School-based healthcare:
Working group materials

January 29, 2018
## Objectives for today’s discussion

### Share progress to date and program objectives

<table>
<thead>
<tr>
<th>Introduction and review of past workgroup efforts</th>
<th>Director Moody</th>
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<tbody>
<tr>
<td>Update on Medicaid reforms</td>
<td>Director Sears</td>
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<tr>
<td>Update on education reforms and why 2018 is the perfect time to launch school-based health care</td>
<td>Superintendent DeMaria</td>
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</tbody>
</table>

### Get the group’s thoughts on key design decisions

| What are the characteristics of schools and primary care providers (PCPs) that participate? | 11:25-12:25 | ODE and ODM small group leaders |
| What should the care delivery model look like between schools and primary care providers? | 11:25-12:25 | ODE and ODM small group leaders |
| What incentives could encourage schools and primary care providers to participate? | | |
| Reconvene group and share learnings from breakouts | | |

### Establish an engagement plan going forward

| 2018 timeline for school-based health care rollout | 12:25-12:30 | Director Moody |
| Operating model for upcoming workgroup sessions | | |
Contents

- Progress and objectives
  - Design choice breakouts
  - Ongoing engagement plan
Starting the discussion in 2014

Our discussion
The last meeting of this workgroup in 2014 started a statewide discussion around the importance of and potential for school-based healthcare to support academic outcomes.

Our outcomes
The workgroup forged an initial view of how school-based healthcare could work, designed a framework for a school support toolkit and built a research base of successful school-based healthcare models both in and out of Ohio.
Since the last workgroup discussion, Ohio has made great strides in improving the quality of healthcare

Medicaid

Patient-centered medical homes

Designed Comprehensive Primary Care in collaboration with providers and payers to create a broader, more holistic version of care – now 44% of Ohioans on Medicaid are enrolled

Transforming behavioral health care

Ohio’s Behavioral Health Redesign provides members access to new services and incorporates behavioral health services into managed care
Ohio has also embraced school improvement practices focused on supporting students both in and out of the classroom.

Preventative approach to absenteeism

Ohio's school improvement efforts recognize that keeping students in the classroom and addressing basic health needs are important contributors to improved academic outcomes.

School improvement looks beyond academics

Efforts to promote school improvement have highlighted the need to address health issues as a precursor to student learning - when students’ health care needs are met, their readiness for learning is enhanced.
Given all of the work in the past few years, 2018 is the perfect time to roll out school-based healthcare

There is collaboration between stakeholders

ODE, ODM and ODH have fostered a unique partnership

There is urgency to act

ODE built a school improvement planning process that places focus on academic outcomes for the students that need it most

The timing is right

House Bill 410 and Ohio’s ESSA submission both place a unique emphasis on schools keeping students in the classroom

The establishment of Comprehensive Primary Care incentivizes health care providers to better support the needs of Ohioans on Medicaid
Ohio could focus school-based healthcare efforts on two academic goals that other SBHC initiatives have been shown to improve:

**Reduce rate of chronic absenteeism**

Students who need dental care, eyeglasses or suffer from other health issues are more likely to be chronically absent and less likely to respond to academic improvement efforts.

Chronic absenteeism is associated with lower math and reading achievement outcomes, educational engagement and social engagement.

They can be impacted by SBHC interventions:

SBHC initiatives have demonstrated a substantial effect on absenteeism (e.g. SBHC vaccination program reduced absenteeism by 63% at ~50 LA schools).

**Reduce number of students in restrictive classroom environments**

Students with emotional or behavioral disorders are more likely to be taught outside the general classroom environment and/or provided a special needs assistant.

Highest student academic outcomes are associated with placement in the least restrictive classroom environment.

They are linked to both health and academic outcomes:

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Chronic absenteeism is associated with lower math and reading achievement outcomes, educational engagement and social engagement.

They can be impacted by SBHC interventions:

SBHC initiatives have demonstrated a substantial effect on absenteeism (e.g. SBHC vaccination program reduced absenteeism by 63% at ~50 LA schools).

Early interventions to mitigate emotional and behavioral disorders are associated with fewer students in restrictive classroom environments and reduced system cost.
Guiding principles for the SBHC program

The SBHC program should

- **Function as an opt-in model** for families, schools and primary care providers
- **Provide support resources to any school**, as well as enhanced support for schools that need it most
- **Remain cost neutral or lower cost** than alternative options

The SBHC program should not

- **Require mandatory participation** of any stakeholder
- **Exclude any schools** that want to participate nor serve as a one-size fits all model
- **Add an incremental new cost** in already heavily constrained school budgets
Contents

- Progress and objectives
- **Design choice breakouts**
- Ongoing engagement plan
Three design questions for discussion

What are the characteristics of schools and PCPs that participate at each level of the model?

