

GIH REACHING KIDS:

*Partnering with
Preschools and Schools
to Improve
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 education experts on May 27, 2009, for an informative discussion about ways in which preschools and schools are working to improve outcomes related to children's health. The Issue Dialogue Reaching Kids: Partnering with Preschools and Schools to Improve Children's Health synthesized the latest research on health-related issues affecting children's educational outcomes. It also provided illustrative examples of foundation-driven initiatives aimed at promoting collaborations between the health and education sectors to improve children's health and development outcomes. This Issue Brief summarizes background materials compiled for the meeting and highlights key themes and findings that emerged from the day's discussion among meeting participants.

Special thanks are due to those who participated in the Issue Dialogue but especially to the presenters: Sharon Adams-Taylor, American Association of School Administrators; Debbie Chang, Nemours Health and Prevention Services; Daniel Domenech, American Association of School Administrators; Katherine Eckstein, The Children's Aid Society; Kim Firth, Endowment for Health; Roel Gonzalez, Rio Grande City Consolidated Independent School District; Linda Juszczak, National Assembly on School-Based Health Care; Amy Latham, The Colorado Health Foundation; Julia Lear, Center for Health and Health Care in Schools, The George Washington University School of Public Health and Health Services; Carl Paternite, Center for School-Based Mental Health Programs, Miami University; Donna Stephens, Learning Well, Inc.; Doug Tynan, Nemours Health and Prevention

Services; Debbie Watson, Winter Park Health Foundation; Howell Wechsler, Centers for Disease Control and Prevention; and Ann Wick, Delaware Early Childhood Council.

Lauren LeRoy, president and CEO of GIH, moderated the Issue Dialogue. Alicia Thomas, senior program associate at GIH, planned the meeting and synthesized key points from the Issue Dialogue into this report. Faith Mitchell, vice president for program and strategy, and Leila Polintan, communications manager, provided editorial assistance to this report.

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EXECUTIVE SUMMARY

REACHING KIDS:

Partnering with Preschools and Schools to Improve Children's Health

Improving children's health and development has been of substantial interest to and investment in by national, state, and local funders for many years. Directly engaging with preschools and schools to improve children's health outcomes is increasingly a way to support a wide variety of efforts and interventions that reach a majority of children in an efficient and effective manner. Many examples of strategies and interventions are available to offer a "roadmap to success" that can be used in funders' efforts to improve the lives of children across the life course.

Over time, more attention is being paid to the role good health plays in children's academic success, from early childhood through the school years. Preschools and schools are major institutions in children's lives, providing oversight for many hours of a typical weekday. Though health improvement is not the primary mission of the education sector, it has extensive influence in shaping children's health and long-term development outcomes.

Historical differences in mission, accountability, governance structures, funding sources, and other systems-level factors have limited collaboration between the health and education sectors. Communication barriers result from the different "languages" educational entities and those in the health arena speak. Early

childhood educators, schools, and those interested in children's health, however, share a commitment to children's well-being. Collaborations among these groups can provide a way to reach a majority of children in an efficient and effective manner. Understanding the education sector's priorities and organizational processes can help health entities identify opportunities for engaging these institutions.

The Grantmakers In Health (GIH) Issue Dialogue *Reaching Kids: Partnering with Preschools and Schools to Improve Children's Health*, convened on May 27, 2009, highlighted intersections between health and education systems in the United States, including influences both systems have on children's healthy development across

the life course. Several themes were discussed for health funders and other organizations to consider as they work with preschool- and school-based programs and interventions.

Improving Children’s School Readiness in Early Childhood

- Early childhood is an extremely sensitive developmental stage during which experiences and exposures set the stage for future health outcomes. The foundation of learning children receive during this period also influences their success in school and later life.
- Early intervention is important for identifying and treating emotional distress and behavioral issues that may affect a child’s ability to achieve important development skills and be ready for school. Intervention at this stage is critical because learning and skill formation depend on brain development and build sequentially upon previous learning.
- Young children benefit from quality preschool programs that include prevention and early intervention components to increase their learning and development. Performance gains children make in preschool programs are more likely to be sustained when linked to high-quality elementary school programs. This includes linking curricula, standards, and assessments from prekindergarten into elementary schools to ensure the continuity of quality instruction. Unfortunately, many preschool programs across the country are of poor or mediocre quality, with wide variations in areas such as requirements and learning standards.

Increasing Children’s Access to Health Care Services within Educational Settings

- School-based health centers (SBHCs) “bring the doctor’s office to schools.” These centers provide a comprehensive range of prevention and health promotion services in a centralized, convenient

location. This care model helps reduce health-related absences and supports students’ health and readiness to learn.

- SBHCs can strengthen the surrounding community by serving a broader population and geographic area beyond enrolled students. These expanded populations include families of students, faculty and school personnel, out-of-school youth, other community members, and children at the preschool level through school-linked services.
- SBHCs reach many needy and high-risk children, including those requiring specialized health services such as chronic care management or mental or dental health services. These services are also provided by schools through linkages with local community-based health professionals.

Encouraging Children’s Healthy Eating and Active Living

- Striking increases in obesity rates draw attention to the need to improve children’s nutrition and physical activity levels. Prevention and intervention efforts targeted at changing children’s energy balance can begin as early as the preschool period. Attitudes and habits formed during these years are more likely to continue in the future.
- Lower levels of student achievement have been linked to physical inactivity, poor nutrition, and obesity. Unhealthy eating and inactive lifestyles also contribute to school absenteeism, chronic conditions, and poorer health outcomes.
- Children’s eating behaviors are strongly motivated by the foods accessible in their immediate environments. Improvements are occurring in the nutritional quality of foods available in education settings, particularly through cafeteria and vending machine options.
- Daily physical activity substantially improves children’s health and quality of life. Promoting positive

physical activity experiences as early as the preschool years can lay the foundation for regular activity across the life course. Other benefits include reductions in the risk of various diseases, increased emotional and psychological benefits, and reductions in antisocial and criminal behaviors.

- Preschools and schools can influence children's dietary intake and physical activity through mandated wellness policies and other nutrition and physical activity guidelines and standards. Unfortunately, regulation and enforcement of these policies and standards vary and are rudimentary in some cases.

Coordinating School Health Services

- A growing number of schools engage in efforts to combine individual health care services with population-based interventions that improve the health and well-being of all students. These comprehensive, coordinated approaches improve attempts to respond to the complex needs of students. Benefits include reductions in absenteeism, as well as improvements in alertness, stamina, and academic achievement.
- Model approaches for coordinating school health ideally address a range of issues such as physical education; nutrition services; and counseling, psychological, and social services. Promoting staff health, encouraging healthy and safe school environments, and involving families and the community also are important for ensuring the success of these models.

Increasing Communication, Linkages, and Formal Partnerships between Schools, Families, and Other Community Stakeholders that Serve Children

- Children's learning is influenced by their experiences in the environments they encounter, including childcare settings, schools, homes, and communities. Educating and involving these entities will enhance

efforts to address the basic social, emotional, and health needs that must be met for children to enjoy academic success.

- The community schools concept promotes children's development and learning, while actively strengthening the surrounding community. Core instructional programs and opportunities for educational and cultural enrichment are offered along with services that remove barriers to healthy learning and development.
- Community schools promote long-term, highly involved partnerships among schools, families, and community organizations and representatives. Programs in many of these schools are tailored to be reflective of the community's strengths, resources, and ability to meet the needs of children and their families.

Working with preschools and schools is an important entry point for providing information and education, and delivering health care services to a large number of children. Though no single entity bears sole responsibility for ensuring children's health and development, the education sector often has the most frequent and sustained interactions with children outside their homes. Funders pursuing collaborations with the education sector can support a wide variety of efforts and interventions that address myriad intersections between health and education-related issues. Engaging in this work takes time and patience. Fortunately, the time appears ripe for the health and education sectors to engage in cross-sectoral partnerships, thereby leveraging their respective resources to ensure the healthy development and academic success of our children.

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INTRODUCTION

In communities across the United States, preschools and schools have a stake, and an important role to play, in children's health and development. Currently, nearly 6.8 million children ages three to five are enrolled in nursery schools, preschools, or kindergarten (KIDS COUNT 2007). Over 50 million young people between the ages of 5 and 17 attend public elementary and secondary schools (GIH 2008a). While health improvement may not be the education sector's primary mission, good health is an important ingredient in the recipe for academic success.

