Delaware School-Based Wellness Center Stakeholder Interview Synthesis

Prepared for the Strategic Planning Steering Committee and Workgroups by Health Management Associates

November 15, 2020

Contents

Methodology

Interviewees were identified collaboratively by the Strategic Planning Steering Committee and workgroups during summer 2020, generating a list of more than 117 potential stakeholders. In consultation with DPH and the Steering Committee, Health Management Associates (HMA) conducted outreach to participants and scheduled group and individual interviews with them during September and October. The HMA team conducted 24 interviews with 51 individuals by video conference or phone, including two focus groups with pediatricians across the state. These included:

- School-Based Wellness Center staff and administrators at the medical sponsor level
- Administrators and providers of behavioral health services for youth, including at DSCYF, DSAMH, and DOE
- Delaware Department of Justice officials
- Parent advocates
- Medicaid agency staff
- Medicaid managed care plans
- 3rd party insurance providers
- Pediatricians (two focus groups)
- School administrators, teachers, and providers of behavioral and physical health services in:
    - New Castle County
    - Kent County
    - Sussex County
- School associations
- Data and information technology experts
- External SBWC experts in Colorado, Maryland, and at the national level

HMA is also in the process of administering surveys of parents and students, whose findings will be available at a later date.

The following synthesis captures qualitative responses to a broad range of questions identified by the Steering Committee and Workgroups. These summaries are not exhaustive but are intended to convey the diversity of opinion among stakeholders, summarizing their perspectives but also providing a sampling of de-identified quotes and comments to provide a fuller picture of their ideas, recommendations, experiences and concerns.

Practices

The Purpose of SBWCs

Summary: Interviewees understood the purpose of SBWCs to be increasing students' access to care for a broad range of services (physical health, mental health, reproductive health services, prescriptions). SBWCs remove barriers to care (e.g. transportation), ease burden on parents, and serve as safety net providers because they cannot deny care based on ability to pay. They also help students become more independent, take charge of their own care and connect students to the larger healthcare system (through referrals to PCPs) and to needed social services. Across stakeholder types, interviewees shared these common perceptions of SBWCs' role. SBWCs' ability to offer confidential services, including reproductive and behavioral health care, were frequently mentioned, as were well-child visits, sports physicals, and immunizations.

- "SBWCs have been strategically placed to bridge that wellness gap when it comes to students being independently in charge of their wellbeing for both medical and mental health services."
- "SBWCs were developed to provide physical health, mental health, reproductive health services to children who may not be able to easily access these services otherwise."
- To assist student with their medical and mental/psychological needs. Great resource for students (especially in rural community) due to lack of potential providers and nearby facilities. Sport physicals, can do it while they are in schools. When nurses identify a student who is ill, we can refer them over there to get diagnosis and treatment. In addition to school-based counseling, they could meet their needs there. Working with the school, families, and students, to be healthy.
- Allows increased accessibility to care for students, broad variety of services, connecting back to community.
- They offer well child visits, sport physicals, immunizations, nutrition counseling, psychologists, social workers to connect kids to services, reach is endless. Can do everything.
- "Also to ensure that and connect students to a primary care physician. And, to what extent possible, students are following up on those visits. So really a connection between students and the healthcare system in terms of ensuring that they're actually getting the services that they need and following up on those services."
- "So it's you know it's the purposes to be where the kids are to help them get the care when they need it, and they specifically are more than often not directed at underserved and poor communities have significant barriers to getting care."
- "One of things is to help kids who fall through the cracks and get them into a medical home. They also can give them mental health services, nutrition and obesity, reproductive services, this is the main thing."
- Barrier remover for many families who don't have easy access. We want our schools to be community hubs for community support, SBWCs plays into this.
- To meet the needs of students who otherwise would not be able to access services outside of school, due to transportation issues, lack of parental involvement, etc., low income families.

The Value of SBWCs to Stakeholders

Students:

Summary: Within SBWCs, students have access to services that they otherwise would not necessarily seek out due to privacy concerns, such as reproductive and mental health care, as well as access to all SBWC services more broadly (regular physicals, immunizations). Students are more willing to access services inside a trusted institution (school). Benefits to the location include immediate care, reduction in interruption to academics, coordination between SBWC staff and school staff, and health education for students.

- "There is a level of trust from students because it is part of the school, they may not have this trust outside."
- Having a different type of mental health provider where they can get more intensive counseling.
- "Immediacy is the benefit. We ever know if recommendation from school nurse may be acted upon by parent, but with a SBWC, the health needs can be taken care of right there."
- Increases students' understanding of health (physical and mental health needs). Students do not always know how to express what their ailments are. Important to use SBWCs to come into classrooms and provide lessons, what is a healthy body, what isn't. Help students understand when they need to seek a service.
- SBWCs can collaborate with school ecosystem. Dietician works closely with school nurse and school counselors, can provide wraparound services.
- Have a lot of students who are not getting regular physicals or immunizations, vision, dental, and hearing issues that were not being addressed. Families didn't have time, didn't have a physician, or were using urgent care to fulfill this need, especially in high need communities. Benefit to having these services onsite. Huge decrease in students without screenings, or immunizations, sports physicals.
- Care where they are an when they can get it. Age-appropriately designed. Different than care in pediatric office, not always their ballpark. The providers are specifically friendly with the age group. Students develop trust with providers.
- "It gives the student the opportunity to take health into their own hands, like taking themselves to appointments. So it centers on kids accessing care."

School Educators:

Summary: SBWCs provide appropriate and timely care for students, which reduces time away from the classroom. Educators can access and consult SBWC staff regarding needs identified in the classroom, and then follow up directly with families to reinforce recommendations made by SBWCs. SBWCs offer a solution for students who are struggling academically due to medical reasons.

- SBWCs provide another reinforcement linking being healthy and ready to learn. Students can't be present and ready to learn unless their bodies are taken care of. Good resource for educators to know a SBWC is available.

- "For elementary school, if the teachers can have access and consult with a school-based Wellness Center in regards to their students. I think that is very, very helpful to them that would be very, very helpful to them when they're dealing with behavioral issues in the classroom."
- "It helps the school principal as well to better ensure that all their identified children who have issues are getting the services that they need. Many times they identify certain issues and they try to get children all the services they can, but this really helps them better address those issues by being able to refer."
- "And to follow up and make sure that the kids are to know what's being recommended and to ensure that the kids and the families are continuing to get what they need and following the proper recommendations."
- "If a SBWC is also available for mental and behavioral health supports, they can really help with tier 3 supports for teachers."
- Some SBWCs are able to provide services to staff. Think it would be good if most SBWCs could provide services to staff, helps to not take time out of school day.
- "I think the mental health part is critical. If a teacher is having a concern about it, they usually don't call pediatrician, so they can go to wellness center."

School Nurses:

Summary: School nurses are limited in their availability (typically only 1 per school) and in the services they can provide. SBWCs provide another layer of support and are a thought partner that nurses can work with to coordinate care. Services that SBWCs can provide that nurses cannot include immunizations, examinations, evaluations, screenings, and reproductive/mental health services. Nurses can refer students directly to SBWC rather than sending them home to go to a PCP. In addition to keeping students in school, this is particularly important for students who do not have a PCP and would end up in ER for non-emergent services.

- Kids may show up in nurses office with other underlying issues like anxiety and SBWCs can address those underlying issues.
- "It helps to have a partner. When school nurses see something, they can act on it and streamline care, they don't have to worry about calling and trying to set up appointments."
- Having the ability to coordinate care with an advanced practitioner right in the building. Helps to bounce things off them.
- School nurses are very overwhelmed, and sometimes get asked medical questions out of their scope (hearing, dyslexia, vision). Nurses may feel pushed past their scope. In Sussex County, there is not a wealth of healthcare resources, and so it would be extremely helpful to have doctors right there.
- Provide support to fill in the gaps (immunizations, physicals, referrals for mental health needs).
- Referral source for sick visits, also for immunizations etc. students who are not meeting requirements for school, SBWCs can help with this.
- Invaluable. There are students with a sore throat who are more than likely to go to the ER when they don't need to. SBWC keeps them out of the ER—they go in, get prescription, and are done

with it. As another example, there are kids whose asthma isn't controlled and they go around between urgent care centers because they don't have a PCP—the SBWC helps the whole health care system.

- "Our school nurses see roughly 18,000 visits a year, and the capacity is just not there. Having a wellness center provide physical health services is a benefit that nurses can't provide."
- Rather than sending the child home, the nurse can have the wellness center take a look at the individual. Child who is known to have asthma and maybe is coughing, nurses could provide nebulizer, but would be helpful for someone else to provide additional care.
- "We get so many referrals from school nurses. In my school there was a great partnership, this is a little above what we could do. Birth control component is huge."

School Psychologists and Counselors:

Summary: School psychologists and counselors work with SBWCs to ensure that students receive the right type of care; they operate as "a big team" and together can prevent students from falling through the cracks. SBWCs can provide services that psychologists and counselors identify but cannot provide (this refers to both medical and advanced behavioral health services). SBWCs can identify medical root causes for students and prevent misdiagnosis of psychological illness.

- It's helpful for doctors to be there in the school environment and watch the individual in their environment. In my heart I know the kid needs help, but I don't want to misdiagnose a psychological illness. In Delaware, they want the medical doctor's note to diagnose ADHD. It is hard because I know that they may have ADHD but I cannot get a doctor to see them and diagnose them. Psychologist is even willing to drive them. We are restrained by what we have access to.
- Also benefits for kids who would slip through the cracks (non-high-fliers) and students who may have behavioral health issues outside of school that are not on school psychologists' radar.
- "It also eliminates barriers for kids and their families. They only need to sign the 1 form for care, whereas the process for outside referrals is complicated and is a big barrier."
- You don't know what percentage of students will be suffering and need to be an extra hand (especially with COVID fallout). Our social worker right now is really focused on one-on-ones, but having counselors with a SBWC could vary group and one-on-one work.
- Especially when there is a crisis, our mental health provider has the resources and ability to be discrete and confidential about everything. If a kid is seen by her no one knows about it. Kids know that so they feel safe sharing information. For children with anxiety, they might not need to see a mental health provider; they just need a plan for here at school. She'll sit down with them, find out triggers, and develop a plan which decreases the amount of anxiety from escalating for these kids. Sometimes all you need is a plan.

Caregivers:

Summary: The benefits to parents include convenience (parents are extremely busy, many live in poverty, cannot afford co-pays or time off from work), and relief that their child is receiving the care he/she needs. There is a fear that parents might disengage from their student's health because they don't need to be involved at the same level. On the other side, there are parents who are hesitant

because of the confidentiality piece (form says SBWCs aren't going to talk to them about their child). At the same time, they see the benefit of the services and convenience factor typically outweighs the hesitancy in the end.

- Not having to take off work to take kids to the doctor, having that service in school is a huge help.
- Very important to have them there to navigate insurance piece. Also exposes parents to what services are available (psychologists, dental work), and makes it easy for parents to link them up.
- "It puts sort of the sense of urgency on the parent and this gives them the support that they need to be able to actually get their child to a primary health physician. I think it also gives them the information that they need in order to manage and support their child's health."
- "And that they're able to connect the dots between the school and their primary health pediatrician for the child which parents often kind of have to be responsible for entirely. But having that sort of go between really can make a difference, especially for parents who for many reasons may not have the wherewithal, the time or the know-how with regard to those things."
- Tricky—a lot of parents, only see the part of the form that says SBWCs aren't going to talk to them about their kid. Several parents who felt that way when child was a freshman, but by senior year they are on board. They see the value when a kid comes in with a sore throat, low grade fever, etc. By the time that it would take for the parent to get off work and get kid, we already know the diagnosis. Parents see the positives for that and sports physicals.
- "Our district's poverty rates are high and we remove the barrier of transportation so students who otherwise might not have transportation to a PCP or be hooked up with PCP or would have to pay $50 at express care for physical, and SBWCs remove all of those barriers."
- "This is an assist to help parents stay where they need to be, it also gives parents peace of mind that the child could be cared for or assessed at the school if something happens."

