School-based healthcare: Working group materials

January 29, 2018

Objectives for today's discussion

Objectives	Time	Facilitation
Share progress to date and program objectives		
Introduction and review of past workgroup efforts	11:00-11:25	**Director Moody**
Update on Medicaid reforms		**Director Sears**
Update on education reforms and why 2018 is the perfect time to launch school-based health care		**Superintendent DeMaria**
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?		
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		

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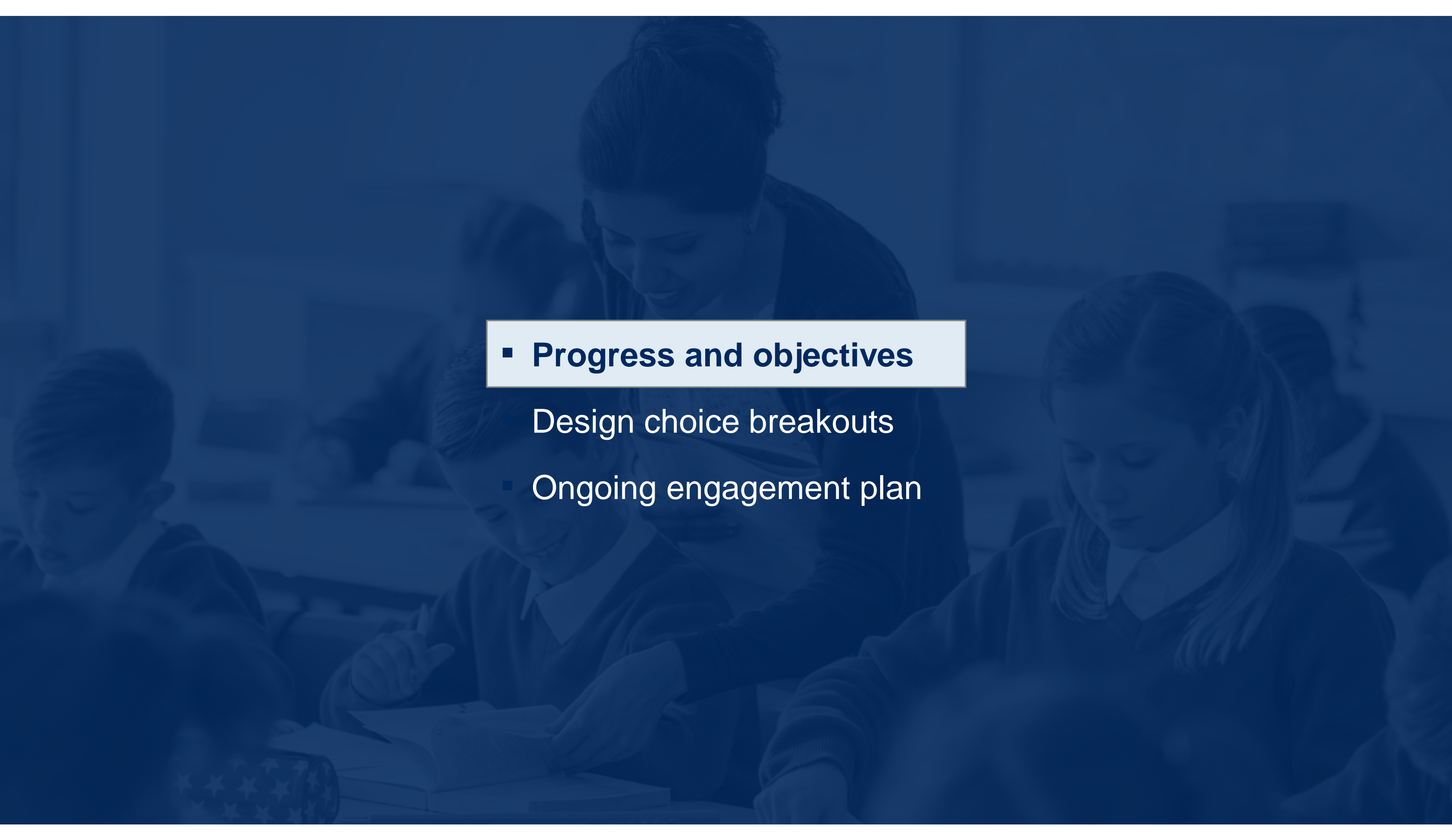

- **Progress and objectives**
- Design choice breakouts
- Ongoing engagement plan

Introduction

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

Financially reward primary care practices that focus on better student health

Support districts to create partnerships that improve student health

Identify proven partners who can assist to improve student health

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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

