School-Based Wellness Center Literature Review

Delaware & National Environment

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Executive Summary

Delaware's FY20 Appropriations bill (HB 225) School Wellness Center Epilogue included funding to establish school-based wellness centers (SBWC) in high-need elementary schools. This funding enables the Delaware Health and Social Services (DHSS), Division of Public Health (DPH) to develop a strategic approach for establishing SBWCs in high-need elementary schools, as well as to advance the integration of SBWCs into more schools with minimum standards for the provision of high-quality, effective services and long-term sustainability. The following is a literature review conducted to support the strategic planning process by synthesizing existing literature and recent Delaware research on SBWCs to identify insights about potential models, opportunities, gaps, or barriers in SBWC programs and policies across Delaware and the nation.

The literature review is categorized into the following overarching topics to correspond with strategic planning workgroups:

- Infrastructure, Policy, and Operations
- Data and Best Practices
- Finance and Sustainability

Each topic is then broken down further to explore key themes and priorities for strategic planning.

A number of operating models for SBWCs exist and have evolved overtime to include a multidisciplinary team that offers a combination of primary/preventive care, reproductive and sexual health care, behavioral health services, nutrition services, and oral health care. Data support an association between increased behavioral health and reproductive health services offered by SBWCs and positive educational, social, and emotional health outcomes. However, there are significant needs associated with providing behavioral health services in SBWCs, including ensuring adequate operational accessibility, protecting patient privacy, and ensuring reimbursement. Several SBWCs also provide social resource navigation and care, either through CHWs or community-based organization (CBO) partners to address upstream social determinants of health (SDOH) for students and their families, including food insecurity, housing assistance, income assistance, and other benefits programs. Across all models, SBWCs are seen as vital providers of population-level public health initiatives and health education. SBWCs are also an important site for providing trauma-informed care (TIC) given the patient population they serve and their potential to integrate with other social and education services for children. Telehealth is also an increasingly integral element of SBWC service delivery and sustainability. Services such as physician or behavior health provider consultations, well visits, screenings and stabilization services, and behavioral health counseling, may be offered via telehealth. SBWCs and the medical sponsor must survey state Medicaid guidance on telehealth service delivery to understand state regulations and billing practices.

Several states have explored establishing SBWCs as primary care medical homes (PCMH) for their students, particularly for the uninsured, or encouraged SBWC to be incorporated into patients' PCMH. When developing an operating model for SBWCs, it is important that community pediatricians/hospital systems, parents/students, and school district staff are involved to determine effective models and referral systems. SBWCs can provide linkages for students to community pediatricians during enrollment and insurance eligibly screening. Community pediatricians can outsource routine health monitoring management (nutritional management, medication management, comorbidity management) and health prevention/education to SBWC providers.

Privacy and confidentiality of patients is one of the biggest concerns of SBWCs, particularly as it relates to billing for reproductive and sexual health services, as well as sensitive behavioral health services. The

main concern in caring for a patient population who are mostly enrolled as dependents on parent/caregiver insurance, is that EOBs will be sent to policyholders (parents/caregivers) that detail services provided. There are also several overlapping policy concerns relating to the records that capture child/student educational, health, and social needs. The application of Family Educational Rights and Privacy Act (FERPA) vs. Health Insurance Portability and Accountability Act of 1996 (HIPAA) is determined by how student/patient records are stored and sent. For most information exchanged from a SBWC, the FERPA serves as the ultimate authority on confidentiality and record disclosure. Additional legislation governs data sharing and privacy related to behavioral health care, substance use treatment, and child welfare information.

To support operating and policy needs, SBWCs must invest in enhanced infrastructure and staffing. EHRs should be customized as much as possible to the unique needs of SBWCs and their partners so that all relevant information is able to be accessed through a single platform. Equally as important in the EHR development process is for SBWCs to understand the documentation and reporting needs of MCOs and third-party insurance to ensure proper billing and quality reporting according to the metrics required. Data collected through EHRs may also serve in SBWC evaluations. Evaluations should be structured to follow a specific, pre-defined theory of change model that emphasizes more proximal outcomes measures. In structuring data reporting and practices aimed at targeting health disparities, SBWCs may consider conducting quasi-community health needs assessments (CHNA), and/or leveraging existing data on community health disparities. Size of and staffing of SBWCs may vary by services performed and size/need of student population, but there are several baseline needs for all SBWCs. Data show that increased hours of operation for SBWCs contribute to more positive health outcomes for their enrolled populations. Enrollment of school staff and student families may increase financial sustainability, security, documentation, and treatment capacity are strong limiting factors.

SBWCs need to be incorporated into the larger school district ecosystem to enhance student enrollment, participation, and quality of care. SBWCs and school staff should also explore options to integrate behavioral health screenings, referrals/communications, and intervention into the school environment. In the current climate, SBWCs should contribute to the school district by creating procedures and rules for sanitation, distancing, capacity control, and personal protective equipment (PPE). Additionally, SBWCs should work with local health departments and schools to understand if it is feasible and appropriate to provide COVID testing. Finally, operational plans must be made on a statewide basis to promote equity and address operational needs related to racial trauma and COVID-19.

A strong factor in determining SBWC sustainability is diversified funding sources (public grants, private donations, billing capacity for 3rd party insurers and Medicaid). Additionally, FQHCs have emerged as a leading medical sponsor to ensure SBWC sustainability because of their familiarity with treating safety-net populations, skilled billing and sustainability capacity, and enhanced reimbursement through Medicaid. SBWCs have been shown to produce substantial savings in the larger healthcare environment given their ability to provide consistent preventive care and health education/public health initiatives to vulnerable populations. Thus, some states have explored incorporating SBWCs into their ACO models to share in outcomes-related health care savings. Both in Delaware, and in other states, efforts have been made to enhance sustainability by finding a more consistent tax base for funding, as well as examining ways to streamline and link services offered across state agencies.

Overall, SBWCs serve a disproportionately high number of Medicaid beneficiaries, thus billing for reimbursement through Medicaid is a potentially valuable investment for SBWCs. Recent research has pointed to financial advantages by incorporating SBWCs into MCO contracts, which more tightly manage

and distribute value-based payments; plans are better able to coordinate and account for services provided and cost savings, and SBWCs are able to cover more preventive health education interventions and initiatives. SBWCs are also an integral safety-net service provider for the uninsured population. In addition to limiting expenses, states have explored including charging sliding fee scales to uninsured patients at the time of service delivery, maximizing billing for services to other patients, and applying for public and private funds to cover the cost of services to the uninsured. There are a large number of barriers for SBWCs to billing third party insurers related to state regulations, insurance policies, confidentiality/privacy concerns, and co-pays/co-insurances/deductibles. Potential solutions to explore include integrating SBWCs into medical homes or larger ACOs so that SBWCs can join in health care savings with other providers. Research argues that SBWCs must leverage quality contributions and state advocacy to push for effective third-party reimbursement.

Introduction

Delaware's FY20 Appropriations bill (HB 225) School Wellness Center Epilogue included funding to establish school-based wellness centers (SBWC) in high-need elementary schools. This funding enables the Delaware Health and Social Services (DHSS), Division of Public Health (DPH) to develop a strategic approach for establishing SBWCs in high-need elementary schools, as well as to advance the integration of SBWCs into more schools with minimum standards for the provision of high-quality, effective services and long-term sustainability. The strategic planning process includes the identification of successful and replicable models from other states, identification of feasible reimbursement models, stakeholder input to inform an effective approach for Delaware, development of an implementation plan and development of an evaluation plan to assess impact. The following is a literature review conducted to support the strategic planning process by synthesizing existing literature and recent Delaware research on SBWCs to identify insights about potential models, opportunities, gaps, or barriers in SBWC programs and policies across Delaware and the nation.

