

HEALTHY SCHOOLS CAMPAIGN

EVERY CHILD DESERVES TO LEARN + THRIVE

Education Metrics for Health Systems Preliminary Report - Executive Summary

June 2018

INTRODUCTION

Healthy Schools Campaign (HSC) has worked at the intersection of education and health for the last 15 years, supporting schools, districts, states and national stakeholders as they work to create healthy schools where children can learn and thrive. The current moment provides several important opportunities for bringing the health and education sectors together behind this shared goal.

In the health sector, new priorities increasingly honor prevention, population health, care coordination and chronic disease management. Health and public health systems are expanding the way they understand the social determinants of health, and realizing that health isn't only an issue for the doctor's office. In fact, health providers have found that school health services are a key way for them to engage with otherwise hard-to-reach populations. School health services can also help them meet many of the metrics they are being held accountable for under the Affordable Care Act. For instance, school health services can reduce children's emergency room usage, facilitate enrollment in Medicaid and the Children's Health Insurance Program, increase immunization rates and lead to an overall healthier school population.

This coincides with important changes in the education sector, which increasingly focuses on the "whole child." The new national education law, the Every Student Succeeds Act (ESSA) includes a variety of elements that encourage or require states to consider non-academic measures of student wellbeing. In particular, ESSA requires all schools to report their rate of chronic absenteeism. Chronic absenteeism—or missing 10 percent or more of school days for any reason, excused or unexcused—detracts from learning and is a proven early warning sign of academic risk and school dropout. While the causes of chronic absenteeism are complex, one stands out as especially significant: student health. This makes chronic absenteeism a natural opportunity for collaboration among the health, public health and education sectors.

EDUCATION METRICS FOR HEALTH SYSTEMS PRELIMINARY REPORT

In the fall of 2017 the Healthy Schools Campaign engaged RESOLVE, a D.C.-based nonprofit specializing in collaborative policy development, to conduct an interview scan exploring whether and how education metrics are being incorporated into health accountability systems in the United States. This brief highlights existing efforts to integrate education data, such as chronic absenteeism, into health and public health accountability systems, highlighting common barriers and best practices, and suggests key opportunities for further exploration to advance this work.

The interview scan indicated that there is a broad “common sense” understanding that addressing children in their daytime environment is a good way to improve children’s health, and that value-based care delivery and payment models will increasingly push interventions upstream and to lower-cost settings, like schools, incentivizing more collaboration between education and health systems.

Some education metrics are already being shared with health systems, and vice versa, both to improve education outcomes (like improved attendance) and in some cases to evaluate school-based interventions to improve health outcomes (such as asthma prevention programs). Nevertheless, this is a nascent field, with many data sharing arrangements between education and health systems still in the pilot phase.

RECOMMENDATIONS FOR FUTURE EXPLORATION

In light of the potential for advancing the goals of both the education and health sector to help millions of children become healthy and productive adults, the issue of coordination and cooperation between these two complicated systems is worthy of more study, development, testing and evaluation. Based on its work in this field and the opportunities and barriers identified in this interview scan, HSC recommends the following areas for further exploration:

Chronic Absenteeism

ESSA requires that rates of chronic absenteeism be reported in every school report card. In addition, 36 states included chronic absenteeism as their non-academic measure of school quality in their state ESSA accountability system. This coincides with increasing interest in the health sector in using and understanding attendance data, making efforts to integrate chronic absenteeism data into health accountability systems an important opportunity.

However, there is no uniform definition of absenteeism or chronic absenteeism. Some states have implemented, or are considering, weak definitions of chronic absenteeism that could obscure its health-related causes and undermine the value of including chronic absenteeism in accountability systems.

ESSA Implementation

As states begin full implementation of their ESSA plans, it will be important to understand to what extent the health sector participates in developing and implementing state ESSA plans, the extent to which states include health data in their needs assessments and the extent to which states include health in their ESSA implementation plans.

Data for Needs Assessment and Evaluation

Early findings from groups working to improve the ability of state Medicaid agencies, state education agencies and local partners to offer school-based health services suggest that the joint use of data to document, monitor and evaluate the delivery of school health services is critical. More exploration of how these stakeholders are identifying unmet student needs, sharing data to improve the delivery of care and using data to evaluate the impact, for both education and health, is critical for long-term systems change.