“Mutual respect is essential for both partners. Without the support of educators, they [the health sector] are not going to be in that school, they are not going to have kids released from class, they are not going to be able to consult with teachers about difficult kids. Without educators’ belief that the “health people” really do understand that school performance and achievement are in both groups’ interests, this work will not move forward.”

— Julia Lear, The George Washington University School of Public Health and Health Services

A robust body of literature points to linkages between children's health and their education outcomes. Children who experience diminished health have a considerably higher likelihood of experiencing lower educational attainment, poorer health outcomes, and lower social status (Eide et al. 2008). Poor health can impede educational advancement because students with health problems may not be able to take full advantage of learning opportunities at school or at home (Eide et al. 2008). The sooner students' health conditions are diagnosed and treated, the better chances they have for long-term educational achievement.

Research indicates that individuals' educational attainment strongly predicts lifelong health and quality of life. Education influences future occupational opportunities, wealth, and social mobility. Additionally, it is strongly associated with risk behaviors related to nutrition, and physical, sexual, and criminal activity (Fiscella and Kitzman 2009). Individuals

with higher educational attainment generally live longer and experience shorter durations of illnesses when compared to those with less education (Zuckerman and Halfon 2003). Conversely, inadequate preparation for school entry, poor academic achievement, and completion of fewer years of education can eventually undermine health. These factors are associated with earlier onset of chronic disease, disability, and declining functional status over time (Fiscella and Kitzman 2009).

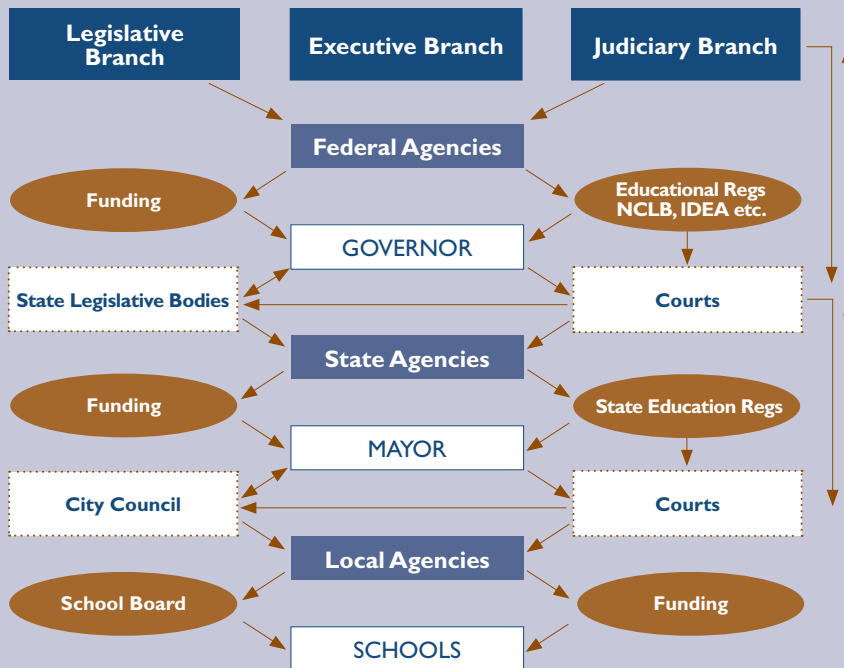
There are many opportunities for health and education sector collaborations designed to influence children's early and later health and development outcomes. This Issue Brief highlights key challenges faced by educational systems, examines the various ways health and education intersect, and explores some of the natural entry points through which health philanthropy can establish partnerships with schools and other educators.

KEY POLICIES AFFECTING SCHOOL RESOURCES AND PRIORITIES

Among public schools, several agencies and policymaking bodies can exercise decisionmaking authority (Figure 1). Federal agencies and legislative bodies influence public schools through incentive programs that tie funding to specific programs, practices, or standards. Ultimately though, states bear formal responsibility for providing public K-12 education to citizens (Richardson 2007). This equates to at least 50 diverse ways in which education is regulated in this country (Domenech 2009). With the exception of Hawaii, states delegate most operational functions and responsibility to the local level. Thus, education sector decisionmaking is highly localized, and a high degree of ownership and investment rests within over 14,000 independent school districts (Domenech 2009). This can result in significant variations in policies across school districts and individual facilities.

Figure 1

Public K-12 Educational Governance



Adapted from Richardson, J.W., "Building Bridges Between SBHCs and Schools," *Journal of School Health* 77(7), 337-343, 2007.

At the state level, governors exert some control over public education allocations. State legislatures possess the broad authority to pass education laws that delineate school districts and with whom they work, distribute funding, and govern the licensure of teachers and administrators. They also prescribe curricula and can redirect resources. The State Board of Education is another influential state policy body that has the power to implement and enforce mandates and dispense regulations and guiding principles for evaluations of school systems' performance (Richardson 2007).

Local school boards and councils are critical decisionmakers for many preschools and school systems. These entities maintain responsibility for

implementing state education policy and managing and distributing operating funds or physical capital resources from federal, state, and local sources. At the district level, directors or supervisors administer preschool or childcare programs, while superintendents serve as schools' chief executive officers (Bureau of Labor Statistics 2009). These leaders and their staff implement myriad directives that funnel down from federal, state, and local authorities (Richardson 2007). These decisionmakers are on the frontline for criticism and repercussions for unsuccessful programming or outcomes in their students (Domenech 2009; Lear 2009).

Oversight and funding for public preschools and schools vary signifi-

MANDATING CHILDREN'S ACADEMIC ACHIEVEMENT: ARE NO CHILDREN REALLY BEING LEFT BEHIND?

The No Child Left Behind Act of 2001 (NCLB) significantly expanded the federal role in elementary and secondary education. NCLB provides funding to schools through appropriations and grants in exchange for rigorous accountability standards (Richardson 2007). NCLB requirements include annual testing for students in grades 3 through 12, more stringent degree requirements for academic teachers, monitoring of achievement gaps between racial and ethnic groups, and establishing equal achievement goals for all students (Grantmakers for Education 2009). NCLB-related outcomes have been hotly debated. Some observers believe federal oversight has resulted in important improvements in academic achievement. In some cases, however, systems have had to divert funding and emphasis from other programs (such as physical education and fine arts) to ensure that they are able to focus on meeting NCLB standards. With these pressing concerns, health often falls low on the list of a school's priorities.

cantly across states, communities, and individual programs. Preschool models include federally funded Head Start centers for low-income children; state- and local-funded programs; government-funded special education programs; and for-profit, nonprofit, and faith-based organizational providers (Levin and Schwartz 2007). In general, these programs are partially or fully funded by state education agencies and are often under the direction of state or local education agencies (NCEDL 2003). State childcare agencies primarily oversee licensing and regulation standards for early childhood providers not operating federal Head Start programs.

In addition to funding from state education agencies, publicly funded preschools receive support from other sources, including federal and local public allocations, private sources, and fees (Levin and Schwartz 2007).

In 2008, total preschool program funding from all sources exceeded \$5.2 billion; per child, spending was approximately \$4,600 (Levin and Schwartz 2007). There is agreement, however, that the level of funding per child is too low for programs to meet many quality standards.

Public school finance mechanisms differ among states and are often extremely complex. In general, the federal government contributes approximately 7 percent of total school budgets, with the remainder split fairly evenly between local contributions (such as local property taxes and school lunch revenue) and state contributions (including income and sales taxes) (Howell and Miller 1997). Though the overall U.S. total expenditure per public school student was \$10,400 in 2006, the average amount provided per pupil varies greatly from state to state (Council of Chief State School Officers 2009).

WORKING WITH SCHOOLS TO PROMOTE HEALTH AND EDUCATION GOALS

Collaboration, even when its benefits are well understood, can be difficult. Bringing the education and health sectors together requires understanding the decision-making constraints that can arise when creating, sustaining, or enhancing these relationships. The different “languages” the education and health sectors speak can create barriers to effective communication (Lear 2009). Frequently there is accountability to different public and private entities. The education system is directly responsible for results such as demonstration of alphabet knowledge among preschoolers or graduation rates and test scores for older children. School administrators may perceive adding health-related goals, regardless of their merit, to be burdensome and unwelcome distractions to their mission.

