Strengthening Collaboration Between Schools and Hospitals in the Management of Chronic Conditions: Taking Hold of Opportunities

Wednesday, November 2, 2016
3:00 – 4:00 PM EDT
Housekeeping

• All participant lines are muted

• Type questions into the Questions box

• Technical difficulties? Use the questions box
National Association of Chronic Disease Directors (NACDD) is comprised of over 6,000 specialized chronic disease practitioners working in public health departments across all 50 States and US Jurisdictions to prevent and control chronic disease.

The School Health Project assists Chronic Disease Directors and their staff to make informed decisions about a variety of school health issues.
Disclaimer

• This webinar was produced under a cooperative agreement with the Centers for Disease Control and Prevention (CDC).

• Its contents are solely the responsibility of the authors and do not necessarily represent the official views of NACDD or CDC.
Learning Objectives

At the end of this webinar, participants will be able to:

• Explain how school and hospital partnership can meet children’s health needs and improve the management of chronic health conditions.

• List three policy and program opportunities to strengthen partnership between schools and hospitals.

• Identify at least two actions you can take that apply strategies and resources from the webinar to improve the management of chronic health conditions in schools.
Presenters

Amanda Martinez, MPH, MSN, RN
Public Health Consultant, NACDD

Anne De Biasi, MHA
Director of Policy Development, Trust for America’s Health
Presenters

**Ann Connelly**, MSN, RN, LSN, NCSN
Public Health Nurse Supervisor,
School Nursing and Asthma Programs,
Ohio Department of Health
Presenters

Marilyn Crumpton, MD, MPH
Interim Health Commissioner, Cincinnati Health Department and Medical Director for Growing Well

Mona Mansour, MD, MS
Director of Primary Care and School Health, Professor of Pediatrics, Cincinnati Children’s Hospital Medical Center
New NACDD Publication!

http://www.chronicdisease.org/?SchoolHealthPubs
Chronic Health Conditions

• Defined: Physical, developmental, behavioral or emotional conditions that last for a prolonged time period, require more than routine health services, and affect usual childhood activities$^{1-3}$

• Estimated 15.9% and 17.5% of children ages 6-11 and 12-17 years old have at least one chronic health condition, respectively$^4$

• Approximately 3 million medically complex children$^5$
Students with Chronic Health Conditions

• Attend school. Time away from school can reduce students’ opportunities to learn and affect quality of life.
• Require careful management at home and during the school day
• Receive school health services largely provided by school nurses
• Experience fragmentation in health care, interface with multiple health care providers and supports, and may not have an identified primary care provider or a medical home
Schools and Hospitals

• Share responsibility in the management of chronic health conditions for children
• Operate with significant challenges
• A strengthened partnership can be a strategy to:
  - More effectively achieve integrated service delivery, enhance coordination and provision of services
  - Reduce duplication of effort when it exists
  - Provide support to parents and families in managing care
  - Improve health and education outcomes
Community Health Needs Assessment (CHNA)

• Requirements under the Affordable Care Act for non-profit hospitals to be treated as tax-exempt
• Hospital facility must conduct a CHNA and adopt an implementation strategy at least once every 3 years
  – Solicit and consider input from persons representing broad interests within the community. Public health departments are one of the required sources.⁶
  – Stakeholders involved in CHNA can be extensive. Opportunity for collaboration and joint planning activities.
  – Prioritizes health needs to be addressed by the hospital
  – Some focus on children’s health, include education stakeholders
  – Can strengthen hospital community benefit strategies
• Effort in improving population health
Chronic Disease Management: Federal Initiatives and Opportunities for Partnership between Schools and Hospitals

Anne De Biasi, MHA
Director of Policy Development
Trust for America’s Health
November 2, 2016
Overview

- National Collaborative on Education and Health
- Models for School Health Services
- Overview of Federal Initiatives
- Free Care Policy
- Innovative Examples
National Collaborative on Education and Health

- Health Systems Transformation
- Health & Wellness Metrics
- Chronic Absenteeism
- Substance Misuse
- Mental Health
- Every Student Succeeds Act (ESSA)
# Models for School Health Services