Data Sharing

The collection, sharing and dissemination of data is essential to a meaningful relationship between education and health, and specifically building a connection between education metrics and health

outcomes. Some challenges that need to be addressed include understanding the interplay between FERPA, HIPAA and state privacy laws and updating health data management systems to allow the incorporation of additional student data.

Messaging and Training

There is an important need for both educators and health professionals to understand one another's sector and speak/develop policy in "common language." To overcome the current barrier around language, philosophy, and lack of training by both education and health in one another's disciplines, Colleges of Education, Schools of Public Health and Medical Schools need to work together to train their students to think and talk about how education metrics can successfully be used to measure and change health outcomes.

Healthy People 2030

Each decade, the Healthy People Report is published by the federal Office of Disease Prevention and Health Promotion. The Healthy People initiative develops a new set of Science-based 10 year national objectives, with the goal of improving the health of this nation. Currently Healthy People 2020 includes some education-related goals and measures, including decreasing school absenteeism among adolescents due to illness or injury. Education and health experts should review these goals and metrics and make recommendations for additional goals and metrics that further align the health and education sector.

CONCLUSION

Healthy Schools Campaign is excited to work with health and education partners to explore these challenges and opportunities in order to make sure that all children have access to a school setting that understands and supports students' well-being and student health as a foundation for learning. In this environment, good nutrition, physical activity, basic safety, clean air and water, access to care and building the knowledge and skills for students to make healthy choices that allow them to thrive.

Education Metrics for Health Systems

Preliminary Report – Full Findings

June 2018

METHODOLOGY

RESOLVE interviewed 18 individuals representing 16 organizations and/or programs working to enhance collaboration between health and education entities. Interviews lasted between 45 and 75 minutes. The findings outlined in this report are aggregate and non-identifying to protect confidentiality for interviewees and their partners, except where specific case examples are used. In these instances, permission was given and the descriptive language was provided by the interviewees directly.

Represented sectors included health systems (including clinicians, community and child health professionals, and school nurses); state and local health departments; state and local education departments; academic institutions; and independent community-based organizations (note: some interviewees represented multiple sectors). Geographically, interviewees spoke on behalf of entities and programs in New England, the Bay Area, Mid-Atlantic, upper Mid-West, and Mountain West regions, as well as several national-level programs. Interviewees and their respective programs operated predominantly in large urban areas. Rural areas were not heavily represented, however, some individuals working at the state level or coordinating national initiatives for large health systems were able to speak referentially to examples of programs in rural settings.

Key questions for interviewees included:

1. To what extent is the health sector incorporating education metrics into accountability systems as part of benchmarking progress on improved health outcomes?
2. Which metrics are identified as education metrics, how are they being used (including in what systems of accountability), and can case examples be identified?
3. What is the overall level of interest in further developing and incorporating education metrics into future accountability systems for evaluating progress on social determinants of health?
4. What options might there be in further fostering within and leveraging interest of the health sector in partnership with the education sector in developing and integrating education metrics?

TO WHAT EXTENT IS THE HEALTH SECTOR INCORPORATING EDUCATION METRICS INTO ACCOUNTABILITY SYSTEMS?

Overall Findings

In the strictest sense, interviewees did not report instances in which individual, student-level education metrics were tied directly to health systems accountability measures, either for practitioners or systems performance evaluations, as an institutionalized practice. In many cases, interviewees attributed this to belief that health practitioners do not have enough influence on classroom outcomes, such as attendance, academic performance, and graduation rates, to be reasonably accountable for them.

However, the scan did reveal numerous organizations facilitating, or working to develop, data exchange arrangements between education and health entities. Under these arrangements, education metrics are being shared with health systems both to improve education outcomes (like improved attendance) and

in some cases to evaluate school-based interventions to improve health outcomes (such as asthma prevention programs). These arrangements exemplify how education metrics can be (and are) used by health systems, and as such they will be the focus of the remainder of this report, which details those education metrics identified, why and how they are being used, and several case examples.

Fundamentally, the scan highlighted that health and education sector collaboration is prevalent across the country in many forms, including: school-based health centers (SBHC) which provide primary clinical services in schools and are often managed by and integrated with a local hospital system; school nurse programs; and a myriad of community benefit programs implemented by health systems providing asthma and obesity prevention, family planning and counseling, health education curriculum development and delivery, mental health services, nutrition education and training, and other services for, and in partnership with, schools and their students. Indeed, more than one interviewee stated that schools and the education system are hospitals' and health systems' most common non-healthcare partners.