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Ohio has also embraced school improvement practices focused on supporting students both in and out of the classroom

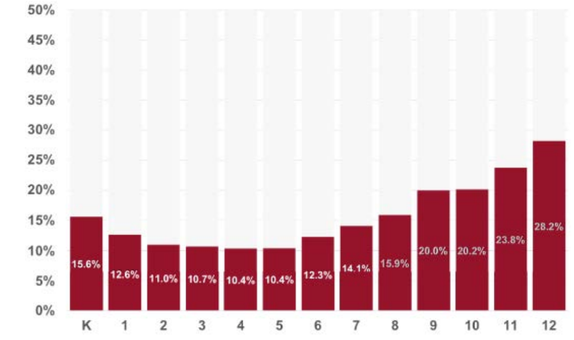
Education

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



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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	Reduce number of students in restrictive classroom environments

They are linked to both health and academic outcomes

Reduce rate of chronic absenteeism	Reduce number of students in restrictive classroom environments
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	Students with emotional or behavioral disorders are more likely to be taught outside the general classroom environment and/or provided a special needs assistant[2]
Chronic absenteeism is associated with lower math and reading achievement outcomes, educational engagement and social engagement[1]	Highest student academic outcomes are associated with placement in the least restrictive classroom environment

They can be impacted by SBHC interventions

Reduce rate of chronic absenteeism	Reduce number of students in restrictive classroom environments
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

1 “Chronic Absenteeism and Its Effects on Students’ Academic and Socioemotional Outcomes” in the Journal of Education for Students Placed at Risk (JESPAR) (Nov 2014)
2 “The Education of Students with Challenging Behaviour arising from Severe Emotional Disturbance/ Behavioural Disorders” in NCSE Policy Advice Paper

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

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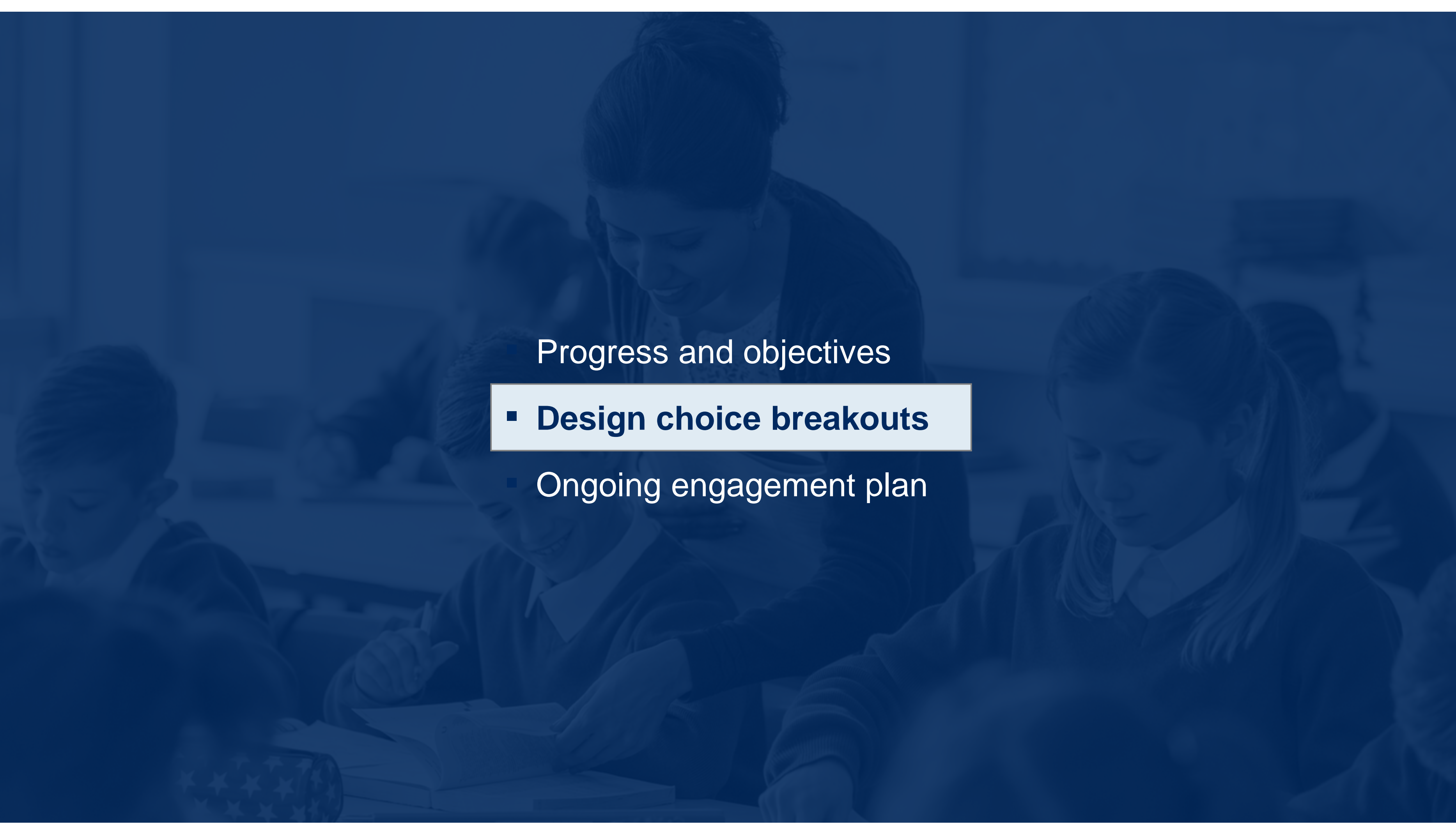

