National Collaborative on Education + Health

Health Systems Working Group of the National Collaborative on Education and Health
Report to the National Steering Committee
December 2014

At the inaugural meeting of the National Steering Committee of the National Collaborative on Education and Health, the steering committee determined that given the growing complexity of the health challenges faced by students and the current redesign of the nation's health care delivery system, an important and timely opportunity exists to examine new or revised partnerships relevant to 21st century health and education systems and identify strategies to catalyze cross-sector discussions and model collaborations. The steering committee developed a charge (Attachment A), which called for the creation of a working group to maximize this opportunity. The Health Systems Working Group was formed in response to this charge and the following report highlights the key activities of this working group.

Background

While schools have always been an important center for providing safety net and emergency care for students (such as with school nurses and school-based health clinics) and student health has always been important to learning, the growing complexity of the health challenges faced by our students (from obesity and food insecurity to managing multiple chronic conditions) requires a reexamination of the health-related services and programming available within schools and the ways they are financed.

The timing of this reexamination coincides with the redesign of the health care delivery system, with an emphasis on population health and building partnerships to ensure comprehensive care. New financing arrangements such as accountable care organizations push the health system to think about partnerships with those who can offer comprehensive health services and programming as well as address the social determinants of health, such as academic achievement. As the United States health system goes through these major changes, the partnership between health and education needs to be reexamined and redefined.

Both the education and health sectors stand to benefit significantly from these partnerships. The connection between good health and academic success is both well-established and logical: when physical, mental and emotional health needs are appropriately addressed at home and at school, students are more ready to learn. Ensuring that students are healthy and ready to learn is a key strategy for supporting academic achievement and addressing the achievement gap.

Better integrating the education sector within the health delivery system can also benefit the health sector: with approximately 49 million children attending public schools across the United States, partnering with schools is an incredibly valuable means of reaching vulnerable and underserved children and addressing their complex health needs.

Ultimately, collaborations between the health and education sectors represent an important strategy to ensure that children thrive.

The focus of the Health Systems Working Group was on identifying strategies, resources and model partnerships to promote increased collaboration between the health and education sectors and maximize the opportunities presented by the transforming health system.

Overview of the Health Systems Working Group

The Health Systems Working Group met on August 14 and November 4 in Washington, DC and brought together 28 health and education leaders from across the country representing federal, state and local organizations, government agencies and health systems. (See Attachment B for full list of working group members.) Key objectives of the working group were as follows:

- Catalyze partnerships to implement best practices for increasing access to and financing of school health services through the opportunities presented by the Affordable Care Act and other supportive policies.
- Build broad support for and momentum to work on policy changes needed to increase collaboration between the health and education sectors to increase knowledge of, access to and financing of school health services.

Working group members were encouraged to use the broadest definition possible of school health, with the hope that the working group would emerge with a range of perspectives with which to view school health and school health systems. In thinking about school health, the group was urged to include all health services, including physical, mental, dental, vision and behavioral, and consider services delivered in any school based or linked setting. The group's definition of school health also included a school environment that provides students with access to healthy school food, physical activity, good indoor air, access to water and the other conditions necessary to ensure students are health and ready to learn.

The working group agreed that there is an important opportunity for catalyzing partnerships between the health and education sectors and that these collaborations can advance both sectors' core missions. In order to support these types of collaborations, the working group determined that a need exists for key resources and tools to assist both sectors in recognizing the opportunities for partnerships and understanding the components of an effective partnership. In addition, the working group recognized the importance of identifying policy opportunities at the federal, state and local levels for incentivizing collaborations. As a result, the working group's conversation focused on the following four areas:

- Developing a framework for health system-education collaboration and continuous improvement.
- Outlining a brief to educate the health and education sectors about the opportunities for and benefits of partnering with one another.
- Identifying policy opportunities for the federal, state and local levels to incentivize adoption of options for integrating school-based services into new health delivery systems.
- Building the foundation for a story bank to highlight innovative partnerships between the health and education sectors that have increased access to and financing for school health services.

An overview of each focus area follows.

Framework for Health System-Education Collaboration and Continuous Improvement

A key focus of the working group was identifying the elements of an effective partnership between the health and education sectors and incorporating these elements into a framework that can be disseminated to support continued partnerships.