Nationally, most of the population served by SBWCs are students in sixth grade and above. However, an increasing number of SBWCs are also serving elementary school students. While the focus most often remains on the health needs of adolescents, there is increasing attention on the health needs of younger students. SBWC models can implement medical standards of care, provide accountable sources of health care, and respond to community needs, despite historically facing a lack of stable funding that challenges sustainability. All public high schools in Delaware have SBWCs operated by five medical sponsors: Bayhealth, Beebe, ChristianaCare, La Red Health Services, and Nanticoke. Delaware has few elementary SBWCs, but early data available from Colonial School District's SBWC (with services provided by the Life Health Center) show promising results in improving behavioral health outcomes and decreasing referrals. Delaware SBWCs are governed by a vision and mission statement:

> **Vision Statement:** *Delaware's children will have quality, integrated school-health services that improve health status, optimize academic achievement and enhance well-being.*
>
> **Mission Statement:** *In partnership with schools, families, healthcare providers and community agencies, DHSS, Division of Public Health will facilitate access to comprehensive preventative, primary and mental health care for adolescents in Delaware public high schools.*

The literature review is categorized into the following overarching topics to correspond with strategic planning workgroups:

- Infrastructure, Policy and Operations
- Data and Best Practices
- Finance and Sustainability

Infrastructure, Policy, & Operations

HIPAA, FERPA, 42 CFR, Child Welfare Regulations

There are several overlapping policy concerns relating to the records that capture child/student educational, health, and social needs. For most information exchanged from a SBWC, the Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 CFR Part 99) serves as the ultimate authority on confidentiality and record disclosure. This means that entities must obtain parent/guardian consent before sharing records, and parents/guardians have the authority to modify records before disclosure. However, there are several notable exceptions. These include, but are not limited to, health

and medical information shared to teachers/school officials because of educational interests and emergency scenarios.

In SBWCs, the application of FERPA vs. Health Insurance Portability and Accountability Act of 1996 (HIPAA) is determined by how student/patient records are stored and sent. FERPA and HIPAA cannot apply to the same piece of information at the same time. Additional legislation governs data sharing and privacy related to behavioral health care, substance use treatment, and child welfare information. Though there are a few exceptions, FERPA is the default act governing the sharing of this information, as it has the strongest privacy regulations. It is advised that state health departments consult with legal counsels to develop a matrix of "givers" and "recipients" of information and detail the policies around confidentiality and privacy for each information exchange.

In Delaware SBWCs submitting claims and billing electronically for their services, the SBWC's records do not become part of the school's academic or operating resource, and the school does not expect the SBWC to store the data created for them (as opposed to in some states where the school district might operate the SBWC). While FERPA protects the rights of the students and their families, they do not have the expectation of the information that the SBWC creates. Therefore, they are not under the official FERPA retention schedule. However, the HIPAA transactions and code set standards and rules governing the electronic exchange of patient-identifiable health-related information apply. While the SBWC services and agreement with DPH themselves do not put SBWCs under HIPAA or FERPA, submitting claims or billing the health plans electronically for the services offered does put them under HIPAA, and they must observe the HIPAA Privacy, Security, Enforcement, Breach Notification Rules, the HITECH Act, and the Genetic Information Nondiscrimination Act.[1]

- States should consult with legal counsel to create a matrix that details the type of information, sender of information, and recipient of information to detail which federal and state laws apply.
- Exceptions to FERPA, when institutions can disclose personal identifiable information (PII) from educational records without consent include: (65)
    - Health and medical information to teachers and other school officials within the school if these school officials have been determined to have "legitimate educational interests"
    - In connection with an emergency in which it is necessary for the health and safety of a student or others that information is known
- HIPAA/FERPA joint application: (63, 65)
    - If a SBWC does not use Electronic Health Record (EHR) billing, then it is not covered as a HIPAA entity and only subject to FERPA.
    - Student health records maintained by a health care provider acting for a FERPA-covered school would qualify as education records subject to FERPA regardless of whether the health care provider is employed by the school.
    - If a SBWC uses EHR billing and maintains health information as FERPA education records, then it is subject to HIPAA Transactions and Codes Set Rules and FERPA, but not

[1] Analysis provided by ChristianaCare Chief Privacy Officer Robert Asante, October 12, 2020.

HIPAA Privacy rules. However, FERPA rules apply when needing to obtain parental or student consent to disclose Medicaid billing info about services provided to student.

  - A student's treatment records can be disclosed to a third-party health care provider without consent if used only for treatment purposes. If a third party is a HIPAA covered entity, normal HIPAA rules apply. If used for other purposes outside of treatment, the treatment record is then considered an education record and normal FEPRA rules for education records apply.
  - Under HIPAA, a school nurse of a SBWC provider may refer a student to a behavioral health provider and this referral information is permissible as disclosure for treatment purposes. But once a referral is put in a student's education records, it is covered by FERPA and not permissible without consent.

- HIPAA does not permit SBWCs to report a student to the National Instant Criminal Background Check System (NCIS) (65).
- 42 CFR Part 2 does apply to SBWCs and protects against sharing of personally identifiable information from drug or alcohol records maintained in connection with a federally assisted drug or alcohol treatment program without patient consent (13).
- Application of 42 CFR Part 2: (10, 13, 61, 63)
  - Under 42 CFR Part 2, certain disclosures are permitted without consent: within the organization or in the case of medical emergency.
  - FERPA allows for certain disclosures of substance use or mental illness treatment unless prohibited by a stricter law.
  - In a Directed Exchange EHR system, behavioral health providers must have patients complete a consent form specifying that they would like for progress notes and information to be sent to SBWC providers via direct message on the patient's EHR.
  - In Query-Based Exchange, behavioral health providers must obtain patient consent to upload patient treatment information to a health information exchange (HIE) and execute a qualified service organization agreement. However, if providers would like to access specific patient information from the HIE they would need the patient's consent.
  - A patient with a substance use disorder (SUD) can consent to disclosure of their Part 2 covered records to an entity without naming a specific person. Meaning that on the consent form, they can name an organization for ease of case coordination.
  - Providers that are non-Opioid Treatment Program (OTP) providers can now query a central registry to determine if patients are already receiving opioid-related care.
  - Emergencies resulting from natural disasters such as "medical emergencies" are covered under non-consent exceptions of disclosing SUD records.
  - Any Part 2 SUD information included in student's medical education or treatment records may only be disclosed if the parent or student gives consent, or if info is needed to treat an emergency, or to FDA to notify FDA of product errors. Minors may consent to release of information given state laws.
- The main interoperability and data sharing needs for child welfare services are related to Medicaid systems, to help determine a child's eligibility for title IV-E foster care maintenance

payments, school to help with stability for a student in foster care, behavioral health (mental health and substance use) treatment coordination (1),

- Principles of Child Welfare Regulations on privacy and exchange of information that may apply to SBWC patients: (1)
    - Child Abuse Prevention and Treatment Act (CAPTA): CAPTA state grant reports on abuse and neglect are protected except if an entity is authorized by state statute or needed to carry out a legal duty to protect against child abuse and neglect.
    - Child and Family Services Improvement and Innovation Act: Information obtained under this act must be interoperable and sharable.
    - Foster Connections to Success and Increasing Adoptions Act: state child welfare agencies must coordinate with education agencies to send records of a child to the school and create coordinated physical and behavioral health documentation plans between agencies.
    - Statewide Automated Child Welfare Information Systems (SACWIS) should be interoperable and interface with education and health information systems.
    - Title IV-E of Social Security Act, Payments for Foster Care and Adoption Services: can only share information with administration of IV-E programs, exception being that they can also share with Medicaid, federal assistance programs, or in the case of suspected child abuse or neglect. Limited information can be shared with educational agencies and health agencies for educational and health care plans and must be provided to a foster parent and agency at the time of each placement.
    - FERPA: FERPA primarily applies over other child welfare rules-can share student directory information without parental consent if general notice has been given to all parents of potential intent to release information if necessary.
    - Uninterrupted Scholars Act (USA): permits disclosure of PII from education records to a caseworker or other representative from a state agency legally responsible for care and protection of a child or for disclosure of education records to parties listed on a judicial order.