“Increasingly there is the realization on the part of school systems, educators, superintendents, and board members of how important the health issue is to ensuring achievement ... that it is not just what happens in the school. This thinking is going to lead the way in terms of establishing partnerships and coordination between health organizations and the schools.”

— Daniel Domenech,
American Association of School
Administrators

How can interactions between the health and education sectors be more successful, particularly when reinforcing—but different—missions are at play? Essentially, successful collaboration requires both parties to respect differences and learn to appreciate and support each other’s priorities. Most people have been exposed to educational systems through their own educational experiences. Relatively few understand the complexity and challenges of these systems. Many health professionals are accustomed to offering and operating programs and services focused on specific conditions or segments of the population, whereas educational systems are generally set up to provide services across the entire student population (Lear 2009).

By understanding how education organizations are structured, regulated, and supported, philanthropic organizations can get a better understanding of how they can engage with the education sector. It is important to realize, however, that preschools and schools may have

little to no experience receiving funds from foundations. Strategic relationship building is needed to promote health interventions in educational settings. This may require securing buy-in from stakeholders involved in education policy, which could require developing a “business case” to demonstrate how health-related activities will lead to improvements in children’s academic performance.

Despite some challenges, working with the education sector may be a natural strategy for health funders interested in children’s health. Early childhood educators, health providers, schools, and health-focused entities share a commitment to children’s well-being (Lear 2009). Collaborations can provide a way for funders to reach a majority of children in an efficient and effective manner. These collaborations can support a wide variety of efforts and interventions ranging from improving children’s transitions across developmental stages, to working with and strengthening communities.

PROMOTING SCHOOL READINESS: THE IMPORTANCE OF THE PRESCHOOL YEARS

Early childhood is a critically important developmental stage (GIH 2008b). Early experiences and exposures set the stage for future health outcomes. A child's success in school and later life builds upon the foundation of learning received during the first years of life. It is an important determinant of a child's readiness to succeed in school and has a direct and enduring effect on future learning, behavior, and health.

Nearly one-third of middle class children and almost one-half of low-income children enter kindergarten without basic skills such as recognizing the letters of the alphabet (Juel 1988). These children are often at greatest risk for delinquency or dropping out before completing high school.

Over 60 percent of children under the age of five have working caregivers (Build Initiative 2009). This results in a significant number of them spending time in formal early care and education settings. Programs in these settings often must address young people's unmet health care or mental health needs, a challenge to which few teachers and staff are prepared to respond (Tynan 2009). This puts some children at risk because early intervention is critical. Learning and skill formation depend on brain development and build sequentially upon previous learning (Fiscella and Kitzman 2009).

Children who start behind in school too often remain behind in subsequent grades. Analyses indicate, however, that targeted investments in early childhood interventions yield substantial long-

term improvements in many areas, including cognitive skills and greater school achievement, performance, and grade attainment (Fiscella and Kitzman 2009; Reynolds et al. 2007). Other notable outcomes include improved employment opportunities and earnings capacity, as well as lower rates of delinquency, crime, and incarceration. Despite this evidence, the level of public investments made for early childhood education and development lags behind that for older children (Tynan 2009). For example, studies indicate that for every dollar invested in school-aged children, only 21.3 and 8.9 cents, respectively, were invested in preschool-aged children and infants/toddlers (Voices for America's Children and the Child and Family Policy Center 2005).

Many public and private programs, such as preschools (also known as prekindergarten (pre-K) or nursery schools), Early Head Start, Head Start, and day care, seek to improve children's school readiness and health outcomes. Approximately 38 states have established universal or voluntary

"You have about 1,000 days to build a child's brain...to create a reader, a communicator, a learner, and a thinker."

— Anne Wick, Delaware Early Childhood Council

preschool programs (NIEER 2008). In 2008, over 1.1 million children ages three to five attended state-funded preschool programs (NIEER 2008). A greater percentage of more affluent children ages three to five participated in these programs than poor children (60 percent versus 47 percent in 2005) (National Center for Education Statistics 2007). Higher proportions of black and white children participate in these programs (66 percent and 59 percent, respectively) than do Hispanic children (43 percent) (National Center for Education Statistics 2007). Targeted programs have made some progress in improving access to preschool educa-

tion for marginalized children, but they still fall short of their intended goals. Unfortunately, many children who would benefit from participating in these programs do not attend. This includes children of parents with low levels of education and income, as well as those whose mothers do not work outside the home.

Quality preschools that provide prevention and early intervention components to increase children's learning and development are especially beneficial for children. For disadvantaged children in particular, randomized studies of model programs show that high-

ENSURING CHILDREN'S SCHOOL READINESS

There are a number of key domains by which school readiness is measured. They encompass children's:

- physical well-being and motor development;
- cognition and general knowledge;
- language development;
- approaches to learning; and
- personal, social, and emotional development.

Additionally, in order for children to be ready for school, it is important for:

- parents to devote time each day to helping their child learn;
- children to have access to high-quality preschool programs;
- children to receive health care, nutrition, and physical activity in their preschool programs so that they "arrive" at school healthy and ready to learn; and
- schools to be ready for children (for example, be ready to tailor instruction to meet individual learning needs).

Source: Association of Small Foundations 2008; Tynan 2009

quality preschool programs produce substantial cognitive gains, reduce later deviant behaviors, and enhance future productivity (Committee for Economic Development 2006).

Pre-K-3 pilot programs have demonstrated that the performance gains children make in preschool programs are more likely to be sustained when they are linked to high-quality elementary school programs. These pilots have integrated curricula, standards, and assessments from pre-K into elementary schools to ensure the continuation of high-quality teaching (Association of Small Foundations 2008). Most elementary school staff, however, have little to no relationship or systematic communication with preschool providers (Domenech 2009). Variations in training, work sites, and reporting structures limit collaborations or alignment of organizational structures or academic curricula. This may differ if the school district is running the early childhood program.

Some health funders have focused on early childhood education and school readiness, including childcare settings. In some cases, these activities have focused on providing health-related interventions in early childhood education settings. In other instances, health funders have offered broad support for high-quality early childcare and education in recognition of the fact that these services positively affect health status. For instance, the Delaware Early Childhood Council, supported by Nemours Health and Prevention Services, is a system that supports children and their families during the early years (Wick 2009). This

multisectoral, public-private council advises the state government on progress toward achieving the goals of the *Early Success: Delaware's Early Childhood Plan*. *Early Success* defines the components of a comprehensive early childhood system that support the state's youngest children and their families. It outlines what the state hopes to achieve by 2015 in five areas: 1) ready children, 2) ready families, 3) ready early care and education programs, 4) ready communities, and 5) ready schools (Delaware Early Care and Education Council and Early Childhood Comprehensive System Steering Committee 2006). The ready schools domain, in particular, seeks to develop meaningful relationships and communication between schools and the early learning community. It is expected that these improved interactions will smooth the transitions young children have from preschool to kindergarten and first grade.

Many preschool programs across the country are of poor or mediocre quality. They vary widely in requirements, teacher qualifications and development, learning standards, and per-pupil spending. Approximately 36 states, including Delaware, have developed a quality rating system (NHPS 2008a; Wick 2009). Delaware Stars, a five-level system, aims to assess and improve the quality of services provided in early care, and education and school-aged settings in the state. To attain higher levels, programs must meet standards in categories such as staff qualifications and professional development, and learning environments and curriculum development. In three years, Delaware

Stars has successfully enrolled 90 programs, including family and large family childcare, early care and education, and school-age centers. By 2015 the goal is to have 75 percent of centers and 15 percent of family care programs participating in Delaware Stars quality improvement efforts, contingent upon funding (Wick 2009).

The Children's Fund of Connecticut has supported local community collaboratives to expand school readiness planning to address children's health needs as they enter kindergarten. The fund provided support to the Child Health and Development Institute of Connecticut, Inc. for a recent report on a framework for improving delivery of child health services in Connecticut. The framework promotes and supports healthy development and school readiness of children in the state and provides a basis for action among advocates, providers, and policymakers to improve the delivery of child health services for infants, toddlers, and preschoolers (Dworkin et al. 2009). The report also serves as the basis for the design of future strategies to promote children's healthy development and resulting school readiness. It provides implications for program development, public policy, and resource allocation that may serve as a model for other states in their own planning efforts.