Community Providers:

Summary: The relationship between community providers and SBWCs varies by county. In some areas, there are few other providers so there is not a perception of competition. In others there are positive relationships between the two entities, and in some cases there is perceived competition with community pediatric providers, particularly given the revenue pressures caused by COVID-19. There is some continuity of care and SBWCs/community providers help to bridge between what happens in school and communities. The relationship can be managed through communication, potentially value-based care (which would allow SBWCs to focus on preventative care and community providers to focus on complex needs), and clearly defining each providers' role. Community providers have the added barrier of insurance (children with Medicaid end up on waitlists), so in some cases SBWCs are able to see students more easily. If SBWCs had consistently more robust relationships with community providers, it would strengthen parents' trust in community providers.

- "It's a referral source and it can provide a nice transition for the child."

- "DuPont Nemours is completely overwhelmed with patients, so I think it would help them. I feel in the past like it was hard for parents to even get an appointment and they were on these waiting lists."
- "This one is sticky. There is a risk that they "taking things away", but if community providers are working in a value-based environment, SBWCs can really dial in on health disparities to make sure that basic preventative care is dealt with and pediatricians can deal with more complex health issues."
- Challenge, especially because we are on FFS environment. Wellness centers can really work together when value-based care becomes more popular. SBWCs can help reduce ED utilization and primary care.
- Providers are no longer getting referrals for urgent care or emergency room. As long as the relationship is clear and partnerships are aligned, this SBWC could be a funnel for patients.
- "Well, depending upon the community, they can actually be that person that gets them hooked back up to their community provider and actually facilitate the handoff to the community provider and with good consents, they can do some case management together and help the community provider if it's a group of like the HMO or managed care organization actually meet some of their metrics."
- "If I am a PCP and I have a child who goes to a high school and they get sick in the school, and I have a busy schedule and I know they can go to a SBWC, then it is an opportunity for follow up. SBWCs need to contact PCPs if something happens. I was in primary care and I was also in SBWCs, most of the kids I saw did not have PCPs. If they don't have a PCP and they have an issue, it can be simple to get minor acute care and treatment. If they do have a PCP, then communication is key to make sure that PCP has an idea of what is happening."

Current services offered by SBWCs vary by school (see service inventory matrix compiled separately), but include:

- Immunizations
- Physicals (school and sport physicals)
- Mental health
    - Counseling for depression, anxiety
- Evaluations
- Crisis screenings
- Trauma screening
- Reproductive services
- Trauma-informed care or referrals
- Smoking cessation
- Groups for parents and students
- Nutrition services

- Dental
- Well visits

Differences in services across school levels (elementary, middle, high school)

Summary: Service offerings are largely consistent across all school levels in that there are immunizations, physicals, and health education. However, even if they are providing the same services there is inequity in staffing, meaning all schools are not providing the same level of services. There are no reproductive or nutritional services at the elementary level for obvious reasons. Consent is different for students ages 12 and older, so in middle school if you are still 11 you will receive elementary-level services rather than what would be offered in high school. Middle school students generally are experiencing a gap in SBWC services that interviewees would like to close.

- "In a previous partnership with our wellness center, they would see students from middle schools for physicals, but now that's not the case and it's left a gap in services for our students."
- For elementary schools, especially for COVID, we are opening up questions about their families, etc. It would be helpful for SBWCs to go into classrooms and talk with child. This may not be part of the SBWC, but it is about the school-based wellness. It is important especially for younger children who don't have access to care. SBWC can't be substitute for primary care but could step in for children that haven't been seen for a few months.
- "It would be good to have mental health component especially at elementary schools."
- "We need to make sure that middle schools are incorporated in SBWCs. Middle schoolers have complex health needs like identity needs, teen pregnancy, mental health disorders. I think if we emphasis the need and importance to all stakeholders, then we can get good buy in."
- In this area, anything at middle school level would be very helpful. This is where they need most of your resources. The school system focuses on K-3, they get extra resources at an early age and by the time you get to middle school they don't have enough counselors etc., and that's when things hit the fan.

Physical health services most commonly used

- Summary: Interviewees named the following as the most common physical health services:
    - Sports physicals (the most common)
    - Immunizations
    - Reproductive health
    - Nutrition counseling
    - Minor acute care (rashes, sore throats, mild cough, heightened temperature, rashes, etc.)

Behavioral health services most commonly used:

- Summary: Interviewees named the following as the most common behavioral health services:
    - Depression/anxiety services (1:1 BH support) (the most common service)
    - Therapeutic intervention group
    - Social skill groups

- Facilitation of counseling with community providers
- Sexual identity services
- Brief intervention for substance use
- Trauma services

Gaps in services:

Summary: There is a strong desire for all middle schools to have SBWCs because of the importance of reaching children during this time period in their lives. Interviewees also would like to see more care coordination with the community and stronger partnerships with teachers. SBWCs should offer more mental health, behavioral health (substance use disorder services specifically), family, dental, and immunizations services to meet needs, they believe. Behavioral and mental health were emphasized because many students cannot access this outside of the school, and there is a greater need now more than ever for mental health care.

- **"**For a number of years we've hoped that middle schools would have wellness centers because it's such a vulnerable time"
- "I would love to see more interaction with teachers about children. The network and partnership is being built now but we have a ways to go and sometimes there are competing priorities."
- BH is one of the most important things for SBWCs, most of the time they can't get it anywhere else. If they are in school for most of the week, they can benefit from having their therapist there, if they have a panic attack there, etc. Child feels like they have that support there that they could go there. Every SBWC needs a behavioral health professional. Behavioral health needs to be available everyday.
- Some of gaps are having to do with larger gaps in state. There is high demand for child psychiatric needs, but DSCYF and healthcare is struggling with services, do not have enough family practitioners in state. Behavioral health professionals at level of services are not even out there.
- Dental services need to be more consistent, this varies by funding [among states/locally – this comment was not specific to Delaware].
- "I think all schools should provide child psychology and mental health, there is a big shortage of community child psychologists in Delaware."

Creating continuity of care:

Summary: Interviewees provided many suggestions for how to create continuity of care—greater student engagement, parent education/ basic education on how to access health care, SBWCs in each school, having warm handoffs, more seamless registration between the schools/ eliminate re-registration between schools, having one medical sponsor per district, universal EHR/improved record keeping, and a needs assessment at the school level because local needs vary. It will require intention and will to overcome the existing barriers, but it is necessary is there is currently no continuity from elementary/middle to high school.

- Doing some bridging work, talking in advance to prior teachers and getting a read on who might need extra support for transition to new environment. There are a lot of barriers now.
- "Also need parent education as well. The parent has to be involved in working with child as well. Parents sometimes do not want work with the child, but there is a need to engage."
- "We need to have some type of interface for all of the health information. You know, the school nurse could really be that coordinator of care between schools and wellness centers, like the health records and school records could come to school nurse for review."
- Medical sponsor should be the same across the schools in the district. Need scope and sequence, when to bring up certain topics and how to bring them up, both for patients and for parents, these guidelines exist.
- Also have to take into account the local dynamics/communities. But also need to make sure that community is on board and hands are not tied, need to be able to do best practices. Specifically hard to do reproductive health care, improving onsite dispensing of birth control.
- We have always had a handoff (school nurses meet) they discuss high-fliers, etc. It would be important to build in the wellness staff for these, but this would require parent permission sent and signed, has to be really structured expectation.

National Best Practices: Infrastructure, Operations, Confidentiality/Privacy, Billing, Funding, and Oversight

Summary: When asked about confidentiality and privacy national best practices, interviewees said that schools don't always know which children are enrolled/receiving services, and possibly a consent form can be changed to fix this problem. On the subject of consent, they also said that there should be bi-directional consent with continuous training for school staff on HIPAA and FERPA so that appropriate information exchange can occur, and identified that there is no universally understood standard for when to break confidentiality. On billing best practices, they said suppressing EOBs is necessary, and if this is not possible then reimbursement should come from commercial insurers. Colorado has an annual training on how to maximize billing, which could be beneficial to implement in Delaware. Staff and medical sponsor training on coding and a robust EHR system were also suggested. Regarding best practices related to funding, interviewees mentioned looking at tax opportunities for consistent funding, and that SBWCs struggle with services that aren't reimbursable through Medicaid. Oversight best practices included documenting services to learn about data trends on quality of services and outcomes.

- "Have to find bidirectional consents that allows information "need to know" exchange. Needs continuous training, not weaponizing HIPAA and FERPA. It is in the best interest of the child. Should be a way to loop back feedback. SBWCs can work with kids to say that it is in best interest for parents/students to sign the release of information. This the recommendation for AMA and AAP."

Service Delivery Models: National Models, Delaware Models, Advantages & Disadvantages

Summary: School-Based Health Alliance and Center for Health and Healthcare in Schools are two resources for best practices for service delivery, and since March SBWCs have been focused on telehealth models. Delaware's service delivery model is unique in how it is arranged with the health system overseeing and staffing SBWCs. Interviewees were familiar with the hub and spoke model, and Colonial was named as an example of this model. The advantages of Delaware's service delivery model are that every high school has one, which leads to increased access to care, they reduce stigma associated with behavioral health because BH services are mixed in with physical health services, and they are convenient for families because all services are housed in one location. Additionally, there is a smooth referral flow from school nurses to SBWCs. The disadvantages are that when a child leaves their school they lose their provider and students can only seek health care services from their school's SBWC. It was suggested that there should be a consortium of providers so there is understanding across the board of SBWC services.

- Delaware is unique in how it is arranged with the health system overseeing and staffing SBWCs. This provides continuity of care between health system and school. Doesn't always work as well as you'd want, but it still provides an opportunity.
- "Hub and spoke is the only model that I am familiar with. This may be fiscally advantageous. I would love for SBWCs to have a psychologist and psychiatrist, but this may not be possible given fiscal constraints."
- "Even if a practitioner isn't coming into the building, it would be a benefit to have some type of a consortium of providers where there is a greater understanding of what is happening at schools."
- Colonial has a hub model. One school with a health care provider and then 3-4 satellite sites where they provide behavioral telehealth, more of a behavioral health model. More of a behavioral health focus than physical health.
- For families, if they can do one stop shop for services, it really helps. Also reduces stigma. If BH services are alongside medical services, no concern for stigma and confidentiality. Can also be difficult to get a release waiver signed because of the number of providers that need to. Also can help get realistic recommendations for school (especially with IEPs/504s, etc.)
- "Right now, students can only seek health care services school from school that they attend, but we are currently trying to allow SBWCs to meet students where they are at. There was an addendum for during pandemic to allow students to be seen at the site that is closest to them as long as it is in the district they attend."