Space, Equipment & Technology

The most prevalent infrastructure issue SBWCs face is ensuring interoperability and maximizing functionality for EHRs. While there are privacy and confidentiality laws that govern data sharing across agencies and platforms, SBWCs need to select and develop EHRs in tandem with the agencies with which they partner, including school districts, medical sponsors/hospital systems, and local departments of public health. Equally as important in the EHR development process is for SBWCs to understand the documentation and reporting needs of MCOs and third-party insurance to ensure proper billing and quality reporting according to the metrics required. To maximize efficiency, it may be advantageous for SBWCs to explore integrating EHRs with Practice Management (PM) systems. SBWCs and school districts can partner with web and application development businesses to help construct these.

There is more consensus on the space and equipment needs of SBWCs. Size of SBWCs may vary by services performed and size/need of student population, but all SBWCs should have, at minimum, a small waiting area, at least two exam rooms, a professional office, a storage area for equipment and records, a bathroom, and two entrances (one that connects to the school, and one external entrance).

The school districts are responsible for providing SBWCs with adequate physical space and office supplies and the medical sponsor is responsible for suppling medical equipment needed.

- SBWCs can partner with private businesses to foster technological innovations in school health, such as EHRs, school-based tele-medicine programs, or record-keeping for managed care organization (MCO) reporting in order to improve coordination of care and extend reach to hospital-based specialists. (53)
- Practice Management (PM) systems should be integrated with EHRs and can assist in: (17)
    - Collecting basic demographic information, with the potential to interface with the School Information System
    - Scheduling and managing appointments
    - Collecting and storing insurance information
    - Checking insurance eligibility for students using an insurance clearinghouse
    - Documenting consent
    - Internal clinical communication
    - Billing
    - Tracking outstanding receivables
    - Creating customized school reports for doctor's notes, physical education notes, etc.
- Recommended and potential space needs (50, 60):
    - Two exam rooms
    - Counseling room(s)
    - Reception area
    - Professional office space
    - Storage area and locked space for medical records and pharmaceuticals
    - Bathroom(s)
    - Infirmary area
    - Clean and dirty prep areas
    - Hand washing sinks
    - Laboratory area
    - Two entrances, one from inside the school, one external entrance
- In Delaware, the school district will provide center space and office supplies to medical sponsors. Medical sponsors provide medical supplies. (21)
- Charts of graduated and withdrawn students of the SBWC will be moved to an inactive file area and will be securely maintained as per health system standards. (21)

Personnel

The staffing model for a SBWC depends largely on the types of services offered and the operational model (telehealth, primary care home, community hub, etc.). Among all models, nurse practitioners (NP) or physician assistants (PA) and an office assistant are the preferred and minimum staff. A primary care physician should be available to supervise either in-person or via telecommunications. Behavioral health services are a priority area for Delaware SBWCs; thus, many Delaware SBWCs also have a full-time behavioral health professional on staff, usually a licensed clinical social worker (LCSW) or psychologist.

- There are three most common staffing models (53):
    - Primary care provider alone
    - Primary care provider and behavioral health provider
    - Primary care provider and behavioral health provider joined by other specialists (oral health provider, optometrists, and substance use counselor, nutritionist/dietician)
- Recommended staffing based on SBWC service model and enrollment: (50)
    - One NP or PA per 700 - 1,500 students with a supervising physician accessible to the NP or PA from the center's sponsoring agency as required at all times during operating hours
    - One full-time licensed mental health provider per 700 - 1,500 students
    - A medical or health assistant on site who schedules appointments, conducts data entry, and assists the NP and PA in patient care
    - One full time dental hygienist per approximately 2,500 enrollees
    - Expanded centers may also have a health educator, a community outreach worker, registered nurses, and/or a nutritionist
- Community health workers (CHWs) may be incorporated to help with health insurance enrollment and home visits/scans for environmental health risks (asthma triggers, etc.). (5)
- In some Delaware SBWCs, the school district provides a registered nurse to support the primary care providers during office hours and for necessary afterhours support during the school year. (21)
- ChristianaCare provides a physician, NP, mental health provider, and support staff to its centers during the school year. (21)
- BayHealth provides services from a NP, licensed mental health professional, or registered dietician as applicable. (12)

Medical Sponsors & Contracting

The literature on SBWCs highlights federally qualified health centers (FQHCs as the ideal medical sponsor for SBWCs due to their familiarity with treating safety-net populations, skilled billing and sustainability capacity, and enhanced reimbursement through Medicaid. Additionally, university medical systems and teaching hospitals are common medical sponsors of SBWCs and utilize primary care residents, who are well versed in the community, as providers.

- FQHCs and community health centers have become the most common and ideal sponsors of SBWCs because they understand contracting and billing needs best and are able to receive enhanced reimbursement through Medicaid. (53, 59)
- Children and youth served by the Division of Prevention and Behavioral Health Services (DPBHS) are eligible for DPBHS mental health and substances use services if: (29)
    - They are under 18
    - They are Delaware residents
    - They are deemed eligible through clinical review by a licensed behavioral healthcare professional
    - They meet insurance category eligibility:
        - Medicaid and require more than 30-hour annual outpatient benefit
        - Uninsured
        - Exhausted all private insurance benefits (not for specific level of care or provider)
        - DPBHS does not function as payor for co-insurance
- DPBHS will work in collaboration with other agencies and providers (if involved in a child's case) to provide necessary services/benefits. (29)
- Miami-Dade SBWCs are sponsored by local teaching hospitals and universities and use resident pediatricians as medical providers. Providers must be well-versed in community preventive programs and referrals. (5)

Operating Models

A number of operating models for SBWCs exist and have evolved overtime to include a multidisciplinary team that offers a combination of primary/preventive care, reproductive and sexual health care, behavioral health services, nutrition services, and oral health care. Several SBWCs also provide social resource navigation and care, either through CHWs or community-based organization (CBO) partners to address upstream social determinants of health (SDOH) for students and their families, including food insecurity, housing assistance, income assistance, and other benefits programs. Across all models, SBWCs are seen as vital providers of population-level public health initiatives and health education.

Several states have explored establishing SBWCs as primary care medical homes (PCMH) for their students, particularly for the uninsured, but most efforts have been unsuccessful because SBWCs are unable to function under standard PCMH requirements given that their patient population is tied to school/district enrollment. Instead, many states have encouraged SBWCs to be incorporated into patients' primary care medical homes through patient choice. Under this model, SBWCs are incentivized to work with community pediatricians to connect students to primary care doctors. SBWCs are then able to provide these students with more non-specialty care that primary care offices are not able to provide, such as routine sexual/reproductive health care, behavioral health care, nutrition services, screenings and tests, and daily monitoring for specific health needs. When developing an operating model for SBWCs, it is important that community pediatricians/hospital systems, parents/students, and school district staff are involved to determine effective models and referral systems.