Discussion of Formal Alignment

Interest in further systems alignment and data sharing between health and education to improve coordination of health service delivery and student performance was high among interviewees. Nearly all interviewees cited the integral, reciprocal relationship between education and health – that healthy students are better able to succeed academically and that academic achievement leads to better health outcomes long term – as reason to enhance collaboration between health and education professionals and pursue greater alignment between the sectors' policies, data management systems, and leadership.

However, most interviewees were agnostic as to whether this alignment included formal development and integration of education metrics into health accountability systems, though they noted that this may become more feasible if sector alignment improves and if identified barriers are overcome. Many interviewees also perceived a "common sense" nature to health and education partnerships. If health systems' (and particularly pediatric systems') objective is to promote the health of children they serve, it seems expected to explore programs and alliances in the environment where those children spend most of their waking hours. Lastly, in addition to interviewees own interest, several health system representatives predicted growing systemic interest in health-education systems alignment, particularly from the health sector as it transitions toward value-based care delivery and payment. They believed that emphasis on value will increasingly push interventions upstream and to lower-cost settings, like schools, incentivizing more exploration and uptake of collaborative models with such partners.

Nascent Field

Finally, the interview series revealed that institutionalized support of education and health system cooperation is still relatively nascent. Many of the interviewed organizations, programs, and initiatives dedicated to enhancing school-health system coordination were established in the last 2-5 years, and few have existed longer than a decade, with the exception of SBHC and school nurse programs which have been long-standing institutions in many areas. Data sharing arrangements, in particular, seemed novel. Most were pilots and were still establishing, or had just established, agreements and mechanisms for exchanging education data with health entities. None had yet collected enough data to evaluate the effects of such arrangements beyond the individual school level. The generally burgeoning nature of these arrangements suggests that more data on their effectiveness may be available in coming years.

WHAT TYPES OF EDUCATION METRICS ARE BEING EXCHANGED WITH HEALTH SYSTEMS AND FOR WHAT PURPOSES?

Data type: Attendance

Attendance was by far the most commonly exchanged metric among those discussed during interviews. Of the 18 interviewees, 12 were either directly involved in, or aware of, arrangements (either in place or being established) within their hospital systems, health departments, or schools in which student attendance records were shared with health entities, such as primary care providers or public health departments. Five such arrangements were in place at the district or county level, four at the individual school level, and two were established as part of research projects conducted through universities. The types of attendance data shared in these arrangement vary, and include both individual student level data (such as in the CHECK example below) and school population level data (such as in the Ohio DOE example below). Through these arrangements, attendance data were most commonly used in several ways:

- *To assist in the monitoring and management of chronic illnesses* – Student health or poor health conditions within a student's family or home are often contributors to chronic absence. When accessible, patients' school attendance records can provide clinicians (and health systems generally) with an indicator to help identify the potential emergence of chronic health conditions or flare ups of known illnesses, even before the individual seeks care. Successive absences may be used to trigger family outreach to help determine whether the absences are, indeed, health-related, whether more intensive treatment is required, what environmental factors may be contributing, and whether referrals to other services are needed. Such data exchanges may also help trigger efforts to improve care coordination at the school level or make additional services available in school settings.
- *To evaluate school-based health programs* – School-based interventions to address a range of health issues – diabetes, obesity, asthma, teen pregnancy, depression, etc. – are prevalent across the country, often managed by, or in partnership with, a local hospital/hospital system or department of health. Student attendance is regularly used as a metric to evaluate such programs. At the student population level attendance data may be used to assess whether, for instance, a flu vaccination education campaign reduced absences during flu season. If more granular student-level data is available, it may be used, again as an example, to compare absenteeism of students with asthma to absenteeism of students without to evaluate the effectiveness of an Asthma Friendly Schools Initiative.
- *To allow physicians to be better advocates for school attendance* – Health professionals are an important thread in the tapestry of individuals who significantly influence young persons' attitudes and behaviors. Real-time access to attendance records during patient visits, in those (few but growing) cases where it is integrated directly into health information management systems, allows pediatricians to inquire about low attendance, perhaps uncovering a previously unknown issue in the student's life. If nothing else, the doctor can reinforce the importance of school attendance and engagement.