<table>
<thead>
<tr>
<th>School Nurses</th>
<th>Accountable Care Organizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Specialized Instructional Support Personnel</td>
<td>Local Health Departments</td>
</tr>
<tr>
<td>School-Based Health Centers</td>
<td>Hospitals</td>
</tr>
<tr>
<td>Mobile Clinics</td>
<td>Federally-Qualified Health Centers</td>
</tr>
<tr>
<td>Managed Care Organizations and Other Health Insurance Companies</td>
<td>School-linked Health Centers</td>
</tr>
<tr>
<td>Telehealth Providers</td>
<td></td>
</tr>
</tbody>
</table>

Students in Schools with FT School Nurse Have Fewer ER Visits for Asthma

# of Emergency Room (ER) Visits for Asthma in Demonstration Schools 2008 - 2011

- None: 46% (Demonstration 2008-09 n=24) vs. 83% (Demonstration 2010-11 n=59)
- One time: 25% vs. 9%
- Two or more times: 17% vs. 9%
- Do not know: 13% vs. 0%

Rodriguez & Austria, 2012
School Nurse Demonstration Project: Elimination of Existing Chronic Health Condition Opportunity Gap on CST ELA in Schools with FT School Nurse

<table>
<thead>
<tr>
<th>Year</th>
<th>Asthma</th>
<th>Neuro-development</th>
<th>Other Physical</th>
<th>No Health Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007-08</td>
<td>26</td>
<td>14</td>
<td>30</td>
<td>31</td>
</tr>
<tr>
<td>2008-09</td>
<td>25</td>
<td>14</td>
<td>30</td>
<td>31</td>
</tr>
<tr>
<td>2009-10</td>
<td>35</td>
<td>12</td>
<td>34</td>
<td>33</td>
</tr>
<tr>
<td>2010-11</td>
<td>36</td>
<td>17</td>
<td>37</td>
<td>37</td>
</tr>
<tr>
<td>2011-12</td>
<td>42</td>
<td>28</td>
<td>47</td>
<td>44</td>
</tr>
</tbody>
</table>

% of Students Scoring Proficient or Advanced on California State Test (CST) English Language Arts (ELA)

Rodriguez & Austria, 2012
School-Based Health Centers

- 2,315 SBHCs in 49 of 50 states + DC
- 67% are staffed by a primary care provider and a behavioral health provider.
- 56% serve populations other than the students in the school.
- 78% serve Title I schools and 77% are located in schools where more than 50% of students were eligible for free or reduced-price lunch.
<table>
<thead>
<tr>
<th>Every Student Succeeds Act (ESSA)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>School Level Needs Assessment</strong></td>
</tr>
<tr>
<td><strong>State Accountability Systems</strong></td>
</tr>
<tr>
<td><strong>State Report Cards</strong></td>
</tr>
<tr>
<td><strong>School Improvement Plans</strong></td>
</tr>
</tbody>
</table>
Federal Initiatives

**Every Student, Every Day**
- Ensure that physical and mental health needs of children and youth are reflected in **local nonprofit hospital community needs assessments**
- Partner with local school districts and schools to support **school health improvement plans**
- Promote **school-based** mental health and behavioral health services

**Healthy Students, Promising Futures**
1. Health Insurance Enrollment
2. Reimbursable Health Services in Schools
3. Medicaid Case Management
4. Healthy School Environments
5. Hospital Partnerships and Needs Assessments
## Free Care Policy

<table>
<thead>
<tr>
<th>Change</th>
<th>Opportunity</th>
<th>Challenge</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Medicaid reimbursement for services provided in schools for all kids</td>
<td>• Increase health services in schools • Leverage new partnerships with health providers</td>
<td>• May require State Plan Amendment (SPA) to CMS • May need to negotiate with Medicaid managed care plans</td>
</tr>
</tbody>
</table>
Innovative Examples

Detroit, MI

- Henry Ford Health System (HFHS) contributes community benefit funds to invest in SBHCs
- Fixed and mobile sites in 14 school and community settings
- Staffed by a nurse practitioner, registered nurse, medical assistant, social worker, rotation physician and a rotating child and adolescent psychiatrist
- SBHCs bill Medicaid directly and is supported by the MI Department of Community Health
- SBHCs can access legal, administrative and financial department support from HFHS
Innovative Examples