Data shows that increased hours of operation for SBWCs contribute to more positive health outcomes for their enrolled populations. This means SBWCs may have hours longer than typical school days, with

some having 24-hr operations, and being open year-round rather than following the academic calendar. However, given that SBWCs are located within school buildings themselves, it may be difficult to ensure that they are open during school closure events (snow days, etc.). Additionally, while enrollment of school staff and student families may increase financial sustainability, security, documentation, and treatment capacity are strong limiting factors.

- Community Schools is a variant model that integrates community development using schools as a hub. Community agencies partner with schools and SBWCs to assess needs, coordinate services, and build networks of services and supports for students and families. In some versions, coordinators, located in schools and SBWCs, may act as case managers. (53)
- Barriers to SBWCs becoming medical homes: (2, 6, 7)
    - Limited operational hours
    - Duplicative services as primary care physicians
    - Movement of students out of schools
    - Lack of written agreements with hospitals and communication systems
- SBWCs with hours of operation limited to regular school hours reduced emergency department (ED) visits and hospitalizations by a median of 5.7 percent. SBWCs with hours of operation outside of regular school hours reduced ED visits and hospitalizations by a median of 37.0 percent. (41)
- New York attempted to develop customized PCMH accreditation requirements for SBWCs with NCQA but was not successful. (6)
- New York is attempting to develop a pediatric accountable care organization (ACO) model with SBWCs, but movement of students that may cause patient unenrollment is a major barrier. (6)
- Oregon Health Authority created coordinated care organizations (an accountable care organization-like model) that manage care for Medicaid enrollees. As part of this, enrollees can choose to have SBWCs included in their primary care homes. (7)
- Services for Delaware SBWCs to consider: (2, 5, 12, 20, 31, 36)
    - Advisory councils for SBWCs in Delaware may assist in setting service priorities for the SBWC given the needs of the student population.
    - SBWCs should require patient education on physical health, growth, psychosocial and sexual development, and document education efforts.
    - Previous planning with SBWCs in Delaware found that the addition of dental services to the SBWC package may meet a critical need among low-income adolescents. Oral health care services should focus on fluoride varnishes and sealants.
- Operational policies for SBWCs for Delaware to consider: (8, 21, 31, 40, 41)
    - SBWCs should have a mix of scheduled appointments and walk-ins available for urgent healthcare needs.
    - SBWCs accept referrals for student enrollment.

- In Delaware, SBWCs follow school district closures. If the school district is closed due to inclement weather, the SBWC will also be closed. If the school is delayed, SBWC staff report along with the regular school faculty.
- SBWCs having increased hours outside of regular school hours is associated with reductions in ED utilization and hospitalization and increased contraceptive use.
- Providing services to students' families, staff, and teachers may increase SBWCs' financial sustainability, but has proven difficult due to initial financial investment, security considerations, and confidentiality/policy considerations.

Explanation of Benefits (EOBs), privacy, and confidentiality

Privacy and confidentiality of patients is one of the biggest concerns of SBWCs, particularly as it relates to billing for reproductive and sexual health services, as well as sensitive behavioral health services. The main concern in caring for a patient population who are mostly enrolled as dependents on parent/caregiver insurance, is that EOBs will be sent to policyholders (parents/caregivers) that detail services provided. The literature has not fully reconciled the issue of protecting patient privacy and insurers' responsibility to inform policyholders of coverage; however, several options (both legislative and regulatory) have been explored.

- In Delaware SBWCs where expanded reproductive health services are offered (condom distribution, contraception, and HIV testing), services are confidential by law. A parent or guardian does not have the right to access information without the consent of the student. (20)
- In Delaware, students requesting pregnancy tests must have consent of the parent/guardian; if not, the SBWC can refer them to community testing providers. (20)
- Strategies: (3, 11, 19, 32, 33, 34, 49, 62, 66)
  - Creating a list of sensitive health services for which no EOBs or suppressed/generalized EOBs are sent (services coded as "office visit", or "screening", or "preventive care").
  - Creating specific current procedural terminology (CPT) modifiers for sensitive services so that, when applied to services, insurers automatically suppress EOBs for those specific services.
  - Giving patients (students) full ownership of health record and insurance record for services they receive (with few exceptions).
  - Creating customized or tiered EOBs to various members based on dependent level and services provided to the individual member.
  - Using secure online portals to share customized EOBs or sending EOBs to patient-specified addresses.
  - Creating standardized educational tools for providers to educate policyholders and patients on privacy rights.
  - Sending EOBs to an alternate address obtained at time of visit.
  - Policy memorandum requiring organizations to suppress EOBs for healthcare services provided to minors who can consent to their own health care services.
  - Require health plans to communicate directly with adult patients (up to age 26), who are covered as dependents on their parents' plan.

- Potential exceptions to EOB privacy and confidentiality: (34)
    - Denial of claims
    - Performance of insurance
    - Court order
    - Protecting and defending provider liability
    - Third party for encrypting or encoding data
- One challenge is reconciling insurers' responsibility to policyholders to document financial obligations. (33)
- Another challenge is understanding rights given to parents and children for filing claims and receiving notices with respect to divorce and child custody-most grant rights to the custodial parent. (32)
- Important consideration is that different departments may regulate different types of plans: Medicaid and public plans, self-funded plans, state-regulated private plans. (English – Colorado)
- ACA helped expand preventive services that are fully covered by insurance so that they do not require EOBs, but this does not cover all sensitive services. (33, 19)
- Sensitive health services are defined as:
    - Mental health services
    - SUD treatment services
    - Reproductive health services
    - Family planning services
    - Services for sexually transmitted infections and sexually transmitted diseases
    - Services for sexual assault or domestic abuse-services include prevention, screening, consultation, examination, treatment, or follow-up (39)
- Sending EOBs should not be required when enrollees receive sensitive services. This can be enforced through ACA mandates for preventive services, changes to state-level EOB requirements, and negotiations between insurers and employers to include provisions in the contract to protect dependents' confidentiality. (3)
- Challenge of not getting consent forms back; state/schools could strategize innovative strategies for consent form return (e.g., open house, back-to-school nights, etc.). (60)

COVID Recovery Operations

SBWCs need to be incorporated into the larger school district reopening conversation. SBWCs will need to create procedures and rules for sanitation, distancing, capacity control, and personal protective equipment (PPE). These should be documented and distributed to students and families, posted as signage in SBWCs, and implemented and enforced in specific ways (e.g., tape on the floor, exam room for sick visits vs. exam room for well visits). Additionally, SBWCs should work with local health departments and schools to understand if it is feasible and appropriate to provide COVID testing. Finally,

states emphasized that operational plans must be made on a statewide basis to promote equity and address operational needs related to racial trauma and COVID-19.

