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# Building a Collaboration Between a Children's Hospital and an Early Childhood Education and Social Services Center



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To address toxic stress among children growing up in poverty, an innovative collaboration was developed between a community center, Operation Breakthrough (OB), and a tertiary care children's hospital, Children's Mercy Hospital (CMH). OB started as a day care center but has expanded and developed ways to provide shelter, safety, food, employment, education and health care. CMH is a traditional academic children's hospital that, in recent years, has been looking for ways to better address the social determinants of health. This article

describes how the two organizations found ways to work together to capitalize on each other's strengths. Although the two institutions shared some common goals, they had very different organizational structure. We describe how a series of complex negotiations and trust-building exercises eventually led to a robust and unique partnership.

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## Introduction

**C**hildren's hospitals provide medical care for the most vulnerable children in their communities. While many children's hospitals may screen for

and intervene in social determinants, their primary goal is pediatric health care service delivery within a biomedical framework. Many community agencies serving children primarily focus on the social determinants of health and well-being. They usually do not have the expertise or resources to provide health care services. This artificial separation in meeting the needs of children is unfortunate since it creates barriers for parents who may lack the resources or knowledge to navigate through multiple complex institutions.

Many scholars and policy makers have called for collaborative relationships with social service agencies, educational systems, and other nongovernmental organizations to maximize the impact and cost-effectiveness of programs that serve vulnerable children.<sup>1,2</sup> Creating and sustaining such effective relationships is a challenge for a variety of reasons. This paper presents a case study of one such collaboration between a children's hospital and a community social service agency.

## *Operation Breakthrough Initiates Health Care for Children*

In 1989, Operation Breakthrough (OB), a large, federally subsidized day care and social service agency serving many of the poorest children in Kansas City, decided to add health care to the list of services it

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*Abbreviations:* ACE, Adverse Childhood Experiences; APRN, Advanced Practice Registered Nurse; CMH, Children's Mercy Hospital; OB, Operation Breakthrough.

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would provide. A grant from a local philanthropic organization allowed OB to hire a nurse. The position was crafted to allow the nurse to take care of children with minor illnesses on-site. This was crucial because most of the parents of children at OB worked at jobs that did not

provide sick leave. Thus, absence from work due to a child's illness meant lost pay or a lost job. On-site care of children with a minor illness would allow parents to keep their jobs. The nurse clinic would also provide education to parents about basic health concerns, such as injury prevention and asthma management.

There was no room at OB for this new service. At first, a large closet was converted to a small exam room and filled with a collection of found and donated items: a used exam table, a nebulizer, and a blood pressure cuff. OB purchased basic supplies and some over-the-counter medications. The local health department provided vision, hearing, and lead screenings.

### Engaging the Region's Children's Hospital

In 1998, OB wanted the clinic hours of operation to be consistent and if possible to be the same as rest of the center. This would allow the provision of well-child care as well as acute care and importantly help establish the OB clinic as a medical home for the children attending the center.

To do that, they would need additional funding and a much larger staff. They turned to a neighbor, the regional children's hospital, for help.

Children's Mercy Hospital (CMH) ran the largest Medicaid managed care organization in the region. This organization provided health coverage for many of the children attending OB. The two organizations negotiated a collaborative model by which CMH provided an off-site medical director and an additional advance practice registered nurse (APRN). This worked well and grew so that, by the late 1990s, the pediatric clinic was staffed by two APRNs, one employed by CMH and one employed by OB, each with different collaborating physicians. As the clinic grew, it needed more space. OB renovated space near its day care classrooms that was large enough for both an exam room and a "sick bay" where children with minor illnesses could stay during school hours. The medical director provided oversight for the APRNs but did not see patients.

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## ***Collaborations between pediatric health care and early childhood education requires willingness to do things in new and unfamiliar ways.***

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The APRNs functioned in a variety of ways—as school nurses and primary care and acute care providers. Tasks included administering nebulizers, giving G-tube feedings, administering skin treatments for severe eczema, calming highly anxious children, and per-

forming well-child exams. They taught both parents and teachers how to care for many childhood illnesses. Because the APRNs interacted with children and families on-site, and because their presence allowed continuity of care, they were highly trusted by parents and children alike. They learned about and valued individual and family strengths, and sought to help parents do the most with their limited resources.

Once OB became a certified Early Head Start program, Head Start health requirements were added to the list of clinic duties. A partnership with a local safety net general hospital allowed some services to be offered to adults, including medical, dental, and vision screenings.

Shortly after the second APRN was added to the staff, CMH approved a much-needed clinic care assistant position. They were fortunate to find a care assistant who was also a trained minister. She brought a broad vision of good medical care, one that sought wholeness and harmony for the body, soul, and spirit. Her official duties included information technology, medical records, and billing, in addition to clinical duties. Her unofficial role was to foster caring and trusting relationships with families.

Growth of the clinic brought with it both opportunities and challenges. It became clear that ancillary services and a supportive infrastructure were desperately needed and that the isolation and distance clinic staff felt from the main campus of CMH needed to be addressed. Furthermore, as the owner of the clinic space, OB was responsible for upgrades to the physical space and it never had enough money. By the early 2000s, the reactive approach to the clinic's development that had worked until then would no longer be adequate.

### Formalization and On-site Medical Direction

After a series of discussions between leaders at OB and CMH, the two organizations agreed, in 2011, to appoint an on-site medical director of the clinic at OB. CMH leadership hoped that this would help formalize the processes of the clinic, consistent with the standard policies and procedures of their hospital system.

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