The interview scan revealed two primary approaches to attendance data exchange: direct systems integration and shared database development. In the most advanced arrangements, student information systems (SIS) are synced directly with patient data management systems allowing for real-time sharing between school administrators and primary care providers (or independent care coordinators). These arrangements are typically facilitated by memorandums of understanding (MOU)

between the school (or district) and hospital, clinic, or coordinating entity, depending on the type and size of arrangement.

Interviewees stressed that MOU establishment is critical to addressing privacy and technical issues as these programs are put in place, issues that become more complicated when working across multiple districts and/or data management systems. Direct systems integration arrangements are not prevalent, and those that exist are still being piloted. Shared databases used to better leverage population-level data across state agencies and community services are more common. School districts in [all states have developed statewide longitudinal data systems](#) that contain a range of aggregated student information.

Many states are exploring ways to cross-reference these databases with other agency's records, including health departments', to better design and target services. For example, in Ohio, the state education agency and state department of health are working to cross reference systems to share chronic absenteeism data, and in Pittsburgh, Pennsylvania, integrated data has been used to address chronic absenteeism among homeless students and those in the foster care system.

Sometimes this is achieved by using a trusted third-party data management firm that collects data from multiple agencies and performs the desired analysis without disclosing any agencies'/entities' full dataset. In some instances, use of a third-party may mitigate legal concerns associated with direct cross-sector data exchange. Integrated databases help align how information is collected, displayed, and accessed across sectors, as well as help improve reporting accuracy and research capabilities.

When asked why their programs or organizations prioritized attendance metrics in data exchange agreements, interviewees gave relatively consistent responses. Attendance records are readily available across nearly all schools and easy to collect and interpret, making the metric "low hanging fruit" with respect to data-sharing arrangements. Some interviewees added that attendance data is perceived as less sensitive than other information (like grades, test scores, or discipline records) and therefore more palatable and easier to adopt into such agreements, though privacy concerns certainly persist and must be managed. Also, while health affects academic outcomes across the board, interviewees noted that the common sense corollary between when a student is sick and when s/he is absent makes the value of sharing this data more understandable and easy to justify.

Given the health sector's existing level of interest in attendance data, implementation of the new federal education law (ESSA), which requires that school report cards include chronic absenteeism, can provide an important leverage point for advancing efforts to integrate chronic absenteeism data into health accountability systems.

Case Example: Coordinated Health Care for Complex Kids (CHECK)

[CHECK](#) is an innovative health care delivery demonstration project funded by the Centers for Medicare and Medicaid Services to improve the overall health and quality of life by making sure that patients and their families get the resources and care they need. The CHECK team provides comprehensive and coordinated health and behavioral health care management to children, and their families, with chronic medical conditions.

Data Sharing with Chicago Public Schools

CHECK is exploring the impact health and chronic diseases have on school attendance. They have a data use agreement with Chicago Public Schools (CPS) and receive attendance data monthly for CPS students who are enrolled in the CHECK project. (It should be noted that this data use agreement took 18-24 months to put in place.) This monthly attendance data is shared with a team of community care coordinators who use it to perform outreach to families and address barriers to attendance.

What data are shared and how?

Through their data use agreement, CHECK receives data directly from CPS monthly. This includes the name of the child's school and their attendance (number of school days attended). The data goes directly in CHECK's care management software used by community health workers (this system is separate from their EHR system). They do receive information on students' academics, disciplinary actions or IEPs. Ultimately, the objective of this arrangement for CHECK and CPS is to decrease school absenteeism for enrolled patients; this was one of the primary aims communicated to CMS for the funding of the grant.

Case Example: Ohio Department of Education

Ohio is working toward a more integrated approach to schools and their healthcare of children. There is recognition of the need to address student healthcare issues, while respecting that the primary role of schools will be to facilitate access to those who have the responsibility to deliver those services. To that end, Ohio is incentivizing Primary Care Physicians (PCPs) to establish direct relationships with schools, as well as developing a toolkit to give schools the information they need to make good decisions about school health. Additionally, there is recognition that state agencies need closer cooperation with their data to better coordinate the overall efforts to help children by relating academic issues such as chronic absenteeism with health issues such as asthma and behavioral health.