- Infrastructure changes that may be considered: (24, 57, 67)
    - Stocking adequate PPE
    - Taping of floors to encourage social distancing and direct traffic flow
    - Installing sneeze guards for reception areas
    - Enhanced sanitation along with the Center for Disease Control and Prevention (CDC) and the Occupational Safety and Health Administration (OSHA) guidelines
    - Signage throughout the space to enforce social distancing and mask wearing
    - Increasing and ensuring proper ventilation of space
    - Providing factsheets and referral sheets for students and families
    - Conducting sick visits and well visits in separate rooms
- Operational changes that may be considered: (24, 57, 67)
    - Maximizing telehealth services offered. Move telehealth services to other locations in the school to decrease traffic to SBWC
    - Developing COVID-19 screening protocol for patients and staff at SBWC
    - Creating flexibility plans for SBWCs to respond to potential changes in school operations
    - Creating new electronic, mailing, etc. outreach modes to students and families about services and ensuring proper confidentiality and languages
    - Separating sick visit and well visits to different times of the day
    - Creating a formal plan for SBWC if student/patient tests positive for COVID-19
    - Considering impact if potential staff leaves
    - Working with public health to determine reporting and case coordination
- Care and services changes that may be considered: (24, 57, 67)
    - Identifying potential changes in patient treatment plans due to COVID-19
    - Drafting potential care plans for symptomatic students
    - Increasing screening for mental health, adverse childhood experiences/trauma, social needs (food, housing, energy, income assistance)
    - Increasing training and proficiency in trauma-informed care modalities
    - Considering car-side care for services like immunizations, rash checks, and fluoride varnishes
    - Using metered dose inhalers (MDI) in place of nebulizers for asthma care
    - Working with public health department to determine reporting and case coordination needs

- Determining if COVID-19 testing can be offered onsite. If so, understand testing practices and policies. If not, develop referral lists for testing sites

Data & Best Practices

Reproductive and Behavioral Health Services and Practices

While more evidence may be needed to understand the full effect of mental and behavioral health care on students, data support an association between increased behavioral health services offered by SBWCs and positive educational, social, and emotional health outcomes. However, there are significant needs associated with providing behavioral health services in SBWCs, including ensuring adequate operational accessibility, using standardized, evidence-based screening tools, and streamlining referral networks with community-based behavioral health providers. SBWCs face similar needs when providing reproductive health services, though there is stronger evidence that increased reproductive health services (contraceptive distribution, sexually transmitted infections (STI) and pregnancy screening and testing) offered by SBWCs result in more positive reproductive health outcomes (e.g., fewer teen pregnancies) among the student population.

- Delaware is consistently higher than the national average in substance use and misuse among children and teens 12-17. (46)
- Increased offering of mental health services in schools has been shown to reduce student violent behaviors, lower truancy rates, and improve school achievement, attention, social skills, and internalizing problems. (53)
- Nationally, there is a lack of uniform screening and diagnosis for behavioral health disorders in SBWCs. SBWCs need to implement the use of evidence-based mental health screening tools for appropriate school-aged children. At ChristianaCare SBWCs, NPs must conduct a drug and alcohol assessment (CRAFFT Version 2.1) with students. (9, 20)
- Recovery High School is a drug-free educational model to support students recovering from substance use disorders and provides additional support services to reduce the factors associated with relapse. Students receive an Individual Recovery Program assessed through academic improvement, attendance, parental involvement, social development, coping and goal setting skills, life skills, access to community resources, and guidance services. Mosaic Academy is the recovery high school developed in the Colonial School District that partners with the district to provide standard education classes with extra emphasis in wellness and wellbeing services. (46)
- Screening, Brief Intervention and Referral to Treatment (SBIRT) interventions may be tailored for SBWCs to effectively help students with SUD and link them to appropriate care. (56)
- Students face barriers to engaging in reproductive and behavioral healthcare in school, including limited services offered, confidentiality of services from EOBs, and limited hours of operation for SBWCs. (45)
- Onsite access to contraceptives is associated with greater use of contraceptives and reduced teen pregnancy rates. (41)
- In Delaware, schools can provide reproductive services (oral contraception, condom distribution, Depo-Provera and Nexplanon) with approval from the school board and

parent/guardians approval. Providers must be Title X certified. SBWCs can be designated Counseling, Testing and Referral (CTR) if the school board approves, and providers are designated by the DPH HIV Prevention Program and Testing Protocol. (31)

- SBWCs and parties interested in providing reproductive healthcare through SBWCs should form a workgroup with youth to assess need and interest of the student and parent/caregiver population, create compelling messaging in response to needs and concerns, and develop a strategy for message dissemination and response from the community. (23)
- When SBWCs provide reproductive healthcare services, the school district and health center must engage in an MOU that includes the definition of confidential services, includes the scope of services for comprehensive reproductive health care, and includes information about relevant state laws for confidentiality. (23)

Trauma-informed treatment modalities

Research shows that SBWCs are an important site for providing trauma-informed care (TIC) given the patient population they serve and their potential to integrate with other social and education services for children. One way to ensure TIC for students is to develop a TIC SBWC team or comprehensive TIC plan for SBWCs that assesses students' exposure to trauma and creates policies and practices for treatment by various institutions. In identifying the need for TIC practices, especially given the current climate of COVID-19 and racial injustice, it is important that SBWCs assess both students and families/caregivers. To enhance this effort, SBWC staff should explore various modalities of care for families and student that reflect and respond to unique traumas in today's climate, including, virtual group discussions on racial injustice, integrated talk therapy and physical exercises, virtual family therapy sessions, etc. Additionally, SBWCs should invest in creating a network of services and communications across school staff, community-based behavioral health providers, and CBOs providing services. Finally, SBWCs should make an effort to staff centers with individuals who represent and are aware of the communities that they serve and should train providers on specific gender, racial, and other identity-based differences.

- A TIC team may develop TIC plans and develop trauma-informed service plans for school staff, administrators, SBWC staff, public health departments, behavioral health providers, law enforcement, and child welfare services if applicable. (42)
- Important efforts in assessing trauma include: (64)
    - Assessing whole family rather than just individual student need for resources
    - Promoting a wider breadth of telehealth services to whole families
    - Creating networks of TIC professionals to assist with palliative care and family support
- Need to prioritize trauma-informed training of SBWC clinicians and ability to serve as case managers for high-need students and families and connect to community resources. (64)
- SBWC staff and behavioral health teams especially should be recruited to reflect students' racial/ethnical backgrounds and have strong relationships and referral systems with medical teams in SBWCs. (15)
- SBWCs should train on gender-differentiated strategies in clinical work (i.e., talk therapy vs. integrated physical exercises, various modalities, group therapy and healing spaces, male-only groups). (15)

- SBWCs should seek out relationships with culturally appropriate youth development organizations to complement services. (15)
- SBWCs should integrate mental and physical health screenings, referrals, and services within SBWCs and within school. Behavioral health and medical staff and school staff and district administrators should have clear communication chains for discussion of student need/trauma. (15)

Integration in school and community

Aside from ensuring effective data sharing, it is also important that SBWCs integrate themselves in the school and community culture to enhance student enrollment, participation, and quality of care. SBWC staff should have a presence at key school events for exposure to the school community. SBWCs and school staff should also explore options to integrate behavioral health screenings, referrals/communications, and intervention into the school environment.

- SBWCs also are more effective when they integrate themselves into the school culture by performing activities such as: sports physicals, connecting the importance of health to academic performance, holistic mental health services or education for school staff like yoga, meditation, etc., group therapy sessions, de-escalation programs, peer mediation programs as alternative discipline methods. For non-medical services, it is important to encourage parent/caregiver participation. (2, 9)
- To enhance enrollment and presence, SBWCs should conduct active outreach and enrollment alongside educational events to integrate themselves into students' experience (parent-teacher nights, class registration, etc.). (15)

Integration into healthcare system

SBWCs should engage with community pediatricians and behavioral health specialists early and consistently to develop strong referral/communication systems and policies around student health. SBWCs can provide linkages for students to community pediatricians during enrollment and insurance eligibly screening. Community pediatricians can outsource routine health monitoring management (nutritional management, medication management, comorbidity management) and health prevention/education to SBWC providers. However, effective and equitable compensation should be coordinated between local healthcare providers and SBWCs.