Grand Rapids, MI

- Spectrum Health System contributes $750,000 of annual community benefits to school health services
- Nurses in 11 of 75 schools
- 4 schools have team-based care
- Subsidizes half the costs
- 97% of the students met current immunization requirements to attend school
- 98% of problems were resolved on-site by the school health care team
Innovative Examples

Austin, TX

- Partnership between Austin Independent School District and Dell Children’s Medical Center
- Provide RN led teams in schools and through Children’s Health Express Van
Innovative Examples

Madison, WI

- Two local managed care organizations (MCOs) pay part of a school nurse’s salary
- Increase health screenings their Medicaid members receive
Innovative Examples

Oregon

- Awarded State Innovation Model model-testing grant
- 15 Coordinated Care Organizations (CCOs)
- Trillium Community Health Plan funds the Good Behavior Game in 50 Oregon schools
Innovative Examples

Chicago, IL

- Partnership between public school and Mobile C.A.R.E. to provide dental, asthma, and allergy care, immunizations and child physicals to public school students.
Thank you!

Anne De Biasi, MHA
adebiasi@tfah.org
202-223-9870
School and Hospital Partnership in Asthma Management

Ann M. Connelly, MSN, RN, LSN, NCSN
Public Health Nurse Supervisor
School Nursing and Asthma Programs
Ohio Department of Health
Overview

• School Nursing in Ohio
• Ohio’s Asthma Program
• Collaboration
• Additional Project Enhancing Asthma Management
• Future Plans
• Challenges, Barriers and Lessons Learned
• Other Efforts
• Summary
• Ohio Department of Education awards a School Nurse License - not mandated
  • Statewide, SN: student ratio is 1 : 1,268
  • 1/3 are assigned to 1 building, but ~10% serve >6 buildings; <25% schools have a FTE nurse
  • Secretary most likely to administer medication
• 16.9% of School Nurse time is spent managing chronic illnesses
  • Most commonly reported chronic illnesses are asthma, ADD/ADHD, severe allergies and other mental health
  • Asthma is ranked 2nd as most difficult to manage (diabetes is 1st)
• ODH School Nursing Program provides technical assistance, resources and training for those interested in health services for children in P-12 and Head Start settings
  • At least 4 face-to-face school nurse conferences per year
  • Live webcasts on a quarterly basis for school nurses
  • Online independent study opportunities for school nurses
  • Development of guidance and resource documents
  • Telephone and e-mail TA
  • Connect Head Start programs and schools with Impact Statewide Immunization Information Services (Impact SIIS) & other services
Ohio’s Asthma Program

• CDC grant-funded program serves Ohioans with asthma with goal of seamless provision of all services across public health and healthcare sectors

• Programming includes 3 prongs:
  • Infrastructure - Leadership, Communication, Surveillance
  • Services - Promotion of Self-Management Education (SME) and Quality Improvement (QI) Practices
  • Health Systems Strategy

• Children’s Hospital Asthma Collaborative (CHAC)
Ohio’s Asthma Program

• Children’s Hospital Asthma Collaborative (CHAC)
  • Visited asthma programs at hospitals after program transition; identified champions and programs already in place
  • All expressed interest in learning from each other; ODH saw opportunity to promote QI, best practices
  • Convened first meeting and group has chosen to meet twice yearly
  • Agendas include speakers, networking, 4 breakout groups
Collaboration

Ohio is fortunate to be home to >6 Children’s Hospitals
Collaboration

• All hospitals identified asthma as an area of interest based on their Community Health Needs Assessments

• All were looking for ways to improve outcomes
  • Ohio Medicaid State Innovation Model (SIM) included asthma as an acute episode for performance based payment
  
• Most had some kind of QI in place to align with the National Asthma Education and Prevention Program (NAEPP) EPR-3 guidelines –
  http://www.nhlbi.nih.gov/health-pro/guidelines/ current/asthma-guidelines
Collaboration

• Many had some level of involvement with schools, but some had none and existing models varied widely

• Partners include Ohio Children’s Hospital Association, Department of Medicaid and Medicaid Managed Care Plans, and others
Additional Project
Enhancing Asthma Management