PCMH Delivery Model Considerations

Summary: Interviewees' opinions about the PCMH delivery model and its potential appropriateness for Delaware varied – they included that there should be a needs assessment to determine if it's a good idea for any given area, it's worth being flexible and exploring the model, it could be a great option for students who do not have a medical home, and SBWCs could operate as an extension of a medical home. Interviewees said that financing depends on managed care and Medicaid contracts. The advantages are that you have a home where you could have all information, and continuity of care and

wraparound supports for students. The disadvantages are that there could be community pushback (and there is perceived competition between community providers and SBWCS), SBWCs would need to serve all students not just those enrolled in the medical home which would be challenging, there needs to be a process in place for serving transient students, the EMR system would need to change, and it could lead to increased competition if roles are not clearly defined. There is a lack of trust in the health care system for some potential users of SBWCs, but that could be addressed through time and relationships. The main infrastructure challenge discussed was difficulties for rural SBWCs.

- Disadvantages is that there is distrust by population in being a part of a system, it takes time to build up the trust. The convenience is important. It could be a medical home or like a distant medical home for hooking folks into medical homes
- "I would like to see it be an extension of medical home so that we could have them do some types of follow up on patients, but this is not how it's working now. I would like to get a notification that my patient has gone there. Often times it's the parent who says something, but the pediatrician can't follow up. Most of our offices have developed good relationships with school nurses, but we have not developed this relationship with wellness centers."
- Depending on who sponsors the SBWCs (ChristianaCare vs. Nemours), they could incorporate SBWCs into the medical home through the hospitals.
- "Also when they send out enrollment packets, they should be asking who is the student's primary care physician, and if they don't have one, then the social worker could navigate to get them connected to primary care home. Through DHIN, this would also allow data sharing with the right consents."
- I think having SBWCs incorporated into the medical home may be good. The SBWCs and PCPs need to be communicating not only data, but also PCP needs to be comfortable to SBWC staff. Quality of care may vary by SBWCs. Start with PCP as the hub, and spokes can be SBWCs.
- "I think for a lot of our kids, the SBWC is their medical home. We do communicate with outside doctors if we need to. I don't know if this would muddy the waters and get lost in the mix."
- SBWC are interested in becoming child's medical home—this is not what payers intended. Medical homes should be where family's PCP, pediatrician, those types of providers are so that we can control quality. As we continue to push primary care and the Primary Care Collaborative (we have a Collaborative in DE to look at why PC seems to be shrinking in DE) and then you have other elements like SBWCs, then you are adding in another dimension or another party who has records on this family/child and [Aetna group member] doesn't know if there is information sharing or if everyone functions as their own island.

Policies

Delaware Policies & Contracts

Summary: Interviewees understand primary responsibility for oversight of SBWCs to lie with DPH, but generally have a limited view into the other policies that govern their operation which may not be directly relevant to their own roles. A variety of data-sharing agreements exist for different purposes, but interviewees do not necessarily feel that more MOUs, policies, or data-sharing agreements are necessary – while they are one tool to enhance collaboration and communication, they are viewed as

part of a strategy to do so rather than a driver of that. Rather than a desire for more MOUs or agreements, interviewees more commonly expressed a preference for standardization or harmonization of those agreements. Data and IT stakeholders see value in greater standardization of data sharing and reporting.

Policy Framework

- Interviewees understand primary responsibility for oversight of SBWCs to lie with DPH, but generally have a limited view into the other policies that govern their operation which may not be directly relevant to their own roles. Interviewees stated that most SBWCs have a contract with DPH and an MOU with their school/district.

MOUs, data agreements and other tools

- A variety of data-sharing agreements exist for different purposes, but interviewees do not necessarily feel that more MOUs, policies, or data-sharing agreements are necessary – while they are one tool to enhance collaboration and communication, they are viewed as part of a strategy to do so rather than a driver of that. Rather than a desire for more MOUs or agreements, interviewees more commonly expressed a preference for standardization or harmonization of those agreements. Data and IT stakeholders see value in greater standardization of data sharing and reporting. For example:
    - To the data and information technology stakeholder group's knowledge, there is no statewide MOU between state and SBWCs.
    - In Colonial, there is a data sharing agreement – one of the things [Group member] worked on was creating an academic system so that information could go into wellness center data with parent consent (which required coming up with new enrollment form). But this type of data sharing is not standardized.
    - Data Service Center/Nemours have data sharing agreement with a school district, and then the district has it with an external agency so they are not violating any FERPA or HIPAA.
    - "One of the biggest challenges is connecting the dots between the different data systems." A data sharing agreement is really important, and consistency in reporting, AND the parent piece that they've given approval for that data to be shared [is key].
    - "There should probably be standardized reporting, regardless of who the provider is."
    - MOUs between individual [outside] providers and SBWCs would enhance connections, but there is a lot of work to be done before we are there.
    - There are recommended data sharing agreements and there are recommended pieces, such as attendance, graduation rates, early dismissals, teacher evaluations, evaluations in class. Would be good to pull this information statewide and also on children served by the wellness centers.
    - Billing information does not capture the full picture of services provided: "The billing codes used don't tell the whole story of what services were provided." In other words, if they do a behavioral health evaluation, the code doesn't indicate what BH tool they used. When we do quality reporting our MCOs work individually with SBWCs to get that

information – this could be improved. "A little more transparency on exactly what services are provided [would be beneficial] because the code doesn't lend itself to that."

- "I want a DOE MOU to pull it all together, to combine the MOUs and have the different programs outlined in it. May not be doable, but could be important."
- "We need a better process for streamlining data process because I feel like streamlining the data helps each provider to feel more comfortable with their role."
- "We don't need more language, we need more funds and we need more sites. Now requiring physicals going into 9th grade is a lot to managed for parents and nurses. We spend a lot of 9th trying make sure that students catch up. If we have wellness centers at middle school, we could get this done there before they make the transition.

- CO was one of the states we examined for best practices, but it was not fruitful in this area because SBWCs are not run by any specific agency and there is no single set of formal requirements. However, Illinois Medicaid developed a contracting toolkit that may be helpful for Delaware.

Health Equity: Perspectives and Strategies to Address Inequities

Summary: Stakeholders defined health equity in a variety of ways, not all of which honed in on the need to identify and address inequities rather than simply providing the same services to all students. This suggests that there may be value in broader stakeholder conversations about what it means and what is required for SBWCs to promote health equity. Interviewees identified numerous opportunities to increase equity and improve cultural responsiveness of SBWC services, including to better identify needs, such as: involving youth in defining needs, increasing SBWC visibility at community events, deploying community health workers to address needs in culturally sensitive and holistic ways, coordinating with schools to identify students' language needs and ensuring that communications meet them, and ensuring that SBWC staffing reflects the local community. Dental care and orthodontics were identified as areas where health inequities exist across the state, and where some interviewees expressed hope that SBWCs could ideally help address the need.

Interviewees' emphasis was less on specific policies that need to be enacted and more on tools and strategies that could be beneficial, but standardization of data also came up repeatedly as an area of interest. For example, an interviewee from DMMA highlighted: "We have created numerous dashboards to make sure gaps in care are taken care of but not in wellness centers. This would be really helpful to have. Slow down and build the infrastructure before opening up more SBWCs. Then you know what you have and what data you need to collect to get those end result reports. This would also help with staffing—e.g. imagine high SES SBWCs where you don't need medical because they all have PCPs. Data might show that we are overly/improperly staffing based on true needs."

Understanding of health equity

- Stakeholders defined health equity in a variety of ways, including: "Health equity means providing access to all students, with a particular focus on most vulnerable or underserved and SDOH"; and "Not just that students have the services available to them, but that they take diversity into consideration and connect services in a way that feels appropriate to the student. Language and culture are important."

- However, others defined it as simply making the same set of basic services available to all (e.g., "It's like physical education—when you can give the same thing to every kid it eliminates the need to go outside to find the solution"). "Transportation is a big barrier that SBWCs work to eliminate," which can reduce inequities. While this convenience, absence of cost-sharing, and other features of SBWCs may have the effect of reducing some inequities, "offering the same services to all" does not fully meet the APHA definition of health equity as a state in which "everyone has the opportunity to attain their highest level of health." As many interviewees pointed out, doing so requires specifically identifying and addressing inequities, rather than a one-size-fits-all approach. These differences in understanding may point to a need for communication, education and consensus around the meaning of health equity so that schools and medical sponsors can proceed with SBWC development from a shared understanding of the impact desired by the state and various stakeholders.

> "[The SBWC] gives you a way to act and a pathway to action, and then to have the support right there that you can, in some cases, you know, prevent extreme illness and save your child's life. I mean, there are quite a few things that having that kind of support provides."
>
> "There are times that I know kids only came to school for medical care."

- Insurance status influences students' access to care outside the SBWC and as a result their health, sometimes limiting the extent to which SBWCs can improve health outcomes. Interviewees pointed to "inequity of ability to navigate [the] beehive of insurance" as an important factor.

Variation by school level:

- The elementary SBWCs are in higher needs areas. There is desire to address equity of access issues by having SBWCs. The needs are still high and there is a lot of drain on resources because teacher burnout/vicarious burnout is high.
- "You would use different strategies between the different levels because the issues would be different and the target population would be different. In high school, you look at students more, at elementary school you have to target parent more."
- It would be the same for elementary or middle school.

Opportunities for Enhancement

- "Everything, there is an opportunity to enhance everything. It is important for students to relate to the provider giving them services. We need trainings, better record keeping to make sure that provider knows who the student is and can meet them where they are."
- Starting an equity committee. Looking at terminology on paperwork, inclusive and culturally appropriate language (gender, race, ethnicity), opportunity to engage more with community and youth (these are recommended practices from another state).

- We are working on our own equity plan for our district. SBWCs can work with districts and state and see how they can be incorporated into work and trainings, etc. When we as a district are looking at policies and practices for equity, SBWCs need to be included, part of the school community conversation and work.
- One of the practices could be, here are the families that did not sign up for the wellness center, what are the barriers they faced in order to sign up. When we say everyone has access, what do we need to do to make sure that everyone knows they have access?
- We need to have access for everyone, and sometimes school is the only meal students get. If you are going to provide some form of medical care, having a wellness center right there is a very positive thing. Adds to the equity if we can make this success.
- There is not a data system and we have to have MOUs—there is no reason in a small state like DE we don't have a standardized system rather than pulling data one-off after the fact. "You need data at the time of service delivery."
- Definitely want to make sure that finance is not a barrier. Also immigration status is a barrier for families, there is reluctance to going to providers.
- Consenting by exception/opt-out for enrollment might be helpful for promoting equity in access.
- Making sure SBWC can be a safety net. Also sponsoring agency policies that talk about training for inclusivity, implicit bias, for SBWC and educational providers. Having some time together out of clinic to talk about this, starts at the top, need state guidance.
- "I am always very hesitant to add policy, policy doesn't have as much meaningful change."
- If there is nothing in place already, this needs to be addressed. Especially where we are because we have a big immigrant population.

Alternative Discipline Policies

Summary: Many school stakeholders indicated that their school is exploring or in some way implementing alternative discipline approaches or policies, though many were in the early stages of doing so. They were supportive of SBWCs collaborating with school staff to bring their expertise to bear in supporting these approaches, but the specific role of the SBWC was not always clear. This was an area where interviewees suggested that greater coordination/integration between SBWC and school staff would be beneficial. The SBWC role could include mental health providers having a role in developing and implementing alternative discipline policies, and as part of the care team, particularly around behavioral health. Interviewees also perceived value of SBWCs in helping to meet basic student needs that could help prevent or address issues that might otherwise become the basis for disciplinary action (e.g., education on vaping). Notable comments included:

- "One of our SBWC mental health providers is now a member of the PBS (positive behavioral supports team). Her ability to look through a behavioral health lens was valuable in developing the positive behavior support guides. She really helped to look at the whole child and look at their needs. I think it's important for SBWC staff to see themselves as part of the school staff. We work really hard to bring them in, because they do crisis response, they are able to see how our tier 1 issues can be strengthened."