- SBWCs can prove an asset to include in patients' PCMH, as long as they complement, and not replace, the primary care practice. SBWCs are in a unique position to:
    - Work with community providers through collaboration, consultation, and referral systems, especially for specific populations who need more tailored, site-specific care. (2)
    - Provide onsite insurance eligibility and enrollment and connect students with PCMHs. (2)
    - Provide more consistent daily monitoring, assistance, and management for students with disabilities and chronic disease. (2)
    - Provide health education opportunities for schools. (2)

- Community pediatricians may increase collaboration and trust with SBWCs by serving as volunteer, medical director, or consultant to SBWCs. (2)

Telehealth service delivery

Telehealth is an increasingly integral element of SBWC service delivery and has been shown to increase positive physical and behavioral health outcomes and reduce disparities. There are varying services that can be offered via telehealth including physician or behavior health provider consultations, well visits, screenings and stabilization services, and behavioral health counseling. SBWCs should designate an in-person staff member or group of staff members responsible for facilitating virtual interaction with a patient. In previous interventions, medical sponsors have provided equipment and technology needs, while schools have stored equipment and provided a fixed, physical site for telehealth services. SBWCs and the medical sponsor must also survey state Medicaid guidance on telehealth service delivery to understand state regulations and billing practices.

- Needs for telehealth service delivery (4, 44):
    - Fixed sites (space) and equipment
    - High speed internet
    - Ability to bill Medicaid for services
    - Medical sponsors to train staff on using equipment
    - Onsite individual to facilitate telehealth interaction (could be school nurse or medical assistant)
    - Compliance with federal and state laws regarding telehealth delivery
    - Onsite and telehealth staff understanding of community culture and needs
- Telemedicine has been used by SBWCs to provide one-to-one talk therapy, medication management, connection of students to mental health providers and other social services needed that impact physical and mental health. (9)
- Recommended model of behavioral telemedicine is the combined use of comanaged direct care and consultation and stabilization services. This means the psychiatrist would complete initial evaluation and diagnostic procedures and stabilization via telehealth, often times prescribing medication or psychologist referral, and then transition direct care back to a primary care provider in the SBWC. (52)
- It is possible to provide telehealth services both by appointment and by walk ins, to allow for greater hours of operation. (44)

Outcomes measures

SBWCs are associated with substantial positive health and educational outcomes. Currently, Delaware DHSS and DMMA requires certain sets of outcome measures to be tracked related to the individual annual goals of SBWCs and each provider has flexibility to develop quality assurance activities to meet their needs. There are a number of challenges in evaluating SBWCs given patient population. Research argues that evaluations should be statewide to increase the data pool and examine population-level trends, while accounting for differences in service delivery models and patient populations. Evaluations

should also be structured to follow a specific, pre-defined theory of change model that emphasizes more proximal outcomes measures.

- Previous work in Delaware found that more attention is needed on health promotion/disease prevention work and outcomes as well as chronic disease management to further show the value of SBWC services. (36)
- Recommendations by stakeholder group convened in 2008 suggested that Delaware explore linking certain outcomes with SBWC usage. (36)
    - Educational outcomes:
        - Graduation rates
        - Attendance
        - Early dismissals
        - Teacher evaluations of student behavior in class
    - Health outcomes
        - Immunization rates
        - Referral rates
        - Health status associated with better management of chronic diseases
- Each Delaware SBWC must submit annual goals and objectives reports to DHSS. Each SBWC must then submit a semi-annual and annual report of data associated that measures progress in reaching goals and objectives. They also must submit a monthly report on services performed using specific metrics. (31)
- For Delaware Medicaid, each provider has the flexibility to develop quality assurance activities that meet the specific needs and expectations of the individual provider but have some specific policies they must address. (27)
- SBWCs are associated with substantial educational benefits: reductions in rates of school suspension or high school non-completion and increases in grade point averages and grade promotion. (41)
- In order to understand needs for outcomes measures and structure evaluation, states should develop a logical theory of change model for SBWCs. (35)
- SBWCs have trouble measuring outcomes given: (14, 35, 40)
    - Selection bias due to unequal and fluctuating enrollment across schools
    - Differential attrition due to underlying differences in student population
    - Differences in models, staffing, services provided, etc.
    - Small sample sizes of student-patient pool
- There are a few potential solutions: (14, 35, 40)
    - Include both qualitative and quantitative data.
    - Focus on more proximal educational behaviors like attendance, seat time, discipline referrals, detention, etc.

- Link SBWC datasets to other large population-level datasets (low birthweights, educational outcomes, etc.) to measure impact of SBWCs (need to be careful of matching and missing data).
- Use Entering-Class Proxy-Baseline as a data collection method. In a high school SBWC, 9th graders are used as proxy-baseline data for later school grades. Must account for demographic differences in grades.
- Do larger scale, state-wide evaluation of SBWCs with standardized data reporting measures and then stratify by subpopulations to understand trends.

Data stratification & health disparities

Research shows that SBWCs are a cost-effective way to reduce health disparities, particularly in behavioral health care, given their accessibility and flexibility to provide services. In structuring data reporting and practices aimed at targeting health disparities, SBWCs may consider conducting quasi-community health needs assessments (CHNA), and/or leveraging existing data on community health disparities. Data should be stratified by race and ethnicity wherever possible, especially for process and outcomes measures on a SBWC, district, county, and state level. Several strategies have been developed to deal with potentially small patient pools.

- Primary care and behavioral health care delivered in SBWCs can reduce disparities in access, utilization, health outcome and healthcare cost for racial/ethnic minority populations, even more than care received in clinical settings. (38, 42)
- Racial/ethnic disparities exist in screening for mental health disorders in SBWCs. (42)
- During SBWC planning, DPH, school districts, and medical sponsors should communicate with the community and conduct a quasi-CHNA to identify the potential patient population, health disparities among the patient population, and health care needs. (60)
- Previous Delaware work emphasized that, in addition to basic demographic information, SBWCs must collect data to understand which populations use services, including English as a second language (ESL) populations, students in foster care, uninsured patients. (36)
- There are data challenges to stratifying SBWC data and evaluation of health equity including: (14, 35, 40)
    - Selection bias due to unequal and fluctuating enrollment across schools
    - Differential attrition due to underlying differences in student population
    - Differences in models, staffing, services provided, etc.
    - Small sample sizes of student-patient pool
- Potential strategies to address these include: (14, 35, 40)
    - Providing incentives and informed consent for participating in SBWC evaluation surveys.
    - Using Entering-Class Proxy-Baseline as a data collection method. In a high school SBWC, 9th graders are used as proxy-baseline data for later school grades. Must account for demographic differences in grades.

- Do larger scale, state-wide evaluation of SBWCs with standardized data reporting measures and then stratify by subpopulations to understand trends.

