

Words of Wisdom from Local CSHP Experts A North Carolina Guide

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What makes some Coordinated School Health Programs (CSHPs) successful? What enables them to sustain their ventures over many years? What are these local CSHPs doing to improve academic outcomes for students in their communities?

This document, *Words of Wisdom from CSHP Experts*, summarizes lessons learned by leaders of four successful CSHPs in North Carolina. Here is the collective wisdom of these leaders, obtained over substantial periods of time working in school systems to improve health outcomes for children, being involved in the community partnerships, and promoting improved academic outcomes. Among the critical success factors are:

- The school district superintendent's commitment to and leadership on school health
- Development and maintenance of a strong relationship with a community-based health entity and with community leaders
- Some funding, even if a small amount, to put on the table to stimulate collaboration

I. Background

North Carolina School Health Infrastructure officials requested technical assistance from Education Development Center (EDC), through its Making Health Academic project, to assist them in answering these questions. By creating a North Carolina "guide" to effective CSHP development, these officials hope to promote dissemination of CSHPs to additional school districts across the state. Such a guide would have two purposes: to help the "model" districts continue to build and institutionalize their own CSHPs and to stimulate the creation of new CSHPs in additional schools.

In North Carolina, four school districts were identified as CSHP "models:" Ashe, Iredell-Statesville, Montgomery, and Wayne. The selection process included an e-mail survey that identified school readiness and information-gathering meetings at the respective sites. In June 2001, the state officials convened the CSHP leaders to share national and state CSHP resources and discuss future technical assistance opportunities.

The next step of the project involved organizing a "Meeting of the Models" conference on October 30-31, 2001. The leadership of each model was asked to bring a team representing the eight CSHP components. Each team brought eight to 10 members representing school and community health leadership.

The two North Carolina infrastructure directors worked with EDC staff to facilitate this conference by organizing two workshops. The first elicited information from the local teams about their development process. The second fostered a dialogue about key issues and themes. EDC then collected additional information by in-depth telephone interviews with coordinators of each of the four model districts after the conference.

North Carolina's *Words of Wisdom from the CSHP Experts* is organized according to the framework of "What is success and what makes these existing CSHPs successful?" and "What do existing CSHPs need to sustain success over time?" "What lessons can observers glean to promote successful replication elsewhere?" Among the key themes we pursued are:

- Generally, what impact did the CSHP have on academic performance and school atmosphere? Even if no causal relationship between school health and academic outcomes exists, can CSHPs find a correlation?
- Could observers identify significant factors that promote CSHP development and implementation, for example, partnerships and leadership, vision and planning, opportunities taken advantage of?
- What level of support from senior school administration is important for success? Support of local health leadership?
- What is coordination and is effective coordination a measure of CSHP success? What are the special challenges in doing the job of coordination?
- To what degree is funding an important factor in success?
- What advice do seasoned leaders have for those people and school districts just starting out?

II. Factors that Promote CSHP Development and Implementation

A. Partnerships

Partnerships are among the most critical elements for CSHP development. These encompass:

- partnerships between schools and outside organizations, including health departments, health providers and community-based organizations
- partnerships within schools, among different departments and those whose work functions intersect
- partnerships with parents and youth and with organizations representing them.

Each of the four North Carolina CSHP initiatives has strong partnerships among many of these entities. Each began around a single issue such as School-Based Health Centers (SBHCs), that is, partnerships between schools and health entities, and have grown to encompass the range of Coordinated School Health Programs. One began as an explicit CSHP and included a SBHC later when funding became available. With schools serving as the hub for CSHP coordination and implementation, visible and active involvement by health departments, hospitals, and school-based health centers has been central to success. In all four districts, likewise, a wide range of public and private social service, community, volunteer, faith-based, and parent organizations is involved. In one community, CSHP leaders fostered dialogue with and involved religious leadership that led to forging an effective partnership on behalf of school health.

Longevity of relationships both among individuals and between schools and community organizations serves as the basis for effective partnerships in all four communities. According to the Wayne County coordinator, for example, many community stakeholders play an active part in the entire school health enterprise. Particularly important is a strong relationship with the local Health Department, without which the CSHP could not get the job done. By contrast, newness to the position of CSHP coordinator in Montgomery County presents a challenge in terms of relationships and authority that need to be developed.

In Iredell-Statesville, Advisory Council members are all major partners: County Commissioners; heads of all public agencies, including the Health Department, Department of Social Services, child abuse prevention group, law enforcement; heads of community-based organizations; and civic leaders such as a bank president, Kiwanis leaders, and others.