- Would love to see SBWCs have a larger role in all areas of student support. They could bring their expertise to the table and share school professional's expertise—deepen collaboration to benefit students (same language, same page)
- "In the best of all worlds, they would be knowledgeable of and if need be, consider what is happening with the case in their counseling piece."
- There is code in Delaware for restorative practices. The problem is that there was not funding and resources from state, schools were just left to figure it out with their own means. But best practice is to have specific funding and resources in school to support it, [the lack of that] makes it more difficult to implement.
- "Yes, SBWCs can help teacher meet students at most basic needs before they can get into restorative practices."
- Great opportunity for substance use discipline, getting screenings, brief interventions, etc. Also tapping into social resources that may be needed in response to behavioral issue. Using it as a carrot to get into services (even outside of SBWCs).
- Because of the vaping problem (big right now), there is a program that the SBWC has helped our disciplinarian person get into. Instead of getting a disciplinary action when students are caught vaping, they go through this in-depth program and learn about the harms vaping. This helps to educate them and they become a support for others to stop vaping.

Trauma-Informed Care

Summary: There has been variable engagement in training related to trauma and varying engagement in trauma-informed and trauma-specific services by school nurses and other school staff, as well as by SBWCs. Training on trauma alone, while it can be informative, does not substantially change practice or policies, interviewees noted. Screening and intervention needs vary by age level because of the types of trauma students may experience in different age ranges, though some interviewees emphasized that the earlier in life trauma can be addressed, the better. Universal screening for ACEs was recommended by an interviewee from the Colorado Association for School-Based Health. At times, behavioral health providers in schools are incorporating mindfulness, yoga, and other techniques aimed at helping students cope with trauma, but not all schools are open to those services being offered. Few interviewees could identify trauma-specific services being offered in a SBWC.

- SBWCs made an effort to engage in training that education community has offered.
- SBWCs understand effects of trauma on the brain.
- At the individual provider level, practicing some of the approaches on being trauma informed would be helpful (especially right now and after the last year- never a more important moment to understand what trauma does to the brain and the body).
- Trainings are not integrated as thoughtfully and rigorously as needed. Need to educate SBWCs and school providers more into school environment. Especially a need in light of COVID.
- Need to go beyond trauma-informed. Need to be people who have specific training in trauma, not just people who know about it. Are there things we can do to involved the family? Not just having folks be trauma-informed, but have specific people have trauma-informed interventions.

Would help reduce overdiagnosis of ADD, ODD, etc, happens especially when kids have less resources.

- More intensive you can be at elementary level, better off students will be at higher level. Especially for tier 1 & 2. Pushing inclusion of more social workers in schools to help with families and bridge gap between home and school.
- Also important to look at traumas that are more characteristic and prevalent of various levels. Need to be deliberate with limited resources.
- Screening structure really varies after middle school, need more confidential screening later (building in more individual time).

Existing SBWC trauma-specific interventions include:

- Mindfulness, relaxation therapy, using the Calm app, teaching youth how to identify a stress reducer that works for them.
- "Have been working with Delaware Guidance on TIC practices and training and SBWC could help with TIC trainings to create alignment in practices."

Opportunities: Translation of knowledge and training into practice, skill-building, support for adults/teachers, screenings

- **"**There's a huge opportunity, particularly in that some of the most stressed out people in school building are adults. Being able to be a force of information and support for adults in the beginning."
- "There is always greater work that can be done to help professionals practice the skills. You can know about trauma-informed practice, but to be able to practice what that means is different. Translation of knowledge to practice needs work."
- "I do not know what training they do actually receive"
- They could have a role. There is a multi-disciplinary approach to trauma, nutrition can play a role in supporting response. Trauma also leads to other health issues. Need approach where we can meet the student/child where they are to overcome trauma and involved the family too.
- At elementary level, you even have to differentiate between grade level. At high school level, you could be more technical with education and the level of trauma may be different. Want to see more sex education and sexual violence education at middle and high school levels, make sure it is developmentally appropriate.
- Take a resilience approach, talk about strengths along trauma. Needs to be more than just for behavioral health providers, primary care providers need to have competence to build resiliency, motivational interviewing skills.
- "We address this the most through the mental health piece. However a kid may have frequent visits to wellness center with frequent stomach pains and PA could refer to mental health counselor."
- Training is always great, but there seems to be good knowledge out there. Some local doctors are now asking kids to complete the ACEs questionnaire.

Telehealth: Policies, Barriers, Services, and Needs

Summary: SBWCs have been adopting telehealth, primarily for mental health services and refills for contraception, using the flexibilities afforded during COVID-19. They hope these flexibilities will continue. However, administrative, billing, logistical, and patient barriers (e.g., inequitable access to internet, lack of privacy at home, language barriers and difficulty that providers and patients have using translation services for virtual visits) do exist. Updating billing systems with new codes is a barrier. "It is challenging to get approval to change, make changes, and operationalize changes," and then quality check on the back end to make sure it is being done. Finally, it is necessary to make sure that telephone or video call actually happened—this is a broad area for potential abuse. Telehealth is also harder to use with elementary-age kids, because they need help from their parents.

While rapidly making changes to provide virtual services has been challenging in some ways, interviewees see this as a promising time where innovation is possible – for example, doxy.me virtual clinics for SBWC providers were mentioned as a promising model. Some interviewees reported finding more compliance and an uptick in visits after adding telehealth and expanded to video. This trend could extend to SBWCs especially for middle and high school, because there is stigma attached to being seen to use the SBWC. also led some providers to realize that they were missing phone numbers for many students, so they worked to gather and update them in order to make it possible. "We use it and we're getting paid for it, and we need to continue that. Using telehealth is also an opportunity/mechanism for integrating parents and caregivers into care," one medical sponsor said. In addition to continuing COVID-19 flexibilities, some interviewees mentioned a desire for policies allowing reimbursement for just a phone visit, as well as policies to allow providers to be able to initiate contact with families.

- Acute care, and we are looking at some dental services (identifying abscess), this is because some students are also our dental patients.
- Advantage to having a telehealth model means that services can be offered all days of the week if schools are closed, but doing this on a broad scale may be a disadvantage. Other disadvantage is not having a one-to-one relationship with a physician.
- Starting to offer telehealth services for counseling and psychosocial services, less for physical health. Also offering refills for birth control for students who were already enrolled in SBWCs.
- Have to get creative (sitting in parking lots for services, etc.).
- Text/chat with older patients has helped. Service and contact can now be provider-initiated.
- Both our school districts have hired additional staff beyond entitlement to support all staff SBWC, guidance, etc. The need exceeds the current resources.
- They are using Doxy.me for telehealth and they are doing virtual sessions for mental health and physicals in-person.

Potential Opportunities:

- Could be very effective for providers if you had a spoke and hub model. It really depends on what they want to use it for.
- "DSAMH and DPH were working with substance use grant to build this infrastructure, but I don't know how well this has taken off, partly because COVID hit."
- Most telehealth would be with the older group and more parent involvement with younger kids.
- We are exploring giving families Chromebooks and hotspots. You need to also try to meet families where they are before to build trust. Any counseling services should be delivered via telehealth, it is really important to have this right now.
- Could do nutrition counseling.

Confidentiality Policies

Summary: Overall, interviewees felt that confidentiality policies are not always fully understood, and that there is a need for training for school staff and providers to ensure that everyone's understanding of these policies is aligned. Rather than additional policies being needed, interviewees felt that the necessary work is in education and appropriate application of the existing policies. At times, schools default to "we cannot share that information because it would violate FERPA," even when restrictions can be mitigated by getting consent. FERPA is sometimes "a shield that schools throw out there when they don't want to deal with something" or fully communicate with a community provider. Not all practices adhere to the law, especially when it comes to care for minors. Above 14, adolescents can consent to their own care, so they can access care, but if their private insurance bills and their parents gets the EOB then it's not confidential. Interviewees do perceive these regulations as creating barriers to data sharing that would enable, for example, matching of health and academic data. One equity-related concern around data sharing is that undocumented families may be more reluctant to participate in SBWCs if they think that their information will be leaving the school system.

Stakeholders understand that the SBWC medical sponsor "owns" the electronic health record, but some expressed frustration about siloed data and limited information. Questions included: "What metrics can we use in a child's learning process? What are they up against and how could we drive change for children with collective data? We understand FERPA/HIPAA, but until we get all the data together we aren't going to see trends in children that are impacting their educational model." "From DOE's side we don't have all the medical data; on the flip side for the medical sponsors if you don't have the full medical picture you don't understand the full picture and that's why you have duplication of services. In DE different agencies are providing the same services because of silos. Why not have tiered services rather than the same service 3 times?" "[We] value collaboration, but it's tough when you're hearing families/students being offended by inappropriate sharing of personal information. We need to get better at this."

- We discuss confidentiality more overtly with students with disabilities and we need to keep it in mind with all of our students.
- There is information. We need to have some type of MOU and policy so that SBWCs, nursing, and guidance can be on the same page. In order for us to help you better, is it ok if we tell educational providers this. Students may not want to tell providers, but it is important that they know. Nurses get feedback from SBWC for medical issues, gets muddier when you are talking

about mental health. We are afraid to share information. There needs to be something that we have for the best interest for the student. Protect students' privacy but understand that we are all on the same team.

- Would be good if someone could list them all out [all the confidentiality regulations] and put them in a matrix. It becomes difficult and team gets confused. It is always a question of what we can do, usually limits what can be done, sometimes they are contradictory. Need to completely understand that behavioral health and reproductive health need to be protected.
- "We do not need another policy, we may policy ourselves to submission and put up our own roadblocks."
- Don't think that protections need to be strengthened, state laws regarding health information privacy are pretty good. Have strict confidentiality laws for minors seeking healthcare treatment.
- "One issue is schools not wanting to allow students to obtain these services on their own without parent consent. But minors are allowed to consent to certain healthcare in Delaware and schools may not always want to accept this."
- Sometimes legal families have informal arrangements (youth may be placed with someone else). Would hate to see a parent shut down the possibility of students getting their own healthcare, so there may have to be a specific age component.
- CO made change in 2019, lowered age of minors being able to seek behavioral health on their own to age 12, made to accommodate middle school students. Can seek substance use treatment and reproductive health care at any age.

Variation by Level:

- They should differ. In elementary school, children can't consent to things, so a parent has to be involved. At some levels, some school personnel may not need to know certain things. This is different with behavioral health issues. If there are issues in the school with the child, they should know that they have someone they are communicated with. This is helpful so that principal does not refer child to someone else. Parents may not always be able to tell what is happening with child's healthcare.
- "In an ideal world there are full teams that are working with wraparound services, but this is not the reality of things."
- I think it is the same across all schools. HIPAA is still enforced with elementary students. Probably share more with parents, but not more with the school.
- Yes there are differences. As students get older, you are dealing with potentially riskier behavior and don't want to get in the way of students getting the services they need because of privacy. Important to determine what it looks like at each level.
- I think that it would differ with parental involvement. Certainly under 12 years there would be more communication and talking with parent than there is at high school level.