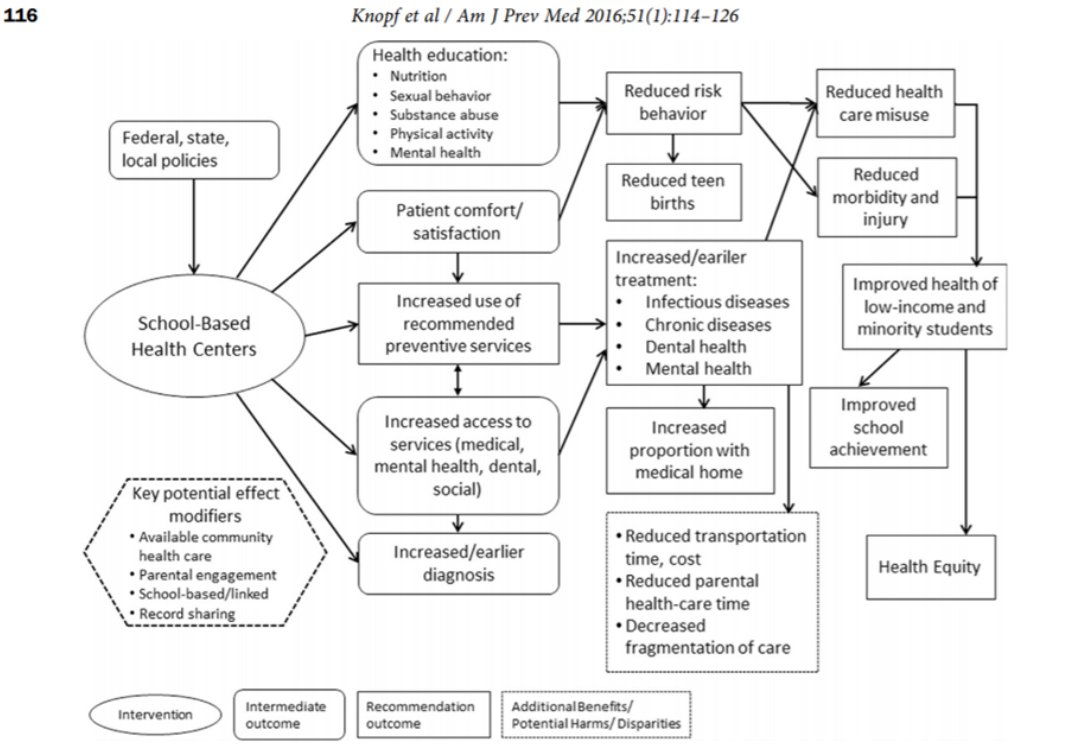

Figure 1. Analytic framework: school-based health centers to promote health equity.

Data sharing across platforms & agencies

Research emphasizes that interoperable EHRs are critical to effectively communicate and respond to health needs across organizations and agencies. Planning must be done to establish how to legally integrate EHRs with other agencies before product selection. EHRs should be customized as much as possible to the unique needs of SBWCs and their partners so that all relevant information is able to be accessed through a single platform.

- Previous work with Delaware noted that it is essential to link or coordinate existing databases from the Department of Services of Children, Youth and Families (DCYF), Department of Education (DOE), and DHSS. (36)
- SBWCs need to communicate early with partners to understand what data are important to show impact and create a plan for how data can be shared. (35)
- Use of EHR systems should be prioritized because of their ability to facilitate care coordination between agencies. However, federal and state laws on data sharing must be abided, proper messaging and consent for parents/caregivers and students must be developed, and MOUs and agreements between agencies must be in place. (17, 40)
- ChristianaCare allows aggregated-level student data to be exchanged between ChristianaCare and the school district to obtain information for evaluation. (21)

- BayHealth will provide DPH with specified data and reporting through EPIC EHR. (12)
- Nemours has an MOU with Delaware school nurses to allow access to student EHRs if students or parents/caregiver provide appropriate HIPAA/FERPA authorization through a consent form. (48)

Finance & Sustainability

Expenses & Sustainability

The main expenses for SBWCs are startup and operating cost, which vary based on the operating model and types of services provided, personnel, and existing infrastructure in schools. A strong factor in determining SBWC sustainability is diversified funding sources (public grants, private donations, billing capacity for 3rd party insurers and Medicaid). Additionally, FQHCs have emerged as a leading medical sponsor to ensure SBWC sustainability because of their enhanced Medicaid billing capacity. Overall, SBWCs have been shown to produce substantial savings in the larger healthcare environment given their ability to provide consistent preventive care and health education/public health initiatives to vulnerable populations. Thus, some states have explored incorporating SBWCs into their ACO models to share in outcomes-related health care savings. SBWCs should create a financial sustainability model to understand, based on their available funding sources, the level and number of services they are able to provide, which then impacts their operating model.

- Median startup costs for SBWCs range from $49,750 to $128,250 and are mostly dependent on the status of the available space for SBWCs in the sites. (51)
- Median annual operating costs range from $16,322 - $659,684 annually depending on provider hours, types of providers, and models of service delivery. (51, 54)
- In Delaware, state funding covers only about 52-60 percent of annual operating costs and billing reimbursement is not reliable, though more reliable from Medicaid. SBWCs have over $600,000 in uncompensated services because of third-party insurers EOB policies, uninsured patients, commercial plans that don't cover services, and students covered by other states' Medicaid. (26)
- SBWCs in Delaware should prioritize implementing analyses of services along with measures to improve service efficiency. SBWCs should map nonbillable services to other funding sources. (36)
- When conducting cost-benefit analysis of SBWCs, benefits should include: (54)
    - Healthcare costs averted associated with:
        - Hospitalization
        - ED utilization
        - Drug prescriptions
        - Referrals
        - Private clinic visits
        - Unintended pregnancy
    - Productivity and other costs averted associated with:
        - Productivity loss

        - Travel cost
        - School time
        - Ambulance use or improved health
- Factors that have been shown to support SBWC sustainability: (25, 54)
    - Diversified funding sources
    - Ability to report data and measure quality indicators
    - Good record keeping
    - Infrastructure and capacity for billing
    - Analysis of financial standing
    - Routine workflows & data analysis
    - Strong partnerships with local providers, medical sponsors, school, and community
    - Medicaid reimbursement
    - State and federal government funding and support
    - Increased contraceptive services
- FQHCs are optimal medical sponsors because they are skilled at taking advantage of public insurance programs, receive enhanced Medicaid reimbursement, and their revenue from billing depends on the number of uninsured students accessing services. (51)
- Given that SBWCs have positive effects on population health, value-based payment models could support SBWC sustainability. Oregon has explored incorporating SBWCs into their ACOs, called coordinated care organizations (CCOs), and incorporating metrics on services targeting SDOH and care for underserved populations. (7, 26)
- University of Miami found that SBWCs saved the health system more than $4.5 billion through increased telehealth capabilities, oral health, mental health services, and medical insurance enrollment services. (5)
- SBWCs should average two wellness checkups and six to eight other visits each day of operation to ensure sustainability. (60)

Government funding & grants

State funding and grants are the most common funding source for SBWCs, particularly in Delaware. Public funding is an important base to cover services provided to uninsured students, as well as those not able to be billed to Medicaid or private insurance. However, state monies may not be the most sustainable funding source for SBWCs. Both in Delaware, and in other states, efforts have been made to enhance sustainability by finding a more consistent tax base for funding, as well as examining ways to streamline and link services offered across state agencies.