During the first meeting of the working group, participants heard three case studies highlighting different types of partnerships between the health and education sectors. Based on the case studies and participants' own knowledge of innovative work taking place across the country, the participants identified a number of themes that are common to effective partnerships. Using these common themes, a framework for health system and education collaboration and continuous improvement was created to articulate how collaborations between health and education sectors could emerge and succeed. In an effort to outline a comprehensive approach, the proposed framework details ten elements of an effective health and education partnership. The elements include a needs assessment; data exchange mechanisms; an integrator; demonstrated buy-in from key players; targeted intervention(s); capacity investment; evaluation, training and performance measures; sustainability; scalability; and community engagement. See Attachment C for the full framework titled "Principles for Emerging Collaborations between the Health and Education Systems."

The framework was shared with representatives from the Center for Medicare and Medicaid Innovation (CMMI) and the Center for Medicaid and CHIP Services who participated in the second working group meeting. The representatives expressed an interest in determining how their centers can be active partners in this work and exploring how schools fit in the transforming health care system. The working group's vision is that health and education systems and key federal agencies, such as the Center for Medicaid and CHIP Services and CMMI, will incorporate the framework into their existing and future programs and practices.

Brief on the Opportunity for Collaboration

The working group determined that a key strategy for catalyzing change and supporting collaboration between the health and education sectors is educating both sectors about the opportunities for and benefits of partnership. In order to accomplish this, the working group recommended developing a brief that can be shared with both sectors which details the opportunities for partnership, key stakeholders who should be involved, where to access existing resources and case studies highlighting effective partnerships.

Outlines of two briefs, one for the health sector and one for the education sector were drafted and shared with the working group. Participants recommended having both aspects of this dialogue (teaching the health sector about opportunities in education and teaching the education sector about opportunities in health) in the same document. Moving forward, there is a need to develop a full brief based on these outlines that can be used to guide conversations between the health and education sectors.

The working group also agreed that the brief should frame the opportunity as supporting thriving children rather than supporting solely the health or academic success of children. Supporting thriving children is everyone's responsibility and a growing collaboration between the health and education systems can help to achieve that goal.

In addition, Kitty Dana, Vice President of Health for United Way Worldwide, expressed a strong interest in developing guides, based on the recommendations from the working group, for United Way Worldwide's leaders in order to promote dialogue between the health and education sectors and explore opportunities at the local levels for advancing these collaborations. She indicated that United Way Worldwide has identified five local impact leaders who have the capacity to and interest in piloting these guides.

Policy Opportunities to Promote Increased Collaboration between the Health and Education Sectors

The working group acknowledged that identifying possible policy opportunities and barriers at the local, state and federal levels is an important component of advancing this work and incentivizing adoption of options for integrating school-based services and programming into education and health systems. A policy chart detailing some of the key opportunities was developed to outline a menu of options and actions rather than formulate a particular policy agenda. The policy chart that was shared with the working group is included in Attachment D.

Story Bank Highlighting Effective Health and Education Partnerships

The working group created the foundation for a story bank to highlight innovative partnerships between the health and education sectors that support school health. The goal of this story bank will be to spotlight different types of effective partnerships between the health and education sectors and to share lessons and strategies learned.

The working group recommended that case studies included in the story bank should incorporate the key elements of effective partnerships outlined in the framework document. A number of stories have been identified for inclusion in the story bank, including the three case studies shared at the first meeting and innovative efforts led by working group members. Working group members will continue to identify and share stories for inclusion.

Next Steps: Advancing the Work of the Health Systems Working Group

Members of the working group expressed a strong commitment to using the group's recommendations in their own work and continuing to stay engaged to ensure the working group's outputs, including the framework and brief, are completed, disseminated and integrated into existing programs.

The working group acknowledged that each community will be in a different place in terms of their readiness to develop partnerships between the health and education sectors and that it is critical to provide communities with substantial support in establishing these partnerships. As a result, the goal is to create tools that are broad enough that they can be adapted to meet the needs of any community.