The Annie E. Casey Foundation's Early Childhood and School Readiness initiative focuses on finding the best examples of neighborhood programs

designed to build the capacity of informal early childhood providers. By identifying and disseminating these strategies, it wants to ensure that children in low-income communities are healthy and ready for school. Grants offered under this initiative connect providers for peer-to-peer learning; use policy and practice to reduce disparities; and support local and state policies that promote quality family, friend, and neighbor care.

The W.K. Kellogg Foundation's Supporting Partnerships to Assure Ready Kids (SPARK) program is a national initiative to smooth the transition to school and align early learning and elementary school systems for children ages three to six who are vulnerable to poor achievement (W.K. Kellogg Foundation 2009). SPARK supports partnerships among selected communities, schools, state agencies, and families to ensure that they leverage community resources and work together effectively for children's early learning. As a result, a number of transition practices have been implemented, including aligning expectations and standards, coordinating training for pre-K and elementary teachers, and increasing parent involvement. Strategies have supported parents in skill building, as well as providing them partners or learning advocates. Additionally, SPARK sites have used early assessments of three- and four-year-olds to identify learning and developmental delays.

INCREASING ACCESS TO HEALTH CARE IN EDUCATIONAL SETTINGS

Educational systems have long played a formal or informal role in identifying or treating student health issues. Many common health conditions can have negative long-term consequences on children's ability to learn and develop. Addressing these concerns through school-based health centers (SBHCs) provides one avenue for expanding children's access to health care.

Each year, over 1,700 SBHCs serve nearly 2 million young people (NASBHC 2009). Almost half of the students served have no other medical home, largely because they live in communities with limited access to health care. School-based health care merges partnerships between schools and community health organizations to “bring the doctor’s office to schools.” This enables the provision of primary care where school-aged children and adolescents happen to be most of the time. This care model is beneficial in reducing health-related absences and supporting students’ health and readiness to learn.

SBHCs first appeared during the late 1960s through the efforts of the American Academy of Pediatrics’ Community Access to Child Health program (Gustafson 2005). There are centers at all school levels, from elementary to high school. SBHCs have proliferated widely around the country and are interwoven into the health care systems serving children (Silberberg and Cantor 2008). Though SBHCs are geographically diverse and dispersed, they are predominantly located in urban areas with largely low-income and medically underserved populations. The majority of students served at SBHCs

are from racial and ethnic minority groups that have historically experienced disparities in health care access (Silberberg and Cantor 2008).

SBHCs are usually located within schools, working cooperatively to become an integral part of the daily routine (Juszczak 2009). The centers provide a comprehensive range of prevention and health promotion services that meet patients’ physical and behavioral health needs. The centers’ clinical services are provided through qualified health providers such as hospitals, health departments, and private medical practices. Multidisciplinary teams of providers (such as physicians, nurse practitioners, physician assistants, social workers, clinical psychologists, and health educators) are responsible for patient care, operating on either a full- or part-time basis. It is notable that over 70 percent of SBHCs are training sites for health care professionals (Weinstein 2006).

SBHCs attempt to advance health promotion in the larger community in which they reside, as well as among their students (Juszczak 2009). Frequently, local community stakeholders play an active role on SBHC advisory boards in

“To work with SBHCs, it takes the development of relationships, a lot of conversations, and a very good understanding of what it is that each one [schools and SBHCs] is responsible for. Space is frequently an issue. Turf can be an issue. But all these things can be worked out if all agree to the greater good for children.”

— Linda Juszczak, National Assembly on School-Based Health Care

efforts to develop the content, quality, delivery, and financing of health care within their communities. Parental involvement, use of community resources, and continuity of care are hallmarks of school-based health care.

A benefit of some SBHCs is that they serve a broader population and geographic area than just enrolled students. These expanded populations include students’ families, children at the preschool level, faculty and school personnel, out-of-school youth, and other community members through school-linked services (NASBHC 2007). Much of SBHCs’ success comes from the longstanding relationships developed, which facilitate communication and an understanding of everyone’s respective roles, responsibilities, and benefits.

SBHCs’ success is attributed to the convenience of their physical location within schools, as well as the participation of the center staff in the school culture and community (Weinstein 2006). Evaluations of SBHCs suggest that they reach many needy and high-risk children, including those requiring chronic care management or mental health services (Silberberg and Cantor 2008). Additional research findings on the performance and outcomes of SBHCs show encouraging evidence such as:

- increased use of health services such as vaccinations, chronic disease management, and dental care;
- decreased use of urgent and emergency care among SBHC-treated individuals;

- reduction in Medicaid expenditures and hospitalization costs;
- increased ability to reach ethnically diverse populations, adolescent males, the uninsured, and those without regular sources of care; and
- greater ability to complement services that individuals receive elsewhere, without duplication of effort.

Despite the utility of SBHCs, ongoing struggles continue around securing reliable funding to sustain them. Section 330 of the Public Health Service Act (PHS) provides funding to SBHCs, which accounts for a large part of the federal government’s contribution. SBHCs, however, survive through a mixture of funding sources that includes federal, state, and local funds; private foundation grants; tobacco taxes and settlement dollars; third-party payers such as Medicaid and the Children’s Health Insurance Program; and in-kind contributions from school and community agency partners. Nearly all SBHCs report billing students’ private health insurance directly. Less than one-quarter, however, indicated success in collecting reimbursements for billed services (NASBHC 2009).

Securing Medicaid reimbursement for eligible services has been particularly challenging for some SBHCs. SBHCs are not universally recognized by state Medicaid agencies as a provider (NASBHC 2008). Medicaid managed care policies limit some SBHCs’ roles as primary care providers. Moreover, restrictions may be placed on the types of services and providers considered

reimbursable by Medicaid or managed care plans. This limits the recovery of costs for a large scope of SBHC services, particularly some preventive care services. Medicaid and PHS Section 330 policies that reimburse health care safety net providers do not include SBHCs in some states. The field, however, is increasingly exploring innovative ways to combat sustainability challenges (Juszczak 2009). This includes examining ways to modify practices to provide services considered billable by insurers or public programs.

Learning Well, the SBHC initiative at The Health Foundation of Greater Indianapolis, Inc., provides SBHC services to schoolchildren throughout Marion County, Indiana, via Learning Well clinics (Stephens 2009; The Health Foundation of Greater Indianapolis Inc. 2008). Collaborative partnerships have been fostered with organizations such as the United Way, school districts, local hospitals, health departments, and providers. These partnerships promote shared models for expanding school-based health services and countering currently fragmented services. Schools provide the space, internet connectivity, telephone, and demographic data downloads of all students for the clinics; health care partners provide the medical staff and supplies (both financially reimbursed by Learning Well) and equipment that is used in the Learning Well SBHCs. Electronic medical records are utilized in all the clinics through the schools' Web-based information system Welligent. Indiana University's Bowen Research Center serves as the evaluator for the initiative.

To date, the Learning Well initiative is operating in nearly 84 clinics in Marion County, serving over 27,000 students (Stephens 2009). The initiative has been instrumental in providing health care at no cost to students, many of whom would otherwise not have access to quality health care services. A major source of Learning Well's success comes from the legal infrastructure that is provided for the Partners-Memorandums of Agreement (school partners) and Provider Agreements (health care partners), which provide guidance, structure, and accountability required for such diverse collaborative partnerships (Stephens 2009). The Health Foundation of Greater Indianapolis, Inc. has provided approximately \$8.5 million to the initiative since its inception. Other funders have been added to meet the present annual budget of \$3.8 million. To ensure future sustainability, Learning Well has been approved to bill for Medicaid administrative claims for health care outreach services provided in the schools. This may provide up to \$5 million a year in additional funding for the program.

The W.K. Kellogg Foundation launched its five-year School-Based Health Care Policy Program in 2004. This \$16.3 million national initiative supports broad-based advocacy related to the quality and financing of school-based health care at national, state, and local levels (W.K. Kellogg Foundation 2008). The foundation has partnered with the National Assembly on School-Based Health Care (NASBHC) and nine of its state affiliates to help build state asso-

ciations' infrastructure and to support local SBHC partners' grassroots advocacy, community organizing, technical assistance, and data collection. Over the last five years, grantees have built their visibility and capacity to represent and advocate for SBHCs in their states. In addition to providing direct technical assistance to grantees and coordinating national communications efforts, NASBHC is building widespread support for policies, programs, research, and funding to advance school-based health care.