While Ohio is just beginning these efforts, the significant hurdle of appropriately protecting student information (FERPA) and their medical information (HIPPA) appears to have been resolved. Such data will help drive identification of those schools most in need of assistance. Also, consent and data sharing (as it relates to FERPA/HIPPA issues) will be addressed at the local level as well.

Recently, the school health work has restarted a broader conversation, involving many educational and healthcare related partners to work collaboratively towards a set of models for school health. Those models will emphasize measurable results, cooperation with local entities, public/private partnerships, and a willingness to look at existing success stories and replicate them throughout the state. Much work still is ahead, but a critical mass of buy-in appears to have been achieved.

Data type: Student records, including grades, test scores, and disciplinary records

In some instances, data sharing arrangements between the education and health sectors extend to include additional student information such as academic performance and disciplinary records, though the scan suggests this information is much less commonly exchanged than attendance. Among interviewees, only three were involved in, or aware of, initiatives within their organizations via which fuller student academic information was systematically shared with a health entity. One, detailed in the example below, is an arrangement in which SBHC clinicians have access to the school district's student information system, allowing them to view their patients academics (grades) and disciplinary records (suspensions and expulsions). Another was a data-sharing relationship established as part of a university-driven research agenda to assess a fully-integrated care delivery model in the elementary and middle school setting. In both cases, the data exchange arrangements were confined to a single school and its health sector partner, and the information was not accessible to health practitioners outside the school setting.

Case Example: Building Healthy Schools and SBHCs in Omaha Public School

[Building Healthy Futures](#) (BHF) is a nonprofit that aims to improve health for the community's underserved children and youth through thoughtful collaboration and advocacy. To that end, Building Healthy Future's role in the community has been to bridge the institutions of health and education – the two institutions with the largest impact on child well-being. BHF serves as a backbone organization and helps to stand up and support SBHCs in Omaha. It's also currently piloting an APHA model of care in Omaha Public Schools in cooperation with the district and its operating partners.

SBHC Data Sharing:

SBHCs operated in Omaha Public Schools have different levels of access to student information and data sharing based upon the model and school building. In all eight SBHC sites in the system, SBHC staff have access to the school district's student information system, called Infinite Campus (IC). This allows SBHC staff to check, on an individual basis, the following:

- child's family and emergency contact information
- state student number
- attendance and disciplinary records
- immunization history
- results of health screenings such as hearing and vision
- psychological evaluations, special education (IEP-MDT) records
- Section 504 Accommodation Plan, and
- information regarding any health condition, such as seizures or asthma.

Why these metrics?

These metrics were chosen based upon 1) Availability of data in the IC system; 2) Clinical relevance; 3) Willingness of the District to allow access to the data. Access to IC has only been granted for point of

service to inform clinical interventions on the individual level as SBHC staff are unable to “run reports” or queries from IC at this time.

How is data sharing facilitated?

BHF operating agencies have Business Associate agreements with the district that include a separate addendum of all data requests necessary for conducting the program. There are timelines and processes defined in these agreements that the operating agency and district adhere to for data sharing. School buildings do not provide any data directly as all data sharing is facilitated through the district with either the Student Information Department or the Research Department.

How is this data being used by health systems?

The operating agencies or health systems are using educational data on an individual basis during clinical encounters and when designing care plans. Building Healthy Futures has used the educational data for program evaluation.

As these examples demonstrate, the way student academic information is used by health providers varies little from their use of attendance data. Poor academic performance or dramatic changes in performance may indicate the presence of a health-related learning barrier (e.g. impaired vision, reading disability, behavioral condition) and the need for additional services or inquiry. Moreover, health providers can also use their position as a trusted authority to reinforce the importance of academic dedication when a student seems to be underperforming.

Despite sparse examples, interviewees expressed interest in increasing the exchange of student records between education and health practitioners. Many reported, anecdotally, that educators informally consult SBHCs and nurses when students seem to be struggling in the classroom. Though this is not a systematic exchange or even documented practice, it suggests that educators understand the value add of sharing information across sectors. Others working to engage education systems in such arrangements reported that teachers and administrators at the individual school-level often fully support such initiatives, but encounter resistance at the district and department level due to privacy and resource concerns (barriers detailed further below).