Barriers:

- "We do not have access to the school records, sometimes there is even the barrier of getting access to Schoology/schedules."
- Barrier is what can we safely share and not share. If you have a student in the office having suicidal thoughts, there is confusion about what can be shared, what the school needs to know.
- Depends on what data do you want shared an who are you sharing it with. School sharing with data may have FERPA issues involved. Have Group Violence Initiative with DHSS that is based on consent (consent forms for incarceration, education, health etc. data sharing) this is a national model.
- There are a lot of people that want to help. SBWC could be the place where this all comes together, but need digital method to align this. Each provider has their own reporting system.
- Ability to have full reproductive health service is a big challenge. Minor consent laws are restrictive in different states. Has come out as overwhelming parental support for reproductive health services (silent majority), need understanding.
- No, they have access to our attendance records and pretty much anything. SBWC might check with me to see what I have for immunizations—I can share that with her. Sharing is governed by HIPAA/FERPA.

Case coordination confidentiality issues:

- Case coordination is on a case by case basis more than consistent protocol across the board.
- There was little case coordination when [group member] worked in schools. There may be some changes more recently.
- School resource officers are becoming more aware of the intersection, particularly with BH and their work. DSAMH was supposed to train them on MH First Aid (in August) but it didn't happen.
- Sometimes it happens, but this is an opportunity area. Need to increase this coordination. They do have student intervention teams, this could be better coordination with them. If you are working with a student and a student has a problem in a classroom and the teacher wants to consult, they should consult with the SBWC. This is a coordination piece.
- "Wellness centers don't have any case managers. There is a fiscal piece to this as well. A lot of insurance companies don't pay for SBWCs to do case management. There used to be different payment mechanisms to include these types of coordination in piece, but now those are lost."
- "There is an attempt, but these regulations get in the way."
- There is variation in policies for case coordinate. Big barrier to accessing information (info on where a student is, big recent issue).
- This happens a lot between schools, especially for chronic diseases like asthma
- Always a HIPAA and state law exception for case coordination. Have DHIN that 95% of providers are subscribed to. Makes a lot sense for school nurses to have access to the DHIN, department of corrections has used some of this. Precedent exists for this relationship. The DHIN has its own special data requirements.

Law Enforcement Involvement

- "Yes, we have a school resource officer who is sometimes called in. They are kind and empathetic, but I don't see it as valuable in helping our students."
- "Sight of police officer may increase traumatic response. When we have a kid who is in crisis and we cannot get ahold of the parent, this is the last resort to transport students to the hospital. There is no alternative. This is very triggering for students."
- "There is a law enforcement component of HIPAA and all DPH subpoenas are HIPAA compliant."
- Varies between schools, school resource officer, and youth involved. Youth was arrested at home for domestic issues with mother, on paper it looked like a violent episode, youth contacted DAG directly. There are certain SROs that are aware of youth and special education issues and have a vested interest in them.
- "Our resource officer and MH provider work diligently together. If someone is in crisis and the only way to get them to hospital is by the resource officer, or – I don't want to know sometimes but they are always in cahoots."
- "Depending on the case, there may need to be coordination for extended care or documentation related to adjudication. Try to keep SRO strictly focused on law enforcement, we don't want them to become quasi-school personnel because of division of duties."

Operations

Student Enrollment Processes

Summary: Parents can enroll students in SBWC through online or paper registration. The SBWC and services are advertised through open houses, enrollment packets, emails, town hall, parent information night, etc. Additionally, teachers and staff serve as monitors for continuous referrals.

- "Parents know about it, they look forward to kids being able to enroll. They are at open-houses, they have enrollment packets, nurses office have enrollment packets and refer to the SWC. They also have online enrollment on website."
- "Throughout the year, we have them available on websites and in person. We also have an e-registration that we send through school listserv emails."
- Online and paper/pen registration. Parents can check the services that they would like their child to receive.
- Every year, they do a mail-in with school paperwork. Our health teacher offers extra credit for students who get consent signed by parents. Mailing them independently was hard. There are announcements made in school.

Improve Enrollment

Summary: Interviewees made the following suggestions to improve enrollment: SBWC presence at community events; promotion by coaches and CHWs; move to an opt-out model rather than opt-in; increase awareness of the range of services SBWCs provide; allow for students to make appointments at the SBWC they live close to, rather than only at the school they attend; accept electronic signatures; and couple SBWC communication with other district information.

- "We should consider an opt-out model rather than opt-in. Our most vulnerable students have challenge of getting enrolled.
- Schools all have the same amount of staff regardless of how many are enrolled. It is important to expand enrollment, but also important to make sure that the staff are distributed equitably (size of school/enrollment).
- Lack of knowledge of what services SBWCs provide, need more education. A large number of people still believe SBWCs are just providers of reproductive health care.
- Best if school and sponsoring agency can have bidirectional consent. SBWC and school consent should be there, one sheet of paper. This consent can follow the kid through the school life in their school district. Especially for older kids, there should be opt-out model.
- "Difficult right now—still doing sports physicals and taking care of reproductive health. Students are making appt, but they still need transportation. Short of doing some sort of transportation I don't know how they'd fix this."
- Barrier that only students who attend high school can use the SBWC. Students should be able to attend the SBWC if it is appropriate and accessible to them. Create policies that allow flexibility for students to receive care in other building.

Variation by level:

Summary: At lower grade levels parents may want to choose the services more from the menu of overall services than they do at higher levels. This is a barrier for streamlined consent/opt-in versus opt-out.

Family Enrollment Considerations

Summary: Interviewees listed advantages, disadvantages, and considerations for enrolling families in SBWCs. Advantages included addressing the negative impact that parents' health have on students (smoking, MH, nutrition), providing health education, and eliminating barriers to care for underinsured/uninsured. Further, SBWCs could provide basic needs that aren't being met – wellness visits, immunizations, and screenings. Opening to families could prove to be financially beneficial as well. Disadvantages include over-utilization for a limited staff and confidentiality. Considerations include space, security, scope of services, and the fact that some medical sponsors are only pediatric entities. Some interviewees expressed more comfort with opening SBWCs to siblings rather than parents.

- A lot of times, a student's parents' health affects their health (smoking in the house, mental health issues in parents). Would be good, especially for TIC, if we could include the family in the care. But there are custody issues. Treating the child's community.
- Don't think it is a good idea, SBWCs were not designed for families. Maybe work with public health. There is a need for more families to have access to healthcare. There could be some tie to this but do not think that school building is the best location for this.
- Challenges are alternate entrance, hours of operations, and competing care.
- "This would be nice on a strategic path, but there is still a lot of work to be done with students care themselves."
- Could be helpful financially. Also can know that whole family is at the same provider network. Also helpful for individuals/families who have barriers to physically getting to providers.

- It is part of our model, depends on school funding. COVID has shown us that families are varied and it is important to consider the full family.
- Maximizes ability to bill and get revenue. Also helps families for continuity of care (count on trusted place). If you build a SBWC, build it for community involvement – external door, hire right scope of practice, mobile units. The best way to do it.
- We don't have many providers in the area—our school district is made up of 3 towns and only 1 of these towns has a provider. This would free up ERs and stuff because they aren't going there. I don't know if it would be a disadvantage, but families would need more services than what SBWC can provide. But they can refer them somewhere that can service them.
- That is something the state was looking at in Wilmington because of high number of low-income families. Especially in low-income communities, it would be helpful. But the issue would be cost associated with creating the appropriate space, would require construction, but would be a great benefit.
- Disadvantage would be having a safe environment for kids, especially for mental health, a lot of the issues were in their same household. It would be important to keep them separate.

Student Engagement Strategies

Summary: According to interviewees, students access and engage in SBWCs primarily by walking in or referral from burses, school staff, or self-referrals. SBWCs could work with and leverage school engagement models through Schoology, social media, creating a youth advisory/youth action team, and through more promotional activities. Additionally, SBWCs should be intertwined and linked with student support team meetings.

- "They can be referred by parents or school staff, can self-refer by email or online"
- "All SBWCs have access to Schoology. This is really helpful!"
- "There should be a youth advisory or youth action team. So they would be involved from the beginning. If it was a planning site, then they would be involved in planning, all the way long. They can be utilized as, you know, looking at how things are done and equity and all these things. And they can then become your trusted advisors to the other student population, like where can we market this, this is great stuff, you know, like for mental health providers, this is Suicide Awareness Month. How can we do that and they come up with very creative ways to do that and they become very integral into their school and they become sort of a place where kids want to go kids want to go to the be part of that youth advisory or your action committee or whatever they might be called."
- Usually they just walk in and make an appt especially for birth control or reproductive health. If they aren't feeling well, they have to see the nurse first and she triages, and refers them if necessary. Or, parents can call in and say my daughter's ear has been hurting for 1-2 days can you check it out.
- The more targeted student support comes through student support team meetings, need to make wellness centers part of the plan and then communicate the plan. One student needed to see therapist twice a week, and so we needed to communicate with staff and teachers this plan. Making sure that we are incentivizing kids who do not want to come to wellness center.

- For mental health, we will have a session with them, and then give them a card for their next appointment. If there are crisis things, we will make it happen.

Variation by level:

Summary: At the elementary level, there is care coordination between school staff, school providers, and families. At the high school level, there is less family engagement because students have more autonomy to call, email, or make in-person appointments.

- Engagement tends to be higher from families in lower schools, high school has lower family engagement. Engagement difference comes form the fact that the wellness centers are primarily for high school, having wellness centers at elementary schools are a way to improve family engagement.
- Engagement tends to be higher from families in lower schools, high school has lower family engagement. Engagement difference comes form the fact that the wellness centers are primarily for high school, having wellness centers at elementary schools are a way to improve family engagement.

COVID Engagement

Summary: Interviewees noted that COVID exacerbated existing communication issues and it is more difficult to get in touch with families who are transient, homeless, etc. At the same time, telehealth as a model for engagement is more accepted now than it was pre-COVID. As students come back to school, SBWCs should be very clear about services they provide for COVID. It was suggested that SBWCs should offer testing and administer vaccine when that time comes.

- There is an opportunity for apps. But what works for us is that nurses and counselors just pick up the phone to call or text them. More provider-initiated care.
- During COVID, the school system has established wellness teams to monitor and discuss indicators of students, now these wellness centers are the better point of communication (access to technology). On the nursing end, most of the school health staff have been involved in testing, etc. Are also now in the school year connecting with families and following through on medical needs etc.
- "We need to include a targeted reminder to families as they come back in to school that there is this resource and that we are clear about what they are and are not doing for COVID."

SBWC Operation Model and Access

Summary: Among interviewees there was a desire for more continuous access to SBWC services, but an understanding of the limitations that constrain it. Limitations include funding issues and transportation (patients have difficulty getting to SBWCs when they aren't already transported there for school).

- "It's based on funding, we only have money for NP, mental health counselor, and admin. When we had more money, we could do more services in the summer, but we do not get a lot of engagement in the summer."
- Have tried after-school, but transportation always is an issue, even with vouchers.

- "In our SBWC, the NP and the MH provider only work when the school is open. The nurse will come in 1-2 days during the summer to continue with reproductive health (e.g. all shots done on one day)."

COVID Innovations

Summary: Suggestions included changing/extending operation hours to reflect students' new school hours and leveraging telehealth for health education purposes.

School-Provider Integration: Opportunities, Barriers, and Policies

Summary: Currently, SBWCs offer presentations to school staff at the beginning of the year so they can be more effective partners and, at the high school level, SBWC providers are involved in IEP development. Interviewees brought up the issue of school record and medical record being held separately, which makes the integration more difficult. Further, the location of SBWC can be a barrier because it isn't usually located in the center of the school. To improve integration, there should be regular meetings between SBWC providers and the school. Particularly during virtual learning, SBWCs and teachers can leverage Zoom classes as an opportunity for virtual health education.