- Progress and objectives
- **Design choice breakouts**
- Ongoing engagement plan

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	**B** Enhanced SBHC – for schools with greatest need
Partner-ship eligibility	▪ All schools ▪ All PCPs	▪ 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
School activities	▪ Secure parental consent ▪ Inform parents of SBHC partnership	▪ Secure parental consent ▪ Inform parents of SBHC partnership ▪ Facilitate PCP appointments ▪ Provide physical space or transport to PCP offices
School support	▪ Access to SBHC toolkit (includes parental consent forms, data-sharing agreements, etc)	▪ Access to SBHC Toolkit ▪ Potentially increased Medicaid Schools Program funding ▪ Potential direct technical assistance
PCP activities	▪ 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
PCP support	▪ Traditional Medicaid payments (plus additional payments for PCPs enrolled in the Ohio Comprehensive Primary Care program)	▪ Comprehensive Primary Care program benefits ▪ Potentially increased per member per month (PMPM) payments ▪ Possible non-financial incentives

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?

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	Ease for schools	Ease for PCPs	Benefit to students and community
In-school, full time *SBHC clinic provides medical support on campus during school hours*	**Low** – Requires dedicated physical space, taking students out of class	**Low** – Requires dedicated PCP staff	**High** – Immediacy of treatment; presence strengthens SBHC partnership; could include family care
In-school, regular schedule *SBHC PCP provides medical support on campus at designated times (e.g., weekly)*	**Medium** – Requires temporary physical space, taking students out of class	**Medium** – Requires school visits	**Medium** – Students receive frequent, convenient medical care
Mobile clinic, regular schedule *SBHC PCP provides medical support at mobile clinic near campus at designated times (e.g., weekly)*	**Medium** – Need to take students from class; need secure space; requires funding for mobile clinic	**Medium** – Requires school visits	**Medium** – Students receive frequent, convenient medical care; not conducive for behavioral health
Off-site, by appointment with school-provided transport *Schools facilitate appointments and transportation for consultations at SBHC PCP offices*	**Low** – Need funding and capacity to facilitate appointments, manage and provide transport	**High** – No travel or changes to existing operating model	**Low** – Likely to experience limited uptake due to complex logistics outside of school hours

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

Method of incentivization

	SBHC value proposition	Base-level benefits	Potential additional incentives
Schools	▪ Improving both student health and academic outcomes	▪ Access to SBHC toolkit and technical assistance ▪ Title I/state funding ▪ Flexibility of funds	▪ Transparency of outcomes / recognition ▪ Financial support (e.g. foundations, local businesses, healthcare providers) ▪ Medicaid Schools Program funding ▪ Rent to PCPs for space ▪ Attendance-related funding
PCPs	▪ Improving patient health and simplifying access to care	▪ Comprehensive Primary Care (CPC) benefits – PMPM payments – Shared cost payment ▪ Additional patient reach	▪ Transparency of outcomes and recognition ▪ Increased PMPM payments ▪ CPC enrollment for non-CPC eligible providers (e.g. dentists)

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?