A strength of the Ashe County CSHP is that all partners are at the table and these are “the same people at the same meetings,” according to the coordinator. This means that there is a history of working together, a set of working relationships among those who implement the CSHP. The

community-based comprehensive health coalition, the local Healthy Carolinians entity, is a key partner in Ashe.

In Wayne County, the local “movers and shakers” are partners with the school and hospital. The county commissioners are invited to everything. These partners “don’t sit around waiting for things to happen. People see a problem and get working together.” Monthly meetings include everyone.

In Montgomery, the school philosophy is to work together with partners that include the local health care provider, health department, social service agencies, sheriff, mental health providers, Smart Start, and other community-based organizations. A particularly strong partnership exists with FirstHealth of the Carolinas, a non-profit medical practice and emergency hospital that has located a SBSL Health Center in the middle schools. Because of this partnership, the CSHP has carried out a multi-tiered tobacco prevention and education program that includes smoking cessation for staff. Creation of a School Health Advisory Council remains on the list of initiatives yet to be undertaken.

B. Parental Involvement

Improvements in children’s learning and academic achievement, and their sense of connection to schools, are associated with parental involvement. All four CSHP leaders noted that strong parental involvement is a key ingredient of successful CSHPs.

Utilization of Wayne County’s Student Health Center requires parental involvement. While there are no parents on the Board of Directors, an Advisory Council is made up of parents and students from every school with a WISH Center. Whenever the CSHP planned to establish a WISH Center in a new school, program leaders started with the PTA and its general membership. Program leaders depend also on the school’s principal to actively identify people to engage, understanding that most people need to be asked to participate; many effective parent leaders will not volunteer.

In Ashe County, parental involvement is “tremendous” at the elementary and middle school levels, but dwindles substantially at the high school level. In one school with 50% of the population free and reduced lunch families, 500 parents attended a briefing session on school health and they donate both time and food. Parents are heavily involved in Healthy Carolinians.

Montgomery County parents are represented on the School-Based Health Center’s Advisory Group, along with school employees and medical personnel not employed by the health care provider.

Iredell-Stateville does “as much as we can” to involve parents. A key strategy is to reach parents, one on one, through the social work staff, which works to engage parents who may not have had a positive experience with school and are intimidated by such a relationship. The CSHP does parent training sessions through the student assistance/mental health program. From time to time, depending on interest, it has provided a course, Parent-to-Parent, to foster parent support groups regarding substance abuse prevention. Another parent involvement strategy uses a community-based mediation service as an alternative to suspension, a strategy that has in fact resulted in fewer suspensions. Finally, the district invites parents to sit in on sixth-grade sexuality education classes, which generates community support.

III. Organization

A. Leadership

Leadership, both internal and external, is critical to the success of the four CSHPs. Internally to the school district, each coordinator provides substantial leadership. Each has standing in her

community as well as her school system. By and large, the coordinators are senior people in the school administration and have immediate access to the superintendents of their districts. The Iredell-Statesville coordinator was explicit about the need to have access not only to the superintendent but also to the Board of Education: "It's a problem if the coordinator does not have access to the superintendent; you have no power and you have to have power to make programs work." Where the coordinator's access is not as great, an alliance with a strong partner, the health provider, offers similar authority.

These coordinators have strong connections to their health and community-based organization peers as well. Starting out to develop their CSHPs, coordinators identified influential "movers and shakers" in the community, some of them not obviously supportive of school health at the program's inception. Each coordinator made a point of explaining that they maintain strong relationships with such community leaders and that such connections are critical. In on-going work with these community leaders, a key to being able to function at this level is the coordinators' own "trustworthiness." Other people with whom they work trust them and respect their judgment.

External leadership provides strength for the effective CSHPs, for example, in Montgomery County with its strong health partner. In general, health officials provide strength to the school-based program, offering in-kind services such as funded nurse positions, and access to hospital and health department programs.

Iredell-Statesville has a strong advisory council that includes political figures, physicians, parents, and other decision-makers. Because the county commissioners were deeply involved with and knowledgeable about the CSHP from the beginning, county officials came to them to offer funding when the health program needed it. These elected officials support CSHP because they know that constituents benefit from its services and interventions.

In Ashe County, local religious leadership helps advance school health. The local director of missions for the Baptist Church chairs the Executive Committee of 15 people, which has developed a strategic plan for five years and established a subcommittee on policies and procedures to provide guidance on how to proceed on any issue.