The working group determined it is important to continue to pursue the following goals and activities:

- Encourage the Center for Medicaid and CHIP Services, CMMI and others to invest in school/education partnerships. This could be accomplished by engaging with Center for Medicaid and CHIP Services, CMMI and others around incorporating the working group's framework into their work.
- Educate local communities about the new opportunities for schools and health systems to work together resulting from the transformation of our health care system. This could be accomplished through the United Way Worldwide pilot project and by working with other working group members to develop dialogue guides and pilot projects to engage their members.
- Promote and support communities in expanding partnerships between education and health systems. This could be accomplished by developing a toolkit to support the framework and working with one or two communities to pilot it.

The following proposal for future work has been developed for the steering committee that outlines a plan to advance the work of the Health Systems Working Group:

Proposal to the National Steering Committee for Advancing the Work of the Health Systems Working Group
Catalyzing Partnerships between the Health and Education Sectors

Goal	Activity	Output	Outcome
Encourage the Center for Medicaid and CHIP Services (CMCS), the Center for Medicare and Medicaid Innovation (CMMI) and others to invest in partnerships between health systems and the education sector.	Engage with CMCS, CMMI and others to incorporate the framework developed by the Health Systems Working Group into their work. Explore opportunities for advancing this work through the reauthorization of CHIP.	The development of key messages to engage CMCS, CMMI and others around this issue. Statement of principles that can be incorporated into the reauthorization of CHIP.	An increase in key agencies' understanding of the issue and need to invest in partnerships between health systems and the education sector.
Educate communities about the new opportunities for the health and education sectors to work together to support schools in creating the conditions of student health and wellness.	Develop and implement messaging projects with United Way Worldwide and the Catholic Hospital Association (CHA) and disseminate this information through their networks.	The development of materials that United Way Worldwide impact leaders and CHA constituents can use to support health and education partnerships. The publication of an article in Health Progress. The development of templates for materials and model programs that can be adapted and used by other organizations and communities.	United Way Worldwide and CHA actively engage and educate their constituents about the need for and importance of partnerships between health and education sectors.
Promote and support communities in implementing and expanding partnerships between the health and education sectors.	Develop a toolkit to support implementation of the framework developed by the Health Systems Working Group. Work with one or two communities to pilot the toolkit.	The development of a toolkit to support implementation of the framework. The development of model programs for school-health partnerships.	Local communities implement school-health partnerships.

Attachment A: Charge for the Health Systems Working Group of the National Collaborative on Education and Health

While schools have always been an important center for providing safety net and emergency care for students (e.g., school nurses, school-based health clinics) and having healthy students is important to learning, the growing complexity of the health challenges faced by our students (from obesity and food insecurity to managing multiple chronic conditions) requires a reexamination of the health-related services available within schools and how they are financed. The timing of this reexamination coincides with the redesign of the health care delivery system, with an emphasis on population health and building of partnerships to assure comprehensive care that can include education. New financing arrangements such as accountable care organizations, push the health system to think about partnerships with those who can offer comprehensive health services *as well as address the social determinants of health,* such as academic achievement. As the US health system goes through these major changes, the partnership between health and education needs to be redefined.

The purpose of this working group is to examine the new or revised partnerships that are relevant to 21st century health and education systems and catalyzing cross-sector discussions and model collaborations. The working group should examine opportunities to improve the health and safety of students such as:

- Options for integrating school-based services (from direct health services to physical activity and healthy eating) into new health delivery systems such as, but not limited to, accountable care organizations, community health homes, insurance plans, or State Innovation Models – and how to finance them in a sustainable way.
- Tapping a growing interest by some health systems in addressing the physical, mental and social needs of complex patients through linkages between health systems and community entities, such as schools.
- Linking non-profit hospital community benefit investments and bank community reinvestment efforts with promoting healthier and stronger schools.

The working group would identify a menu of options that can be adapted at the local level, based on local capacity and need. The working group would also identify federal, state and local policy changes that would incentivize adoption of these options.