• American Academy of Pediatrics (AAP) offered The Enhancing School Health Services through Training, Education, Assistance, Mentorship, and Support (TEAMS) project
  • Dayton Public Schools (DPS) applied

• TEAMS Project required collaboration among public health, schools and local practitioners

• Training provided by AAP, not funds

• DPS identified uncontrolled asthma as a key cause of absenteeism
Additional Project
Enhancing Asthma Management

• Specific characteristics of DPS:
  • Strong School Nurse/School Health leadership and School Nursing team
  • Robust data collection system
  • Already established partnership with some healthcare providers

• DPS convened stakeholder group and identified schools with high poverty and asthma prevalence for pilot
  • Identified barriers to communication with hospital/healthcare providers
  • Identified SME training to be offered in schools by School Nurses
  • Provided training to other school staff
  • Expanded to additional schools the next year
Future Plans

• Competitive grant funding opportunity for Children’s Hospitals to:
  • Partner with an urban school in high poverty area with high asthma prevalence
  • Provide training to school staff about asthma
  • Ensure students have an Asthma Action Plan and medication access
  • Provide SME to students (and families) about asthma
  • If student has emergency department (ED) visit due to asthma, there will be a home visit to reinforce SME and assess for environmental triggers; provide resources for mitigation
  • Provide data as required by CDC
• Explore methods to educate community health workers (CHWs) about asthma care
Challenges, Barriers and Lessons Learned

- Money talks—need to offer adequate funding to encourage program participation
- Time is a limited resource—especially School Nurse time
- Management of expectations—CHAC has a long list of items they would like to accomplish, but only want to meet 2x a year
- Each community, school and hospital are unique—need to balance our need to have consistency in programs with flexibility in resources and characteristics of each community
- Evaluation can be challenging
Other Efforts - Health Policy Institute of Ohio (HPIO) Report


• Report to provide recommendations for population health planning and align with the Patient Centered Medical Home (PCMH) model

• Used with the State Health Assessment (SHA) and the State Health Improvement Plan (SHIP) for public health planning
Other Efforts - HPIO Report


• Asthma is mentioned numerous times in the document, including in the glide path framework, PCMH quality measures

• Schools are also mentioned as part of the life course perspective, a place to influence health behaviors, up/downstream health factors, opportunities for data sharing

• HPIO recently held a forum to address the intersection of health and schools—work is underway to expand planning and partnerships
Summary

• Schools provide clinical and educational health services to students and communities
• Hospitals and public health are interested in improving health outcomes
• BOTH areas are interested in improving effective asthma care
• Timing & flexibility are important:
  • Many groups became interested in improving asthma outcomes for children and were looking for partners
  • The needs, resources and effective plans vary by community and must be considered in order to be successful
Thank you!

Ann Connelly
Ohio Department of Health
246 N. High St
Columbus, OH 43215
Ann.Connelly@odh.ohio.gov
614-728-0386

Photo rights:
OHD
Healthcare and Public Health: Finding Common Ground

Marilyn Crumpton, M.D.

Mona Mansour, M.D.
About Cincinnati Children’s Hospital Medical Center (CCHMC)

• Full service non-profit pediatric academic medical center in Cincinnati, Ohio

• 629 Beds
  – 95 Inpatient behavioral health beds
  – 36 residential behavioral health beds

• Ranked #3 in US News and World Report

• In 2015, almost 34,000 inpatient (IP) admissions and over 102,000 Emergency Department (ED) visits
About Cincinnati Health Department (CHD)

- A Public Entity Federally Qualified Health Center (FQHC)
- 8 primary care health centers and 13 school-based health centers (SBHCs) that serve 39,000 adults/children
- School Health Program for Cincinnati Public Schools (CPS)
  - Medical/public health consultant for CPS
  - 31 School Nurses covering 33 schools
  - Supervision of 28 CPS LPNs for students with medical needs
  - Oversight/training for 22 School Health Assistants in 23 schools
  - 14 nurse practitioners in 13 SBHCs
About Growing Well Cincinnati

http://growingwell.org

• Community Learning Center school model
• Promotes optimal health for optimal learning for students in the Greater Cincinnati area
  – Original focus on CPS
  – Active proponent of the SBHC model
• CHD and CCHMC co-lead the Primary Care Subcommittee
• Currently 25 health centers in CPS
School Health Partnership