- We are not integrated, but everyone talks. Medical record that SBWCs use is different than school records, no harmony and probably duplicity.
- Integration means that school partners will stand by if funding is threatened. Have offered SBWCs to take over Zoom class time from teachers to provide health education/promotion
- Policy from sponsoring agency to allow staff to work on integration. SBWCs should have representation on school wellness committees. Have meetings with champions of SBWCs on school staff.
- EXAMPLE: kids with anxiety; if teachers see that kids are struggling with being in class (maybe they are absent a lot) they could refer them to wellness to get a plan set up. Teachers might also refer them to the nurse. Even if we try to do outreach to the teachers, they don't always take us up on it. The NP would gladly go into classrooms and do a lesson on hygiene or hand washing but teachers forget.
- As we build new centers, being really explicit about how other schools are already integrating them are important. Response of principal is how am I going to make this work, need to explicit about value for principals.
- Would be ideal if there could be more of a partnership and knowledge of services made to staff from an admin level. For a while, we were the liberals, very supportive and all inv. A lot of it has to do with who the principals are, educating principals about the need and important of SBWCs.
- Advice from Montgomery County, MD: They have weekly 2-hour work sessions about these issues, need to make sure that we have a unified response and have vetted through each of the institutions. We have people-personnel workers in school system, these types of people are on those teams, but the teams themselves structure themselves, think creatively about other ways that they can keep tabs.

Infrastructure

Infrastructure Challenges: IT/EHRs, Billing, DHIN, Contracting, Equipment, Space

Summary: A variety of infrastructure challenges exist, varying by school district, school, and SBWC. Some SBWCs still use paper records. Space challenges in schools are a perennial issue because they are already over capacity, and this will be an issue for elementary schools – e.g., in one school district teachers don't even have space for a planning period because it all had to be used for classes. SBWCs may not be a priority – e.g., "As much as this is an important thing to offer, they see it as instructional space." There are also regulatory requirements, such as ensuring that the space has a bathroom, that can limit what space is usable. Buy-in from school leaders and from parents is critically important, and key to promoting equity - "I've been in parent meetings where there are more affluent parents who don't see the value in a wellness center because they've never needed to rely on it." That drives the decision making during the referendum process when the taxpayer weighs in. Instead of just saying this school is high need so we are going to put it here, taking a holistic approach to getting buy-in has benefits (e.g. in Colonial, they canvassed PCPs because they knew transportation was an issue, so they wanted to see how to connect the kids that weren't connected).

- Various information technology challenges exist across the state. It's "Always a question of the best path for routing of IT between schools, SBWCs, and providers. [Sometimes technology challenges arise when systems are not aligned or updated, e.g.] School system upgraded to Windows 10, but hospital hadn't. "We ended up getting our own internet provider to avoid challenges."

Infrastructure Needs

Summary: Space needs and challenges were a focus of this discussion; interviewees mentioned factoring space needs into formulas for siting SBWCs, and generally incorporating the need for space into policies so that it can be a priority. Schools are driven by academic metrics, forcing SBWCs to compete with those priorities. Issues related to confidential services and billing were also raised – e.g., "Some SBWCs may not be able to mark services as confidential in the EHR, so the provider must do this. It would be good if the EHR could identify this automatically." Some interviewees again raised inability to suppress EOBs as a challenge. Best practices flagged by the Colorado Association for School-Based Health included providing robust training for SBWCs to make sure they are capturing everything they can bill for, and ensuring that they are aware of and using case management codes that are relevant. Looking at timing in billing (when you can bill for services and when you cannot based on service delivery) is also key.

Siting Process and Considerations

Summary: SBWC siting is based on "whatever space is available," which is often very limited ("There are some SBWCs that are tiny and shoved in a corner") rather than on what the best location might be, and medical sponsors may not have much say in how it is designed. Improvements could be made to ensure that the layout is conducive to the services provided, e.g. privacy for behavioral health and reproductive services, privacy for waiting rooms and check ins, improvements to equipment to do testing or screenings. There is also a need to think about fridges for immunizations. One SBWC noted that it was beneficial to have the nurse's office back up to the wellness center, which helped to decrease stigma, enabled multiple entries, and overall was a strategic location. Regarding the budget process,

interviewees noted the challenge of needing budget referenda for financing: "Because of the model, even if you get state approval you still need local taxpayer approval through referendum. For most schools, without buy-in from individual district voters you can't ensure that SBWCs are going to be one of their priorities in this process. The wellness of kids is very important, but the logistics of how that is funded is complex." Newcastle County ended up using capital money to build the SBWC in one district because they went to referendum and it didn't pass.

- Factors that interviewees suggested be considered in siting new SBWCs included rates of: students who are disabled; low income families; underserved minorities; absenteeism; percentage of students who have a medical home; income level; providers available in the community; rates of asthma, mental health conditions, childhood stressors and trauma, overdose rates, prevalence of abuse, assault, and other crime rates;
- Also look at the physical space available, especially if construction is needed it can be more costly.
- Advice from Montgomery County, MD: Health systems can collaborate with the school system and look at what is coming up in school construction recycling program, it costs 50% less to add onto a school that is going under construction anyway. Costs a lot more to build standalone. We used a lot of criteria, limited English proficiency, TB cases, high risk lead poisoning, school enrollment, asthma, uninsured kids, which schools had linkages to care program, analysis of teen pregnancy, location of other resources in community, also looking at neighboring crime rates, juvenile justice involvement. Also looking at suspension rates, office referrals, equity accountability model.

Staffing

Summary: Interviewees expressed the value of hiring SBWC staff from the communities the center will serve: "It creates jobs in our communities, and the child has the comfort of knowing the folks who they are working with. Not the model everywhere, but could be a positive thing." "Staff need to match belief systems and attitudes of students and families…Kids need to trust providers," and staffing that reflects the community can help address implicit biases. "Providers in wellness centers are driven by the mission so there is little turnover, but when there is, recruitment is an issue," one provider said. Interviewees highlighted that in order to address workforce challenges, they need strong connections to educational institutions so that nursing and medical students know that SBWCs exist and so that there are internships for students to go into in SBWCs. There is a lot going on with youth and children that is more than health system gets involved in (health equity, TIC), I think there should be a way to better leverage the public health system, not sure of the format of this, but there should be a way to incorporate more in the SBWCs. Interviewees reported that their typical staffing model includes an NP or PA, licensed mental health providers, and a dietician in some cases, though interviewees had limited information about what was typical across SBWCs and this was not necessarily representative of all centers. One provider noted that because of medical staff credentialing, they have to collaborate with an outside medical provider for physician sign off on charts.

Partnerships

Enhancing Collaboration with Community Providers

Summary: Interviewees recognized that collaboration with community providers is necessary, in the best interest of children (particularly high-utilizers), and that families often don't have a readily available

network and PCPs/SBWCs could work together to fill that gap. At the same time, they acknowledged that collaboration is tough and they need adequate staffing and proper consent in order to open these lines of communication. Pediatricians expressed discomfort with SBWC's promotional tactics. Suggestions for better partnerships included regular check-is, using DTRN, Unite Us, or United Way's 211 as potential models for referral systems (because it should be coordinated at the state level, not district to district), and SBWCs operating as the hub of the wheel and refer patients out. Incentives were centered around how to make it a two-way street between SBWCs and PCPs to promote continuity of care. This could mean inviting PCPs and BH providers to the SBWC or having SBWCs work on care caps. Barriers include access to specialists, lack of trust in the school as an advocate, and confidentiality.

- There aren't that many providers in DE, so everyone recognizes that we need to collaborate better.
- "This can be such a good relationship, especially for parents/families. SBWCs need to recognize limitations and then can connect students with specialty care and with primary care for students with complex needs. They also can help to establish provider relationships for students who are not already connected, like they are not really trying to take students who are already integrated with medical home."
- Esp for BH; our provider has a monthly meeting with doctors where they talk about resources and programs that they offer that they could utilize. Insurance stuff associated with MH is very confusing. Our MH provider was explaining that if she sees someone here and insurance covers it, but if they go outside provider and are only allowed 10 visits then the 2 they had at SBWC counts toward that 10. You have to really know how to navigate systems so you aren't taking away from someone else. That's how MH providers try to work with outside forces.
- "It's not a level playing field because their care is free. If they want to make the schools into urgent care centers, that is a different story. It should be focused on high risk kids."
- "I think we could do a better job with communicating back to PCP when we know who the PCP is. Some of the students are our patients so we already have this collaboration, this happens for NPs and BH providers. It's more of a challenges for when providers are outside of our health system."
- A lot of PCPs don't know what SBWCs are and what they can do. The more patients they see, the more they are paid so they miss out of patient goes to SBWCs. It should be more about continuity of care. As we transition to value, which is all prevention based, then it doesn't matter who does the vaccine. Insurance companies are changing payment models so that should alleviate some of the pressure.
- Most of our BH providers are already mobile, so they would be thrilled to be welcomed into SBWCs and deliver services there. This may be a time issue for private practice pediatricians.
- I think there is good data on SBWCs impact on quality, this is helpful for PCPs. For reproductive health, also marketing to providers what they are and what they are not. I've never heard SBCWs say that they are in primary care, they are more of specialists for students, they do not want to be competitive.

    - In Sussex County, we struggle most with access to specialists, helping them with access to specialists is the hardest. Don't have local providers (eye doctor, hearing, brain, etc.). Need latest health/research for their care but those resources are not always here.
- Advice from Montgomery County, MD: Collaboration works best when you have constant TA, administrators for stakeholders that deliver services, co-management of services, and had collocated offices (HHS, school system, CBOs).

Strengthening Engagement with Families and Caregivers

Summary: Interviewees expressed the need for balance between parental needs, which is necessary, and prioritizing actual health needs. All adults should be involved, but this also shouldn't take away from agency for students. Caregiver/family involvement varies by school level. Specifically, in the younger grades, there is more involvement, SBWCs communicate with parents more than children, and parents need to be more informed about the SBWC services.

- "For older kids, it is not as important. It's more about removing barriers, especially for interventions that need to happen at home, need parent input."
- In elementary level, it is so important, parents have an effect on their health. Parent may not have buy-in on medication. Or parents playing pharmacist. They need to be informed, probably across all levels but especially in elementary school.
- "Parents are the constituents of a SBWC. When SBWCs are establishing, they should be looking to families for the appropriate model."
- Elementary: a lot more interactive with caregiver; that would be your communication not with the student. When they get to middle school, parents could collaborate along with student. At high school, there is communication between parents and wellness center but don't know to what extent.
- "They should not be the primary drivers of the design, but I do think it is important to get their input."

Enhancing Engagement with Students

Summary: Interviewees said that students should be involved in planning their care and should have representation on any oversight boards, particularly because active involvement helps students develop ownership and responsibility over their care. This sentiment was expressed for students across all grade levels as the best way to know what services are valued. Students and SBWCs should have a two-way relationship to ensure students are getting the most out of their services. This means SBWCs are providing them with information about their services and supports, and students are providing feedback so that they can measure value.

- Student can help to drive their services when parents may be a barrier.
- "Even at elementary level, it is important to know that they have control over their own bodies, nutrition, mental health. They can start to have an understanding on certain levels of what happens in their bodies and brain and what their care does."