The Wayne County CSHP includes local elected leaders as part of everything it does. As a result, county commissioners recognize the CSHP's track record and want to fund such programs throughout the county.

B. Coordination

Coordination involves bringing together key players from the school and community to assess needs, design a program, implement the CSHP, involve families and youth, create community linkages, and spread the message about activities. A coordinated approach to program implementation focuses on integrating funding, providing professional development, and pulling the diverse elements of health and education programming into a harmonious operation to best meet student needs. Coordination is the "glue" that makes order from energy-draining disorder. For a discussion of steps that coordinated teams take, please refer to the web site www.edc.org/Makinghealthacademic/Concept/Partnerships.

Coordinators should be able to accomplish the following tasks and responsibilities:

- Engage community support for school health initiatives by creating and maintaining an active advisory council consisting of parents, students, school staff, community agencies and organizations.
- Assess and analyze the physical and mental health needs of the students, staff and families in the community through a needs assessment process guided by the advisory council.

- Using this data, conduct a strategic planning process with the advisory council to determine short and long-term health and academic outcomes that these key stakeholders desire for the community.
- Identify a variety of research-based strategies that together build a comprehensive initiative to achieve these outcomes.
- Provide administrators, staff, parents and community-based organizations the support and training needed to implement appropriate interventions.
- Evaluate the success of selected interventions with a formal process.
- Market the initiatives to various segments of the community.
- Sustain the initiative by pursuing other funding sources, developing resources and infrastructure and maintaining the support of key community and school stakeholders

The coordinator's role is often complex and difficult. "Coordination" is essentially an art, sometimes a bit formless, that requires the coordinator to stamp her personality, energy, and knowledge on a many-layered process of bringing disparate programs and people into focus. Ashe County Coordinator Brenda Walters defined coordination as "mobilizing resources to pull it all together." Iredell-Statesville Coordinator Brenda Wilson described the coordinator as "someone able to steer people in the right direction, to push it all along," also someone who knows when and how to pick battles. Montgomery team member Teresa Reynolds defines the tasks as goal setting and "doing what no one else is doing." Wayne County Coordinator Allison Pridgen says that coordination involves strategic planning: one cannot "sit around waiting for things to happen." Rather, when people in the school and community see a problem, the coordinator takes charge and gets working on solving the problem. At the same time, "this is not a job for a perfectionist personality; you have to go with the flow, make mistakes and move on."

Critical to effective coordination, according to these coordinators, is an ability to see and then seize opportunities to move the CSHP agenda into action, once a school or community health need has been identified. Having convened a group of interested partners around a common vision and goals, the coordinator is able to mobilize them to act on a range of opportunities, often unanticipated.

IV. Funding

Certain tasks can be undertaken with little or no funds, but all four coordinators agreed that a "pot" of special funding jump-starts a CSHP. The prospect of funding causes the school and community partners to join together in creative ways to address multiple elements of the eight components.

For each of these four CSHPs, the catalyst for focusing partners on creating the program was a grant opportunity, for example, from the Robert Wood Johnson Foundation Making the Grade grants, Duke Endowment grants, and funding from the state's Healthy Carolinians initiative. Additional resources by means of a state-funded health coordinator in a local school district also resulted in initiation of CSHPs.

In Ashe County, for example, the possibility of getting a school swimming pool for children with special needs resulted in different leaders pooling resources for whole school and community. The CSHP coordinator wrote a grant to get physical training for developmentally disabled children that resulted in funding to bring an existing swimming pool up to code and then to maintain it. The community and other school children will be able to use the pool.

V. Academic outcomes and school health

More than ever, educators are held accountable for improved test scores, increased attendance, higher graduation rates, and less violence and substance abuse on school grounds. All initiatives linking health, social services, and community services with schools are premised on a common hypothesis: that they contribute to improving academic outcomes, that “healthy kids make better students and better students make healthy communities.” Programs that are narrowly drawn tend to have a narrow impact. More comprehensive programs, however, show gains in academic, social, and risk-taking arenas.*

All of the four schools can show linkages between their CSHPs and improved academic outcomes:

- For Iredell-Statesville, improvements have come in the positive social environment of the school, which in turn influences academic outcomes. With a school system considered to be the safest in the region, credit is given to the health and mental health services program. In the high school, a team of a mental health specialist and a health educator has worked to improve student behavior, using small support groups to promote anger management. These initiatives resulted in preventing a shooting. Performance on state achievement tests has improved since the inception of the school health program, with its breakfast program that helps support student nutrition and minimizes students’ experiencing low blood sugar. Attendance is up and suspensions are down, both results attributed to the CSHP’s impact.
- In Ashe County, improvements in upper respiratory health improved school attendance. The school health partners had identified a high number of Emergency Room (ER) visits for upper respiratory infections as a major problem. They also found that 43% of visits to the school nurse were asthma related. These two respiratory problems are the major reasons for children’s absence from school. The school-based health center’s goal was to reduce ER visits for such respiratory infections by 20%; instead, they reduced them by 40%. Simultaneously, they found that school attendance for the same age group improved. Principals believe the CSHP was responsible for this achievement. Another academic outcome from the CSHP: dropouts were reduced by 37% in schools that expanded mental health and counseling services. Finally, CSHP proponents point to the fact that all schools in the district are tobacco-free as one of the program’s successes.
- In Wayne County, not only does the CSHP coordinator see a correlation between the school health program and academic outcomes, but parents and community leaders in this district believe that the CSHP has a proven track record for improving their schools. Preliminary evidence suggests that test scores have improved and attendance is up. There is some evidence that dropout rates in the four schools with WISH (Wayne Initiative for School Health) centers have declined.
- In Montgomery County, preliminary outcomes suggest that attendance has improved at those middle schools with health centers. As well, attendance is up at those schools that provide breakfast. Statistics on test scores are not yet available.

VI. Advice to those starting out

A person with professional qualifications, knowledge, experience, and long-term relationships with other stakeholders is helpful for providing effective coordination. However, it is not always possible to find or to be this person. Many coordinators are starting out in the job and face challenges. What words of wisdom do long-term coordinators have for their more recent peers?

The successful North Carolina initiatives sought out opportunities on which to build their CSHPs:

- School leadership with a philosophy that academic achievement is based on healthy children and a safe learning environment
- Participation in Healthy Carolinians, a state-driven effort to create local health planning groups
- Some funding, either a grant (sometimes small) or a state-funded position

Seasoned coordinators' words of wisdom for new districts are:

- Ensure that the district makes health a priority and requires that the coordinator's job be done by someone with proper qualifications and background
- Have a strong connection to someone at central office with administrative experience and political clout
- Have some dollars to put on the table; this helps stakeholders be more flexible about relinquishing turf
- Develop trust: Take the time to build trust and good relationships
- Understand that it takes a very long time to establish the foundation for collaboration and even longer for successful results
- Develop a "kitchen cabinet" of a few people you can trust and who are committed to the success of the initiative
- Make sure there is "stick-to-itiveness" to keep people working on a common goal
- Know when to pick battles and when to avoid them

VII. Moving to the Next Level: Sustainability and Replicability

What do existing CSHPs want and need to move forward? With regard to dealing with and overcoming obstacles to institutionalizing CSHPs, the successful coordinators feel they have built in sustainability by creating strong networks of stakeholders with real investment. Further, they have garnered public support because children have access to needed services. An increase in student achievement and attendance elicits school administrators' support.

Nevertheless, they did ask for technical assistance around getting more funds as they identify needs that stakeholders want to address but do not have the resources for and they seek assistance in long-range strategic planning.

VIII. Conclusion

Successful North Carolina CSHPs have in common a commitment to partnerships among multiple health, education, and community entities; parental involvement; access to and ability to use strong leadership; and experienced and effective coordinators.

Each had origins in and then maintained access to a school district superintendent and other key education personnel who understood the purpose and value of school health; interest on the part of a School-Based Health Center (SBHC) or local health provider, (e.g., hospital or local health department; and involvement of local elected officials, religious leaders, other community "movers and shakers," and families).

As a result, these CSHPs serve as a model for moving forward in North Carolina to expand school health to improve education outcomes.

NOTE: This document is not a step-by-step guide to creating a CSHP from scratch. For such a guide, we refer you to Talking About Health Is Academic, six workshop modules for initiating and promoting a coordinated approach to school health programs, developed by Education Development Center, Inc. (EDC). It can be purchased from Teachers College Press by going to the Making Health Academic web site: www.edc.org/makinghealthacademic, and clicking on Resources, About the Modules Talking About Health Is Academic. From there, access the Teachers College Press web site and order forms.

*Roth, J., Brooks-Gunn, J., Murray, L., & Foster, W. (1998). Promoting healthy adolescents: Synthesis of youth development program evaluations. *Journal of Research on Adolescence*, vol. 8, no. 4, 423-459. Cited in *Linkages to Learning*, Coalition for Community Schools, Working Draft, June 2002.