• Longstanding partnership between CCHMC and CHD
• Partnership expanded with implementation of SBHC in Greater Cincinnati area in late 1990s
  – Integration of SBHCs with existing CHD school nurse activities/roles
• Partnership on Pursuing Perfection initiative (supported by the Robert Wood Johnson Foundation) to improve asthma care in SBHCs in early 2000s
• 2 of many organizations that supported the development of Growing Well
School Health Partnership

Together CCHMC and CHD:

• Support training and professional development for school nurses and school health assistants

• Support development of health services documentation in PowerSchool (CPS student data)

• Provide health care services and programs for students

• Provide CHD school nurses with “read-only” access of CCHMC Electronic Health Record (EHR) to support coordination of care
CCHMC Population Health Strategic Improvement Priority 2015

- **Target Population**: Hamilton County: 190,000 children ages birth – 17 years

- **Purpose**: Lead, advocate, and collaborate to measurably improve the health of local children and reduce disparities in targeted populations
CCHMC Population Health Strategic Improvement Priority 2015

High Level Measures Goal (By June 30, 2015):

• Reduce the occurrence of **unintentional pediatric injuries** by 30%
• Reduce **infant mortality** by 15%, 20 infant deaths per year
• Reduce the use of the ED and inpatient services by 20% in children with **asthma** covered by Medicaid
• Reverse the trend of increasing **childhood obesity** in grades K - 3
The Story of Darryl

The Triple Aim:
The Best Care
For the Whole Population
At the Lowest Cost

Source: IHI Triple Aim,

Photo rights:
CCHMC, CHD
The Story of Darryl

Who am I?
• 9-year-old with severe persistent asthma
  ➢ My first admission was when I was age 7.
  ➢ I have had 4 - 8 ED visits/year, but no ICU (intensive care unit) admits yet.
  ➢ My dad and younger sister have asthma.
  ➢ My medications are Symbicort, Qvar, Singulair, Flonase, and Albuterol.
    ❖ I take them sometimes.
  ➢ My triggers are activity, changes in weather, tobacco smoke, animals, and dust.
  ➢ I go to Rockdale School.
  ➢ I am getting admitted today.
What’s going on with me?

- I live with my mom and siblings. I just relocated AGAIN due to apartment fire and my mom’s boyfriend did not move with us due to domestic violence.
- I spend weekends with my dad and his girlfriend, but my aunt and grandma also care for me.
- I have difficulty getting some of my medications due to insurance denial.
- My new apartment is very old, dusty and might have mildew in the basement.
- My sister has bi-polar disorder and my mom has to spend a lot of time caring for her.
- I am 9, and I forget to take my medications or can’t take them sometimes if I’ve left them at another caretaker’s home.
Darryl from a School Nurse View

- Darryl is new at his school and came to the school nurse with respiratory distress.

- His asthma action plan (AAP) and medications were not available at school, but his health history and asthma details were available in the PowerSchool database.

- Darryl had a consent for the SBHC and was referred to the nurse practitioner who then referred him to the ED.
### Outcomes Strategic Goal

- **Strategic Operating Plan 2015 Goal**
  - Reduce the number of asthma related ED visits and admissions by 20% for Hamilton County children ages 2-17 by 6/30/15.

### SMART Aim

- Reduce 12 month rolling average of asthma-related ED visits/10,000 Hamilton County Medicaid patients ages 2-17 from 20.9 to 16.7 and the 12 month rolling average of asthma related admissions/10,000 Medicaid patients ages 2-17 from 7.2 to 5.8 by June 30, 2015.

