

Opportunities for School and Hospital Partnership in the Management of Chronic Health Conditions

An Issue Brief for Health Departments that Integrates Community Health
Needs Assessment Requirements for Non-profit Hospitals Under the
Affordable Care Act, Medicaid Initiatives, and Additional Opportunities



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INTRODUCTION

Chronic health conditions and diseases are common, costly and often preventable,¹ and central features of health care reform are directed at their management in improving public health. Chronic health conditions can be physical, developmental, behavioral or emotional conditions that last for a prolonged time period, require more than routine health services, and affect usual childhood activities.^{2, 3, 4} Schools are experiencing increased numbers of children with chronic health conditions such as asthma, diabetes, food allergies, and seizure disorders with increased levels of need. While students with chronic health conditions can be medically approved to attend school, their disease and treatment may require extensive daily management by health care professionals, primarily registered school nurses, during the school day and at times emergency response.

Schools have a key role in implementing approaches to support students with chronic health conditions, but not without significant limitations and barriers. Hospitals are experiencing their own challenges, and they are particularly affected by major changes in health care delivery and financing such as a shift from fee-for-service to value-based payment systems and demands for operational efficiency. Schools and hospitals share responsibility in the management of chronic health conditions for children even if they are on different continuums, and there are transformations in health care that call for their partnership in improving health and education outcomes. A strengthened partnership can also reduce duplication of effort when it exists.

Federal and national efforts are enhancing the integration of health care and public health in partnership with other sectors. The Triple Aim, a framework developed by the Institute for Healthcare Improvement to optimize health system performance, pursues three dimensions: 1) improving individual experience of care, 2) improving population health, and 3) reducing health care cost. This model established a unifying approach stating, “For the health of our communities, for the health of our school systems, and for the health of all our patients, we need to address all three of the Triple Aim dimensions at the same

time.”^{a, 5} The National Quality Strategy led by the Agency for Healthcare Research and Quality focuses on six priorities to advance aims and improve health and health care quality.^b The Patient Protection and Affordable Care Act (2010), known as the Affordable Care Act (ACA), is a significant driving force, along with Medicaid initiatives through the Centers for Medicare & Medicaid Services (CMS).^c One particular area of opportunity for schools and hospitals under ACA is the Community Health Needs Assessment (CHNA) requirements that can harness the capacity and resources within a community to affect change aligned with health needs. These efforts and others, such as Healthy People 2020 with its inclusion of the social determinants of health, are encouraging hospitals to expand their work in population health to address the health of those they medically serve and the community.^d

The purpose of this issue brief is to help inform and strengthen school and hospital partnership including CHNA engagement related to the management of chronic health conditions in schools. It is directed to state health departments with a focus on school health and nursing services, and to state education departments as essential collaborative partners, particularly when oversight of school health and nursing services falls under their purview. The information presented in this brief is based on a review of relevant federal and national resources and key informant interviews with stakeholders at the national, state, and local levels. The brief highlights examples of school and hospital partnership in improving children’s health, along with the ways state and local health departments intersect

a The three dimensions of the Triple Aim: “Improving the patient experience of care (including quality and satisfaction); Improving the health of populations, and Reducing the per capita cost of health care.” <http://www.ihi.org/engage/initiatives/tripleaim/pages/default.aspx>

b The National Quality Strategy focuses on six priorities that address most common health concerns and can guide improvements to health and health care quality and nine levers stakeholders can use to align activities with the National Quality Strategy. <http://www.ahrq.gov/workingforquality/about.htm#priorities>

c The Patient Protection and Affordable Care Act (Public Law 111-148) is a Federal law “...to increase the number of Americans covered by health insurance and decrease the cost of health care.” <http://www.hhs.gov/healthcare/about-the-law/read-the-law/index.html>

d Healthy People 2020, developed by the US Department of Health and Human Services in partnership with extensive stakeholders, sets the nation’s 10-year goals and objectives for health promotion and disease prevention. <http://www.healthypeople.gov>

and support their collaboration. In addition, it features opportunities through Medicaid, including models of care that can expand work between schools and hospitals. It culminates in approaches state health departments can consider as they move forward in this area.

WHY IS SCHOOL AND HOSPITAL PARTNERSHIP IMPORTANT IN THE MANAGEMENT OF CHRONIC HEALTH CONDITIONS?

Management of Chronic Health Conditions in Schools

There are millions of children living with a diagnosis of a chronic health condition, and many of these children who are in school require management during the school day. Data from the National Survey of Children's Health indicates that an estimated 15.9% and 17.5% of children ages 6-11 and 12-17 years old have at least one chronic health condition, respectively.⁶ Students with chronic health conditions include medically complex children, as advances in medicine and technology have led to higher childhood survival rates and increased capacity for these children to attend school with outpatient support.^{7,8} According to the Children's Hospital Association, there are an estimated three million medically complex children classified by a Clinical Risk Group that have significant chronic health conditions in two or more body systems or a single dominant chronic condition.^{e,9} Most of these children are enrolled in Medicaid or the Children's Health Insurance Program (CHIP), and although they account for 6% of all children covered by Medicaid, they represent 40% of Medicaid spending for this

group.^{9,10} While children's hospitals care for most of these children during times of medical need, they participate in school to the extent they are able and school engagement is important to their overall quality of life.

Students with chronic health conditions can have high acuity and need multiple interventions.^f For example, they may require prescription medication, assistive technology devices, and procedures to safely manage their condition at school. In addition to physical health needs, those with chronic health conditions frequently need social, emotional, and mental health support and assistance to cope with the stress of illness.^{4,11} Policies such as the Individuals with Disabilities Education Improvement Act of 2004 protect students' access to education, and Section 504 plans, Individualized Healthcare Plans, and Emergency Care Plans help in the management of their care at school.^g However, there are vast areas for improvement regarding the capacity of schools in the management of chronic health conditions and how schools implement policies and practices to meet whole needs of these students. Adverse symptoms or a need for medical treatment during the school day can keep students from attending school if chronic health conditions are not managed well or an exacerbation occurs due to the nature of disease. Prolonged school absence reduces students' opportunities to learn and potentially increases the burden of living with disease.

It is well recognized that school nurses are leaders in the delivery of school health services and have a significant role in the management of chronic health conditions for students, including the implementation of supportive policies, procedures and individual care plans.^{12,13} As stated by the National Association

^f Definitions for acuity vary. Acuity is generally the level of severity and anticipated need of an illness and can be used as a parameter to guide nursing staff decisions, budget projections and other areas in health care delivery. <http://medical-dictionary.thefreedictionary.com/acuity>

^g The Individuals with Disabilities Education Improvement Act is a reauthorization of the Individuals with Disabilities Education Act originally enacted in 1975, <http://idea.ed.gov>

^h Individualized Healthcare Plans, as described in this position statement of the National Association of School Nurses, and other individual plans, <https://www.nasn.org/PolicyAdvocacy/PositionPapersandReports/NASNPositionStatementsFullView/tabid/462/ArticleId/32/Individualized-Healthcare-Plans-IHP-Revised-2008>

^e Medically complex children are those living with conditions defined by Clinical Risk Group (CRG) categories 5-9: Lifelong Chronic (e.g., type 1 diabetes), Complex Chronic (e.g., diabetes), and Malignancies. Asthma and depression fall under Episodic Chronic through CRG classification. https://www.childrenshospitals.org/~media/Files/CHA/Main/Issues_and_Advocacy/Key_Issues/Children_With_Medical_Complexity/Fact_Sheets/Defining_Children_With_Medical_Complexities_100113.pdf

of School Nurses (NASN), "...the school nurse coordinates student health care between the medical home, family, and school."¹³ According to a NASN position statement, "...daily access to a registered professional school nurse can significantly improve students' health, safety, and abilities to learn." It also recommends that "...school nurse workloads should be determined at least annually, using student and community specific health data" and "...a one-size-fits-all workload determination is inadequate to fill the increasingly complex health needs of students and school communities." The acuity of students and factors such as integration of the social determinants of health and health equity issues weigh into the decisions to determine adequate nurse staffing.¹⁴ The American Academy of Pediatrics issued a policy statement for optimal staffing in schools that recommends one full-time nurse in every school and school physician medical oversight at the school district level.¹⁵ Importantly, not all schools are equipped with appropriate levels of school nursing staff positions or health services personnel who are qualified and trained to meet the pervasive and growing needs.