Attachment B: List of Health Systems Working Group Members

CO-CHAIRS OF THE NATIONAL STEERING COMMITTEE

Rochelle Davis
President and CEO
Healthy Schools Campaign

Jeff Levi
Executive Director, Trust for America's Health
Chair, Prevention Advisory Group

FACILITATOR OF THE HEALTH SYSTEMS WORKING GROUP

Abby Dilley
Vice President of Program Development
RESOLVE

MEMBERS OF THE HEALTH SYSTEMS WORKING GROUP

Carol Backstrom
Program Director
National Governors Association

Stacey Barbas
Senior Program Officer
The Kresge Foundation

Jim Bender
Executive Director
NEA Health Information Network

Marty Blank
President
Institute for Educational Leadership

Ellen Braff-Guajardo
Program Officer
W.K. Kellogg Foundation

Joaquin Tamayo
Special Assistant
U.S. Department of Education

Maureen Byrnes
Lead Research Scientist
George Washington University

David Cicccone
Senior Impact Director
United Way of Central Ohio

Joe Damore
Vice President of Engagement and Delivery
Premier

Kitty Dana
Vice President of Health
United Way Worldwide

Carolyn Duff
President
National Association of School Nurses

Michael Farrell
President
Advocate Children's Hospital

Wayne Giles
Director of the Division of Population Health
Centers for Disease Control and Prevention

Peter Gorski
Chief Health and Child Development Officer
The Children's Trust

Kayla Jackson
Project Director - Coordinated School Health
AASA

Deborah Kilstein
VP of Quality Management and Operational Support
Association for Community Affiliated Plans

Sarah Linde
Chief Public Health Officer
HHS – Health Resources and Services Administration

Whitney Meagher
Project Director
National Association of State Boards of Education

Kathleen Nolan
Director of State Programs
National Association of Medicaid Directors

Naomi Post
Programme Executive
Atlantic Philanthropies

Chelsea Prax
Senior Associate
American Federation of Teachers

Christopher Revere
Director, Office of Child Health Policy
and Advocacy
Nemours

John Schlitt
Interim President
School Based Health Alliance

Loel Solomon
Vice President, Community Health
Kaiser Permanente

Julie Trocchio
Senior Director, Community Benefit and
Continuing Care
Catholic Health Association

Jeanee Weiss
CEO
Building Healthy Futures

Attachment C: Principles for Emerging Collaborations between the Health and Education Systems

Overview

Attending to the physical, social, and emotional health of students is now a shared value of the education and health systems. Education leaders must think about the well-being of all people on a school's campus—students as well as teachers, administrators and staff—to create the larger culture of health that has been demonstrated to improve academic achievement.

The health care system is undergoing a major transformation that promotes an emphasis on rewarding better health, not just volume of care. Passage and implementation of the Affordable Care Act (ACA) represents just one of the new opportunities for collaboration between the health system and education system. Indeed, as health reform pushes the health care sector to think in terms of population health—and as the education sector increasingly focuses on the "whole child" —the need for a strong partnership between health and education has become more apparent.

Further, as the financial imperatives of the health system change, with a new focus on outcomes rather than volume, the possibilities for more and/or different partnerships between the two sectors increase significantly. While examples of strong collaboration between health systems and the education system already exist, there have been challenges with bringing them to scale. Many of these have yet to be tested or sustained in the new financing and structural environment created by the Affordable Care Act. In a sense, this framework can be seen as outlining possibilities for the next generation of health system and education system collaboration.

Collaboration between the education and health systems can occur at various levels: between an individual school and a hospital; between a local school district and a health plan; and at the state and federal levels, where education and health departments come together to create policy and systems change. In short, what follows is meant to be a framework for the various types of collaboration that could occur. It is expressed in comprehensive terms, but different elements can be used to foster initial, more focused efforts.

Key Elements of the Framework

New approaches to collaboration between a health system and education system, with the goal of addressing health issues that impact both the health of children and their academic performance, should have most, if not all of, the following elements.

1. **Needs assessment and implementation strategy**: A needs assessment is a systematic process for determining and addressing needs or gaps in a community. What key problems rise to the top—and how can they be expressed in a way that is meaningful to both sectors? The needs assessment should reflect the co-benefits of collaboration and articulate needs in language meaningful to each sector. It should be noted that all non-profit hospitals are now required by the ACA to do regular Community Health Needs Assessments (CHNAs). Hospitals should be encouraged to engage their local school district(s) in the CHNA process; and any health-education collaboration could well start with the CHNA that has been developed (either by the local hospitals or by the local health department). That said, school-related needs may well go beyond a hospital's or health department's CHNA and so this should only be the starting point of the assessment. Broadly speaking, the assessment should focus

not just on school-specific needs, but the larger context of the social determinants of health experienced by those in the education system.