Data type: Educator turnover and wellness

It is well documented that educators experience high levels of occupational stress. Nearly half of educators leave the profession within five years, and this rate continues to rise. Contributing to this, along with routine demands of the job, is the emotional and psychological stress school staff can experience from working with children who have faced adverse and traumatic events. Tragic realities such as abuse, food and housing insecurity, and exposure to drug and alcohol abuse affect students’ health and behavior. And though these experiences may occur outside of the educational setting, their effects are not left at school doors. Many educators find themselves managing and internalizing the stress and

trauma that comes into their classrooms and disrupts learning for the individual student and class. This “vicarious trauma,” over which educators have little/no control and are not often trained to manage, contributes to the profession’s high degree of turnover and, in turn, negatively impacts student performance.

Given the adverse effects school professional attrition has on students and school environments, at least one large health system deploys community benefit programs that focus on teacher well-being, as well as students’, and is using teacher attrition rates and self-reported educator stress, depression, and job satisfaction levels as metrics to evaluate these programs.

Case Example: Kaiser Permanente’s Thriving Schools – Resiliency in School Environments Program

[Thriving Schools](#), one of a myriad of school-based and other community benefit programs managed by Kaiser, is unique for its focus on school employee wellbeing. One of Thriving Schools’ initiatives involves resiliency training for schools and school employees to help combat consistently high occupational stress and create trauma informed learning environments. Through the Los Angeles Education Partnership, Thriving Schools has put professional coaches in 20 schools in California, Colorado and Georgia to help improve school wellness by: 1) providing professional development courses for staff on adverse childhood experiences, biology of the brain, and child psychology; 2) coaching on healthy responses to different types of student behavior and implementing restorative justice techniques in the classroom; 3) coaching on staff wellbeing (self-care) techniques and developing community among colleagues; and 4) consultation on school policies including discipline systems, leave policies, and staff breakroom “makeovers.” The program aims to create school workplaces in which staff are absent fewer days, more likely to stay in their positions, and experience reduced stress and increased job satisfaction.

What metrics are collected and how are they being used?

To evaluate this program, Thriving Schools is collecting teacher attrition data and measuring school staff stress and job satisfaction levels. These indicators are self-reported via regular staff surveys. Participating schools enter into MOUs that memorialize their buy-in and commitment to the process. Thriving Schools hopes that this partnership will show decreases in teacher turnover and stress levels, though there is not yet enough data to formally evaluate the program and its outcomes.

Data type: High school graduation and kindergarten readiness rates

Many hospitals and hospital systems, such as Trinity Health, Children’s Hospital, and Kaiser Permanente, include education data as part of their ACA-required, tri-annual community health needs assessments (CHNA). Commonly these indicators include high school graduation rates, kindergarten readiness, and 3rd grade reading levels. (One interviewee mentioned that some systems are also exploring more early-childhood education metrics, as high school graduation rates and even 3rd grade reading levels are often “too late” an indicator to inform effective interventions.) Similar metrics are also collected and used by

state health departments in developing state health improvement plans. For example, Maryland Department of Health collects and reports county-level high school graduation rates in its [data dashboard](#). This data is made available so local programs (health and education) can access it easily as they consider other public health indicators. This type of resource leverages publicly available information (there is no school-level data), and so there is no need for MOUs or sharing agreements.

Although the health sector's use of population-level education data in this way is not as innovative as direct systems integration, the widespread practice has contributed to the proliferation of education-health system partnerships and the implementation of school-based health interventions and programs. Moreover, the collection and use of aggregated, publicly-available education data sidesteps many of the privacy and technical barriers associated with the sharing of individual-level information.

COMMON BARRIERS TO SYSTEM INTEGRATION BETWEEN HEALTH AND EDUCATION ENTITIES

Privacy concerns associated with data exchange

Student and patient information is sensitive and statutorily protected by the Family Education Rights and Privacy Act (FERPA) and Health Insurance Portability and Accountability Act (HIPAA), respectively. Navigating the legal requirements and restrictions to establish data-sharing arrangements is challenging, and understandably, those responsible for protecting these data are often reticent to engage in programs that might undermine (or be seen to undermine) regulations. Still, while HIPAA and FERPA present procedural barriers, the existence of data-sharing arrangements show they can be overcome. Several interviewees believed HIPAA and FERPA were more of *perceived* barriers, the result of administrators overcorrecting for privacy concerns without fully understanding their legal obligations. Of interviewees' recommendation to enhance health-education integration, most common was cross-sector trainings for health and education professionals on the restrictions and allowances of HIPAA and FERPA.