Hospitals and their affiliated health professionals, including primary care providers, in addition to other community medical care providers play a strong role in these children's lives. Students with chronic health conditions experience fragmentation in health care, and they interface with multiple providers and supports and may not have an identified primary care provider or a medical home.ⁱ It is costly and inefficient when children with manageable chronic health conditions have health-related exacerbations that require care through urgent use of emergency departments, inpatient hospitalization, and/or readmission following hospital discharge. To that end, partnership between schools and hospitals can respond to the transformations in health care today and improvement efforts unified by the Triple Aim as well as National Quality Strategy aims and priorities to improve health and health care quality. Promoting care coordination as a priority example is imperative to the effective management of chronic

i The medical home concept is "...a cultivated partnership between the patient, family, and primary provider in cooperation with specialists and support from the community." One of the criteria is to determine if a child has a physician (e.g., primary care provider) or nurse who knows the child well and is a usual source for health care. <http://www.hrsa.gov/healthit/toolbox/Childrenstoolbox/BuildingMedicalHome/whyimportant.html>

health conditions and can improve outcomes among patients, providers and healthcare payers.^{j, k, 16}

School and Hospital Partnership in Improving the Management of Chronic Health Conditions in Schools

Schools and hospitals can be strong partners in improving children's health, including the management of chronic health conditions. According to survey data from the Children's Hospital Association, a total of 51% of children's hospitals report they have a formal partnership with early childhood education and/or schools and more than 35% have an informal partnership.¹⁷ Additional data related to hospitals' partnership with community organizations collected by the American Hospital Association and the Association for Community Health Improvement supports that primary and secondary schools are hospitals' primary partners (78% of 1,198 hospitals), and that they work with schools primarily for obesity and prevention and screening services.^{18, 19}

Fostering their partnership is a strategy to more effectively achieve integrated service delivery in the management of care for students with chronic health conditions.^l Schools and hospitals can enhance their coordination and provision of services and do so in ways that aim to alleviate the difficulties parents and families experience in managing the care between them. The partnership can also provide an opportunity to supplement school health services including school nursing capacity.

j Care coordination involves "...deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care." <http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/index.html>

k Promoting effective communication and coordination of care is one of the six national priorities identified by the National Quality Strategy to improve health and health care quality. <http://www.ahrq.gov/workingforquality/about.htm>

l Integrated service delivery as defined by the World Health Organization is "The management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system." http://www.who.int/healthsystems/service_delivery_techbrief1.pdf

Ways in which schools and hospitals partner include but are not limited to the following:

- ▶ **School nurse and physician staffing and provision of health care services** in schools and school-based health clinics (SBHCs), through mobile units that visit the school site, and via telehealth.^m Hospitals can also provide guidance to school leaders as they make decisions regarding school nurse staffing needs.
- ▶ **Case management services** to assist children with transition planning and meeting home and school needs, including access to appropriate prescription medication.ⁿ
- ▶ **Delivery of evidence-based programs** to manage chronic health conditions, especially episodic conditions such as asthma.
- ▶ **Professional development and training** for school nurses and school personnel for select educational topics and procedural assistance with medical device and technology.
- ▶ **Interdisciplinary networking opportunities and forums** that bring together school nurses and physicians and nurses in primary care and specialty practices to build relationships and referral systems.
- ▶ **Access to electronic health records (EHR) for children shared by schools and hospitals.** One example is Nemours Children's Health System in Delaware that provides school nurses with access to view their students' EHR if a parent or guardian signs an authorization form permitting this use.^o School nurses may also have access to information shared between multiple health care organizations

through a Health Information Exchange (HIE).^p

- ▶ **Funded opportunities that may include schools as community stakeholders.** For example, Trinity Health is investing an estimated \$80 million in grants, loans, and community match dollars and services in six collaborative community partnerships through a Transforming Communities project.^{20, 21}
- ▶ **Working together in conducting the CHNA and/or developing joint plans and activities** in response to children's health needs.

The examples included within this issue brief highlight and expand on the scope of collaboration between schools and hospitals. Some identify improved health and education outcomes associated with these partnerships. Furthermore, they collectively exemplify the vast opportunity that exists within the context of permissible data and information sharing activities, since alignment with federal laws, particularly Family Educational Rights and Privacy Act (FERPA) (1974) and the Health Insurance Accountability and Privacy Act (HIPAA) (1996), as well as any state laws and policies that govern student privacy strongly concern schools and hospitals.^{q, r}

Importantly, hospitals partner with schools when students are too ill to regularly attend school and have extended inpatient hospitalization. Hospitals often provide assistance to meet educational needs in addition to health care needs or help facilitate homebound instruction in coordination with schools. This document does not focus on the partnership between schools and hospitals when the child is not physically present in school for an extended time, although there are significant challenges and opportunities to strengthen school and hospital collaboration to support children in these circumstances as well.²²

^m Telehealth is "...the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration." <https://www.healthit.gov/providers-professionals/faqs/what-telehealth-how-telehealth-different-telemedicine>

ⁿ Transition planning involves coordination of activities for students with chronic health conditions around changes such as beginning school, moving from one school to another, and returning to school from hospitalization. <https://www.nasn.org/PolicyAdvocacy/PositionPapersandReports/NASNPositionStatementsFullView/tabid/462/ArticleId/644/Transition-Planning-for-Students-with-Chronic-Health-Conditions-Adopted-January-2014>

^o Nemours Children's Health System, Student Health Collaboration, <http://www.nemours.org/health-professionals/nemourslink/student-health-collaboration.html>

^p A Health Information Exchange "...allows doctors, nurses, pharmacists, other health care providers and patients to appropriately access and securely share a patient's vital medical information electronically..." <https://www.healthit.gov/providers-professionals/health-information-exchange/what-hie>

^q Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 CFR Part 99) is a Federal law that protects the privacy of student education records. <http://www2.ed.gov/policy/gen/guid/fpco/ferpa/index.html>

^r Health Insurance Portability and Accountability Act (HIPAA) (Public Law 104-191) is a Federal law that protects medical information. <http://www.hhs.gov/hipaa/>



“Schools and hospitals share responsibility in the management of chronic health conditions for children even if they are on different continuums, and there are transformations in health care that call for their partnership in improving health and education outcomes.”

HOW CAN INVOLVEMENT IN A HOSPITAL COMMUNITY HEALTH NEEDS ASSESSMENT PROCESS STRENGTHEN SCHOOL AND HOSPITAL PARTNERSHIP?