### Outcomes-Key Drivers

1. **Reliable Preventive Services**
2. **Effective management/co-management of active CCHMC patients during/after asthma related visits to CCHMC or other regional hospitals**
3. **Effective patient & family engagement in self-management**
4. **Effective, continuous and appropriate use of prescribed medications by patient**
5. **Mitigation of socioeconomic/psychosocial barriers to optimal asthma care**
6. **Effective partnerships with community agencies (i.e., schools/school based health centers, CHD, safety net providers, pharmacies)**
7. **Reliable contact and communication with patient and family**
8. **Reliable Access to Medication in the Patient’s Home**
9. **Community Engagement and Awareness about Asthma**
Outcomes

• Achieved 35% reduction in the rolling 12 month average of asthma-related admissions by June 2014, one year ahead of goal
  – 7.2/10,000 to 4.6/10,000

• Achieved a 36% reduction in the rolling 12 month average of asthma-related ED visits by June 2014, one year ahead of goal
  – 20.9/10,000 to 13.3/10,000
# How Did CCHMC Achieve this Success?

## INPATIENT - PHASE 1

30-day and 90-day readmissions

Examples:
- Point of Care Medications
- Standardized History, Physical & Risk Assessment
- Appropriate and reliable referral to internal and community services

## OUTPATIENT - PHASE 2

Well-Controlled Asthma

Primary Care Patients & 90-day readmissions

Examples:
- Care Coordination Model
- EPIC based Registry for General Pediatrics and Pulmonary
  - Standardized assessment
  - Pre-visit planner

## COMMUNITY - PHASE 3

Well-Controlled Asthma

ED Utilization

Examples:
- Partnership with schools and CHD
- Pharmacy-based interventions
- FQHC Asthma Collaborative
- Student-based education videos in collaboration with School for Creative and Performing Arts
Community Asthma Team Learning Model

**Reliable Healthcare**
1. Decrease Asthma Absences
2. Increase % CPS’s with ACTs
3. Effective co-management on shared patients

**Engaged/Activated Community**
1. Reliable Preventive Services
2. Reduce ED Visits
3. Reduce IP Admits

**Student with Asthma in Cincinnati**
Goal 1) Asthma is Well Controlled
Goal 2) At School to Learn

**Effective School Partnerships**
1. Willingness to partner with School RN
2. Educated and engaged parents
3. Reliable Access to Medication at Home

**Engaged/Activated Families**
1. Mitigate environmental barriers
   *i.e. Idle Trucks at Schools*
2. Improve public housing conditions
Our Partnership Goal

Partners: Cincinnati Children’s Hospital (CCHMC) 
Cincinnati Public Schools (CPS) 
Cincinnati Health Department (CHD)

Our Goal: Improve Asthma Control Among CPS Students (N= 4400)

– Goal: Increase the percentage of documented asthma control score (ACT) scores to 80% by June 30, 2015
– Start with small number of schools; learn and spread
– Reliable measurement of ACT
– Linkage back to medical home for those that are poorly controlled
Improve Asthma Control - Strategies

• Shared Population-Level Goal
  – Increase the percentage of CCHMC primary care patients with well-controlled asthma

• Hot Spotting
  – To identify the neighborhoods/schools for focus
    • Additional variables for selecting schools

• Developing algorithms for screening

• Establishing reliable communication to primary care practices for high-risk children
Children from dark red neighborhood:

- More likely to be exposed to cockroaches
- More likely to live in poverty
- More likely to lack reliable transportation
- More likely to have a depressed parent
SMART AIM
Shared CPS-CCHMC Goal

Increase the percentage of documented ACT scores for students with asthma in all CPS schools from 64% to 80% by June 30, 2015.

*Documented = 1) School RN documents ACT Score in PowerSchool Database

GLOBAL AIM
Improve asthma control and ability to succeed in school for students with asthma

CPS School RN ACT Completion KDD

KEY DRIVERS - “WHAT”

- Reliable ACT Screening
- Timely & Accurate ACT Score Documentation in PowerSchool Database
- Reliable Two-Way Communication with CCHMC on Shared Students
- Educated & Engaged Classroom Teachers
- Supportive School Administrators of School RNs Work with Students with Asthma
- Reliable Contact Info for Parents
- Empathy for Parents in Crisis Mode
- Engaged & Activated Parents in Child’s Asthma
- Relentless Follow-up with Difficult Parents/Students Parents in Child’s Asthma

INTERVENTIONS - “HOW”