The Blue Cross Blue Shield of Michigan Foundation collaborates with the Kellogg Foundation to support 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 was trained on how to use the system, which tracks health services that are not covered by private or public insurance. Results have been promising, with over \$90,000 in revenue received over a two-year period. The program is expected to become a national model for delivering comprehensive services to children of all ages while becoming financially self-sufficient (W.K. Kellogg Foundation 2008).

The Colorado Health Foundation recently announced a four-year, \$10.8 million school-based health care initiative. This initiative provides

grants of up to \$400,000 over four years to develop new SBHCs or to integrate mental/dental health services into existing centers in Colorado (The Colorado Health Foundation 2009a; Latham 2009). The initiative focuses on producing state and federal policy change, improving operating efficiencies, and maximizing revenue to help SBHCs become more sustainable. Eligible organizations must build partnerships and conduct readiness assessments to reveal disparities and gaps in needs and resources. They are required to develop business plans that address efforts to ensure sustainability from the start of the project. The foundation will provide technical assistance to grantees, in partnership with the Colorado Association for School-Based Health Care.

Spotlight on Mental Health

Access to specialized health services, such as mental health and dental and vision care, is vital to children's healthy development. These services are provided within some educational settings, as well as through health professionals within the community. At the Issue Dialogue, the discussion focused on mental health care, which plays a critical role in influencing a child's ability to learn and succeed.

School personnel, childcare providers, parents, and policymakers increasingly recognize the importance of addressing children and youth's mental health needs (Paternite 2009). Mental health costs pose a significant financial and social burden on families and society in

general in terms of distress, disability, and costs for associated treatments. Persistent behavioral difficulties arising as early as the preschool years can affect an individual's social development, educational attainment, employment opportunities, and risk of engaging in criminal activities.

Approximately 12 to 22 percent of youth under age 18 are in need of services for mental, emotional, or behavioral problems (HHS 1999). One national study of kindergarten classes found that 10 percent of the children arrived at school displaying problematic behaviors (West et al. 2000). Each year, an estimated 20 percent of children have some type of mental health problem; approximately half of these children suffer from serious disorders that cause significant functional impairment in their daily lives (UCLA Center for Mental Health in Schools 2006). Among preschool children, research suggests that as many as 21 percent may meet criteria for a diagnosable disorder, of which 9 percent of the problems were considered severe (Lavigne et al. 2006). By the year 2020, neuropsychiatric disorders (which include mental and behavioral disorders) are projected to become one of the top five causes of mortality, morbidity, and disability among children (HHS 1999).

Children with more persistent behavioral problems, especially those with early onset in the preschool years, face difficulties that increase the likelihood of continuing antisocial behaviors into adolescence. Without intervention, these conditions often lead to a lifelong downward trajectory. Unfortunately,

services available for children may not be comprehensive or are marginalized and function in isolation of each other. Moreover, stigmatization and poor understanding of mental health create additional barriers to the development of integrated school mental health services. Fragmentation of services additionally compounds the problem.

Few early childhood and school settings have sufficient resources to handle the full range of students' increasing mental health needs. In some cases, the number of students in need is over half of the enrolled population (UCLA Center for Mental Health in Schools 2006). Some educational systems have instituted interventions to address mental health and psychosocial issues such as violence, school adjustment, and delinquency issues. Programs can serve all students, those identified as "at-risk," or those in specific grades. They can be implemented in regular or special education classrooms, or separately through entities such as SBHCs. Other programs connect external community programs and personnel with schools. Mental health programs in educational settings are likely to be more successful if they utilize a full array of strategies, including education, promotion, and intensive intervention (Paternite 2009).

The Endowment for Health in New Hampshire launched its Children's Mental Health theme in 2008. The endowment is supporting research to assess the existing landscape of children's mental health issues within the state, including exploring the system of providers, practices, and services available to improve access and outcomes for

"The vast majority of classroom teachers report feeling inadequately prepared to deal with the social, emotional, and behavioral issues of kids. However, educators are the linchpins for effective school mental health practices because they are with kids, day in and day out. Numerous opportunities exist in their work to promote the well-being of students."

— Carl Paternite, Center for School-Based Mental Health Programs, Miami University

children. To date, the endowment has supported projects to develop integrated, collocated, and/or coordinated systems of care; launch high-quality, research-based interventions; and strengthen advocacy capacity (Firth 2009). In the education arena, the endowment has supported planning and piloting models for enhancing school-based mental health, including strategies for early identification within afterschool programs. It also supports efforts to increase awareness and educate the public, providers, and families about the prevalence of children's mental health problems, effective treatments currently availability, and best practices.

Since 2001 the Health Foundation of Central Massachusetts, Inc. has funded the Together for Kids (TFK) initiative, which it began in response

to the growing incidence of young children exhibiting challenging behaviors in preschool classrooms. TFK aims to improve the capacity of childcare staff, childcare agencies, and families to meet the emotional and mental health needs of preschool children effectively. TFK provides on-site mental health consultation to centers; behavior management coaching and training for teaching staff; family outreach and parent involvement; and a strong program, research, and evaluation component. To date, TFK has reported improvements in children's behavior and development skills, reductions in preschool expulsions to near zero, and increased satisfaction of parents with the overall quality of their child's preschool classroom environment (Health Foundation of Central Massachusetts, Inc. 2009).

HEALTHY EATING AND ACTIVE LIVING

Dramatic increases in childhood obesity over the past few decades are raising awareness of the need for improvements in childhood nutrition and physical activity. Currently one-third (33.6 percent) of American children and adolescents are either obese (17.1 percent) or at risk of becoming obese (16.5 percent) (Institute of Medicine 2007). Between 1971 and 2004, obesity rates increased from 5 to 14 percent in two- to five-year-olds, quadrupled (from 4 to 19 percent) for older children ages 6 to 11, and tripled (from 5 to 17 percent) for adolescents ages 12 to 19.

Obesity has well-documented physical, psychological, and social consequences (Wechsler 2009). Obesity-related diseases, such as type 2 diabetes, once only seen in adults, are now on the rise among children. Medical costs for children treated for obesity are approximately three times higher than for the average insured child (Institute of Medicine 2007). National health care costs for childhood-related obesity (including undiagnosed cases) are estimated to be approximately \$11 billion for private insurance and \$3 billion for those with Medicaid (Institute of Medicine 2007).

The preschool years are a critical period for engaging in efforts to prevent or intervene on obesity issues. Attitudes and habits formed during these years are likely to continue in the future. Research indicates that overweight three-year-olds are nearly eight times as likely to become overweight young adults in comparison to normally developing children of the same age (Lumeng 2005). Children with increased body mass index (BMI) before age five may be at higher risk for future obesity than children with increased BMI after age seven. Parents

have an advantage with preschoolers because they have control over their child's eating and physical activity patterns. With younger children, even small changes in energy balance can yield significant improvements.

Particularly for younger children, childcare centers play a major role in influencing children's dietary intake and physical activity. These facilities provide stable environments where young children can receive healthy foods and regular physical activity. Evidence indicates, however, that the nutritional quality of meals and snacks children receive in these settings is poor (Story et al. 2006). For example, it appears that meals served in childcare centers are not consistent with the U.S. Department of Agriculture's Dietary Guidelines for Americans as they relate to intake of fruits and vegetables, sodium, and fat content (Story et al. 2006). Furthermore, no broad policies or uniform standards currently govern physical activity for preschoolers in childcare. As noted earlier, with the exception of federal Head Start programs, these facilities generally are regulated by each state.

For school-aged children, evidence is growing on the association of physical inactivity, poor nutrition, and obesity with lower levels of student achievement (Action for Healthy Kids 2004). Unhealthy eating and inactive lifestyles can contribute to school absenteeism, chronic medical conditions, and poorer health outcomes. Between 70 and 80 percent of overweight children and adolescents remain overweight or become obese in adulthood (Action for Healthy Kids 2004). Unfortunately, school priorities related to academic achievement requirements often eclipse

efforts to create healthy learning environments and combat childhood obesity.