Community Health Needs Assessment and Implementation Strategy Requirements Including Partnership with Health Departments

The ACA added §501(r) to the Internal Revenue Code, which outlines requirements non-profit hospitals under §501(c)(3) need to meet in order to be treated as tax-exempt. The Department of Treasury and the Internal Revenue Services (IRS) released final regulations regarding these requirements in December 2014, and it is estimated that more than 80% of US hospitals must comply with these requirements to avoid penalties.^{23, 24} As part of these requirements, a hospital facility must conduct a CHNA and adopt an implementation strategy at least once every three years, effective for tax years beginning after March 23, 2012.^{s, 23, 25} The IRS amended Schedule H that accompanies Form 990 for hospitals to provide additional details regarding §501(r) compliance. The hospital implementation strategies are submitted to the IRS as Form 990 attachments, and hospitals do not have to make these publicly accessible unless state or local law requires it.^{23, 24}

The CHNA assesses and determines prioritized health needs within the community that the hospital defines as the community it serves, without exclusion of medically underserved, low-income, or minority populations. Hospitals are required to solicit and consider input received from persons representing broad

^s ‘Hospital organization’ is defined ... “as an organization recognized (or seeking to be recognized) as described in section 501(c)(3) that operates one or more hospital facilities...” A ‘hospital facility’ is “...a facility that is required by a state to be licensed, registered, or similarly recognized as a hospital.” https://www.irs.gov/irb/2015-5_IRB/ar08.html

interests within the community and use at a minimum the three sources specified in the regulations.²³ One of these required sources is “...at least one state, local, tribal, or regional governmental public health department (or equivalent department or agency) with knowledge, information, or expertise relevant to the health needs of the community.”²³ Hospitals access key public health data including local and state health department statistics and other analyses, such as *County Health Rankings*, a program implemented by the University of Wisconsin Population Health Institute with support from the Robert Wood Johnson Foundation, and the *Community Health Status Indicators*, a project of the Centers for Disease Control and Prevention (CDC) and partners.^{t, u} Common technical resources hospitals use to conduct their CHNA are 1) Mobilizing for Action through Planning and Partnerships developed by the National Association of County and City Health Officials in cooperation with the Public Health Practice Program Office, CDC and 2) the CHNA and community benefit guides developed by the Catholic Health Association of the United States.^{v, w} Conducting the CHNA also involves documenting the CHNA in a written report (CHNA report) that is adopted by an authorized body within the hospital facility and made widely available to the public. The CHNA report contains: “1) a definition of the community served by the hospital facility and a description of how the community was determined; 2) a description of the process and methods used to conduct the CHNA; 3) a description of how the hospital facility solicited and took into account input received from persons who represent the broad interests of the community it serves; 4) a prioritized description of the significant health needs of the community identified through the CHNA, along with a description of the process and criteria used in identifying certain health needs as significant and prioritizing those significant health needs; and 5) a description of

^t The County Health Rankings use multiple national and state data sources to measure health within counties and rank these county-level measures within states. <http://www.countyhealthrankings.org>

^u The Community Health Status Indicators uses multiple data sources to provide county health status profiles. Indicators of a county can be compared to demographically similar counties, the U.S. and Healthy People 2020 targets. <http://www.cdc.gov/communityhealth>

^v Mobilizing for Action through Planning and Partnerships, <http://www.naccho.org/programs/public-health-infrastructure/mapp>

^w Catholic Health Association of the United States, Community Benefits, <https://www.chausa.org/communitybenefit/community-benefit>

resources potentially available to address the significant health needs identified through the CHNA.”²³

The implementation strategy “...is a written plan that, with respect to each significant health need identified through the CHNA, either: (1) describes how the hospital facility plans to address the health need, or (2) identifies the health need as one the hospital facility does not intend to address and explains why the hospital facility does not intend to address the health need.”²³ Hospitals may discuss health needs identified through sources other than the CHNA. For the prioritized health needs to be addressed by the hospital, the implementation strategy describes the hospital’s 1) intended actions and their anticipated impact and demonstrated impact as shown through evaluation of an immediately preceding CHNA, 2) programs and resources being committed, and 3) any planned collaboration with other facilities or organizations. Hospitals can build upon previously conducted CHNAs, but they must solicit and consider input from broad interests of the community with each new CHNA. They also must respond to written comments received through public input on the previously adopted CHNA report and implementation strategy.²³

The stakeholders involved in the CHNA process can be extensive and include an array of hospital organizations and facilities, governmental departments, nonprofit organizations, individual community leaders and residents, and more. Hospitals have the flexibility to decide at which level to work with government public health departments as appropriate to their CHNA.²³ Many work with their local health department versus other jurisdictional levels based on their defined community, although there are some communities without a local health department. In addition to engaging stakeholders from one or more health departments in the CHNA, hospitals may partner with multiple hospitals that share a common community to conduct joint planning activities and joint implementation strategies together as long as they comply with CHNA requirements on a facility-specific basis including that authorized bodies of each hospital facility adopt the CHNA report and implementation strategy.^{23, 24} They can individually report supplementary information on how they focus on selected localized needs.²⁴ The Treasury Department and the IRS received feedback during the public comment period expressing support for such collaboration “...to make

the most efficient use of resources in assessing community needs and devising strategies to address those needs and that communities would benefit from strengthened collaborative partnerships that help build broad-based support for community-wide solutions to the underlying causes of health problems.” Several commented “...that joint CHNA reports would more effectively leverage the health data expertise of governmental public health departments without placing an unreasonable burden on departments that serve jurisdictions with more than one tax-exempt hospital facility.”²³

Hospitals continue to learn and improve processes and partnerships in conducting the CHNA requirements. They are at different levels in developing the CHNA and implementing aligned actions, and this may be reflective of their approach to population health based on their organizational priorities, resources, and health needs.²⁶ Many hospitals have had active community benefits programs aligned with community needs and extensive community partnerships for years that contribute to the goal of improving population health. In these cases, the CHNA requirements add formality and strengthen community benefit strategies.

The CHNA requirements and how they embrace collaboration in achieving health equity and population health present tremendous opportunity. Multi-sector strategic approaches can result in health improvements locally and at a larger scale within a region, the second being more appropriate for state health department involvement in the CHNA process. Examples that point to the breadth of the CHNA include:

- ▶ Children’s hospitals can conduct a CHNA alone or partner with an affiliated larger hospital.
- ▶ Various hospitals that define a common community can work together on a CHNA.
- ▶ As health care consolidation continues, some hospitals are campuses integrated into a larger health care organization and are consequently involved in a more extensive CHNA effort.
- ▶ One or more local health departments representative of a defined community may be involved, which may help leverage capacity to meet broad needs in metropolitan areas or provide technical assistance to small, local health departments. For example, the Illinois Public Health Institute is working with 26 non-profit and public hospitals, six accredited local health departments and more than 100



community-based stakeholder organizations in the Chicago area. They are developing a collaborative CHNA in three regional subgroups, using common indicators, assessment tools, and planning processes, with a goal of working together to make improvements in the priorities identified by the CHNA.

The accreditation program for local and state health departments launched in 2011 by the Public Health Accreditation Board (PHAB) can also be a driver to a broader systematic approach inclusive of hospital CHNA requirements. It involves a documented completion of 1) a community health assessment (CHA), 2) a community health improvement plan (CHIP), and 3) an agency strategic plan at least every five years.²⁷ Public health departments seeking accreditation can either continue with that cycle with integration of the CHNA to inform their own CHA or conduct a CHA more frequently, e.g., every three years in alignment with the triennial cycle requirement for hospitals. North Carolina, for example, mandates accreditation statewide and changed its standard to ‘three to four years’ to facilitate hospital and health department collaboration.²⁸

State health departments may develop plans to strengthen local level partnerships in improving population health and CHNA intersection with state assessments and plans. For example, Ohio developed recommendations to strengthen population health planning and implementation infrastructure. A recommendation for both the Ohio state health assessment (SHA) and state health improvement plan (SHIP) is to “...to provide statewide leadership on population health goals and to foster alignment between state and local-level planning.” (p. 7).²⁹ Ohio plans to issue guidance to encourage local health departments and hospitals to select 1) at least two health priorities in their plans from those identified in the SHIP, 2) at least one core metric from the SHA and SHIP for each SHIP-aligned priority, and 3) evidenced-based strategies from the SHIP to address SHIP-aligned priorities. Local health departments and hospitals will be required to align their assessments and plans with use of a three-year timeline and submit their completed assessments and plans to the state, which will be housed in an online repository.²⁹ In addition to leveraging assessment processes by public health department partners, there are a

number of organizations such as the United Way that conduct community assessments that can parallel and contribute to the CHNA. Needs assessment requirements for some schools under the Every Student Succeeds Act (ESSA) (2015) may offer further opportunity for partnership in children's health.^x