- For secondary students, should create a survey/advisory to design care. For elementary students, need to better incorporate them into education of what it means to be healthy. Combine education with school.
- Sometimes they don't know what to ask for because don't know what they need. School nurses can help them with access and to know what to ask for. Students could be instrumental in getting a wellness center.
- what is the service you would like us to provide you? How do you want the SBWC to benefit from having you? We want to be part of your care. They want a safe place. They want a safe space to be able to talk about their physical and mental health issue. And also the basic sports physical.
- "We are going to have these students as 18-year old health care consumers, so it is advantageous for us to be training and teaching students how to be a health care consumer. Also how to be advocates for themselves."

Data & Evaluation

Recommended Measures, Data Collection, Gaps, and Reporting

Summary: Interviewees highlighted a wide variety of needs-related and demographic data, service utilization, screening, health outcome, and academic outcome data as potentially of interest, while recognizing the capacity challenges that data collection poses and the utility of standardizing measures. The identified sexual health and behavioral health as of particular interest to track for high school students and middle-school students, with immunization and school attendance being higher-priority for elementary-aged children. They highlighted the importance of looking at SBWC patients' specific outcomes for evaluation; interviewees expressed interest in looking at academic outcomes data, including how attendance and seat time is affected by access to a SBWC. Other key metrics included referrals and follow-through on referrals (school nurse referrals, school counselor referrals, decreased visits to ER, urgent care) to provide important context for the care that SBWCs provide. That community context is especially important for evaluating SBWCs in high-need communities. One interviewee noted that Kids Count could be a potential collaborator because of the volume and type of data it collects, and may have data analysis capacity. Many interviewees noted the value of collecting patient satisfaction data.

- **Suggested measures included:**
    - Social validity measure—was the service you received helpful? Satisfaction? Engagement/self-actualization around health? What services would students and families like to see? This could be done anonymously. [Note: Some SBWCs do currently conduct satisfaction surveys].
    - **Service utilization measures:** How many students are being served, how many are enrolled, frequency of use of the SBWC and various service types, which students are coming in for medical service vs. BH services, data on services during weekends/summer hours, etc., care that is provided at SBWC that would otherwise have not been provided (perhaps challenging to measure), referrals and whether referrals were completed, emergency room and urgent care visits, number of students connected to primary health care.

        - Figure out the population of people enrolled in SBWC compared to school population, utilization rate deduplicated (is it the same people), what reasons are they using it. If you see repeat visits, that is a red flag that something is going on.
    - **Cost measures:** Burden of health care expenditure and cost benefit analysis
    - **Screenings**: behavioral health and development issues, particularly for minority populations who may not be getting needed attention. Screenings for drug, alcohol, and tobacco use. Screenings for STDs and reproductive health needs, vaping as well. Cyber-safety/bullying.
    - **Academic measures of interest to interviewees included:** Graduation and dropout rates, grades, behavioral incidents, grade movement, attendance, seat time, disciplinary data (though this measure is complicated by inequities in how disciplinary action is taken).
        - "I think it would be interesting to track student attendance before and after they are seen by wellness center. Class avoidance, class cuts, especially for students who use behavioral health services. How often they use SBWC, do they follow up with PCP, is there a decrease in SBWC use overtime. We hope that students may be connected with PCP."
    - **Health outcome measures of interest included:** chronic disease treatment and outcomes (asthma, diabetes), immunizations (a big emphasis for managed care plans, but some felt this could be left to medical home to be the "owner" of), health behaviors (self-reported), contraception use, suicide rates, number of students with complete physicals, healthy weight, patient satisfaction
        - Pre/post surveys for teachers and students about health behavior, to understand if there is a change in habit, e.g. for smoking and drinking.
        - Looking at engagement, how much they come back for services and what services. Risk screenings that we do to assess areas of risk, look at something that would show progress other than our notes, maybe a case plan with treatment goals.
    - Example: Nemours collected data at the elementary level that would be useful for HS (all HS report BMI, so they did). Also tracked depression screening/follow up, diagnosis, because we wanted to ensure that staffing was adequate, PCP status, and other academic outcomes we added which allowed us to better see if homelessness was an issue, etc. We used the data to create programs to help students be more successful academically. These measures were developed collaboratively: data collectors, school, providers.
- **Variation in measures by school level:**
    - **For elementary school**: for immunizations; the state already looks to see if they meet the standards and at what levels; absenteeism.
    - **For middle school**: Reproductive health and incidence of STDs (this is probably tracked through PH as well).
    - **For high school:** pregnancy counseling and how may are referred to OB, identified SUDs and how many are referred, suicide screenings, depression screenings, SBIRT or craft screenings, type of sexual education provided, dispensing Narcan (for high

schools), data for risky behavior and reduction (sexual and reproductive health, STDs, substance use).

- Would be good to do longitudinal studies, starting to providing services at elementary school all the way through vs just starting in high school.

Gaps in data collection:

Summary: Stakeholders generally see opportunity to enhance data collection and analysis, as well as technical assistance to medical sponsors, to better inform the provision of high-quality services at SBWCs, and to inform the state, schools, medical sponsors, and health plans about service utilization and outcomes. They perceive gaps in data collection analysis and capacity, but are also not clear on the extent to which MCOs and the state could synthesize data from existing sources—including combining health and educational outcomes data—and share it in ways that would be helpful to all. The limited information available from the current coding system came up as one barrier to getting a fuller picture of services provided at SBWCs.

- Unless they have a dedicated data person, it's really hard for some of these providers to do it in a way that's helpful to them to inform practice and policy. Not a unique challenge to SBWCs.
- There is a need for technical assistance related to data to understand how all these things are connected—collection, reporting, analysis, etc. Data reporting is tied to funding but stakeholders may not understand how.
- There is opportunity for tracking for SBWC services, especially for HEDIS measures and individuals who are receiving evaluations. This is one of the things that MCOs look at and talk to SBWCs about.
- "The coding isn't conducive to telling us exactly what's happening just that they are visiting for a BH or well visit." More information around there is an opportunity that we are missing out on. It would be fine to track the standard medical guidelines rather than just that students had a visit.
- "MCOs only receive the claims data, so we can only advise from what we see in the claims data. One question we have is how do SBWCs operate, like do they use EMRs or do they use the DHIN? Because there are probably many areas where SHBCs could capture data that the MCOs don't receive."
- I think this is where we fall short. There are a lot of measures that you see that we haven't be able to connect them. Members of SBWCs with behavioral issues, emergency visits, educational outcomes. We have tried this but we have not figured this out yet.
- "We know the students who are enrolled. Payors know the claims associated with the panels. As a state, why wouldn't the payors be required to aggregate the claims with the students. I would push on the state to connect and aggregate this data, make the connection through DHIN. We submit so many pieces of information through claims, even just in Medicaid"

Third party insurers' perspective on measures and covered services:

- [SBWC services are] a benefit mandate, they comply with it because they have to, so picking unique measures is not a priority. In their SBWC claims, they see a "dump code." Medical sponsors know that when they perform any services for kids in SBWCs, they are to bill to that code with different modifiers. Then they know that the child has received services at the school and the provider is to receive the Medicaid rate. If they don't have a dump code, they would receive normal contracted

rate rather than Medicaid rate (which is lower). If they have questions or concerns they would expect clinical notes to back up claims sent by SBWCs. It's a per diem rate.

- For payers, SBWC services are covered because they are required; the number of SBWC enrollees is small enough that they don't have much interest in value-based payment based on quality measures.
- They are not interested in funding a pool for uncompensated SBWC care, e.g., reproductive health or behavioral health services that cannot be billed because of confidentiality.
    - When [focus group member] sat in working group meeting [someone from Highmark] said why not create a pool. Aetna would not contribute to that pool because they are already paying higher rates to take care of uncompensated care. Trying to get all the stakeholders to buy in is very difficult. Someone from DPH said there was funding at some point but now there is less of it.

To support development of strategic plan and evaluation plan for SBWCs:

Summary: Interviewees felt that similar metrics should be considered in the strategic planning process as for SBWCs generally – service utilization and chronic health condition outcomes data, reproductive health outcomes, behavioral health outcomes, as well as patient satisfaction data, were raised often, as well as the importance of standardization of the data.

- "If we continue to seek public resources and funding, then ultimately [payer group member] would need to know if this is a good use of the state's funding and everyone's time. Or should we try a different model or go back to encouraging/piggybacking off of PCP Collaborative."

Medical Sponsor Data Barriers and Opportunities

Summary: Interviewees raised a variety of challenges related to data sharing and analysis, including: the limitations of the current coding system, which does not distinguish among the purposes of visits beyond categorizing them as physical or behavioral health; the lack of shared EHRs between SBWCs and community providers with whom they may have referral relationships; lack of understanding by MCOs of what data can be pulled from SBWC EHRs; concerns about EOB suppression and confidentiality, which school nurses for example may not always be clear on the rules around; desire for greater use of the DHIN but a lack of clarity on how that would work; and concerns that data limitations constrain providers' and schools' ability to identify and address health inequities.

- There is currently just an all-inclusive code for physical health visits and behavioral health visits. SBWCs are not billing with qualifiers, they are just billing overall codes, so they are missing "a ton" of data on what was performed on that day for the specific setting. MCOs are limited to what SBWCs put on the claim and most times SBWCs only bill the all-inclusive encounter code without putting more information of services rendered on the claim as line items.
- Similar but different issue on the commercial side, we don't recognize the T code, each payor has option to reimburse based on FFS methodology or per diem rate. For confidentiality reasons on EOB suppression, we do not always get billed at all (EOBs, confidentiality).
- "By not reporting this information [reproductive health care], this is a health equity gap that we have created, this is a whole population that we don't know anything about. This is a structural inequity that we don't know what more can be done."

- Because we all use different systems, it is kind of hard to compare data for different sites. Maybe need some universal repository where we collect data (even raw data) and then it gets reported on.
- "Payors get feeds from DHIN that include emergency visits from the hospitals on a real-time, but how it is coded and what information is there varies"
- MCOs could break out data by SBWCs. Take member data and run ED claims from claims against any SBWC codes. They do not do this now.
- "There are way too many confounding factors, the biggest problem we have is thinking that you can measure outcomes that cannot necessarily be controlled. I think we can set ourselves up to fail if we try to measure too many things that we cannot control."
- Montgomery County, MD borrowed Massachusetts' self-sufficiency matrix and assessment form, have different domains and helps to rate individuals, look at progress within those scales, and this determines treatment plan. Have someone who does this analysis for us, can see that we have an impact in scales related to income management, housing, and health access. While it's not integrated, we can see the impact.
- Need a clear data sharing agreement [to analyze health and academic outcomes]. Would be good to look at it by student ID code and also by various cohorts (students going in for mental health, etc.) and look at resulting educational outcomes). Come together at set times throughout the year.
- Our school has team meetings where they bring high risk kid cases there and often times, the wellness center counselor is there. It is important to have these lines of communication open. These teams involved wellness center counselor, teacher, school nurse, "ICT", psychologist, nurse. Each person gives a little bit of input.
- There is a disconnect with school data system and wellness center data system, I couldn't access this other data, we couldn't talk to each other.

Data Best Practices

Summary: Interviewees had limited recommendations on data best practices from Delaware or other states. One suggested source was the Council of Chief State School Officers regarding information technology best practices. Others emphasized the potential to leverage EHR data more extensively to enable interdisciplinary care coordination, where data-sharing is possible. One other suggestion was that the Data Service Center help analyze health and school attendance records.