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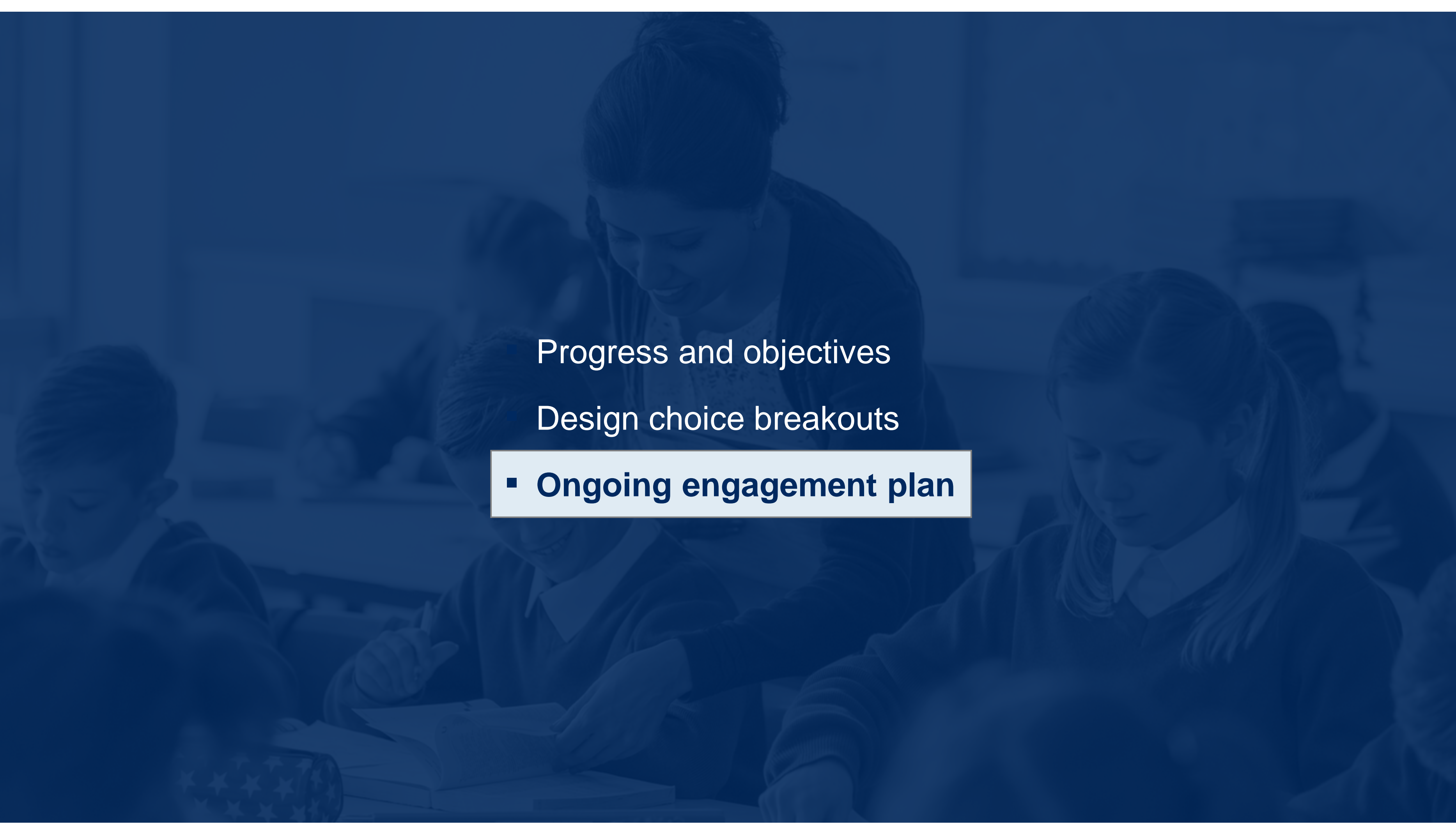
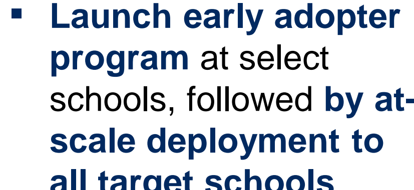


Vision for school-based healthcare in 2018

Phase 1: design and setup

Phase 2: school application

Phase 3: school implementation

	Phase 1: design and setup	Phase 2: school application	Phase 3: school implementation
Vision	▪ **Design of promising program** for providing PCP care to students **including support measures** to maximize probability of success	▪ **High rate of target schools completing application** to participate ▪ **Appropriate arrangements** made for **PCP participation**	 ▪ **Launch early adopter program** at select schools, followed **by at-scale deployment to all target schools**
Proposed timing	▪ **Current to March 2018**	▪ **March to June 2018**	▪ **June 2018 to Q4 2018**

