**School Based Health Care In Delaware**

**A White Paper to Explore Financing Opportunities for Growth and Sustainability**

**Delaware School Based Health Alliance**

**INTRODUCTION:**

**The purpose of this paper is to present provocative and challenging strategies for financing and resource development that will support the growth and expansion of high quality school based health care – strategies that will stimulate system wide innovation. The Alliance wishes to generate a robust discussion and vigorous action by a wide array of constituents to advance the health and well being of school age children.**

**Section I: OVERVIEW OF CURRENT SYSTEM AND CHALLENGES**

For more than 35 years the Delaware Legislature has approved funding for school based health centers (SBHCs) based in public high schools. These funds are allocated and managed by the Division of Public Health (DPH). The Department of Education and local school districts cooperate with DPH through policy support and coordination with school nursing. The Department of Children and Youth, Child Mental Health Division, also allocates resource to schools, but at this time those resources are not systematically coordinated with or integrated with school based health centers. Twenty-nine SBHCs are sponsored and implemented by Delaware’s hospital-health systems through contractual arrangements with DPH. The health systems are a critical component of the school based health center system – assuring quality health care by offering primary multidisciplinary health services including clinical oversight and staffing. The health systems include: Christiana Care (15 sites), Bayhealth Medical Center (7), Beebe Healthcare (3), Nanticoke Health Services (3) and La Red Health Center (1).

**The management of these health systems provided the Alliance with information about current SBHC operation and some of the challenges they face:**

* School-Based Health Centers in Delaware are typically staffed with a mid-level health provider (1 full-time), a licensed clinical social worker (.5 FTE-1.0 FTE per center), an administrative assistant (.6 FTE-1.0 FTE per center), and dietary services (<.25 FTE per center, if at all)
* Most Centers are able to maintain hours of operation during the typical school day. Most Centers either close or drastically reduce hours of operation during the summer.
* The majority of students in each high school participate in their Health Center, with some Centers achieving over a 90% participation rate.
* During the past 5-year period the percentage of total operational costs covered by State funding has decreased each year. As of the most recent fiscal year, most sponsors reported State funding represented 52%-60% of total expense. Sponsors are seeing State funds being exhausted as early as January or February, well before the school year ends in June.
* Revenue from the collection of insurance claims has been unreliable. Schools with a high percentage of students covered by DE Medicaid experience more reliability, as State policy requires DE Medicaid to pay. (See comments below specific to commercial carriers).
* **Since July 2012, sponsors report operating deficits for their Health Centers that total more tha**n **$4.8M.**
* Health Centers often must provide uncompensated care because:

1. Commercial insurance companies will not agree to adjudicate claims confidentially (i.e. no EOB suppression)
2. Students are covered by a Medicaid plan in an adjoining state
3. Commercial insurance companies do not cover all services of the Centers. (ex: certain mental health services)
4. Uncompensated services are more difficult to quantify, but it is known that *they exceed $600,000.*

* Not all Centers can provide reproductive prevention services, which would reduce un-planned pregnancies. This means higher numbers of students absent from school due to pregnancy and increased costs to DE Medicaid to pay for the un-planned pregnancies

**Challenges to Continued SBHC Operation by Sponsoring Health System:**

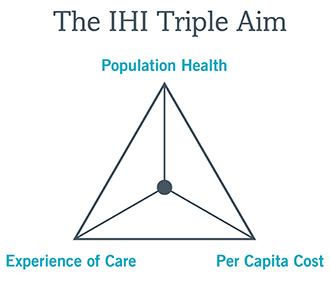
1. Downward spiral of State funding creates greater risk for health systems regarding covering future operational costs.
2. Highest percent of students covered by insurance have DE Medicaid. State government’s budgetary concerns place that funding source at risk.
3. A significant percentage of students have commercial insurance coverage. There is no incentive to urge these companies to cooperate with EOB suppression. This means their beneficiaries are receiving care at no cost to the health insurance company. ***Regulatory assistance to require payment would aid sponsors and the State.***
4. During the current school year sponsors are reporting increased challenges in collecting payment from the DE Medicaid managed-care companies. The increased administrative burden to collect those funds is adding to indirect costs.
5. Shortages in financing sources will lead to reduction in hours of operation and/or services. Providing fewer services could lead to reduced effectiveness of Centers and lower student participation.
6. No long range plan exists to address finances of the Centers. Current system promotes staying in the Centers to provide services to students (and thus generate higher revenue through insurance claims). This approach de-emphasizes education and prevention to students in group settings and in the classroom. *Student health care is thus not managed with a long term goal of reducing demand for services.*

**Section II: THE IDEAL SYSTEM and IDEAL FUNDING**

**What is the Vision:**

In a perfect world SBHC would be part of a true population health model with a strong partnership between schools, community based hospital-health systems, primary care, and behavioral health. In addition, a sound business model would support high quality centers that respond to their community, school districts, and student needs while producing quality outcomes and patient satisfaction. School based health centers would add significant value to the Triple Aim[[1]](#footnote-1) proposition:

* Improving the patient experience of care (including quality and satisfaction);
* Improving the health of populations; and
* Reducing the per capita cost of health care.