Dramatic increases in childhood obesity over the past few decades have compelled many grantmakers and policymakers to focus on improving educational system policies on childhood nutrition and physical activity. For instance, the Robert Wood Johnson Foundation (RWJF) is committed to reversing the childhood obesity epidemic by 2015. To this end, RWJF seeks to change public policies at all levels, social norms, and local environ-

MANDATING WELLNESS POLICIES FOR CHILDREN

Schools remain critical links for providing healthy environments to children that promote good nutrition, regular physical activity, and the importance of lifelong healthy behaviors. Educational systems cannot be held accountable for changing the level of obesity in a community, but some maintain that they can be held accountable for improving the dietary options and physical activity provided for children through the school system (Wechsler 2009).

The Child Nutrition and Women, Infants, and Children Reauthorization Act of 2004 mandated that public schools develop and implement specific policies to address children's health and wellness needs (Action for Healthy Kids 2004). The act sets goals around nutrition education, physical activity, the types of food and beverages available on campus, and other school-based activities that promote student wellness. These policies affect all school districts participating in the National School Lunch Program or other child nutrition programs such as the School Breakfast Program. During the 2007–2008 school year, the School Lunch Program served over 31 million students; the School Breakfast Program served over 10 million (Chriqui et al. 2009). Though unfunded, the requirements of the act provide an opportunity to focus on improving nutrition and physical activities in schools. The law also ensures that key community stakeholders contribute to decisions regarding the content of local wellness policies. These programs may also boost physical activity levels and improve dietary habits among school employees.

ments in order to make all communities healthier. Special emphasis is being placed on reaching children at greatest risk, including minorities and low-income populations. RWJF supports multiple approaches to meet its 2015 goal. They include providing only healthy foods and beverages to students at school; increasing physical activity at school; increasing the availability of affordable and healthy foods in all communities; improving access to safe places where children can play; and limiting screen time for television and video games (RWJF 2009).

Another approach is The Colorado Health Foundation's recently announced Healthy Schools Investment Strategy. This strategy promotes healthy eating and active living by expanding the number of preschools and public schools that offer health and nutrition education, access to health care services, opportunities for physical activity, and healthy food in vending machines and cafeterias (The Colorado Health Foundation 2009b; Latham 2009). It is designed to help children learn and maintain healthy habits into adulthood. The initiative promotes leadership,

The Robert Wood Johnson Foundation commissioned the Bridging the Gap program to conduct a comprehensive evaluation of the prevalence and strength of school district wellness policies nationwide. This work builds upon larger efforts by the foundation to identify and evaluate policies and environmental factors that affect dietary patterns, physical activity levels, and body mass indices among U.S. children and adolescents. The evaluation establishes a baseline by which to examine and improve these policies. Written policies from districts in 47 of the 48 contiguous states were examined. This review also included a nationally representative sample of 579 districts and 641 districts with wellness policies in place by the first day of the 2006–2007 and 2007–2008 school years, respectively (Chriqui et al. 2009).

By the start of the 2007–2008 school year, most students were enrolled in districts with wellness policies that included implementation plans for the new provisions (Chriqui et al. 2009). Policy quality varied, however, with many underdeveloped and fragmented policies that lacked sufficient implementation and monitoring plans. In addition, most policy strategies did not specify funding sources to facilitate policy implementation. Policies improved during the first two years evaluated. They were still weak overall, however, and did not necessarily oblige schools to take action. Nonetheless, having these policies in place creates the opportunity to improve and expand them to ensure that they ultimately serve children's wellness needs.

“We must make sure vending machines and school lunches offer nutritious choices. We do not want to create an obesogenic environment for our children in schools, thereby making it easier for them to make the unhealthy choices.”

— Howell Wechsler, Centers for Disease Control and Prevention

parental support, and political will for health and wellness. The foundation’s future investments in this strategy will cover a range of areas, including providing professional development, training, and staffing for childcare providers and teachers, and assisting early childhood councils, preschools, and school districts in improving health insurance, access to care, food service programs, and vending options.

With its initial area of emphasis on childhood obesity prevention, Nemours Health and Prevention Services (NHPS) aims to influence long-term changes in policies and practices that promote healthy lifestyles and lead to better health outcomes for children (Chang 2009). Three key strategies have been established to achieve this goal: 1) developing strategic partnerships with organizations that serve large numbers of children, 2) mobilizing knowledge at various levels of the health and social system, and 3) utilizing social marketing campaigns, such as “5-2-1-Almost None,” to raise awareness and mobilize the community and its leaders (NHPS 2008b). Through this work, NHPS is measuring changes in systems and child health outcomes. Over time, this evaluative tracking of processes and performance will ensure efficacy in increasing knowledge and awareness. It will also assist with influencing and ensuring policy and practice changes. Data collected are being used for recommendations on tailoring programmatic efforts toward areas of greatest need (NHPS 2009a).

Childhood obesity reflects an energy imbalance that results when children

consume far more calories than they burn. Responding to this epidemic will require a range of strategies directed at both improving nutrition and increasing physical activity. Most experts advocate a harmonized approach to healthy eating and active living in which the components are addressed in concert. Doing so, however, requires an understanding of the types of strategies that are necessary in each case.

Nutrition

Trends in children and adolescents’ eating habits are alarming. Research indicates that many children’s diets do not meet current dietary recommendations for good health (Story 2009). Fewer than 5 percent of children consume the recommended daily servings from all five of the major food groups (Institute of Medicine 2006). Fewer than 30 percent consume the recommended serving amounts of milk products, and only 20 percent eat five servings of vegetables or fruit a day. Consumption of carbonated beverages has increased, with upwards of a third of adolescents drinking over three servings of soda per day. Consumption of excessive total and saturated fat is a problem for over 80 and 90 percent of children and adolescents, respectively (Institute of Medicine 2006).

Unbalanced eating contributes to lower intake of critical nutrients for growth, reduced cognitive function, and being at increased risk for chronic illnesses. Alternatively, a balanced diet gives children the nutrients necessary for optimal

PROMOTING CHILDREN'S HEALTHY EATING & ACTIVE LIVING:

5-2-1-Almost None

Nemours Health and Prevention Services (NHPS), a regional operating foundation based in Newark, Delaware, works with families and over 200 community partners to ensure that children grow up healthy. It is taking a leading role in efforts to promote understanding of the causes and health implications of obesity, including the best ways to promote healthier lifestyles among children and families. A portion of NHPS' work is being achieved through the "5-2-1-Almost None" healthy lifestyle message (NHPS 2008b). The components of the message indicate that, each day, children should:

- eat at least **five** servings of fruits and vegetables;
- watch **two** or fewer hours of screen time, including televisions, video games, and computers;
- engage in **one** or more hours of physical activity; and
- drink **almost no** sugary beverages such as sodas, sports drinks, and juice drinks that are not 100 percent juice.

"5-2-1-Almost None" is part of a multiyear, statewide social marketing campaign to "Make Delaware's Kids the Healthiest in the Nation" (NHPS 2009b). This campaign focuses on policy and practice changes needed to help children and youth live the "5-2-1-Almost None" healthy lifestyle. It also focuses on providing information, tips, and resources families need to support the lifestyle. To date, campaign accomplishments include over 850 people signed on to the campaign; over 10 million media impressions; several awards and accolades; and numerous "5-2-1-Almost None" print, radio, billboard ads throughout the state (NHPS 2009b).

growth, development, and energy to explore their world. Research linking nutrition to academic achievement indicates that well-nourished children tend to perform better as students. Hungry children and those at risk for hunger are more likely to have impaired functioning, irritability, lower standardized achievement test scores, and difficulty concentrating in comparison to their non-hungry peers (Institute of Medicine 2006). These children also have higher rates of absenteeism, tardiness, and hyperactivity. Even for well-nourished children, omitting a meal such as breakfast can detract from learning.

Children's eating behaviors are strongly influenced by the foods available in their immediate environments. Because of the large proportion of time children spend in schools each day, these environments are responsible for a significant amount of their daily food intake. In many schools, high-calorie, low-nutrition foods and beverages are readily accessible. More than 80 percent of school districts sell these foods via vending machines, à la carte lines, or school stores (Institute of Medicine 2006). Schools may sell non-nutritious products, such as cakes, cookies, and doughnuts, for fundraising purposes. Teachers may use candy or soft drinks as rewards for student accomplishments. Research indicates that nearly half (40 percent) of all schoolchildren consume one or more competitive foods (defined as food available at school that competes with healthy food offerings) in a usual school day (Story 2009). Unhealthy food choices can make participation in meal programs

with more nutritious options less attractive to students and can financially backfire for schools. Consequences may include losing potential revenue derived from federal reimbursement for students participating in the National School Lunch and Breakfast programs.