It can be anticipated that the CHNA requirements will strengthen the role of hospitals in meeting comprehensive health needs in communities. The final regulations stipulate that health needs can "... include not only the need to address financial and other barriers to care but also the need to prevent illness, to ensure adequate nutrition, or to address social, behavioral, and environmental factors that influence health in the community." Moreover, the "... implementation strategy may describe interventions designed to prevent illness or to address social, behavioral, and environmental factors that influence community health."²³ Hospitals may vary their approach to address health and wellness beyond health care alone with an investment of community benefit resources, so long that these activities respond to health needs identified through the CHNA. According to national survey data around population health collected by the Children's Hospital Association, top issues identified in the IRS-required CHNA are 1) obesity, 2) access, 3) and asthma.¹⁷

Why the Community Health Needs Assessment Strengthens School and Hospital Partnership and Building Blocks to Consider in Reaching an Optimal Partnership

The community health needs that hospitals identify through the CHNA often resonate with schools and education stakeholders as they also encounter these needs on a daily basis. The CHNA is a partnership opportunity for schools and hospitals that can give a strategic framework and strength to implement new or existing activities. It can identify shared goals and align actions that are appropriate to their respective organizations. Engagement of state health and education department expertise and information along with the local health department can

guide, support, and improve effectiveness of these efforts. For example, staff from these agencies have leadership and insight regarding:

- ▶ Data collection and analysis with use of both health and educational measures to drive decision making including need-based resource allocation.
- ▶ School health and education policies, practices, and priorities across a state and within localities. The content knowledge and working familiarity in this area is broad and can include an understanding on health-promoting policies and school board and administrator leadership to support them, school improvement plans that incorporate health and wellness and can integrate CHNA, and strengths and gaps regarding school nursing capacity and school staff professional development and training.
- ▶ Research evidence and best practices regarding programs and services to improve the management of chronic health conditions and outcomes for children.

State health departments have a role in leveraging partnerships to benefit the public by bringing promising partners like schools and hospitals more closely together. A fundamental part to facilitating an optimal partnership involves creating a vision and addressing reasons why the partnership matters to achieving goals and aims as well as resolving challenges specific to schools and hospitals. These are important considerations as they collaborate to improve children's outcomes.

Hospitals generally have varied perspectives regarding the integration of school stakeholders into the CHNA and partnership in implementing actions to improve health outcomes. Children's hospitals and those with pediatrics or expertise with children likely include children as a target population in their CHNA. These hospitals view the school setting as a natural fit aligned with their mission, vision, and values and schools as extensions to their reach where children spend significant time and need health services, and they may be most capable to work with schools. Many hospitals including those that have a religious affiliation prioritize working with underserved populations and partner with public schools. All hospitals can understand the value in promoting children's health to inspire a trajectory of lifelong health success, and some act accordingly and integrate the early intervention potential of schools. Moreover, schools play a pivotal

^x Every Student Succeeds Act (Public Law 114-95) is a Federal law to govern public education for grades K-12. <https://www.congress.gov/114/plaws/publ95/PLAW-114publ95.pdf>

role in education as a social determinant of health, to which health care and public health are aligned through Healthy People 2020, and can help inform hospitals about structural barriers and the impact of social determinants of health in the communities they serve. Hospitals aim to reduce costly, preventable emergency department visits and hospitalization, including readmission after discharge, and working with schools more intentionally through the CHNA may result in improved management of chronic health conditions for their shared students where children need the hospital less for such episodic care. Schools intersect with a larger health system and are a setting where hospitals can intervene in coordinating care and reducing challenges to achieving the Triple Aim and the National Quality Strategy aims and priorities.

Additional factors underlie why the inclusion of education stakeholders in the CHNA and partnership with schools can be of benefit to hospitals. Family engagement and employee wellness are components of the Whole School, Whole Community, Whole Child (WSCC) model, and the school setting is a place where hospitals can reach significant numbers of adults in addition to children.^y It is well known that parents play a significant role in children's health and that parental engagement can be protective against adverse health and education outcomes.³⁰ School staff also model health-promoting behaviors to children, and they can be involved in school employee wellness programs that "...can reduce employee health risk behaviors, absenteeism, and escalating costs of health care, as well as identify and correct conditions in the workplace that threaten employee health, reduce their levels of productivity, and impede student success."³¹

Unlike hospitals, schools serve as community centers where school personnel, parents, families, neighborhood residents, and others more naturally gather. Partnering with schools in meaningful ways can give hospitals access to an adult population that has strong investment and influence in children's overall health and well-being, and an inroad to improving population health by reaching both adults and children. There is opportunity to build positive hospital publicity and improved community perception when hospitals

have a consistent presence and commitment to making differences in issues also of importance to schools.

Schools have much to gain from partnering with hospitals, including being engaged through the CHNA, and the partnership can help schools advance in meeting goals and accountability measures focused on student learning and academic achievement. More hospitals than schools have the expertise to address chronic health conditions that can often be medically complex. Schools increasingly recognize the connections between health and education, and that improved health outcomes can contribute to improved educational outcomes and lifelong success. However, they face many competing priorities and limited resources. Although school nurses primarily manage chronic health conditions in schools, many schools often have shortfalls in nursing infrastructure and capacity to manage the medical acuity of students at an optimal level. Hospitals can be partners in helping inform school decisions regarding school nurse staffing needs and in some cases provide direct staffing support. There are also educational implications when children do not feel well or experience health-related exacerbations. For example, health-related absenteeism reduces a student's opportunity to learn and absenteeism is associated with reduced academic achievement.³² Reducing absenteeism is a national priority in education and efforts like Every Student, Every Day: A National Initiative to Address and Eliminate Chronic Absenteeism call for a multi-sector comprehensive approach.^z In addition, there may be opportunities to increasingly integrate hospitals as strategic partners in implementing final regulations per ESSA.

Furthermore, a consideration for schools is the importance of building a consistent and sustained partnership that can be woven into the CHNA and evaluated over time for its effectiveness. External groups often interface with schools for short-term activities and projects, and it can be challenging for these entities to navigate and work with schools in meaningful ways and measure success. Interventions also may be focused at an individual school building-level versus a school district-level and widely vary across schools. Hospitals have roots

y Whole School, Whole Community, Whole Child Model, <http://www.cdc.gov/healthyyouth/wsc/>

z Every Student, Every Day: A National Initiative to Address and Eliminate Chronic Absenteeism, <http://www2.ed.gov/about/initis/ed/chronicabsenteeism/index.html>

within communities, and they may be large employers with potential to leverage resources and capabilities.^{aa} Hospital leadership is involved in the CHNA process and adopting the CHNA report and implementation strategy, and that level of accountability can be a bridge to engage school board and administrative leadership and foster opportunity and assurance to a steady partnership between schools and hospitals.

WHAT OPPORTUNITIES EXIST TO STRENGTHEN SCHOOL AND HOSPITAL PARTNERSHIP IN THE MANAGEMENT OF CHRONIC HEALTH CONDITIONS THROUGH MEDICAID?

Most children who have high acuity because of medically complex conditions are enrolled in Medicaid and CHIP.¹⁰ State Medicaid profiles vary across the nation, and there are opportunities for strengthened partnership between schools and hospitals. The ACA encourages new and expanding ways in health care delivery. A few examples highlighting the intersection of school and hospital partnership with Medicaid in the management of chronic health conditions are provided below.