The centers would also be a core of health care innovation and emerging Delaware initiatives such as those proposed by the Delaware Center for Health Innovation[[2]](#footnote-2) and the Community Schools Model developed in Wilmington under the leadership of the Children and Families First organization[[3]](#footnote-3). Another exciting development is the comprehensive approach to integrated health and education being pursued by the Colonial School District, which opened the first Delaware elementary school community wellness center in 2016[[4]](#footnote-4)

A connection between innovation and school based health care is prudent and increasingly urgent. If the goal of health innovation is to promote integration of services and for Delaware to be one of the healthiest states in the nation, then school based health services must be a significant part of the work.

**Core Competencies for School Based Health Centers:**

The core competencies for SBHCs outlined by the National School-Based Health Alliance serve as the basis for a SBHC framework that guides future development without being overly prescriptive to a “one-size fits all” model. Delaware’s Hospital-Health Systems and School Districts need flexibility to develop a model of care for SBHCs that works for their school districts given the needs and resources available.

***Access:*** The SBHC assures students’ access to health care and support services to help them thrive.

***Student-Focus:*** The SBHC team and services are organized explicitly around relevant health issues that affect student well-being and academic success.

***School Integration:*** The SBHC, although governed and administered separately from the school, integrates into the education and environment to support the school’s mission of student success and partner with the school on health related issues.

***Accountability:*** The SBHC routinely evaluates its performance against accepted quality and safety standards to achieve optimal outcomes for students. SBHCs will also comply with all rules and regulations, evidence-based practices, and standards of care.

***School Wellness:*** The SBHC promotes a culture of health across the entire school community, that includes support of evidence-based practices in the provision of healthcare services, health education, nutrition, and behavioral health.

***Systems Coordination:*** The SBHC coordinates across relevant internal and external systems of care that share in the well-being of its patients.

***Sustainability:*** The SBHC employs sound management practices to ensure a sustainable business. As outlined by the School-Based Health Alliance, the most important characteristics of strong and thriving SBHCs include strong partnerships, sounds business model and high quality practice.

**Ideal Center Staffing :**

Working from the core competencies, a needs assessment ideally dictates services to be provided and the staffing model warranted for each community. At the core of each model, medical, behavioral health and nutrition counseling are key to child health. Potential options for dental and vision services and other family oriented services might be considered in some centers - based on analysis of the community needs assessment.

**Section III: OVERVIEW OF INNOVATIVE FUNDING MODELS**

**Payment Models that Promote Comprehensive Preventive Services (John Snow, Inc and California SBHA)**

This paper presents models to cover school based health services that are not now reimbursed in the traditional health care fee-for-service system. Some of the most comprehensive strategies are in-line with payment reforms being developed by the Delaware Health Innovation Center. Options include:

* Primary Care Medical Home: Becoming a more formal part of a “Primary Care Medical Home” would enable SBHC to enhance the local health care system by integrating the team approach with primary care physician practices – eg. Care coordination, social work, nutrition, management of chronic disease. This strategy uses a per-member-per-month payment approach.
* Prospective Payment System: This method pays a fixed amount based on a bundle of services and models the method used for FQHCs
* Pay-for-Performance: This model pays based on benchmarks and outcomes. It uses the Triple Aim goals of patient experience, value and quality.
* Accountable Care Communities: This model combines community based agencies to reach population health goals with a focus on the social determinates of health. SBHC is positioned to be an essential component of ACC.

**School Based Health from an MCO Perspective (Amerigroup and Maryland SBHA)**

This presentation endorses the idea that school based health care combined with primary care can improve access and convenience for adolescent care while reducing emergency department use. A co-management style is employed. Patient education, prevention and data sharing are enhanced. MCO’s use HEDIS measures to monitor access and quality.

**Michigan’s Medicaid Matching Initiative (Kellogg Foundation)**

Michigan looked for a financing strategy that would be reliable and less vulnerable to political changes. Medicaid Managed Care funding is used to finance outreach and education. State appropriated funds for health education in the education budget and funds for SBHC were used to match federal dollars. The per member/ per month (PM/PM) capitated rate paid to MCOs was increased to cover additional SBHC services. Medicaid established reporting requirements to support the funding.