At the same time, interviewees stressed that student and patient data are protected for good reason. Personal data (particularly health data) is valuable, and too often stolen and sold. Health systems invest heavily in data security, and are thus justifiably wary of linkages to less secure systems and potential vulnerabilities. Moreover, there still exist unfortunate social stigmas associated with illness and academic ability. In addition to legal privacy obligations, there are the expectations of students, patients, and their families who put their trust in these institutions. One interviewee said that in efforts to use education data to inform health interventions (and vice versa) the objective should not be to maximize data flow, but to minimize it – to thoughtfully establish what information sharing is essential to improving health and academic outcomes and to limit exchange to those data. This could be one of a number of principles promulgated to facilitate education-health partnerships and data sharing while mitigating privacy concerns.

Systems interoperability

Systems interoperability was the second most commonly cited barrier to data sharing between health and education entities, particularly in direct systems integration arrangements. Frequently, SIS and

health information management software are simply not designed to be compatible. The technical assistance and resources needed to patch incompatible systems (or adopt different, more compatible platforms) may be prohibitive. Interviewees added that technical complexities are compounded when attempting to align multiple data management platforms used by multiple districts or health systems. Indeed, systems interoperability issues and the inability to exchange data are pervasive problems *within* each sector and have been for years. Given this, leaders in both professions may be disinclined to invest in the development and management of yet more crosstalk.

In addition to technical barriers, some interviewees noted that SISs often do not contain the data that would be most useful to health systems. For example, while nearly all schools record student attendance, they do not regularly document the reason for absences. Student attendance data would provide better insight to physicians if they could isolate, for instance, absences due to illness from those due to family travel.

Professional capacity and evaluation “mismatch”

Health and education occupations are demanding; professionals in both sectors feel chronically over-extended and are asked to track an ever-growing amount of student and patient information. The “metric fatigue” reported by several interviewees may be preventing proliferation of health-education data-sharing arrangements, particularly if those arrangements require educators and/or health professionals to input more data than they already are. Exacerbating this, schools and school employees are not typically evaluated or funded based on student health metrics. Likewise, health systems are not evaluated based on their patients’ academic outcomes. This “mismatch” lowers the priority of cross-cutting programs. As an interviewee noted, for example, when schools face budget cuts, physical education, health, and nutrition programs are often among the first to go.

The professional capacity to manage health and education collaborations is also stretched, particularly in some school settings, by turnover and instability of leadership. Interviewees in the education sector said data-sharing pilots or other collaborative arrangements are often championed by an individual principal or superintendent, joining success of the program to the longevity of that person’s tenure. Amidst high turnover rates across education, school staff may not buy into such arrangements, seeing them as the “flavor of the year,” rather than an enduring partnership.

Lack of coordination between related programs/initiatives within institutions

Several interviewees, particularly from large state or nation-wide hospital systems or state health departments, noted a lack of coordination between school-based programs within their systems. Often hospitals and health entities partner with educators at many different intersections and through a host of community benefit programs, but to those staffing each program the larger web of touchpoints is not always clear. Greater alignment and whole-system awareness of initiatives within these institutions could create opportunities to share learning and better leverage resources and relationships. In this spirit, hospital systems such as [Children’s National](#) are working to catalog, improve coordination, and align policies between its school-based services.

Cross-sector communication and bureaucratic hurdles

Two interviewees, both in the health sector and both of whom led efforts to establish data-sharing arrangements between local schools and primary care providers at the district level, noted that initially it was a challenge just to identify a district administrator in the appropriate position and with appropriate decision-making authority to approach about developing an exchange. In their experience, navigating organization charts and opening lines of communication through bureaucratic requirements can be a time-consuming hurdle itself. Indeed, one interviewee reported that it took several months to find his appropriate counterpart in the school district. The time and energy required to establish, let alone maintain, such data-sharing arrangements compounds professional capacity issues and may prevent their uptake in some areas, particularly in the absence of staff specifically dedicated to managing these arrangements.

OTHER FINDINGS

Commonly identified best practices and elements of successful data-sharing arrangements

While speaking with interviewees, several key elements were repeatedly raised as essential to successful data-sharing programs and collaborative relationships between education and health entities. Though not one of the scan's primary inquires, these factors should help inform the Healthy Schools Campaign as and if it supports relationship building between the two sectors, including promulgating data sharing arrangements and the use of education metrics to improve student health.