In December 2014, CMS rescinded the “free care rule” in a State Medicaid Director Letter, thus providing schools with the opportunity to receive Medicaid payment for health services given to Medicaid-eligible students.³³ Prior to this communication, school health services had not been able to bill Medicaid for eligible students for services since 1997, with exception of some services

^{aa} Hospitals are an example of anchor institutions. These are “...rooted in their local communities by mission, invested capital, or relationships to customers, employees, and vendors. As place-based entities that control vast economic, human, intellectual, and institutional resources, anchor institutions have the potential to bring crucial, and measurable, benefits to local children, families, and communities.” <http://democracycollaborative.org/democracycollaborative/anchorinstitutions/Anchor%20Institutions>

for children with disabilities covered by an Individualized Education Program.^{ab, 34} The former CMS rule affecting reimbursement negatively impacted schools’ offering of some school-based preventive and primary care services, and many states adopted their own policies reinforcing the rule that Medicaid could not be billed.^{34, 35}

There are increased efforts at the state level to align with this CMS “free care rule” reversal. Several states have begun amending individual state plans. States are also exploring how to navigate financial arrangements through Medicaid and anticipated Medicaid billing by school districts. Some with state Medicaid programs handled by managed care are determining how services can be coordinated since there are set fees Medicaid pays to cover all services for enrolled children rather than fees for service. Advocates are hopeful that this could be particularly helpful in addressing asthma, since many Medicaid-eligible children use costly, emergency care for asthma-related exacerbations.³⁴ In addition to other benefits, the withdrawal of the “free care rule” may present opportunities for schools and hospitals to partner with respect to care for students with chronic health conditions and improve the coordination of care.

A revised final rule published by the Center for Medicaid and CHIP Services effective in 2014 regarding reimbursement for preventive services (e.g., screening, immunizations, etc.) also can assist schools in meeting health needs of Medicaid-eligible children and enhance how they collaborate with hospitals. The rule expanded practitioners who may provide recommended preventive services, at state option, to include those other than physicians or licensed practitioners.³⁶ This change can help reimburse for select services that school nurses can provide and assist in care coordination. For example, a covered service is obesity screening and counseling that can offer or make referrals to behavioral interventions for weight status improvement.^{ac, 37}

^{ab} Individualized Education Program pursuant to the Individuals with Disabilities Education Act, <http://idea.ed.gov/explore/view/p/,root,dynamic,TopicalBrief,10>,

^{ac} The rule covers preventive services assigned an A or B grade by the US Preventive Services Taskforce (USPSTF) and Advisory Committee on Immunization Practices-recommended approved vaccines and their administration under the ACA. USPSTF A and B Recommendations, <http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/>

School-based health centers function as primary care clinics, and they are key to the management of chronic health conditions, involving partnership between schools and community health organizations that can include hospitals. SBHCs and their operations are distinct from but complementary to school nursing services, and they collaborate in providing comprehensive care to shared students.³⁸ SBHCs can be an entry point for hospitals to engage and begin working with schools. There are several state Medicaid programs that promote the provision, quality, and reimbursement of services provided by SBHCs. For example, some SBHCs contract with managed care organizations (MCO) in the delivery of care for Medicaid-enrolled children or are located within states that assure Medicaid MCO payment for designated services.³⁹

In addition, hospitals may offer special programs through Medicaid that can partner with schools. For example, Partners for Kids is an accountable care organization involving Nationwide Children's Hospital in Ohio and more than 1,000 physician providers. It intersects with the state's Medicaid Managed Care Plans to provide care to an estimated 330,000 children and has a strong emphasis on care coordination. This model results in a lower cost of care, and the surplus funds are invested into child health programs and services.⁴⁰ One of the programs supported by Partners for Kids is School-Based Asthma Therapy (SBAT). It aims to reach children having poor asthma control and challenges that affect their compliance with recommended medical treatment. School nurses and physicians refer children to SBAT, which then obtains family consent and intervenes as a liaison between the school and the primary care physician to coordinate care and improve medication administration and services that can be provided in the school setting.

Other programs such as the State Innovation Models Initiative (SIM) funded by CMS Innovation Center are incorporating children's health. Through SIM, various states are working with the testing of multi-payer delivery and payment reforms that address population health and linkages between primary care and community services.⁴¹ Medicaid is also facilitating delivery and payment reform initiatives to connect health care to social determinants of health. One example is the Oregon Coordinated Care Organization (CCO) that has 16 local networks of various providers working together to serve people who receive health

care coverage by the Oregon Health Plan (Medicaid) throughout the state. The CCOs have a focus on managing chronic health conditions.⁴² They also have early learning hubs connecting all stakeholders for early childhood education including K-12 school districts.⁴³ The CCOs serve approximately 230,000 children, and children represent 40% of those enrolled. They are demonstrating improvements across most metrics for the entire population served.⁴⁴



EXAMPLES OF SCHOOL AND HOSPITAL PARTNERSHIP IN THE MANAGEMENT OF CHRONIC HEALTH CONDITIONS

SPOTLIGHT Schools and Children's Hospitals in Ohio

Five of six children's hospitals in Ohio partner with schools in their respective communities, although the extent of their involvement varies. One of the primary ways in which they partner is through the management of pediatric asthma, which is frequently identified in CHNAs as a priority. With funding from the CDC's national asthma control program, the Ohio Department of Health (ODH) is working with children's hospitals throughout the state to strengthen services for students with asthma. In 2015, ODH convened a day-long collaborative meeting with the Ohio Children's Hospital Association and all six children's hospitals in Ohio to share and learn about hospital strategies for students with asthma and identify ways

ODH can support alignment with national guidelines for asthma, or EPR-3 guidelines.^{ad} ODH involved the Ohio Department of Medicaid and Medicaid Managed Care Plans in a subsequent 2016 meeting.^{ae} In moving forward, ODH plans to help ensure consistent coverage of services and facilitate continued meetings to share best practices and collaborate in the management of pediatric asthma within the state. ODH issued a funding announcement and awarded select hospitals to work with schools in areas for improvement such as asthma medication self-administration. ODH also has fostered opportunities for several children's hospitals to advise the implementation of Ohio Revised Code Section (RC) 3313.7112 (2014), which requires diabetes training to school employees by licensed health care professionals with expertise in diabetes.

Cincinnati Children's Hospital Medical Center (Cincinnati Children's) has led an asthma program in partnership with Cincinnati Public Schools and the Cincinnati Health Department that is a part of an Asthma Improvement Collaborative (AIC) launched

ad Guidelines for the Diagnosis and Management of Asthma (EPR-3), <https://www.nhlbi.nih.gov/health-pro/guidelines/current/asthma-guidelines>

ae Ohio Medicaid Managed Care Program, <http://medicaid.ohio.gov/PROVIDERS/ManagedCare.aspx>

in 2008 to enhance the quality and coordination of asthma care for low-income, Medicaid-insured children in Hamilton County, Ohio. Pediatric asthma is a priority in the hospital's 5-year strategic plan that was tied to the CHNA process, and Cincinnati Children's views schools as a key partner to improving population health and community connected primary care. The hospital works directly with school nurses to identify children with asthma and coordinate care. Examples of services Cincinnati Children's offers schools include:

- ▶ Training and professional development for school nurses, including dissemination of quality improvement methodology and skills to build their capacity to manage chronic health conditions.
- ▶ Home delivery of prescription medications to high-risk children through a clinic-based program.
- ▶ Development of a home health nurse educator program.
- ▶ Shared use of EHR for students through "read-only" access to Cincinnati Children's medical records to support coordination of care.
- ▶ Six funded staff positions for three school-based health centers: three nurse practitioners at 0.75 FTE and three full-time access service representatives.