- Successful ACT Screening Day Checklist
- CCHMC EPIC Read Only Access
- Call CCHMC on shared students needing more info & USE SBAR SCRIPT
- Batch F AX CCHMC kids ACT Scores
- Rescreen Students w/ Low ACT Scores
- Share Data with Teachers on negative impact of Asthma on learning Tierney
- School RN / Students present @ Staff mtg to share data on impact of asthma Shannon
- Partner w/ School Admin to TRACK real ABSENTEE data for student w/ asthma & Call parents daily for missing kids Cathy
- Review “Asthma Tips Sheet” with Teachers & Parents to get buy-in Sheila
- Home Visits, TOOLS to parents to easily TRACK RX usage & exacerbations Amanda
- Use Empathetic Script when call parents i.e. “I know this is the last thing you need, but your child’s Asthma is critical…” Barb
Additional Strategies

• Leveraging Lessons from Hospital Safety Work
  – SBAR (Situation Background Assessment Recommendation) Huddles with school nurse and primary care / sub-specialist

• Leveraging Technology
  – CCHMC EPIC access for CHD school nurses
Additional Strategies

- Building Community Improvement Capacity
  - Early Phase Work as part of Rapid Cycle Improvement Collaborative (RCIC)
  - CCHMC provides training on improvement science through 5-month training
    - Team with shared goal
    - Initially focused internal teams; spread to include community-based teams working on shared goals
  - CHD uses this training in other venues
Our Partnership

- Foundation based on a trusted partnership
- Focus on co-production
- Meet partner where they are
- Create a strategic plan to increase quality improvement (QI) capability

**FY ’13**
- 10% Capability

**FY ’14**
- 40% Capability
  - Mini-learning collaborative

**FY ’15**
- 100% Capability
  - School Nurses Trained (n = 50)

**FY ’12**
- <10% Capability
Our Partnership
Academic Year 2015 - 2016

• Asthma Friendly Neighborhood/School
• Deep Dive Into One Community
  – To understand the interface between health and educational outcomes
  – Start with understanding reasons for absences in children with asthma
  – Use of QI methodology
Our Partnership
Academic Year 2016 - 2017

For students with asthma in CPS:

• ACT score screening of ≥80%
• Identify/document medical home of ≥85%
  – Primary Care Provider (PCP) identified and in PowerSchool
• Asthma Action Plan (AAP) for ≥80%
• Share lessons learned between Children’s Hospital and schools with one of the health department primary care centers and schools
  – Measure bi-directional communication between this center and schools
• Include school as a demographic in CCHMC EMR
• Improve transitions of care from hospital to home/school
Contact Information

Anne De Biasi, MHA
Director of Policy Development,
Trust for America’s Health
adebiasi@tfah.org

Ann Connelly, MSN, RN, LSN, NCSN
Public Health Nurse Supervisor,
School Nursing and Asthma Programs, Ohio Department of Health
Ann.Connelly@odh.ohio.gov

Marilyn Crumpton, MD, MPH
Interim Health Commissioner,
Cincinnati Health Department and Medical Director for Growing Well
Marilyn.Crumpton@cincinnati-oh.gov

Mona Mansour, MD, MS
Director of Primary Care and School Health, Professor of Pediatrics, Cincinnati Children’s Hospital Medical Center
Mona.Mansour@cchmc.org
New NACDD Publication!

http://www.chronicdisease.org/?SchoolHealthPubs

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

PUBLISHED 2016

NATIONAL ASSOCIATION OF CHRONIC DISEASE DIRECTORS
Promoting Health. Preventing Disease.
Additional Resources

  http://www2.ed.gov/admins/lead/safety/healthy-students/toolkit.pdf

• The Association of State and Territorial Health Officials (ASTHO) CHNA-related resources and links. 
  http://www.astho.org/Programs/Access/Community-Health-Needs-Assessments/

Additional Resources

• U.S. Department of Education. (2016). Data-Sharing Tool Kit For Communities: How To Leverage Community Relationships While Protecting Student Privacy. [Link]

References


Questions?

Amanda K. Martinez, MPH, MSN, RN
Public Health Consultant, NACDD
amartinez@chronicdisease.org

Post-Webinar Survey:
https://www.surveymonkey.com/r/K9DX3WX