**Children’s Health System Transformation (UCLA Center for Healthier Children)**

SBHC is envisioned as a tool to achieve “Triple Aim” core goals.[[5]](#footnote-5) A 3.0 Model Health System focuses on optimal health, life course development and population health – each of these are enhanced by SBHC. This model moves to a comprehensive vision of school health rather than the isolated SBHC and it combines with community-based services. This paper proposes an action framework to move from planning to action.

**Section IV: NEW STRATEGIES for DELAWARE – OPPORTUNITIES for SBHC TRANSFORMATION**

1. **Children’s Health Care as a Public Service**

School nursing started in the US in the early 1900s in response to infectious disease out-breaks and high absenteeism. It has long been a tradition in Delaware that every public school employ a school nurse, with regulations established by the Department of Education. State government provides approximately 70% of the salary cost for one nurse for every 700 students. Local districts supply 30% of total salary, which comes primarily through county property taxes. While school nurses have been a part of the education system and the public funding of education, school based health centers were developed through the medical and public health systems and were not seen as a basic part of public education. This has kept school based wellness centers mired in the complex medical funding paradigm rather than being part of a system of care needed for child well-being and education success - with state formula funding and a local tax base.

***Now is the time to make a fundamental shift from the Medical Services Model to the Education Model – health care as an essential service for successful education funded as a public service for all children***

The CDCs model of Coordinated School Health – combining school nursing, wellness centers, health education and counseling to create a comprehensive approach to children’s education and health – offers a framework.

**The Coordinated School Health Program** is an organized set of policies, procedures, and activities designed to protect and promote the health and well being of students and school staff. It is a holistic approach to health and education with eight components: school health services, health education, health promotion programs for faculty and staff, counseling psychological and social services, school nutrition services, physical education services, health school environment and family and community involvement.

This model is suited to address health problems that have a negative influence on student achievement and success including an increase in chronic health conditions such as asthma, allergies, diabetes, addictions, teen pregnancies, HIV/AIDS, STDs, suicide and auto accidents.  Many of these health problems are the result of poverty, homelessness, poor nutrition, lack of exercise, smoking, early and/or unprotected sexual activity, substance abuse, stress, and depression.

To move this model forward a new approach to funding is needed that brings school health care into a stable tax base. Local governments, school boards, state legislators, Department of Education and DHSS will need to come together to create a new vision of comprehensive child services organized around schools and coordinated with community services. A tax based might include a tax on health insurers (who benefit from care not now covered by insurers), a portion of property tax designated to school health, or a new tax such as a “soda tax”, which is showing promise in other states.

1. **Integrate School Based Health Centers into Outcome Based Payment Models/ Create a School and Community Accountable Care Organization (ACO)**

The Delaware Center for Health Innovation (DCHI), as part of its strategic plan to implement Delaware’s State Innovation Model (SIM) grant, is contemplating an outcomes based payment methodology to support better integration and coordination of care for high risk populations. According to a DCHI white paper produced in February 2016, two types of outcomes-based payment models are being considered: Total Cost of Care and alternatively, Pay 4 Performance. These models reward providers for controlling growth in the per capita total cost of care (i.e., primary care, behavior healthcare, medical care and/or pharmacy costs), or in the case of Pay 4 Performance, provide bonuses based on quality and efficiency measures. The goal of both models is practice transformation – to move from a fee for service system that rewards volume, to a more integrated healthcare system that rewards quality and cost control, while preserving access to services (the Triple Aim).

A common response to outcome based payment methodologies is the creation of Accountable Care Organizations or Clinically Integrated Networks. ACOs and CINs are a way for providers to formally organize in order to achieve scale and capabilities necessary to succeed under an outcome based payment model. SBHCs could become valuable partners in an ACO model of care if they can be linked in a more formal way to primary care providers, behavioral health specialists, and other stakeholders who share a common goal to improve population health.

In some states, such as Ohio, SBHCs are members of Accountable Care Communities that incentivize prevention and population health. ACC’s are organized geographically and include multiple stakeholders who work collaboratively to improve service delivery and prevention efforts across the continuum of care. A similar population health model is emerging in Delaware, called Healthy Neighborhoods. The Healthy Neighborhoods initiative has rolled out in Wilmington/Claymont and in Sussex County, and will focus on some of Delaware’s most vexing population health issues such as obesity. SBHCs, as a key provider of adolescent health services, must be included in the Healthy Neighborhoods initiative.