- Nation-wide, 70 percent of SBWC funding is from states, with general funds and Title V Block Grant money making up the main sources. (53)

- The Affordable Care Act (ACA) created Accountable Health Community grants that could be used to help SBWCs link clinical services to local health departments, government agencies, and CBOs to explore cost-savings through integration. Evaluation is underway to measure their impact. (5)
- In Colorado, SBWCs found they could not just rely on grant funding for sustainability of SBWCs but needed to bill for services to generate patient revenue (Colorado Health Foundation).
- Delaware SBWCs have been funded through a state grant given to DPH with DOE as an active partner. SBWCs were built on cooperation between health and education officials at school, local, and state levels. (22)
- If Delaware SBWCs pursue increased public investments, they need to also increase and standardize outcome effectiveness reporting. (36)
- One option for sustainability of public funds in Delaware is to find a more consistent tax base for SBWC funding, such as a sugar sweetened beverage (SSB) tax, insurer tax, portion of property tax, with the goal of moving to coordinated school-health programs. (26)
- For enhanced sustainability of public funds in Delaware, SBWCs should explore options to further integrate resources with DPH and child mental health programs that have complimentary missions and goals. (26)

Third party billing & reimbursement

Billing private insurance has been explored as a potential opportunity for increasing SBWC sustainability. However, there are a large number of barriers for SBWCs related to state regulations, insurance policies, confidentiality/privacy concerns, and co-pays/co-insurances/deductibles. Potential solutions to explore include integrating SBWCs into medical homes or larger ACOs so that SBWCs can join in health care savings with other providers, but no research exists on financial efficacy of these approaches. Research argues that SBWCs must leverage quality contributions and state advocacy to push for effective third-party reimbursement.

- Third party reimbursement is desirable to pursue, but MCO contracting has proven difficult and state mandates for third party reimbursement are not necessarily effective. (59)
- Barriers to billing third-party insurance for services in SBWCs: (25, 36, 40, 53)
    - Some types of services conducted in SBWCs are not traditionally billable to payors (consultation with teachers, classroom health education, school-wide health fairs).
    - SBWC services may not be considered preventive or wellness services, and so private insurers can deduct to co-pays, co-insurance, and deductibles from reimbursement. SBWCs are prohibited from collecting these payments from clients.
    - Disruption in billing for mental/behavioral health services, which is needed for assuring continuum of care.
    - Third-party insurers do not negotiate rates with SBWCs and pay 80-90 percent less than Delaware Medicaid regulated rates.
    - Many insurance companies do not pay more than two services per day per client.
    - Self-funded plans are exempt from SBWC code compliance.
    - Many insurers do not allow SBWCs to bill for oral health services.

- To take advantage of third-party billing, Delaware SBWCs should explore: (26)
    - Becoming part of a PCMH with a per-member per-month funding approach
    - Prospective Payment System, which pays a fixed amount based on a bundle of services and models (the method used for FQHCs)
    - Pay-for-performance model, which pays based on benchmarks and outcomes
    - Creating accountable care communities, which combine community-based agencies to reach population health goals with a focus on SDOH
- The following best practices emerged in Colorado as keys to successful billing: (25)
    - Having a medical sponsor understanding of the SBWC model and savvy in insurance billing and government regulations
    - Maximizing enrollment and billing through Medicaid
    - Becoming credentialed to bill private insurance taking into account needs of patient population
    - Closely monitoring coding and reimbursement through an EHR
    - Educating community and providers about the importance of billing
    - Connecting students to insurance options that accommodate SBWC reimbursement

Uninsured Population

SBWCs are an integral safety-net service provider for the uninsured population, but this can lead to challenges for financial sustainability. Colorado has explored several solutions to providing care to uninsured populations – in addition to limiting expenses – including charging sliding fee scales to uninsured patients at the time of service delivery, maximizing billing for services to other patients, and applying for public and private funds to cover the cost of services to the uninsured.

- In communities with high uninsured populations, many services go unreimbursed. (25)
- Delaware SBWCs do not turn students away based on lack of health insurance or ability to pay. As part of the SBWC program, assistance to students and families identified as uninsured will be provided. (20, 31)
- Colorado found that SBWCs often provide services to uninsured students, but have a hard time generating patient revenue from billing to offset the cost. (25)
- Colorado developed the following best practices in financing services provided to uninsured: (25)
    - Charge a sliding fee scale to uninsured patients at time of service delivery
    - Increase enrollment outreach efforts especially as health coverage access continues to expand
    - Reduce unnecessary expenses
    - Maximize billing for services and limit non-billable services to offset cost

- Increase applications for public and private grant funding (long-term flexible non-patient revenue)

Medicaid/MCO contracting

Overall, SBWCs serve a disproportionately high number of Medicaid beneficiaries, thus billing for reimbursement through Medicaid is a potentially valuable investment for SBWCs. SBWCs have also been proven to enhance quality of care and contribute substantial cost savings to Medicaid programs. Delaware Medicaid has specific policies on service reimbursement and required data metrics for reporting. Recent research has pointed to financial advantages by incorporating SBWCs into MCO contracts, which more tightly manage and distribute value-based payments. While research is ongoing, initial data have shown that by incorporating SBWCs into MCO contracts, plans are better able to coordinate and account for services provided and cost savings, and SBWCs are able to cover more preventive health education interventions and initiatives. Several potential regulatory or legislative barriers to SBWCs participating in MCO contracts have been identified, but also identified is flexibility within state and federal legislation as potential solutions.

- Fee for service is the most common Medicaid payment method for SBWCs (78%), followed by monthly or annual capitated payments for primary care (35%) or care coordination (19%), or pay-for-performance supplements (27%). (53)
- Medicaid has clarified that its “free care” rule preventing Medicaid reimbursement for services that other individuals receive for free does not apply to school-based services. It has also clarified that its Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit can be used to pay for mental health services. (Price, APHA)
- Current Delaware Medicaid agreements with SBWCs: (27, 28)
    - Can be reimbursed for children’s oral health services such as risk assessment, fluoride varnish, and anticipatory guidance
    - Reimbursement for fluoride varnish includes oral health risk screening using the Oral Health Risk Assessment Tool
    - Practitioners must also, provide referrals to Medicaid participating dental providers, coordinate care, check plan eligibility, provide educational materials on good oral health, document services
    - Services are covered once every six months
    - Medical sponsors can check Medicaid eligibility for students using the Delaware Medical Assistance Portal (DMAP) and Navinet
    - Can be reimbursed for EPSDT services for member if the provider complies with workbook guidelines
    - Local school district is considered the enrolled provider for services in an individualized education program (IEP) or school health program to be reimbursable by Medicaid
    - Services can only be reimbursable for individuals who are enrolled on the date services provided, providers must enroll individuals before they provide services
    - All services must be related to a medical diagnosis and services are administered as part of a written treatment plan or IEP

- To better support Medicaid reimbursement for SBWCs, best practices have emerged in other states: (26, 49, 53, 59)
    - Define SBWCs as eligible provider types
    - Waive preauthorization for SBWCs or for specific services they provide
    - Clear “product definition” of SBWCs for MCOs
    - Require MCOs to reimburse or contract with SBWCs and reimburse for specialized care and public health education service
    - Give SBWCs Medicaid financing inclusive of a per-member-per-month rate
    - Increase the per member/per month (PM/PM) capitated
    - Adequate and standardized quality assurance and reporting from SBWCs for MCOs
- SBWCs providing more Medicaid services, especially reproductive health and asthma-related services, is associated with greater Medicaid savings. The net Medicaid savings of SBWCs have been estimated to be $1,352,087 over three years. SBWCs could save Medicaid about $35 per student per visit. (38, 54)
- Maryland best practice: Per regulation, SBWCs can receive reimbursement from MCOs for designated services without contract or prior authorization. (50)
- Michigan best practice: SBWCs use a streamlined, centralized billing system for all billing claims, which enables them to receive payment fluidly from managed care plans. (50)

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