

TEN PRINCIPLES FOR COLLABORATION

Health and Education Systems

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Under the Affordable Care Act, 2015 brings nonprofit hospitals to the next round of Community Health Needs Assessments. This is a moment of exceptional opportunity for health systems and education systems to collaborate and advance their core missions.

We know schools long have been important centers for providing safety net and emergency health care for students — think school nurses and school-based health clinics. We also know student health and nutrition are important to learning. However, the growing complexity of the health challenges our students face — from obesity and food insecurity to managing multiple chronic conditions — requires us to re-examine both the health-related services and programming available within schools and the ways they are financed.

At the same time, the U.S. health care delivery system is going through a redesign, one that emphasizes population health and building partnerships to ensure comprehensive care. Also, new financing arrangements — such as accountable care organizations — push health systems to think about partnerships with others who can offer comprehensive health services and programming as well as help address the social determinants of health. Both the education and health sectors stand to benefit significantly from such partnerships, and it makes sense to redefine them now, in

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the context of community health.

The critical 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 achievement gaps, that is, persistent disparities in academic performance between groups of students.

Better integrating the education sector within the health delivery system also can benefit the health sector. With more than 50 million children attending elementary and secondary schools across the United States, partnering with schools is a valuable means of reaching vulnerable and underserved children and addressing their complex health needs.

THE OPPORTUNITY FOR HOSPITALS

Nonprofit hospitals can play a key role in driving collaborations between the health and education sectors, whether it is as a part of their community benefit program or as a part of their overall strategy to ensure children are receiving comprehensive and coordinated care.

There are many ways for hospitals and schools to work together on meeting the health needs of their community. Collaborations can support the delivery of health services, including hearing and vision screenings, immunizations and chronic disease management, and behavioral health services for both students and staff. In addition, hospitals and schools can collaborate to increase access to nutrition education, physical activity and healthy indoor environments, among other health programs.

The National Collaborative on Education and Health, a multisector, public-private partnership, has developed a set of principles that can serve as a framework for effective health-education collaborations. The principles were developed with input from 28 health and education leaders who reviewed existing partnerships to identify best practices and combine their findings with their own knowledge of innovative work taking place across the country. They determined that collaborations between hospitals and education systems should have most, if not all, of the following elements:

1 Needs assessment and implementation strategy. Health care organizations should be encouraged to engage their local school district(s) in the CHNA. The needs assessment should reflect the co-benefits of collaboration as well as articulate needs in language meaningful to each sector. Next, a strong implementation plan should be developed to clearly identify the collaborators' joint or parallel strategies to address the needs and clearly delineate responsibility and performance measures.

2 Data exchange mechanisms. Access to and exchange of health and education data will be critical to any project's success. Collaboration between the health and education systems, both at the systems level and for the individual child, requires understanding what each system needs. In other words, data sharing should go both ways. Regarding privacy issues and the Family Educational Rights and Privacy Act and Health Insurance Portability and Privacy Act, a growing number of school and health systems have found ways to share data in limited capacities that are compliant with the federal privacy requirements. Solving such challenges is critical to health care systems achieving their quality goals and schools systems understanding the needs and challenges their students face.

3 "Integrator." Identify one organization as the leader or backbone for the effort. This organization should be perceived as working with all parties evenly and fairly and able to keep the process moving. It requires true leadership capacity.

4 Demonstrated buy-in from key players. Letters of agreement aren't enough; some demon-

strated experience working together, even if at a more modest level, is much better. There can be two levels of effort: capacity-building and planning, during which the organizations gain experience by working together, and during implementation, when an initiative is under way.

5 Targets. Set boundaries for the project's scope, and build evaluation measures into the design. The goals should be meaningful, achievable within a reasonable time frame and clearly based on addressing gaps found in the needs assessment. Balance innovation with respect for existing roles and assisting players in adapting to a new environment and in taking on new roles. The needs assessment and the stage of commitment among the collaborative stakeholders generally present a variety of possible undertakings. Short-term "wins" that focus on high-need and high-return projects may help cement the collaborative relationship, while other projects that focus on building a broader culture of health will require longer time frames for seeing results.

6 Capacity investment. The partners need to be willing to help create the infrastructure necessary for collaborating in new ways. Just one example would be creating health information technology for school nurses and 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. The interventions and performance 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 the time frame for each.

8 Sustainability. One critical goal of any project should be to identify ways to assure sus-

tainable 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 succeed only 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.

While each of the elements described here would be necessary for a comprehensive approach, narrower collaborations might not require every one. In addition, there could be an incremental approach — starting with capacity building (that is, doing a needs assessment, identifying an integrator, establishing early relationships and moving later to implementation).

Creating a system in which children are able to thrive is everyone’s responsibility, and a growing collaboration between the health and education systems can help to achieve it. Hospitals not only can play a key role in driving these collaborations, they can help underscore the integral role schools can play in meeting community health needs.

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A Shared Statement of Identity for the Catholic Health Ministry

We are the people of Catholic health care, a ministry of the church continuing Jesus’ mission of love and healing today. As provider, employer, advocate, citizen — bringing together people of diverse faiths and backgrounds — our ministry is an enduring sign of health care rooted in our belief that every person is a treasure, every life a sacred gift, every human being a unity of body, mind, and spirit.

We work to bring alive the Gospel vision of justice and peace. We answer God’s call to foster healing, act with compassion, and promote wellness for all persons and communities, with special attention to our neighbors who are poor, underserved, and most vulnerable. By our service, we strive to transform hurt into hope.

AS THE CHURCH’S MINISTRY OF HEALTH CARE, WE COMMIT TO:

- + Promote and Defend Human Dignity
- + Attend to the Whole Person
- + Care for Poor and Vulnerable Persons
- + Promote the Common Good
- + Act on Behalf of Justice
- + Steward Resources
- + Act in Communion with the Church

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