If one considers the Healthy Neighborhood initiative as DE’s Accountable Care Community, then it may be possible to expand on it and apply for demonstration funding that could be used to test SBHC payment reform options incentivizing prevention and population health. Payment to SBHCs could be tied to better health outcomes, rather then payment based on the current fee for service system.

1. **Integrate SBHC resource with DPH and Child Mental Health Programs that have complimentary missions and goals**
2. **Develop a New Behavioral Health Model that Leverages Child Mental Health Initiatives and Resources**

Delaware’s Child Mental Health System currently contracts with community based providers to serve school age children. If cooperative arrangements could be developed, those providers could be brought into the schools to reach children more effectively and efficiently while also enhancing a more comprehensive approach to care. Child Mental Health also receives federal funding to focus on prevention, which could have a greater impact by working with SBHC.

While a robust dialogue with Child Mental Health is needed to design this strategy, opportunities for consideration include leveraging the array of social services to support comprehensive care models integrated with school health. For example, how can SBHC contribute to drop out prevention; how can it break up the school-to-prison pipeline? A few ideas to explore in more depth include:

1. Using a confidential type of Skype system, telemedicine in the Psychiatry area could be used to offer a higher level of treatment within the school setting.  SBHC staff would refer the appropriate cases to the higher level of treatment and the students would not need to leave the school for services.  Great for continuity of care for the difficult mental health cases.
2. Assist Department of Family Services with counseling for families and students (foster care), not related to placement or placement reviews.
3. Collaborate with Department of Justice on school climate and bullying programs.
4. Establish seats on the SBHA for members of related Delaware Departments to foster collaboration of services and eliminate duplication of services to use funding more effectively.
5. **Work with DPH to fully Integrate Population Health Programs Managed by DPH into SBHC.**

DPH develops and manages funding for a number of population health initiatives focused on the health of women and children and the prevention of chronic disease. Most of these programs have staff, and both state and federal funds. For many programs, DPH could increase its reach and impact by integrating approaches with SBHC. Historically, DPH has managed its SBHC program in isolation from its population health program, thus missing out on opportunities for more effective and efficient deployment of resources. Creating a management initiative at the Director level that would encourage integration across all relevant programs could be one way to kick-start some innovative resource sharing that would benefit children and gain greater impact on shared program goals across schools and DPH.

**Section V: ACTION AND ADVOCACY PLAN**

**The Action Plan for the future development and funding of School Based Health Care requires the engagement and sustained effort of many stakeholders. Some action steps are short-term to make changes that are feasible within the current administration, some are to lay the knowledge and advocacy foundation for system change, and some are transformative and future oriented. The Alliance, its leadership and members, is committed to stimulating and guiding the process so that sustained action is practical and feasible. The action steps presented are a starting point for deliberation.**

**Steps to Build Advocacy and Lay the Foundation for Action:**

* Meet with the Governor and Lt. Governor to gain their support and address the family services cabinet council. Ask for a coordinated effort from DHSS, DOE and DCYTF
* Form a strong connection with the Delaware Center for Health Innovation
* Meet with DPH and Child Mental Health Directors and DOE Secretary to begin a dialogue about integrated resources
* Work with friendly state legislators to establish a legislative task force for public funding of SBHCs
* Form local health systems/primary care/school board/DPH work groups to develop local integrated care initiatives and support for more local funding
* With the support of the National Alliance, bring national experts to a Delaware Forum to present innovative ideas to CEO’s, Superintendents, School Board Presidents, Cabinet Secretaries and Legislators

**Short Term Action Steps:**

* Call a meeting of the Alliance Strategic Leadership Group to further develop the plan
* Ask DPH to facilitate a leadership discussion with Medicaid about new Medicaid strategies that can be implemented in the next year.
* Work with the Insurance Commissioner on legislation that will require suppression of “Explanation of Benefits” (EOB) statements by insurers
* Ask DPH to arrange for a consultant study to assess the cost benefit and revenue versus administrative cost of trying to collect third party insurance for SBHC

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Copies of this paper have been provided to DHSS, legislative leaders, and members of the Delaware Health Alliance.

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2. https://pages.dehealthinnovation.org/dchi-strategic-plan [↑](#footnote-ref-2)
3. http://www.cffde.org/community-schools [↑](#footnote-ref-3)
4. http://www.colonialschooldistrict.org/ribbon-cutting-one-kind-wellness-center [↑](#footnote-ref-4)
5. **TRIPLE AIM**. The term “**Triple Aim**” refers to the simultaneous pursuit of improving the patient experience of care, improving the health of populations, and reducing the per capita cost of health care. Note that the **Triple Aim** is a single **aim** with three dimensions; Oct 17, 2014

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