A needs assessment alone is necessary, but insufficient. A strong implementation plan that clearly identifies the strategies that can be undertaken—jointly or in parallel—to address the needs articulated in the assessment should be developed. Clear delineation of responsibility and performance measures should be built into the implementation plan.

2. **Data exchange mechanisms**: Access to and exchange of health and education data will be critical to a needs assessment and ongoing monitoring and evaluation of any project. Collaboration between the health and education systems (both at the systems level and for the individual child) requires a mutual understanding of the needs of the health system and the education system. In other words, data sharing should be bidirectional. While this may well raise issues associated with FERPA and HIPAA, a growing number of school and health systems have found ways to share data in limited capacities that are compliant with these privacy requirements. Solving these challenges is critical to health care systems achieving their quality goals and schools systems understanding the needs and challenges faced by their students.

3. **Integrator**: A lead organization should be identified as the backbone organization for this effort. This organization should be perceived as a credible convener (i.e., works with all parties evenly and fairly) and able to keep the process moving, even if that organization is also a player in the intervention. This is more than a ministerial function; it requires true leadership capacity.

4. **Demonstrated buy-in from key players**: This element should be more meaningful than letters of agreement and should include some demonstrated experience working together, even if at a more modest level. There can be two levels of effort: capacity/planning building (where experience is gained working together) and implementation (where an initiative is actually under way).

5. **Targeted intervention(s)**: Boundaries should be set for the scope of the project so the goals are meaningful and achievable in a reasonable time frame and are clearly based on addressing gaps found in the prior needs assessment. Innovation needs to be balanced with respect for existing roles, and assisting players in adapting to a new environment and taking on new roles. A variety of interventions could be considered based on a needs assessment and the stage of commitment among the stakeholders in the collaborative process. Short-term "wins" that focus on a high-need/high-return intervention may help cement the collaborative relationship, while other investments that focus on building a broader culture of health will have longer timeframes for seeing results. Evaluation (see below) should be *built into* the design of the interventions. It should also be noted that a variety of interventions may be considered: from programmatic interventions that affect individuals or entire populations to policy changes that can have long-term impact on the health of those in the education system.

6. **Capacity investment**: There needs to be a willingness to help create the infrastructure that is needed to collaborate in new ways. Just one example would be creating health IT capacity for school nurses and/or school-based health centers.

7. **Evaluation, training, continuous improvement and performance measures**: These should be used to assess the overall impact of an initiative *as well as* to permit continuous quality improvement. (Indeed, the primary goal of these efforts will be to *learn* what works—and what doesn't work—in education-health collaborations.) Demonstrations that do not adapt to experience are more likely to

fail. Also, as the clinical science and the surrounding health system change, so must interventions. These measures need to be of value to both the education and the health systems. As part of the evaluation, there should be clarity about performance measures (including outcome measures, interim process measures, and timeframe for each).

8. **Sustainability**: Sustainability for the new collaboration is critical. One goal of any project should be to identify ways to assure sustainable funding for the new approach, particularly integrating the approach into existing education or health payment models. But sustainability must go beyond financing to include how successful projects are built into the culture of the education and health systems going forward.

9. **Scalability**: No project should be undertaken unless there is sufficient investment in evaluation and replicability assessment, so that those who wish to bring this effort to scale will know how best to do so.

10. **Community engagement**: Collaborations of this nature will only succeed if the communities that are being engaged—health providers, health systems, teachers, administrators, staff, parents, and students—are empowered. Building a culture of health is founded on this kind of engagement; the changes that are needed cannot be imposed on any one system by another.

The Way Forward

While each of the elements described here would be necessary for a *comprehensive* approach (whether in the context of a special Center for Medicare and Medicaid Innovation initiative, a philanthropy based demonstration, or some other kind of demonstration), narrower collaborations might not require each element. In addition, there could be an incremental approach to this kind of collaboration—starting with capacity building (e.g., doing a needs assessment, identifying an integrator, establishing early relationships) and moving later to implementation. Whether the approach is comprehensive, narrow or incremental, there may be elements that are central to *any* collaboration. But the bottom line is: creating a system where children are able to thrive is everyone's responsibility, and a growing collaboration between the health and education systems should help to achieve that goal.