What should the care delivery model look like between schools and PCPs?

What non-financial and financial incentives could encourage schools and PCPs to participate?
## Two-tiered support model: Any school and PCP can partner, but schools with the greatest need receive enhanced support

### A: Baseline SBHC – for any school and PCP

- All schools
- All PCPs

### B: Enhanced SBHC – for schools with greatest need

- Target schools based on metrics including: chronic absenteeism, prevalence of specific conditions, prevalence of IEPs or 504 plans, Medicaid enrollment, etc.
- Only PCPs enrolled in Comprehensive Primary Care

### Questions to consider:

1. Which metrics should define high-support schools?
2. What activities should be required of schools?
3. What activities should be required of PCPs?
4. What should be in the school support toolkit?

### Partnership eligibility

- Traditional Medicaid payments (plus additional payments for PCPs enrolled in the Ohio Comprehensive Primary Care program)
- Secure parental consent
- Inform parents of SBHC partnership
- Access to SBHC toolkit (includes parental consent forms, data-sharing agreements, etc)
- Reserve slots for SBHC appointments
- Share academically relevant diagnoses
- Inform parents of SBHC partnership
- Facilitate PCP appointments
- Provide physical space or transport to PCP offices
- Secure parental consent
- Inform parents of SBHC partnership
- Access to SBHC Toolkit
- Potentially increased Medicaid Schools Program funding
- Potential direct technical assistance
- Reserve slots for SBHC appointments
- Share academically relevant diagnoses
- Reserve slots for SBHC appointments
- Share academically relevant diagnoses
- Potentially set up satellite clinic at schools
- Comprehensive Primary Care program benefits
- Potentially increased per member per month (PMPM) payments
- Possible non-financial incentives
## Care delivery model: Possible partnerships between schools and PCPs require a tradeoff between ease and benefit for all involved

### Potential care delivery models between PCPs and schools for Enhanced SBHC

<table>
<thead>
<tr>
<th>Ease for schools</th>
<th>Ease for PCPs</th>
<th>Benefit to students and community</th>
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<tbody>
<tr>
<td><strong>In-school, full time</strong>&lt;br&gt;SBHC clinic provides medical support on campus during school hours</td>
<td>Low – Requires dedicated physical space, taking students out of class</td>
<td>Low – Requires dedicated PCP staff</td>
</tr>
<tr>
<td><strong>In-school, regular schedule</strong>&lt;br&gt;SBHC PCP provides medical support on campus at designated times (e.g., weekly)</td>
<td>Medium – Requires temporary physical space, taking students out of class</td>
<td>Medium – Requires school visits</td>
</tr>
<tr>
<td><strong>Mobile clinic, regular schedule</strong>&lt;br&gt;SBHC PCP provides medical support at mobile clinic near campus at designated times (e.g., weekly)</td>
<td>Medium – Need to take students from class; need secure space; requires funding for mobile clinic</td>
<td>Medium – Requires school visits</td>
</tr>
<tr>
<td><strong>Off-site, by appointment with school-provided transport</strong>&lt;br&gt;Schools facilitate appointments and transportation for consultations at SBHC PCP offices</td>
<td>Low – Need funding and capacity to facilitate appointments, manage and provide transport</td>
<td>High – No travel or changes to existing operating model</td>
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### Questions to consider:

1. What kinds of schools will be most successful in each model?
2. What logistical challenges must be overcome in each model?
3. What other models could be successful (e.g., telemedicine)?
4. What types of health interventions can and cannot happen in each model?

*NOT EXHAUSTIVE*
Stakeholder incentivization: SBHC can encourage schools and PCPs to participate with a mix non-financial and financial factors

<table>
<thead>
<tr>
<th>Method of incentivization</th>
<th>SBHC value proposition</th>
<th>Base-level benefits</th>
<th>Potential additional incentives</th>
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</thead>
<tbody>
<tr>
<td>Improving both student health and academic outcomes</td>
<td>Access to SBHC toolkit and technical assistance</td>
<td>Transparency of outcomes / recognition</td>
<td></td>
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<tr>
<td>Improving patient health and simplifying access to care</td>
<td>Title I/state funding</td>
<td>Financial support (e.g. foundations, local businesses, healthcare providers)</td>
<td></td>
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<tr>
<td></td>
<td>Flexibility of funds</td>
<td>Medicaid Schools Program funding</td>
<td></td>
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<td></td>
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<td>Rent to PCPs for space</td>
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<tr>
<td></td>
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<td>Attendance-related funding</td>
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Questions to consider:

1) Which incentives will most encourage PCPs to participate?
2) Which incentives will most encourage schools to participate?
3) What will be the key sources of financial support?
4) What are other incentives not listed that should be added?
Contents

- Progress and objectives
- Design choice breakouts
- **Ongoing engagement plan**
Vision for school-based healthcare in 2018

Phase 1: design and setup
- Design of promising program for providing PCP care to students including support measures to maximize probability of success
- Current to March 2018

Phase 2: school application
- High rate of target schools completing application to participate
- Appropriate arrangements made for PCP participation
- March to June 2018

Phase 3: school implementation
- Launch early adopter program at select schools, followed by at-scale deployment to all target schools
- June 2018 to Q4 2018

Proposed timing
- Small-group follow-up calls over the course of February as needed on specific design questions
- The whole group reconvenes on 3/14 to align on school toolkit supports, review a refined engagement plan and program narrative and preview activities for phase 2

Next steps with this workgroup
Well-designed national school-based healthcare initiatives have shown measurable impact on academic and health outcomes.

**Type of SBHC intervention outcomes**

**Academic achievement**
- Improved grades
- Improved test scores
- Increased classroom engagement

**Academic-related outcome**
- Lower rate of absenteeism
- Connection with a role model
- Reduced academic stress
- Improved community perception of school quality or safety

**Health outcome**
- Improved vaccination rate
- Reduced teen pregnancy rate
- Improved physical health
- Improved family health

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The Connecticut SBHCs found a 31% decrease in course failure among the 16K+ students that received services.

Students and parents in 400+ SBHC schools rated “academic expectations” and “school engagement” significantly higher than those in non-SBHC schools.

In ~25 San Diego schools, the nutrition intervention significantly reduced BMI among boys.

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1 San Diego M-SPAN program
Health issues most tied to student absenteeism and relevant SBHC interventions

<table>
<thead>
<tr>
<th>Health issues</th>
<th>Relevant statistics and description of SBHC intervention</th>
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</table>
| Asthma                         | • ~10% of students nationally aged 4-14 are diagnosed with asthma and are 3X more likely to be commonly absent than their peers; this may be underdiagnosed in Ohio, as only 5% of students had an asthma Medicaid claim in 2017<sup>1</sup>  
  • SBHCs improve asthma control by managing asthma triggers and treating asthma-related episodes  
  • 20% of students ages 5-11 have at least one untreated decayed tooth; students in low-income communities are twice as likely to miss school for oral health reasons, with 73% missing at least 2 days<sup>2</sup>  
  • School-based dentists identify dental issues and increase knowledge on proper dental hygiene  
  • 12% of Ohio students had a Medicaid claim for a mental or behavioral health issue in 2017, including 17% of high schoolers; 70% of US adolescents with mental or behavioral health issues do not get the care they need<sup>3</sup>  
  • Interventions to increase awareness/reduce stigma of mental and behavioral health issues, improve access to care, and change behaviors to support positive socio-emotional growth  
  • Students that participated in a free eyeglasses intervention in Florida were associated with an increased probability of passing the standardized reading test by 2.5 percentage points and the standardized math test by 3.4 percentage points<sup>4</sup>  
  • Interventions to identify vision issues and increase access to vision care  
  • An immunization intervention in Los Angeles decreased absenteeism by 63%<sup>5</sup>  
  • SBHCs provide a provision of immunizations necessary for school attendance and/or beneficial for health outcomes (e.g., flu)                                                                 |
PCP interventions have relied upon a few consistent public and private funding options

<table>
<thead>
<tr>
<th>Most common funding options for SBHCs¹</th>
<th>Examples</th>
<th>Sponsors include</th>
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<tbody>
<tr>
<td>State and federal governments</td>
<td>FL Vision: Free vision screenings for elementary school students, Asthma Self-Management for Adolescents</td>
<td>Title I Funding, New York Department of Education</td>
</tr>
<tr>
<td>Private organizations (e.g. foundations)</td>
<td>Elev8 Chicago primary care services, SBIRT Substance Use Prevention</td>
<td>The Atlantic Philanthropies, Conrad N. Hilton Foundation</td>
</tr>
<tr>
<td>In-kind contributions (e.g. from school districts)</td>
<td>Connecticut Association of School-Based Health Centers, Seattle School-Based Health Centers</td>
<td>LEAs, local community centers, local government, local healthcare providers and payers, local education councils</td>
</tr>
<tr>
<td>Patient-care revenue (e.g. Medicaid, private insurance)</td>
<td>Washington State Take Charge, Rural Kentucky HPV vaccination program</td>
<td>Medicaid, Lake Cumberland District Health Department</td>
</tr>
</tbody>
</table>

¹ 2007 Report from Robert Wood Johnson Foundation on national SBHCs