Next steps with this workgroup

- 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

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Handouts

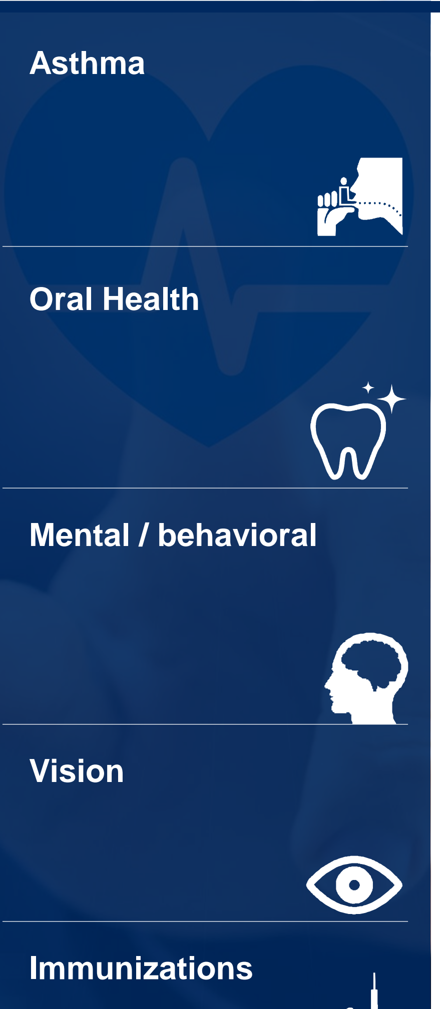
Well-designed national school-based healthcare initiatives have shown measurable impact on academic and health outcomes

Type of SBHC intervention outcomes

	Example outcomes	
Academic achievement	▪ Improved grades ▪ Improved test scores ▪ Increased classroom engagement	**The Connecticut SBHCs found a 31% decrease in course failure among the 16K+ students that received services**
Academic-related outcome	▪ Lower rate of absenteeism ▪ Connection with a role model ▪ Reduced academic stress ▪ Improved community perception of school quality or safety	**Students and parents in 400+ SBHC schools rated “academic expectations” and “school engagement” significantly higher than those in non-SBHC schools**
Health outcome	▪ Improved vaccination rate ▪ Reduced teen pregnancy rate ▪ Improved physical health ▪ Improved family health	**In ~25 San Diego schools, the nutrition intervention significantly reduced BMI among boys[1]**

1 San Diego M-SPAN program

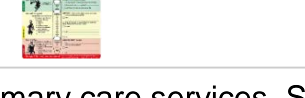
Health issues most tied to student absenteeism and relevant SBHC interventions



Health issues	Relevant statistics and description of SBHC intervention
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[1] ▪ SBHCs improve asthma control by managing asthma triggers and treating asthma-related episodes
Oral Health	▪ 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[2] ▪ School-based dentists identify dental issues and increase knowledge on proper dental hygiene
Mental / behavioral	▪ 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[3] ▪ 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
Vision	▪ 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[4] ▪ Interventions to identify vision issues and increase access to vision care
Immunizations	▪ An immunization intervention in Los Angeles decreased absenteeism by 63%[5] ▪ SBHCs provide a provision of immunizations necessary for school attendance and/or beneficial for health outcomes (e.g., flu)

1 Data from Ohio Department of Medicaid, Ohio Department of Health
2 “Chronic Absenteeism” from the Health Schools Campaign
3 Data from Ohio Department of Medicaid, Ohio Department of Health; “Key Mental Health Statistics”, National Center of Inclusive Education
4 Florida Vision Quest
5 LA FluMist vaccination program

PCP interventions have relied upon a few consistent public and private funding options

Most common funding options for SBHCs[1]	Examples	Sponsors include
State and federal governments	FL Vision: Free vision screenings for elementary school students, Asthma Self-Management for Adolescents 	Title I Funding, New York Department of Education
Private organizations (e.g. foundations)	Elev8 Chicago primary care services, SBIRT Substance Use Prevention	The Atlantic Philanthropies, Conrad N. Hilton Foundation
In-kind contributions (e.g. from school districts)	Connecticut Association of School-Based Health Centers, Seattle School-Based Health Centers	LEAs, local community centers, local government, local healthcare providers and payers, local education councils
Patient-care revenue (e.g. Medicaid, private insurance)	Washington State Take Charge, Rural Kentucky HPV vaccination program	Medicaid, Lake Cumberland District Health Department

1 2007 Report from Robert Wood Johnson Foundation on national SBHCs