Attachment D: Policy Opportunities for Promoting Collaboration between Health and Education Sectors to Support School Health

Policy Lever	What is it?	What could be done?
CONGRESS		
CHIP Reauthorization	The Children's Health Insurance Program (CHIP) provides health coverage to nearly eight million children in families with incomes too high to qualify for Medicaid. The Affordable Care Act (ACA) extended funding for CHIP through October 1, 2015, and Congress is currently debating whether and how to extend the program beyond FY2015.	Extend the *Pediatric Accountable Care Organization Demonstration Project*, which was created through the ACA and calls for participating state Medicaid programs to allow pediatric medical providers to form and Accountable Care Organization (ACO). The demonstration project encourages efficient health delivery models beyond a physician's office, such as a school. School health providers should be listed as an example of pediatric medical providers.
Elementary and Secondary Education Act (ESEA) – Title 1	Title I of ESEA is intended to provide education funding to states and school districts with high concentrations of low-income and disadvantaged students. Federal funds are currently allocated through four statutory formulas that are based primarily on census poverty estimates and the cost of education in each state. Congress is currently debating whether and how to reauthorize ESEA.	Through the reauthorization of ESEA, Title 1 schools should be allowed to use Title 1 funding to support the delivery of school health services and programming.
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS)		
Center for Medicare and Medicaid Innovation (CMMI)	CMMI was established by the ACA to develop and test innovative health care payment and service delivery system models.	1. CMMI should integrate the health-system and education framework developed by the Health Systems Working Group into a number of its programs and funding streams, including the health care innovation awards. 2. CMMI should develop and provide technical assistance to states with State Innovation Model funding (see below) that highlights

Policy Lever	What is it?	What could be done?
		the role the education sector can play in meeting the goals of the ACA and incentivize partnerships between local health systems and education.
Free Care Rule	The "free care rule" – a policy that, though in wide practice, is unsupported by statute – states that Medicaid will not pay for services that are offered to the general public for free. Its application has created difficulties in seeking Medicaid reimbursement for the services of school nurses because nurses typically serve the entire school community without charging individual students.	The Centers for Medicare and Medicaid Services (CMS) should issue guidance to states to clarify that school districts may receive Medicaid reimbursement for health services provided by a school nurse to Medicaid-enrolled students. The guidance should take the form of either a State Medicaid Director Letter or revisions to the 2003 Medicaid School and Administrative Claiming Guide.
Patient Centered Medical Homes	A patient-centered medical home (PCMH) is a model of primary care that is "patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety." The ACA embraces the medical home concept in the "Medicaid health home" (see state policy discussion below), but PCMH models exist in the private sector as well. In addition to defining PCMH, HHS' Agency for Healthcare Research and Quality (AHRQ) offers many resources on PCMHs.	1. AHRQ should recognize schools and school based health centers as a member of the provider infrastructure that makes up a PCMH health team. 2. AHRQ should share resources and briefs highlighting the important role schools can play in providing comprehensive, continuous care to children. 3. CMS could waive provisions of Medicaid law that would present obstacles to schools participating in Medicaid health homes, including the free care rule and third party liability restrictions. CMS has the authority to do this within health homes.
Prevention and Public Health Fund	The ACA established the Prevention and Public Health Fund to provide expanded and sustained national investments in prevention and public health, to improve health outcomes, and to enhance health care quality. To date, the Fund has invested in a broad range of evidence-based	The Chronic Disease Center at CDC, which oversees a series of community-based prevention programs, should more systematically urge community prevention coalitions to include the education community and provide tools and guidance for how these programs can work with schools.

