-based and school-linked health services. The alliance developed a centralized third-party billing and reporting system to enable SBHCs in the state to bill insurers for covered health services provided to students with public or private health care coverage. Staff were trained on how to use the billing system, which also tracks health services that are not covered by private or public insurance. Results have been promising with over $90,000 in revenue earned over a two-year period. The program is expected to become a national model on how to deliver comprehensive services to children of all ages while becoming financially self-sufficient.

Others have focused more specifically on enhancing specialty capacity in oral and mental health. The John Rex Endowment has successfully expanded dental screenings in schools through the Dental Outreach and Access Program. The goal of the program is to provide children with the services they need in the communities in which they live. In Wake County, North Carolina, Title I children

in kindergarten and second grade are screened, and parents are notified of the outcomes. The program works to enroll eligible families in Medicaid or to seek other methods of payment for dental care. Challenges in accessing care persist, however. Dental resources in the county are very limited for children without insurance. Some pediatric dentists accept Medicaid, but few oral surgeons do, making special services like root canals almost impossible.

United Methodist Health Ministry Fund's oral health initiative Healthy Teeth for Kansans includes projects aimed at preventing oral disease and improving access to oral health care. One of the initiative's goals is to increase the integration of oral health prevention and education practices into medical and other non-dental settings. The fund has awarded grants to colocate a dental clinic at a community health center, to integrate oral health education and prevention into existing services for an estimated 30,000 children and pregnant women through a county health department, and to provide training for school nurses to perform laser detection technology screening. Other fund-driven efforts include providing dental sealants to children to protect against tooth decay, developing oral health training curricula, and increasing awareness about oral health issues through a coordinated communications campaign.

To address the burden of untreated mental and oral health conditions in children, RWJF developed a national initiative, Caring for Kids: Expanding Dental and Mental Health Services Through School-Based Health Centers. Unveiled in 2002, the program supported eight projects to expand mental health services and seven projects to increase dental care in SBHCs. One grantee, HEALS, a school-based dental clinic in Alabama, was able to expand dental services for children without insurance to five days per week. By hiring an office manager, a dental hygienist, and two dental assistants, and relying on newly graduated and volunteer dentists, the clinic was able to provide area children with over 4,000 dental visits and became a model for school-based dental programs. In Queens, New York, a student health center expanded mental health services by increasing service capacity, quality of care, and reimbursement. The student body of the Franklin K. Lane High School was over half Latino, over one-quarter African American, and mainly lived in areas with high rates of poverty and health problems. With RWJF funding, the health center hired a full-time psychologist, several social work interns, expanded group programs, provided staff training, and focused on enrolling more students in public insurance programs. Because of its efforts, the center was able to screen 95 percent of newly registered students for mental health problems, establish programs to dispel the stigma of mental health conditions, and increase staff use of evidence-based practices.

The fragmented nature of the mental health service delivery system also requires attention to how Medicaid interacts with other public child-serving programs.

The Assuring Better Child Health and Development (ABCD) program, administered by the National Academy for State Health Policy and funded by The Commonwealth Fund, has been a model for change in the healthy development of young children. The most common payment policy change reported among ABCD states relates to clarifying the services for which providers can bill Medicaid. This included clearly identifying which types of screening tools were suitable for reimbursement, disseminating billing codes for these services, and raising providers' awareness of appropriate billing practices. Some state Medicaid programs, such as Minnesota, developed incentives as part of contractual agreements with health plans designed to increase the use of developmental and mental health screening tools. Illinois has made strides in promoting the mental health of young children by allowing pediatricians to bill Medicaid for parental depression screenings (Kaye et al. 2006).

Changes within the Medicaid program represent clear opportunities to improve children's oral and mental health, but the fragmented nature of the mental health service delivery system also requires attention to how Medicaid interacts with other public child-serving programs. In 1991 RWJF established the Child Health Initiative, a national demonstration project to develop mechanisms at the community level to coordinate the delivery of children's health services and to pay for those services from a flexible pool of previously categorized funds. Few examples of decategorization existed at that time. The underlying assumption was that if funding streams could be blended, then health care delivery and access to health services would be improved. Each grantee was required to address three areas: performing ongoing community needs assessment, developing individualized care coordination, and creating a decategorization mechanism to achieve flexible financing.