Progress is being made on improving the nutritional quality of foods available in schools through the expansion of cafeteria and vending machine options to include nutritious meals and snacks. From preschools to high schools, changes in menus and food offerings are steadily occurring. Whole grains and fresh fruits and vegetables are now replacing processed foods and high-fat content items. Findings from the 2006 School Health Policies and Programs Study indicate that 32 percent of states prohibit schools from offering junk food options in vending machines. Additionally, only 25 percent of schools sell cakes, cookies, or other high-fat baked goods in school stores or vending machines. Seventy-three percent of schools responded that they offer salads as an à la carte option.

The use of product/name branding strategies to promote healthier eating is on the rise. Child-oriented licensed cartoon and other "spokes-characters" have historically been used to promote consumption of low-nutrient, energy-dense food and beverage products. Recently, licensed characters have been used to promote foods and beverages that contribute to healthful diets, especially for preschoolers. This is particularly powerful because research indicates that children as young as two or three years of age show awareness

of particular food brands (Institute of Medicine 2007). Preschoolers also demonstrate recognition of particular brands when they are cued by the familiar spokes-characters and colorful packages.

To promote early childhood nutrition, The Kresge Foundation recently provided nearly \$400,000 to the Occidental College Urban and Environmental Policy Institute's Healthy Preschool Food Project. The project seeks to reach preschool children and their families to improve eating habits in early childhood. Pilot projects will be established in preschools and childcare facilities that primarily serve low-income families. Within these settings, demonstrations of the applicability of early childhood nutrition education will occur. In addition, they plan to examine the feasibility of introducing fresh produce into both these settings and the greater community (Occidental College 2009).

Physical Activity

Children's health and quality of life substantially improve when they participate in daily physical activity. Physical inactivity is a major risk factor for conditions such as coronary heart disease and diabetes, as well as being associated with obesity and premature death. Conversely, regular participation in physical activity is linked to reductions in the risk of some diseases; increased emotional and psychological benefits; and a longer, higher-quality lifespan (Bailey 2006). Positive physical activity experiences beginning as

early as the preschool years help lay the foundation for regular activity throughout a person's life. Appropriately structured physical activities contribute to developing "prosocial" behaviors and combating antisocial and criminal behaviors. It is recommended that children engage in at least 60 minutes of age-appropriate physical activity all or most days of the week. During the preschool years, children should practice movement skills in a variety of activities and settings. During this developmental stage, providing instruction and positive reinforcement is critical to ensure that children develop most of these skills before entering school.

For many children, preschools and schools represent the primary environment for physical activity, although, disturbingly, fewer than one in four children get even 30 minutes of regular physical activity per day (Action for Healthy Kids 2004). This activity may occur through in-school physical education and sport programs, unstructured recess, or afterschool activities. Physical activities in these settings generally utilize qualified instructors that teach structured physical activity and lifestyle knowledge and skills to children in safe, supportive environments. Increased physical activity does not interfere with academic achievement, even when the available time for educational activities is reduced (Bailey 2006). In fact, schools offering intense physical activity programs have seen promising effects on academic achievement and performance in areas such as math, reading, and writing test scores (Action for Healthy Kids 2004).

To improve physical activity opportunities in early childhood settings, the BlueCross BlueShield of North Carolina Foundation recently provided funding for the Preventing Obesity by Design initiative that provides training and design assistance to childcare centers in order to enhance outdoor physical activity environments and increase physical activity and nutrition awareness in preschool play areas. Activities supported by the program include: 1) teacher training on the use of the outdoors to promote physical activity and healthy nutrition; 2) participatory design assistance to preschool staff/volunteers to help them modify the outdoors to support children's daily nutritional and physical activity needs; 3) start-up incentives to buy plant materials and tools, and honoraria to support lead teachers to

implement projects; and 4) dissemination of information to ensure transfer of knowledge (Preventing Obesity by Design 2009).

The California Endowment supports efforts to increase physical activity in schools through its Accelerating School Activity Promotion (ASAP), which develops recommendations for improving physical education among California's more disadvantaged schools. ASAP's publications and recommendations are used by stakeholders to promote best practices and policies in school physical education. Strategies have been identified for prioritizing and advancing key policies and cost-effective approaches to school physical activity promotion (The California Endowment 2009).

COORDINATED SCHOOL HEALTH APPROACHES

Schools are pursuing comprehensive, coordinated, and systematic approaches that combine individual health care services with population-based interventions to improve all children's health and well-being. These approaches help systems respond to the complex needs of students, especially those with chronic conditions like asthma and diabetes or those previously diagnosed through early intervention. Potential benefits to students include reductions in absenteeism and medical emergencies, and improvements in alertness, stamina, and academic achievement (Fiscella and Kitzman 2009).

The Coordinated School Health Program (CSHP) of the Centers for Disease Control and Prevention (CDC), established in 1992, provides an organizing framework of school health guidelines, surveillance systems, research application tools, and recommendations for promising practices (Wechsler 2009). CDC provides funding to 22 state and territorial education agencies and tribal governments to assist schools in developing infrastructure and implementing CSHPs. The programs bring together administrators, teachers and other staff, families, and community organizations to assess students' health needs, set priorities, and monitor and evaluate school health activities (CDC 2009). Major issues affecting youth are tackled through CSHPs, including physical activity, nutrition, tobacco use, and sexual behaviors that increase the risk for unintended pregnancy or HIV and other sexually transmitted infections.

Model CSHPs coordinate health related programs, policies, and services to meet K-12 students' health and safety needs at the school district and individual

school building levels. The programs encompass eight key components, including physical education; health education and services; nutrition services; counseling, psychological and social services; promoting school personnel health; encouraging healthy and safe school environments; and involving families and the community (CDC 2009). Combining these elements provides opportunities for synergy and reinforces the strength and importance of each individual component.

Overall benefits of CSHPs for students include improved student performance and test scores, decreased risky behaviors, improved rates of physical activity, and reduced drop out rates and absenteeism (Center for Research Strategies 2009). Schools benefit from these programs through cost savings from reduced duplication of services and education provided to students, improved morale among staff, and improved support for teamwork among teachers.

In central Florida, the Winter Park Health Foundation's Coordinated

Youth Initiative (CYI) is attempting to eliminate barriers to learning and to improve children's academic performance through a comprehensive school-based health and wellness program that cares for the whole child, utilizing school nursing care and mental health service provisions (Watson 2009; Winter Park Health Foundation 2006). The CDC's CSHP model was the inspiration for CYI. Through CYI, the foundation supports licensed nurses and school-based health centers (SBHCs), mental health professionals for the Community Help and Intervention in Life's Lessons (CHILL) program, and healthy school teams (HSTs) at the elementary through high schools levels. HSTs require communitywide involvement of

parents, families, teachers, counselors, school administrators, health care professionals, and other related agencies to ensure children's health. These teams are established at each of the schools in the Winter Park consortium and are tasked with developing programs geared toward promoting good health for students. Recent evaluations of CYI demonstrate its success in reaching target populations. For example, it has provided additional one-on-one and group counseling to students, as well as nearly 36 percent more classroom or whole school educational presentations. Additionally, school nurses made over 1,700 referrals, of which over 60 percent were to physicians or nurses practitioners in the SBHCs supported under CYI (Watson 2009).

SCHOOLS AS ANCHORS FOR COMMUNITY HEALTH PROMOTION ACTIVITIES

Community schools are another approach for uniting schools and communities (Eckstein 2009). Also called “full-service” or “extended service” schools, community schools focus on both the promotion of children’s development and learning and efforts to strengthen the surrounding community. A comprehensive intervention framework combines academic environments with a range of in-house services and supports to achieve a core set of results considered critical to student development and learning (Eckstein 2009; The Children’s Aid Society 2001; Pearson and Shah 2009). Desired outcomes include increases in attendance and graduation rates, narrowing of the achievement gap, reductions in problem behaviors, evidence of family involvement, and changes in the desirability of the neighboring community. In the last decade, community schools have spread to nearly all states and the District of Columbia (UCLA Center for Mental Health in Schools 2009).