Quality Improvement Frameworks

Summary: Interviewees generally supported exploring and putting in place a quality improvement framework for SBWCs, though there was not a clear recommendation on which framework to use, though the School-Based Health Alliance has a continuous quality improvement framework developed in consultation with its stakeholders (https://www.sbh4all.org/resources/quality-improvement-module/step-two-familiarize-mfi-framework-2/ and performance measures at https://tools.sbh4all.org/s/clinical-performance-measures-playbook/ [these are in the process of being updated])

- These members would benefit from continued monitoring and oversight of the programs themselves. Not all SBWCs are created equal. Understanding and having clear guidance and

documented procedures would improve SBWCs (might be there, but having a bigger hand in oversight would be beneficial).

- "[This is an] area that needs to be explored. Basic Quality Improvement principles should be in place. There's no process for site visits by MCOs to SBWCs to ensure quality."
- "I would think that SBWCs would be one of the first to adopt quality metrics that improve overall health outcomes for school settings, and especially for pediatric health metrics. If this is not in place, then it definitely should be in place. Especially as it pertains to EPSDT and behavioral health. Although we would need statewide quality metrics to ensure improved population health."
- School nurses use a quality framework that brings in community, data, quality improvement, leadership – potentially this could be aligned with SBWCs.
- "Start with goal (based on metric) and then work back from there. I'm going to advertise for sports physicals, etc. draw interest into SBWC, staying active etc. Invite participants in to how you are going to get there. They need to know that you are there and accessible."
- "The problem that I see if that we are not always looking at the full picture, we are not talking with PCPs, we need better collaboration with PCPs to bridge the gap and figure out how we can improve quality for pediatricians. If we have tight collaboration with PCPs, then the pediatrician will be benefited too."

Finance & Sustainability

SBWC Financial Operating Model

Summary: Most of SBWCs' budget is spent on salaries – one medical sponsor cited 95% as the total. Some costs are absorbed by medical sponsors - education for the CEUs, medications, and some supplies are absorbed by the larger health system. Operating costs are fixed based on what is included in the DPH RFP, interviewees indicated. "Anything else that you add [beyond the baseline of staff and services that are billable] is cost. If you want to support the students differently, then you add costs."

- "None of us have "frills" -- most of our expense is staffing. The only thing you could do is cut down on staffing. We try to get enrollment as high as possible. I have not been successful in getting grant funding that could cover salaries. My strategies is to talk about population health with my CEOs. As long as I have him as a CEO, we're good. We are always having to show our worth."

Start Up Costs: Lessons Learned

Summary: There is a "decent amount" of cost (no total cost estimate given) that is required to do coalition building (awareness, marketing) and then systems for data alignment. If you are given a space, you have to figure out how to use that space, then it is the usual startup costs for equipment, beds, computers, etc. "We are part of a bigger system, so we beg, borrow, and steal from our used equipment."

SBWC Funding Models

Summary: 80-95% of students served have Medicaid. Significant revenue is from Medicaid (one medical sponsor indicated 95%). "It is a quilt" of funding sources, particularly for confidential and sensitive

services which are not billed, and for health promotion or prevention which is not reimbursed. "Medicaid is the best payor, Medicaid pays 98% of what we bill, commercial payors pay 8% of what we bill." Lesson from Colorado on diversifying funding sources - look at who are the stakeholders in the state that will invest (foundations), public agency funding to bridge services, but diversifying is hard. SBWCs do not want to charge students and families (and in Delaware are not allowed to).

Reimbursement: Medicaid and Commercial Payers

Summary: Reimbursement varies by payer. Interviewees described the rate-setting process DMMA uses annually to develop cost-based reimbursement, following CMS requirements and the Medicaid State Plan to set a floor for MCO reimbursement. Each of the commercial carriers approach reimbursement based on what is published in the mandate which follows FFS or all inclusive payment system, but beyond this mandate, there is not a lot of directive. Regarding credentialing, any provider who starts through CAQH gets credentialing and then a contract. There is a provider liaison assigned to each SBWC, but could be through the hospital. Process is same for Medicaid side, they get credentialing and then get the same standard agreement and then rates are dictated by the state and they are assigned a representative. Education will take place with expectations of claims submission following that. Sometimes the credentialing is "very slow" and takes too long, one medical sponsor said.

- It would be different from one payer to the next (counting Medicaid as a payer). For commercial carrier competitors they are using CPT codes and they aren't incorrect—there isn't anything wrong with that. And because those providers have contracted with payers and covered under contracts they are getting paid. To the extent that [a provider at an SBWC] is providing services for a Highmark member, they are going to get reimbursed at the Highmark rate. Huge bulk of Cigna and United's DE business is self-funded. Aetna has educated medical sponsors on how to bill and properly get reimbursed.
- We can't do anything until a SBWC is a SBWC. Once they are, they are like any other provider to us. Once they are enrolled, they have to submit analysis of what they think cost will be, which determines the rate. For Medicaid, SBWCs need to know three different ways they bill, etc. It's a complaint but that's the way it works in health care—you have insurance companies you work with and they have different practices.
- "MCOs don't see us any different [from other providers], they see SBWCs as part of scope of practice within the bigger picture. We had some challenges with billing, needed to see the detail of the services provided, they wanted the billing to be more specific.
- "I think we need to do a better job at working with the insurers we are working with at the hospitals."
- "Some commercial insurances don't consider us part of a credentialed group, this is complicated."

Care Coordination

Summary: The degree to which it's happening varies widely, and when SBWCs rather than MCOs are providing it, it is unfunded. In some places it may happen "organically," and some SBWCs are using an interdisciplinary care team approach (this was described at Indian River). It has been a complaint for a long time that we need to be reimbursed for care coordination. Could do it similar to capitation, or they should develop some CPT codes to submit care coordination. MCOs argue that they do the care

coordination, the health care system is doing a lot of the care coordination but it's not reimbursed. PMPM charges would be helpful to provide more infrastructure to some of the care coordination.

Collaborative Financing Opportunities and Limitations

Summary: Stakeholders are interested in exploring opportunities to diversify funding sources, but are skeptical of many options. There are limitations to public matching given the amount of Medicaid revenue funding SBWC services, and third-party insurers are not interested in funding a pool that for uncompensated care, for example. State agencies may be interested in potential value-based payment models, but these have had limited success elsewhere to date. "This planning process is an opportunity for our MCOs to look at quality measures and see if there is a quality-based payment possibility that we could take advantage of." The national School-Based Health Association has not seen much success in other states with a managed care model that pays PMPM, though it has been piloted. "So they've done pilots all over the place… they take zip codes and this managed care is supposed to be seeing these kids. And so then could we find a financing model that we paid per kid. Not by the individuals, but just the numbers. So, I mean, there's all sorts of things that have tried and been piloted [in other states] but I can't say anything that has stuck," one outside expert said.

Third party insurers:

- They heard commercial insurers pay more. There are a lot of kids out there that have a primary insurance and Medicaid might be their secondary. Why aren't they paying?—these are covered services. There is tension because commercial insurers should be paying.
- "We have talked about establishing fund on commercial side to bridge gap of services that they cannot bill for, because of confidentiality concerns. But I'm not sure where this stands now."
- "We were meeting with insurance companies to figure out the best strategy to secure some of their revenue and the challenges in billing. Insurance companies should be charged with some type of grant funding for confidential services and care coordination. Insurance companies benefit from better value of SBWCs, so how can we leverage this?"
- AmeriHealth caritas has value-based plan very interested in pursuing options for more value-based payment, not sure if this is the case for the providers.
- Key component of determining the utility of a value-based plan is the volume of members who visit each site, 100 members vs. 250 members, what is the ROI to enter into strategic plans? This determines what type of plan, cannot be a one-size fits all. How will attribution work?
- Cost and quality are factors in value-based care and there needs be a volume that is possible to track these measures. Given the small patient size and number of centers, there needs to be a conversation to see if value-based care is even feasible.

3rd party insurance concerns about sustainability:

- "It comes down to the question of sustainability for this program. Everyone is passionate about the need for these kids in the SBWC setting. There are other obstacles that this program has—nothing that insurance department can control or carriers can control unless we are willing to open up our wallets which isn't exactly what we are going to do. There were many elements that factored into Aetna's decision in 2012 to come to Medicaid rate. There are only so many commercial dollars that you can get out of this—there needs to be another source of funding."

- "There needs to be serious thought on how the program is going to sustain itself given all of the liberal manner in which they want to handle their patients who are kids and their parents are not super excited about paying for mysterious services. During the last year we have been thinking, how are SBWCs going to continue to function under limits and restrictions they are under now? Funding is getting smaller and smaller." COVID has exacerbated this.
- "Exploring models that could expand primary care for the community as a whole is a great idea, but in terms of willingness to change this group is concerned. Even though you could get everyone in the community to learn that the wellness center exists by doing COVID testing, this isn't being taken on."

COVID-19 Impact, Adaptation, and Barriers

Summary: The long-term impact of COVID-19 on SBWCs is still not entirely clear, though the financial impact on community providers that serve children, like pediatricians and PCPs, has been severe. Telehealth implementation has been proceeding, and billing has been implemented in a rush but relatively smoothly, with providers valuing the ability to bill for phone visits – the full impact may not yet be clear. Billing for services that cannot be provided through telehealth did decrease nationally, per experts outside Delaware, but there is variation depending on how schools are handling reopening. Confidential services are harder to provide by telehealth (though contraception refills are a key opportunity). Despite inequities and barriers in who can access telehealth because of access to the internet and privacy concerns for some students, telehealth implementation has been valuable in increasing access to behavioral health services and for contraception refills, primarily. Medication management, particularly for asthma, is also an opportunity for telehealth expansion. The rapid expansion of telehealth has led SBWCs to think about how it can be sustainably funded, and they hope reimbursement flexibilities will be extended. Families may not always be aware that telehealth is an option, so outreach and education, as well as addressing any concerns about using it, continue to be important.

- They use telehealth now, but in the very beginning there wasn't a provider across the board that COVID didn't affect.
    - Note: If we can't interview the MCOs, email Group 5 and she will get these answers for us.
- Billing is not complicated. extends beyond SBWCs, primary care visits have dropped across the country. For SBWCs this also intersects with school re-openings. Still trying to figure out the impact. There are some things that can be done by telehealth, MCOs will continue to promote telehealth services, especially for telehealth. Potential for drive through immunization clinics.
- "When we were building our systems we were seeing some claims denials, but now that the systems are configured and policies are set in place, we are not seeing many claims processing barriers"
- There is still an opportunity for services through telehealth. Promotion of telehealth piece is vitally important.

- There are still barriers. Even just getting things set up and making sure individuals feel comfortable and capable to handle telehealth needs. One positive is they can bill for telephone calls.
- External access point (door) is critical for COVID safety, need to work with schools for planning this where it is feasible.
- Aetna covers telemedicine visits—as long as they have the correct telemedicine modifier then it is paid at the same rate. They didn't see a lot of these bills yet, and doesn't know if they will see them. Based on the way high schoolers are using the services it might not be something that they know they have the ability to seek remotely. Elementary would be even more difficult because children probably don't have access to smart phones or know what to do.
- To the extent that we can make it easier we are doing so at least through the end of the year telemedicine visits will count as visits. We are hopeful that there will be a push to modify the code in the regulation (in the area that prohibits telephonic communication as telehealth in the normal sense) the insurance code already allows it to be covered in the same way as an in person visit.
- We don't have as many kids coming in so we can't see them. Telehealth has helped but kids are tired of it. It is harder to do referrals and connections over telehealth. Kids are sleeping later, it has been difficult to get ahold of them.
- For confidential services, there has been a negative impact, they may not want to do telehealth at home.