As a result of comprehensive improvements through the AIC, Cincinnati Children's has improved several healthcare measures for hospital use. Cincinnati Children's has maintained a 50% reduction in the combined rate of asthma-related emergency department (ED) revisits and inpatient readmissions within 30 days of inpatient discharge for asthma among Medicaid-enrolled children (ages 2 to 17), along with a reduction in the rate of 90-day readmissions for asthma when compared to baseline data collected prior to intervention. In addition, Cincinnati Children's exceeded its institutional strategic goal of creating an integrated community asthma program to reduce both hospital inpatient admissions and ED visits by 20% by the end of 2015.⁴⁵

Akron Children's Hospital (Akron Children's) has had a shared financial model for school health services with 26 school districts across five counties, including Akron Public Schools. This partnership serves over 76,000 children, with additional in-kind and educational support provided by Akron Children's. Schools contract with Akron Children's and support a team of 220 employees, comprised of school nurses and health aides, an education and

outreach coordinator, a clinical coordinator to provide case management including school entry and hospital discharge coordination, a nurse manager, and a director of school health services in addition to a medical director as a consultant. Akron Children's reviews data for medication administration and medical needs and works with school leaders to make decisions regarding staffing needs. One of the greatest benefits of this collaboration relates to the engagement school nurses have with the hospital to communicate with health care providers and refer students and their families to appropriate hospital and community resources, as well as help them navigate a comprehensive system of care. The model continues to make strides in improving care coordination. For example, School Health had 39,091 touch points with shared Akron Children's Hospital patients with diabetes at school. Among the 185 students with diabetes in 2014-15, providers report improvements in blood glucose testing for A1C, decreased hospitalization, and decreased absenteeism.^{af,46}

The school health services partnership model is woven into Akron Children's CHNA and implementation strategy, and the strong relationships between hospital and school administrators have helped coordinate activities to improve population health by way of children's health. Akron Children's contracted with Kent State University's College of Public Health in 2013 and 2016 to prepare its CHNA and implementation strategy. As part of the 2013 CHNA process, Akron Children's engaged community partners including schools for consultation and incorporated data and information from Akron Children's school health services collaboration with schools, local health and state health and education departments, and other sources. A community benefit/CHNA steering committee and ad hoc committee identified priorities per the CHNA: asthma, diabetes, mental health, and infant mortality.⁴⁷ Akron Children's developed internal data dashboards to monitor progress related to the implementation strategy. Teams and subcommittees assigned to the strategies for these priorities meet regularly, and the community benefit/CHNA steering committee meets on a quarterly basis for monitoring and continuous improvement. Akron Children's provided a community update in 2015 that demonstrated progress in achieving goals, to which

af The A1C is determined by a blood test that provides information related to an individual's average blood glucose levels over the past three months. <http://www.niddk.nih.gov/health-information/health-topics/diagnostic-tests/a1c-test-diabetes/Pages/index.aspx>

school leaders were invited to participate. The CHNA process in 2016 expands upon the approach conducted in 2013 to include new chronic health conditions data and greater data analysis by location and zip code to better reach marginalized populations.

SPOTLIGHT Schools and Hospitals in Massachusetts

The Massachusetts Department of Public Health (MDPH) funds school districts across the state to strengthen school nursing through a number of School Health Services programs. These programs have a strong emphasis on collaboration and requirements related to building sustained linkages between schools and health care partners. They also leverage other state efforts led by MDPH. For instance, the Massachusetts Prevention and Wellness Trust Fund provides further support to addressing chronic health conditions within communities.⁴⁹ With funding from the CDC's National Asthma Control Program, MDPH supports a state-level Massachusetts Asthma Action Partnership that has a healthy schools component and an asthma disparities initiative for community health centers to implement clinical improvements for children in high-risk families. In addition, the partnership works with local asthma coalitions to strengthen community outreach and systems changes affecting schools and other environments.^{48, 49}

The MDPH School Health Services team stays familiar with school nursing at the local and regional levels including individual nurse leaders' strengths and challenges and offers opportunities for them to share their experiences. Two school districts supported by MDPH for years through the Essential School Health Services (ESHS) program and as regional consultant districts are exemplified below for their school and hospital partnership. In addition, MDPH funds selected ESHS districts including Springfield Public Schools (SPS) to provide innovative models for care coordination focused in three areas: 1) asthma, 2) behavioral health, and 3) diabetes. Aims are to enhance collaboration between school nurses and chronic disease management specialists and improve the knowledge, abilities and skills of school nurses

related to the management of chronic health conditions, and districts can work directly with hospitals. This program is demonstrating early success in health-related indicators as well as those for education, such as decreased absences, dismissals and tardiness among students involved in the project.

► Lowell Public Schools (LPS) partners with Lowell General Hospital (Lowell General), a part of Circle Health, and the Lowell Health Department (LHD), which employs school nurses. A professor of economics from the University of Massachusetts at Lowell (UMass Lowell), with experience in asthma interventions and housing led Lowell General's CHNA. The CHNA included the regional director for MDPH in its advisory committee. Priority areas identified through the CHNA include asthma, diabetes, substance abuse, and mental health. The Greater Lowell Health Alliance has engaged community leaders and stakeholders, including school administrators, to drive the hospital's implementation strategy. Extensive community coordination along with funding from the U.S. Housing and Urban Development for environmental remediation to support home visits for children diagnosed with asthma have led to decreased rates of asthma exacerbation and emergency department visits among children, equivalent to monthly healthcare savings greater than \$70,000.⁵⁰

► SPS has partnered with Baystate Medical Center (BMC) since 2012. The BMC CHNA, which included MDPH in its steering committee, enhances their collaboration by building cross-sector support and alignment to address social determinants of health. SPS and BMC partner through the BMC Community Benefits Advisory Council and BMC Community Health Management. They developed a shared understanding of their collaborative effort and jointly implement a strategic plan to act on identified community needs. BMC established a leadership team to operationalize patient care, health management, screenings, and education in the school setting. The scope of their collaboration entails: 1) alignment of health priorities, including health protocols and standards of care, 2) improved care coordination (e.g., shared patient visits, systemic patient education, etc.), 3) pragmatic educational framework, and 4) continuous interaction and active collaboration. There have been reductions in two health office disposition data points, specifically school dismissal and 911 calls, and improvements in medical referrals and implementation of best practice recommendations since the partnership

ag The Prevention and Wellness Trust Fund, <http://www.mass.gov/eohhs/gov/departments/dph/programs/community-health/prevention-and-wellness-fund/>

began.^{ah} SPS has also helped BMC understand and facilitate student and family barriers to care. Example partnership activities include:

- ▶ School nurses participate in grand rounds at the hospital to work with providers treating students with diabetes and asthma.
- ▶ Physicians-in-training experience a clinical rotation to school health offices.
- ▶ School nurses engage in students' medical appointments as feasible.
- ▶ School nurses receive professional development through regional community educational forums for Western Massachusetts and lectures conducted by specialty providers that address core competencies specific to health practice transformation, such as procedures within the school setting and in-school training provided by hospital staff.⁵¹

SPOTLIGHT Austin Independent School District and Dell Children's Medical Center in Texas

Dell Children's Medical Center of Central Texas (Dell Children's), the pediatric hospital for Seton Healthcare Family, has contracted with Austin Independent School District (AISD) for the provision of clinical school health services since 1996. The Student Health Services partnership is primarily funded by AISD. Dell Children's oversees and manages services provided by 75 registered nurses and 65 health assistants, three clinical managers, an educator, a director, and a medical director employed by the hospital to care for over 84,000 students in 128 schools. Examples of support services Dell Children's provides AISD include:

- ▶ Extensive analysis to determine medical acuity in schools on an annual basis and determine staffing and professional development needs.
- ▶ Illness and injury protocols and algorithms for when the health assistant or designated school personnel provide care and need to contact the nurse. School nurses also inform the development of relevant health policies adopted by AISD.