The nine grantees met varying levels of success in their efforts, but some valuable lessons were learned. The program evaluation noted that the fragmentation of child health services presents a real barrier to effective health care but that efforts at integration can improve outcomes. Since many of the barriers to integration are rooted in the way various agencies operate and interface, specialized technical assistance can substantially streamline service delivery. Although these types of coordinating activities may require some level of financial support, grantees were often able to secure support from state and local governments, school systems, and local donors. Effective communication strategies and a strong care coordination plan helped several grantees sustain their programs after the foundation's support ended (RWJF 1997).

Despite these local level improvements, systemic integration proved difficult absent broader financing reforms. Most changes in financing

require approval at state and federal levels as well as buy-in from other stakeholders in children's health programs. Such reforms were most viable when pursued in conjunction with service delivery innovations. Evaluators found that high-level political commitments across all levels of government would be necessary to move future decategorization projects, that grantees require significant technical assistance, and that service integration should focus on both the health and social sectors (Hughes et al. 1997).

Some states have recognized the pivotal role that state-level policy decisions play in service coordination and have taken steps to streamline administrative processes. New Jersey's Division of Child Behavioral Health Services (DCBHS) serves children and adolescents with behavioral health needs and works across three child-serving systems: Medicaid, child welfare, and the state mental health department. A contracted system administrator serves as the single point of contact for families and conducts utilization management, monitoring, and outcome tracking. Children and families with complex needs are referred to a county-based care management organization. Restructuring the publicly funded systems that serve children enables DCBHS to use pooled funding to provide services. Despite budget constraints, New Jersey was able to improve the efficiency of services provided to children in juvenile detention centers.

At the national level, the Early Childhood Comprehensive Systems initiative, launched in 2003 by HRSA's Maternal and Child Health Bureau, works with state maternal and child health programs to develop a more comprehensive and integrated system for children. The initiative brings together health care, early education, social and emotional health, parent education, and family support services. Other goals include building stronger multisector leadership; implementing family-centered, coordinated care; and developing better-financed systems to support the health and development of young children. Although not focused exclusively on oral and mental health issues, this initiative seeks to expand access and reduce fragmentation across all public child-oriented services.

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CONCLUSION

The forces that have led to inadequate, poorly integrated oral and mental health services overlap and intersect through a variety of reinforcing dynamics. Severe limitations on funding through third-party insurance mechanisms have suppressed demand for services. In turn, limited demand has stunted the development of robust oral and mental health service capacity. Because provider supply is so limited, available practitioners have the market clout to refuse significant discounts from their established rates, making the low payments offered by Medicaid uncompetitive. Efforts to expand training programs, improve early identification and intervention, and stimulate service utilization are likely to have limited systemic success absent changes to payment incentives.

Increased coverage and reimbursement through both private and public insurance, particularly for clinical preventive services known to be cost effective, will help improve access, both by encouraging workforce growth and minimizing demand for "deep-end" treatment services. Yet, financing changes must be pursued in tandem with population-based primary prevention, patient education, provider training, community engagement, and delivery system reform to ensure that financial resources yield value in terms of health outcomes, not just volume in terms of service use.

Innovations in clinical services and creative approaches to delivery system practices promise significant reductions in the burden of disease caused by oral and mental health disorders. Long stigmatized as afterthoughts in medical care, both oral and mental health play pivotal roles in dictating a child's development, overall health status, and long-term potential. Sustained attention and activity must be given to both expanding the use and availability of oral and mental health services and integrating these services in a holistic fashion. Public investments in these services are currently inadequate, but such programs may offer a valuable base for building future service enhancements.

Innovations in clinical services and creative approaches to delivery system practices promise significant reductions in the burden of disease caused by oral and mental health disorders.

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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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