The community schools concept can be illustrated using a developmental triangle analogy. The three angles of the triangle represent the core instructional program offered to children, opportunities for educational and cultural enrichment, and services that remove barriers to healthy learning and development (Eckstein 2009). Many schools may have one or two of these components such as an afterschool program or school-based health center. The strength of the model, however, is that each component is deliberately connected to ensure a holistic, multi-sectoral approach to serving children’s needs. Having a full-time coordinator is necessary for seamless operation of this approach. The coordinator is accountable to and collaborates with the school’s staff and administration to ensure the availability and effectiveness of a wide range of programs and services.

Many community schools are making intentional links to early childhood education programs within their communities to improve services for preschool children and their families. For example, early care and education programs are being incorporated into some elementary-level community school buildings. These practices allow a continuum of services to be provided from prekindergarten through elementary grade levels. Young children attending these classes benefit from developmentally appropriate practices geared specifically toward their needs. They build strong school-readiness skills and have access to, and support of, the educators and overall community school program for a longer period (American Educator 2009).

Long-term, highly involved partnerships between schools, parents/families, and community entities enable community schools to serve as hubs for

“This work demands a paradigm shift. We must break down silos between state and federal agencies and localities. To move forward with a full-service community schools agenda, think about it as a strategy and not a program—a strategy for organizing existing and new resources around a set of shared outcomes that schools, health systems, and everyone else has agreed upon for young people and their families.”

— Katherine Eckstein, The Children’s Aid Society

programs and services for the whole community, all day, every day of the week (The Children’s Aid Society 2001). Other programs and services offered in these schools include social services, parent support programs, adult education, and onsite health and mental health services. Programs are tailored to be reflective of the community’s strengths, resources, and ability to meet the needs of children and their families.

Some young people, families, and other community members participate in advocacy training through community schools. This equips them with knowledge about the importance of these programs and skills to effectively make their case to policymakers and funders.

In 2008 the Hartford Foundation for Public Giving committed \$3.1 million over three years to support public-private partnerships to develop community schools in Hartford, Connecticut. These partnerships aim to create a new system of high-quality, high-performing schools to close the urban-suburban achievement gap. Members of the “Hartford Community-School Partnership” include Hartford public schools, the City of Hartford Mayor’s Office, the Office for Young Children, the Office for Youth Services, and the United Way of Central and Northeastern Connecticut. Implementation of the

initiative in five local schools over the next several years will expand the provision of an array of educational, cultural, medical, and social services for the entire family. Nonprofit agencies are receiving grants to coordinate the community schools services with school officials (Hartford Foundation for Public Giving 2008).

Several funders are supporting the Kent School Services Network (KSSN), a community schools initiative in Kent County, Michigan. KSSN was formed over three years ago to provide support and opportunities students need to help them succeed academically. This initiative is demonstrating how integration and coordination at multiple levels can have a positive impact on schools and communities. Nine schools in the Grand Rapids, Comstock Park, and Godfrey Lee school districts were selected as sites for the first phase of the initiative. The multidisciplinary, school-based team leading each KSSN school reflects the assets of its particular neighborhood. These leaders work in partnership to link student and family needs to community resources. Philanthropic support for this initiative comes from the Grand Rapids Community Foundation, Frey Foundation, Steelcase Foundation, Doug and Maria DeVos Foundation, and the Heart of West Michigan United Way (The Children’s Aid Society 2009).

LESSONS LEARNED

Engaging with preschools and schools provides an important entry point for efficiently and effectively providing information and education, as well as delivering health care services, to a large number of children. It also allows opportunities for funders to support a variety of efforts and interventions aimed at improving children's health and development. A number of key themes have emerged based on the research and work funders and other experts have contributed in this area over the years.

No one entity has sole responsibility for promoting and ensuring children's healthy development.

A variety of sectors play a role in children's development and well-being. Beyond the family, they range from schools; to health care providers; to the social services, child welfare, and family and juvenile justice systems (GIH 2008b). The education sector, nonetheless, is the setting outside of the home with the most frequent and sustained interaction with children. It represents a key potential entry point for providing public information and education, highlighting community-building opportunities, and delivering health care services. Change within the education sector must occur across multiple levels and among multiple, diverse stakeholders in order to improve children's health and development outcomes. Under heightened pressure due to the economic downturn, systems continue to struggle to create comprehensive systems that support student development and learning. This provides both the opportunity and incentive to promote cross-sectoral collaborations and leveraging of available resources.

Child health policy will need to be coordinated with education policy to address key factors that contribute to whole-child health and well-being.

In many instances, it may appear as if the health and education sectors are separated by insurmountable differences in "culture," language, rules, funding streams, and methods of operation. Each group, however, is dedicated to improving outcomes for children. This commonality may be the starting point for identifying additional similarities and opportunities to blend missions and practices. Better articulation and understanding of the respective sectors will be required to improve communication and partnership efforts. To prepare children for school as early as possible, further coordination is needed to strengthen linkages between early childhood education providers and school systems. This includes a greater effort to support the development and dissemination of early education and intervention programs.

Funders can play critical roles as trailblazers, conveyors, and collaborators with public and private sector partners working on health and

"Sometimes you can support a great program, but after a year or two, it fizzles apart unless you have built the foundation... unless you have really moved the culture of the school to the point where they accept that promoting health is a fundamental part of their mission."

— Howell Wechsler, Centers for Disease Control and Prevention

education issues. Some of the key areas — within schools and the broader community — that remain to be addressed include:

- supporting needs assessments and planning processes among early care and education providers, as well as primary and secondary schools;
- building capacity among researchers, practitioners, and communities to synthesize and translate research evidence into effective practices across all relevant early education and school domains;
- improving children’s health insurance status and access to health services, including oral and mental health;
- monitoring children’s early childhood outcomes, especially those related to school readiness, mental/behavioral health diagnosis and treatment, and prevention of overweight and obesity;
- addressing reproductive health issues and risky behaviors (such as sexual behavior, substance abuse, exposure to violence), particularly in adolescents;
- combating persistent poverty;
- reducing educational inequities and widening achievement gaps;
- assuring the adequacy of family and community supports; and
- understanding the effects changing family patterns and overall population demographics will have on

provision of education to children in this country.

Ensuring sustainability is another important component in health initiatives geared toward preschools and school systems.

If sustainability issues are not identified and addressed, effective programs may be discontinued once their start-up funding sources end. Programs must be able to raise money effectively or have the ability to develop strategies to convince districts or councils to include health-related programming in their budgets. Bringing new partners to the table contributes to opportunities to leverage existing expertise and resources. The availability of new federal funds dedicated to education provides an important opportunity for rethinking how early childhood providers and school systems carry out their work.

There is greater willingness to support programs when they demonstrate continued success and flourishing partnerships.

The initiatives that enjoy the most success often have evolved over time to fit into programming already in place. These efforts can be supported through provision of technical assistance and other resources to guide educational systems’ planning and implementation processes. Ensuring the long-term success of quality preschool programming and health and education components in schools greatly increases the odds that children receive the resources and support they need to grow into healthy, productive adults with fully maximized potential.

“This isn’t about education alone. We could have the best schools, the best teachers, and the best curriculum in the world. But if children come to us hungry, sick, or from a negative home environment, it will affect their lives. It will affect whether these kids will learn.”

— Daniel Domenech,
American Association of School
Administrators

CONCLUSION

Foundations can become involved in efforts to improve children’s health in pre-school and school settings through numerous avenues. Health funders must be prepared, however, to deal with the intricacies of a complex system. Educational systems operate under varied conditions, including accountability to multiple entities, traditional academic performance expectations, occasionally inadequate resources, and other potentially limiting factors. Nonetheless, they remain just as deeply invested and involved in ensuring the successful and positive development for children in their care.

The challenge of “leaving no child behind” will prove virtually impossible if the myriad health-related factors that directly influence students’ ability to learn are not considered and addressed. Developing and maintaining partnerships between the

health and education sectors will help overcome many challenges. It may foster new models of leadership, will, creativity, and imagination. Engaging in this work, however, will take time and patience.

“We know that schools are a very important player with access and influence on the health of children. We also know that working with schools on health issues can be challenging, very frustrating. But when it works, when it WORKS, it can be just about the most rewarding thing for you personally, but especially for the children we are dedicated to serve.”

— Sharon Adams-Taylor,
American Association of School
Administrators

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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* 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.

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).