- **Articulate mutual benefit** - Schools and school employees must understand the value of collaboration with health systems, particularly if they carry additional data collection and sharing requirements. These arrangements cannot be seen as another "check the box" exercise, or responsibility pushed down by the district. Efforts should be made early in the program/relationship building process to clearly articulate how the arrangement will positively impact the outcomes educators care about and are evaluated (e.g., attendance rates, student health). Interviewees stressed that this can be a significant undertaking, requiring multiple conversations and genuine listening, but it is a critical step and should not be overlooked.
- **Locally driven** - Several interviewees remarked that, in their experiences, data-sharing arrangements are most successful when they are locally driven, meaning the impetus comes from a school or community school system and a local hospital or clinic. This indicates buy-in amongst on-the-ground leaders, leaders who benefit from an intimate understanding of their community and its policy frameworks. In contrast, "one-size-fits-all" programs developed at the state level must account for a myriad of different communities and policy environments, which can prove an insurmountable task. This is especially salient in local control states, as local governing bodies have more direct control over school policies and functions in their community.
- **Mutual education** - Mutual education is key for both health and education personnel. Often, health professionals do not fully understand the host of (sometimes overwhelming) requirements, responsibilities, and legal restrictions educators navigate daily; the reverse is equally true. Two interviewees, both involved in the development of data-exchanging

arrangements, said that bringing health and education staff together to gain understanding of their respective professions (and of the restrictions of HIPAA and FERPA) enormously benefitted their initiatives and built respect and appreciation between the two communities.

- Dedicated staffing - Given lack of capacity and the already substantial professional burdens of educators and clinicians, establishment and maintenance of integrated data systems cannot be an “add-on” responsibility for these staff. Successful programs have staff dedicated to this role and to serving as liaison between the two sectors. This is especially critical considering the legal and bureaucratic hurdles and associated time and energy commitments (detailed above) often required to establish these arrangements.

Interest in learning collaboratives

Interviewees also consistently reported a desire to engage more with others working at the intersection of health and education. While some were already part of school-health learning collaboratives, others were not, and in some cases were not aware such forums existed. It was also not clear how much, if any, exchange is occurring between those working specifically to develop and pilot data-sharing arrangements between health and education partners. At least one major health system plans to develop an internal learning collaborative for its school-based staff. However, it seems there is opportunity to expand such platforms, both in other organizations and across organizations and initiatives, to engage a growing and enthusiastic stakeholder base.

Healthy Schools Campaign thanks [RESOLVE](#) for conducting the interview scan that forms the basis for this report. RESOLVE works with partners in the U.S. and internationally to design innovative, sustainable solutions to the 21st century's toughest natural resource, environmental, and public health challenges.

RESOURCES

HSC Resources:

[Using Needs Assessments to Connect Learning and Health: Opportunities in ESSA](#)

[Supporting Children's Health through ESSA: Overview for the Health Sector](#)

[Addressing the Health-Related Causes of Chronic Absenteeism: A Toolkit for Action](#)

[Healthy Schools Campaign's Framework for Action: Addressing Chronic Absenteeism through ESSA Implementation](#)

[Brief on Chronic Absenteeism and School Health](#)

[Metrics Working Group of the National Collaborative on Education and Health Report to the National Steering Committee](#)

[Chronic Absenteeism Working Group of the National Collaborative on Education and Health Report to the National Steering Committee](#)

Resources referenced and recommended by interviewees:

[Children's National School-Based Health Programs: Environmental Scan and Recommendations Report](#), Prepared by the Child Health Advocacy Institute Community Affairs Department (2017).

[Advancing Education and Health through the Community Schools Strategy](#), National League of Cities Mayors' Institute (2017).

[Schools, Government Agencies Move to Share Student Data](#), Benjamin Herold, *Education Week* (2015).

[Hospitals and Schools as Hubs for Building Healthy Communities](#), Stuart Butler Carmen Diaz, the Brookings Institution (2016).

[Public Health Access to Student Health Data: Authorities and Limitations in Sharing Information Between Schools and Public Health Agencies](#), Association of State and Tribal Health Officers (2012).

Examples of more highly integrated education and health delivery models:

[Policy Center for the Integration of Health and Education](#)

[The Primary School](#)