- ▶ Training to support health assistants who work in pairs with nurses. The model involves frequent nurse observation of the health assistant role and implementation of procedures.
- ▶ Health informatics assistance to collect and analyze data. Annual reports that include data for special populations (e.g., asthma, diabetes) and customer satisfaction are publicly available on Dell Children's and AISD websites.⁵² The partnership also allows for the ability to examine two different but complementary data sets through real-time use of school and hospital data. In monitoring students for H1N1, for example, Dell Children's emergency department was not seeing symptom severity, which informed a decision to not shut down AISD although there were school district closings in other locations.^{ai}
- ▶ School nursing leadership and advocacy provided by the director of Student Health Services who collaborates with the health department, the Texas School Nurses Organization, and other school nurse leaders to identify and implement priorities for health services.
- ▶ Collaboration with partners under a Texas State 1115 Medicaid Waiver project to provide behavioral health services through Campus Based Counseling Referral Centers to any student who is referred by AISD staff or parents/guardians for services and receives parental consent for participation.^{aj}

The partnership model that exists operates well, and Dell Children's is seen as the expert in health care for AISD students. The School Health Services partnership is part of a comprehensive school health team supervised by AISD. The comprehensive school health team is comprised of school personnel for behavioral health, wellness, hearing and vision screening, and integrated case management. School Health Services provides care for students during school hours in collaboration with AISD school staff, with the school nurse leading the campus health team to promote health, wellness, and safety.

ah Health office disposition data points assess rates of students returning to class for academic instruction, being sent home due to illness, or requiring emergency services or 911 following visits or encounters with a registered nurse during the school day. https://www.nasn.org/portals/0/2016_SUBC_Data_Points.pdf

ai Symptom severity is the severity of perceived adverse changes in physical, emotional, and social functioning. <http://medical-dictionary.thefreedictionary.com/symptom+severity>

aj Texas Medicaid Transformation Waiver, <http://www.hhsc.state.tx.us/1115-waiver.shtml>

WHAT CAN STATE HEALTH DEPARTMENTS DO TO STRENGTHEN SCHOOL AND HOSPITAL PARTNERSHIP IN THE MANAGEMENT OF CHRONIC HEALTH CONDITIONS?

State health departments and partners, particularly through school health and nursing services personnel in state health and education departments, are instrumental to facilitating success of school and hospital partnership at the local level. They can leverage the CHNA and other opportunities to improve population health by addressing children's health and the management of chronic health conditions. Below are considerations for state health departments to move forward in this area. These approaches incorporate the insight of those who helped inform the development of this document and relevant information from federal and national resources that are available. State health departments are not usually directly involved in the CHNA, and there is a spectrum of CHNA models and the level of collaboration they involve across a state. The intention is that these ideas may inspire plans that can initiate or strengthen efforts around integrating health care and public health within the context of working with schools.

Learn about how schools and hospitals are partnering across the state in the management of chronic health conditions by reaching out to schools including school nurse leaders or hospitals directly to inquire about these partnerships. **Ask about the role of the CHNA as a way to strengthen the partnership and learn if and how schools are incorporated into this process to inform determining health needs.** The CHNA reports must be made widely available to the public and can be located on hospital websites and/or through the IRS. There are efforts to establish a searchable database of CHNA reports through the Association for Community Health Improvement, and states may also be collecting and reporting this information at a state level. These reports

identify the stakeholders and can be reviewed to determine at a glance if schools were involved. State hospital associations and state children's hospital associations can serve as additional resources to learn more about the CHNA processes occurring throughout the state and their partners.

Learn about how the state health department as a whole has been involved in CHNA or the extent to which those within the agency have worked with local health departments around these regulations. Larger health care organizations in the state may define a broadened community reflective of their expanded catchment area and be more inclined to have a state presence. Academic medical centers and children's hospitals that have a regional approach are also more apt for state health department integration. The level of involvement can vary from 1) inclusion in a steering or advisory committee to 2) consultation and communication during CHNA development to 3) response to specific requests for data and other information. In addition, state health departments and partners can have input into the CHNA by filing written comments on the previous CHNA report. As part of seeking this information, **ask about how the CHNAs throughout the state rise to the state level and are coordinated with or incorporated into the development of the state health department assessment and improvement plan and how hospitals are included in state processes for health department accreditation.** Find out if and how state Medicaid programs are involved with the CHNA in relation to addressing children's health.

Explore and be able to speak to the messages that resonate with potential partners in facilitating collaboration at a state level to support school and hospital partnership. Hospitals, for example, are seeking ways to make an impact with limited resources and would like to know how best to accomplish that aim from a public health perspective. They are particularly interested in the impact their efforts could have in reducing emergency department and inpatient hospital use including readmissions among those with episodic chronic health conditions, including children covered by Medicaid that have higher usage rates. Schools strive to enhance academic achievement, and they seek ways to reach educational goals and



“State health departments and partners... are instrumental to facilitating success of school and hospital partnership at the local level. They can leverage the CHNA and other opportunities to improve population health by addressing children’s health and the management of chronic health conditions.”

accountability measures. Any partnership effort should explore and examine both health and educational outcomes. In developing a win-win approach to improving the management of chronic health conditions, explore if and how schools and hospitals can help meet each other's needs. There are other building blocks to consider in reaching an optimal partnership that are less obvious but still important considerations to collaboration (e.g., schools as a community center and a place to access both children and adults).

To leverage partnership between schools and hospitals, communicate who is ideal to contact within each local organization and how to best connect them directly with each other. Schools and hospitals can be difficult to navigate as an outsider, and specific contact information may not be publicly available or easy to find. Hospitals should contact school nurse leaders, district-level health service coordinators or directors, school-building principals, district-level administrators, and/or school board members. Schools should contact clinician and pediatric specialty leaders, community benefit, population health, or strategic relations directors and personnel, children's health program administrators, and/or clinical operations and hospital executive team leaders. Importantly, leader-to-leader contact between school superintendents and hospital chief executive officers may best move a partnership forward including its integration with a CHNA, and they may find themselves at the same community meetings. Partners such as hospital associations, state education departments, and local health departments can help recommend individuals who may be most appropriate to contact. State health department personnel with a focus on school health and nursing services and those whose work more closely relates to the CHNA should make their contact information accessible to schools and hospitals.

Explore and identify what state health departments can offer schools and hospitals to begin or strengthen their partnership, including through the CHNA.

Some examples include:

- ▶ Accessibility of data using both health and educational measures and disaggregated school-level health services data, including data for students with chronic health conditions.

Education system data, such as rates of chronic absenteeism and high school graduation can be relevant since education is a social determinant of health. Those conducting a CHNA commonly search for state-level data, but do not necessarily find the data they seek.

- ▶ Consultation and expertise on the scope of school health and education including needs and priorities across a state and within localities to provide insight into:
 - ▶ Staffing for school health services, specifically school nursing and professional development and training for school nurses and school staff related to chronic health conditions.
 - ▶ School health needs assessment findings collected through use of the School Health Index or other assessment tools.^{ak}
 - ▶ School district improvement plans that can incorporate health and wellness and have integration with CHNA.
 - ▶ School board and administrative leadership and commitment to health and school leaders' support in adopting and implementing health-promoting policies.
 - ▶ Established and high-functioning school wellness committees that encourage active participation by school leaders, health professionals, parents and families, community members, and additional stakeholders. Broad stakeholder engagement in these committees may help promote and sustain health efforts to prevent and better manage chronic health conditions.
 - ▶ Identified geographical hot spots for increased numbers of students diagnosed with chronic health conditions. These places of priority reach vulnerable populations, those with high needs in education, health care, and public health who could best benefit from interventions to improve care coordination and health and educational outcomes.
 - ▶ Strategies and best practices for working with schools and addressing chronic

ak School Health Index (SHI): Self-Assessment & Planning Guide 2014, <http://www.cdc.gov/healthyschools/shi/index.htm>

health conditions through programs and services in schools to strengthen health care organizations' strategic approach in the development and implementation of CHNAs. Quality improvement expertise can also be beneficial in advising school health services.

