School-Based Health Models

There is no ONE active model that is providing care to every student in every building within a district *and* that has demonstrated longevity and financial sustainability. Each district that is doing this work, and in some cases individual school buildings, has a slightly different model. Below is a short description of the most common models across the country engaged in this work.

Independent health care providers: In the majority of districts, trusted regional or local health care systems/entities provide the clinical staff and, in many cases, cover the costs of operating the clinic itself (supplies, cleaning, maintenance). These partners are federally qualified health centers (FQHCs), the public health department, or a private health care system. The health care provider partner mix often depends on financial needs. For example, FQHCs usually have an enhanced Medicaid billing rate that assists with sustainability, making them more likely to take on the financial risk of serving students.

If the clinic is inside the school building, it is usually staffed entirely by the health care provider's employees, although they may work with a school nurse for triage and communication. Mobile unit staff are also typically employees of the health care provider. If the health care system offers telehealth, sometimes the school nurse, or another school district employee, operates the technology inside the school while the clinician is an employee of the health care provider.

The patient population in these settings depends on the physical location, financial standing, and comfort level of both the school and community. All serve the students of the building they are in, many serve students in other school district buildings, some serve community members and/or families of students, and a small number serve staff for physical health needs. Students can also receive behavioral/mental health services at many clinics, but community, family, and staff who need behavioral/mental health needs are referred out at virtually every district.

City Connects: This model is most similar to the Say Yes/Cleveland family support specialist model. A City Connects school has an on-site individual who works with teachers to create individualized plans to meet the social-emotional-health care needs of each student. City Connects creates a database of all available services in the community and then connects the student and his/her family to the appropriate services based on the individualized plan. The

model does not serve staff. Services are not typically provided in the school building, and are not provided by City Connects directly. Funding for City Connects services is usually community driven.

SMART Health: This model serves five schools in Chicago and rural Alabama and uses an opt-in process, aiming to consent 100% of students. It also offers physical health services for teachers, and behavioral/mental health services for families; all services are provided by a local health care provider partner. SMART Health includes an up-front behavioral assessment and medical history collected for each student, which helps providers establish individualized care plans for each student and serve them on-site. It uses private funding and relatively high Medicaid billing rates to achieve sustainability.

Hazel Health: This is a telehealth-only model operating in 11 school districts across the country. Rather than building brick and mortar clinics, Hazel Health uses technology and a stocked medical cart to connect students to Hazel Health providers who deliver an array of physical and behavioral/mental health services. This model relies on school nurses to operate the app in a private and designated space inside the school. While it has its own provider staff, Hazel Health also contracts with local health systems, including FQHCs, to provide the services whenever possible, and makes a point to connect with patients' primary care provider. The school districts pay for the services. The model currently serves only students.

School-Based Health Models – Key Policy Evaluations

School-based health care sustainability is an area of concern across the nation. Each district that chooses to provide services must evaluate its particular state, regional, and local environment to determine how to provide services in a sustainable way. Districts evaluate funding options and state and local education and health care regulations to determine whether providing health care is feasible or incurs too high of an administrative burden or financial liability.

Even in areas where the environment is amendable to school-based health care, improvements can always be made. Using the key takeaways from our research, Advocacy & Communication Solutions (ACS) recommends exploring the following policy areas in Ohio to determine if there are opportunities to better support school-based health care.

1. **Medicaid funding**: In Ohio, Medicaid reimbursement rates rarely, if ever, cover the full cost of a service. Even for Federally Qualified Health Centers (FQHCs) that receive an enhanced reimbursement rate due to their emphasis on treating the underserved, the payments are usually below cost. Because many of the children served at school-based health centers in Ohio are Medicaid-eligible, one important way to ensure financial sustainability is to increase Medicaid rates generally. That significant change is unlikely to occur in the current political environment, but another option would be to include services provided within school-based settings as part of the Comprehensive Primary Care Program so every provider could access the higher reimbursement rates within that program. A full analysis of Medicaid reimbursement rates and managed care policies may provide other avenues for maximizing revenue.

2. **Medicaid eligibility and enrollment:** An oft-cited challenge for school-based health care providers is the amount of "free" services that are provided to students without health care. Ohio has worked hard in the last few years to make the process of determining eligibility and enrollment easier, but barriers remain. An assessment studying how to reach parents and assist them in enrolling their children in some form of health insurance could cut down on the number of non-reimbursable payments.

3. **Telehealth options:** Ohio recently passed legislation that will require parity between telehealth and in-person services covered by both Medicaid and private insurance. The parity is required for the types of services covered; it doesn't require that telehealth services be reimbursed at the same rates. Nevertheless, as the process for writing rules to implement this new language moves forward there should be an effort to ensure that both telehealth and in-person services are covered to maximize the options available to school-based health providers.

4. **Privacy requirements:** A challenge for any school-based health care program is being able to adequately show the positive impact to the students' overall health and academic performance. Both health care and the educational system have important regulations protecting the privacy of those in the system. It would be helpful to understand specifically how those privacy requirements interact to determine what options exist for measuring outcomes and if there are small policy changes that could ease the process while still protecting privacy.

5. **Data-sharing requirements:** As with privacy, data sharing between health and educational systems is heavily regulated and often cumbersome. There are policy reasons for the difficulty, but it can lead to inefficiencies in the delivery of services. Districts that use more than one health care system for the delivery of services also must contend with hurdles in sharing information between those entities. For example, a student may receive physical health care from one system, but behavioral/mental health care from another. Access to a comprehensive record would improve care in every setting and help districts identify gaps in care and high-need students. State information-sharing regulations and data-sharing procedures used by health care partners should be evaluated to determine if avenues for greater cooperation exist.

6. **Capital funding needs:** Even the most basic health care clinic in a school requires capital funding for construction, technology, and equipment. These start-up costs can be a barrier. There may be Say Yes to Education funds available to help defray these costs here in Cleveland. It also may be worth considering whether policy changes can be made at the state level to allow for school facilities or capital budget dollars to cover these costs.

7. **Parental consent:** Cleveland Metropolitan School District (CMSD) is currently reviewing the parental consent forms required for any student to receive physical or behavioral/mental health care to determine if forms can be combined or simplified. Many districts cited failing to receive consent in a timely fashion as a barrier to providing health care to as many students as possible. CMSD should continue to look for ways to make the parental consent process as easy as possible.

8. **Local regulations:** There may be city or county regulations that affect the ability of a school-based health clinic to open or operate. Examples could include zoning restrictions, health codes, or permitting requirements. An examination of county and city provisions that impact school-based health care could reveal opportunities for greater efficiency.

9. **Federal regulations**: Multiple federal regulations and laws intersect with school-based health. Given the current political climate, it is unlikely sweeping changes could be made, but it is worth exploring the feasibility of some changes. For example, pushing for direct funding for school-based health care, explore whether there are 1115 Medicaid waiver options that would streamline or expand access to care for school-aged children, and modifying the scoring process for new FQHC access points to promote school-related sites. A helpful first step could be to engage with the national School-Based Health Alliance, which does engage in policy advocacy and works with a network of state-level alliances.