Policy Lever	What is it?	What could be done?
	activities including community and clinical prevention initiatives; research, surveillance and tracking; public health infrastructure; immunizations and screenings; and public health workforce and training.	
U.S. DEPARTMENT OF EDUCATION (ED)		
Office of Safe and Healthy Students (OSHS)	OSHS is the only office within ED with a mission to address health-related issues among students. This office focuses primarily on drug and violence prevention activities and on specific programs such as the Carol M. White Physical Education Program (PEP).	1. ED should expand the mandate of OSHS to increase the office's capacity to support schools in addressing the vast prevalence of growing health issues, including chronic disease management and prevention and lack of access to health services. 2. ED should appoint a Deputy Assistant Secretary to OSHS to provide strategic leadership to ED on integrating health and wellness into education policy and practice.
School Improvement Grants (SIG)	SIG is a $5 billion program to provide funding to help local educational agencies address the needs of schools in improvement, corrective action, and restructuring to improve student achievement.	1. ED should encourage SIG grantees to use funding to support school health services and programming as a strategy for improving student achievement. 2. ED should provide grantees with technical assistance that highlights the connection between health and learning and offers best practices for partnering with the health sector to meet student health needs.
INTERNAL REVENUE SERVICE (IRS)		
Non Profit Hospital Community Benefit Requirements	To maintain their tax-exempt status, non-profit hospitals are required to provide measurable benefits to the communities they serve. These new requirements push hospital community	The IRS should issue guidance that requires consideration of schools and education as part of the CHNA process and highlights school health services and programming as an eligible use of community benefit resources. This guidance should encourage non-profit

Policy Lever	What is it?	What could be done?
	benefit activities beyond simply providing charity care to uninsured residents. One starting point is the requirement that all hospitals do community health needs assessments (CHNAs). These drive the decisions about where to invest.	hospitals to implement school-based strategies to meet their community's needs and consider programming that goes beyond direct health care and addresses issues such as nutrition education, safety and physical activity.
STATE POLICY		
Accountable Care Organizations	An ACO is a network of doctors and hospitals that shares responsibility for providing coordinated care to patients with the goal of limiting unnecessary spending. ACOs give a financial incentive to providers to manage patient care beyond the physician's office: generally, in an ACO model, providers share in any savings that accrue because of their coordination efforts.	1. As states create comprehensive plans for ACOs, they should include representatives from the education sector in the planning and implementation processes that take place. 2. States should encourage local ACOs to partner with community providers, such as schools, and include them in their delivery and financing models.
CMMI State Innovation Models Initiative	The State Innovation Models (SIM) Initiative, funded by CMMI, provides funding to 21 states to support the development and testing of state-based models for multi-payer payment and health care delivery system transformation.	States should integrate school services and programming in their State Health Care Innovation Plans. As SIM projects develop, and as additional states are awarded funding through this initiative, the education sector has an opportunity to become integrated into emerging state-wide models of care.
Increased Access to Community-Based Preventive Services under Medicaid	Under a regulation released in July 2013, Medicaid will now reimburse for preventive services "*recommended by* a physician or other licensed health professional." Previously, Medicaid would only reimburse for preventive services that were actually *provided by* a physician or other licensed health professional.	States must choose to implement this new flexibility. Once a state makes this change, state Medicaid programs will be able to cover numerous interventions in school settings carried out by non-clinical school personnel. The new rule will be especially important in school districts that employ health care aides, asthma educators and other community health workers. Once adopted, states should also provide guidance on the new regulation and encourage school-based providers to seek reimbursement.

Policy Lever	What is it?	What could be done?
Medicaid Health Homes	The ACA introduced a new state Medicaid option to allow individuals with two or more chronic conditions to seek care through a health home. A health home is a provider or team of providers responsible for delivering or arranging for all patient care, as well as a set of "health home services." States have flexibility in determining the range of eligible types of health home providers and treatment settings.	States should specifically designate schools and school based health centers as a member of the provider infrastructure that makes up a health team under the Medicaid medical home model. To date, Missouri is the only state that does this.
LOCAL POLICY		
Accountable Care Organizations	ACOs are established at the local level and may encourage innovative local organizations to experiment with delivering care in various community settings, including schools.	Local ACOs should include school health providers in their service delivery and financing models. For example, in Oregon, a pilot project is taking place where school nurses are partnering with a local ACO to reduce the total cost of care and achieve their goals.
Non Profit Hospital Community Benefit Requirement	While community benefit relationships are overseen at the federal level (described above), they are implemented at the local level and provide important opportunities for collaboration between the health and education sectors.	1. Non-profit hospitals should engage the education sector in the CHNA process. 2. Non-profit hospitals should include school-based activities in their implementation strategies and consider programming that goes beyond direct health care. For example, a hospital may invest community benefit resources toward enhancing capacity at nearby schools to address obesity prevention through supporting physical activity programs.