- ▶ Opportunities including HIE to facilitate EHR data and information being shared and guidance related to FERPA and HIPAA that concern schools, hospitals, and their partners. Advocacy for the inclusion of schools in regional HIEs that coordinate various information technology across a region may be a consideration.^{al}
- ▶ Capacity-building through funded projects and/or technical assistance to improve evidence-based practice for activities being conducted by hospitals for schools, guided by national and state recommendations and guidelines around the management of chronic health conditions. Even small projects can be done that leverage state resources and grant support if there are recognizable ways to improve the actions taken by hospitals in schools.
- ▶ Direct involvement in a committee for a CHNA, if feasible. School stakeholders' inclusion at the school district, local health department, and/or state health department level in CHNA can initiate collaboration between schools and hospitals or strengthen the partnership activities that already exist.

■ Learn about and advocate for state-level policies and procedures that can assist and promote school and hospital partnership and be meaningful to improvements in health and education.

There are policy levers through policies such as the "free care rule" and other opportunities through Medicaid and perhaps through ESSA that can integrate school health services to improve the management of chronic health conditions and capitalize on partnerships between schools and

hospitals. Hospitals can also assist in advocacy for education policies and may be willing to add them to their advocacy agenda, especially policies tied to health.

■ Offer platforms to share and promote locally effective collaboration between schools and hospitals.

Peer-to-peer learning opportunities, meetings, and other formats can help spread the word to share the extent of activities these partnerships involve, their benefits to schools and hospitals, and if and how CHNA may be integrated and strengthen the partnership. In showcasing the scope of school and hospital partnership, exemplify how the state health department can provide support.

WHAT RESOURCES CAN FURTHER INFORM THIS WORK?

There are a number of resources available that discuss the need and collaborative opportunity to improve health at a population level in response to changes through the ACA and with use of the CHNA as a pillar. Many are identified at the close of this document. Below are several key resources to be familiar with in strengthening school and hospital partnership. They are directly relevant or apply to addressing the management of chronic health conditions in schools and the integration of state health departments.

- 1 The National Collaborative on Education and Health launched in 2014, established a Health Systems Working Group that brought together multiple sectors representing federal, national, state, and local organizations including government agencies, school districts, health systems, and others.^{am} The Collaborative developed a resource in collaboration with the Catholic

al Regional health information organizations involve various stakeholders in a region to coordinate health information exchange mechanisms in improving health and care in the community. <http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Collaboration/whatisrhio.html>

am The National Collaborative on Education and Health was launched by the Healthy Schools Campaign <http://www.healthyschoolscampaign.org> and Trust for America's Health <http://www.tfah.org> with funding from the Robert Wood Johnson Foundation. It is overseen by a steering committee and has a health systems working group. <https://healthyschoolscampaign.org/policy/education/national-collaborative-on-education-and-health-redesigning-the-health-syste-5548/>

Health Association: Ten Principles for Collaboration: Health and Education Systems, <https://www.chausa.org/docs/default-source/health-progress/community-benefit-ten-principles-for-collaboration.pdf?sfvrsn=0>

2 *Healthy Students, Promising Futures: State and Local Action Steps and Practices to Improve School-Based Health* released in 2016 by the U.S. Department of Education and U.S. Department of Health and Human Services describes five high-impact opportunities identified below that are relevant to schools, hospitals, and their partnership. This toolkit available at <http://www2.ed.gov/admins/lead/safety/healthy-students/toolkit.pdf> provides a rationale, examples, and a list of links and resources for each opportunity and includes information on key federal laws protecting student data and privacy.

- #1: Help Eligible Students and Family Members Enroll in Health Insurance
- #2: Provide and Expand Reimbursable Health Services in Schools
- #3: Provide or Expand Services that Support At-Risk Students, Including through Medicaid-funded Case Management
- #4: Promote Healthy School Practices through Nutrition, Physical Activity, and Health Education
- #5: Build Local Partnerships and Participate in Hospital Community Health Needs Assessments

3 The Association of State and Territorial Health Officials (ASTHO) through their Health Systems Transformation team has published a number of resources and links to supportive information regarding the CHNA, all available at <http://www.astho.org/Programs/Access/Community-Health-Needs-Assessments/> A few example ASTHO resources include:

- ▶ ASTHO's Overview of IRS Final Rules, <http://www.astho.org/Public-Policy/Public-Health-Law/Resources/IRS-CHNA-Final-Rules-Issue-Brief/>
- ▶ Case studies that describe how state health departments work with non-profit hospitals on CHNA to improve the coordination of hospital community benefits with other efforts to improve community health. ASTHO may prepare more case studies into the future as progress in this area continues.
- ▶ A consensus statement from ASTHO and other partners about how hospitals can most effectively work with public health experts to maximize community benefits, <http://www.>

astho.org/Programs/Access/Community-Health-Needs-Assessment/Consensus-Statement/

4 A study conducted by the University of Kentucky described in *Improving Community Health through Hospital - Public Health Collaboration: Insights and Lessons Learned from Successful Partnerships* examined 12 hospital partnerships in 11 states and identified factors that contribute to their success. According to the report, "The overall purpose of the study is to *identify and examine successful partnerships* involving hospitals, public health departments, and other stakeholders who share commitment to improving the health of communities they jointly serve and ascertain key lessons learned from their collective experience." (p.5)

Prybil, L., et al. (2014). Improving Community Health through Hospital-Public Health Collaboration: Insights and Lessons Learned from Successful Partnerships. Health Management and Policy Faculty Book Gallery. Book 2. Available at http://uknowledge.uky.edu/hsm_book/2

5 Guidance developed by the U.S. Department of Education and/or the U.S. Department of Health and Human Services provides information and resources for schools in navigating data sharing aligned with FERPA and HIPAA. Two documents are highlighted below.

- ▶ U.S. Department of Education. (2016). Data-Sharing Tool Kit For Communities: How To Leverage Community Relationships While Protecting Student Privacy. Available at <http://www2.ed.gov/programs/promiseneighborhoods/datasharingtool.pdf>
- ▶ U.S. Department of Health and Human Services and U.S. Department of Education. (2008). Joint Guidance on the Application of the Family Educational Rights and Privacy Act (FERPA) And the Health Insurance Portability and Accountability Act of 1996 (HIPAA) To Student Health Records. Available at <http://www2.ed.gov/policy/gen/guid/fpcd/doc/ferpa-hipaa-guidance.pdf>

ADDITIONAL RESOURCES

Association for Community Health Improvement
<http://www.healthycommunities.org>

Catholic Health Association of the United States,
Assessing and Addressing Community Health Needs
<https://www.chausa.org/communitybenefit/assessing-and-addressing-community-health-needs>

Centers for Disease Control and Prevention,
Division of Population Health
<http://www.cdc.gov/nccdphp/dph/>

Community Health Status Indicators
<http://www.cdc.gov/CommunityHealth/HomePage.aspx>

Centers for Medicare & Medicaid Services, Innovation Center
<https://innovation.cms.gov>

Children's Hospital Association, Analyses or Summaries, Population Health
<https://www.childrenshospitals.org/Resources/Analysis-Summary?topic=243E1A87C33F451692131F28DFC6D593&contentType=Analysis+or+Summary>

Community Commons, Community Health Needs Assessment Toolkit
<http://www.communitycommons.org/chna/>

County Health Rankings & Roadmaps, a Robert Wood Johnson Foundation program
<http://www.countyhealthrankings.org>

Dialogue4Health Web Forum, a partnership of the American Public Health Association, Prevention Institute, Public Health Institute, and Trust for America's Health
<http://www.dialogue4health.org/web-forums>

National Academy of Medicine Perspectives, Expert Commentaries and Discussion Papers by Leading Voices in Health and Health Care. Several Perspectives address community health needs assessments.
<http://nam.edu/perspectives/>

National Association of County & City Health Officials, Community Health Assessment and Improvement Planning, Community Benefit
<http://www.naccho.org/programs/public-health-infrastructure/community-health-assessment>

The Robert Wood Johnson Foundation, Focus Areas and Initiatives
<http://www.rwjf.org>

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