California School-Based Health Alliance

Strategic Plan

July 2014 - June 2016

CALIFORNIA
SCHOOL-BASED
HEALTH ALLIANCE
Putting Health Care Where Kids Are

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Executive Summary

The California School-Based Health Alliance (CSHA) is the statewide association dedicated to advancing the delivery of health services in schools.

The most comprehensive school-based health model is a school-based health center (SBHC). As of June 2014, there were 226 SBHCs in 80 different school districts in California. SBHCs emphasize:

- **Enhanced access** by bringing health care directly to where students and families are and engaging the school community as the "eyes and ears" of the health care system.
- **Stronger prevention** by going beyond a traditional doctor's visit to integrate prevention throughout the school.
- **Intensive support for the highest need students** by being present on a daily basis to manage chronic disease, deal with crises, and help families access resources.
- **A shared mission with the school to improve academic achievement** by working together to address absenteeism, school climate, classroom behavior and academic performance.

Beyond SBHCs, health services offered to students include mental health programs, school nursing, dental screenings, etc. We believe that comprehensive SBHCs are the optimal model for meeting the health needs of students, but that even when an SBHC is not feasible, all schools can implement other school-based health models to ensure that health needs are not a barrier to learning.

Over the past decade the number of SBHCs in California has almost doubled. There has been great interest from schools, health care providers, policymakers, and many community and advocacy organizations. Health care reform and changes in California's school financing system open possibilities for further growth and, ultimately, a chance to make school-based health an integral part of both health care delivery and education. Our strategic priorities for the next two years build on the successes of our past strategic plan and address the challenges of scaling up school-based health, maximizing its unique value-added, and ensuring its sustainability.

Priority 1: Engage more school districts in expanding a variety of school health services, especially mental health services.
There are 226 SBHCs in the state and 10,000 schools. While the growth in SBHCs has been impressive, they are not feasible for every school. However every school has children in it with health needs, and every school can do more to address those needs. We aim to have a bigger impact by promoting models, in addition to SBHCs, that are feasible for more schools, especially in the area of school mental health.

Priority 2: Increase the number of SBHCs that are well-integrated with the school to maximize their impact on student health and learning.
The number of SBHCs has grown in California, but with that growth has come wide variation in practices, such that some sites have little connection to their host schools. Over the next two years, our goal is to see more SBHCs in California work closely with their host schools to deliver a level of access to care, prevention, and individualized support that makes a unique contribution to children's health and educational outcomes.

Priority 3: Advocate for health care financing for the key elements of the school-based health model that are not currently reimbursed.
There is no sustainable source of funding for the prevention services, such as peer health programs or nutrition classes, that make SBHCs a unique and valuable model. To take the school-based health model to scale, it needs to be integrated into a broader delivery system and funded as part of that delivery system, rather than through special grants and budget line items. Our goal is to integrate school-based health into the new delivery and payment models that are emerging as part of health care reform.

Introduction

The California School-Based Health Alliance (CSHA) is the statewide association dedicated to advancing the delivery of health services in schools. Our staff of 13 is based in Oakand with a field office in Fresno. We coordinate our work closely with regional Affiliates in Los Angeles, San Diego, and Alameda County. *Our mission is to improve the health and academic success of children and youth by advancing health services in schools.*

The most comprehensive school-based health model is a school-based health center (SBHC). SBHCs are health clinics located on school campuses. They offer a range of primary care services such as screenings, immunizations, physicals, mental health, health education, and other prevention programs in the school. As of June 2014, there were 226 SBHCs in 80 different school districts within California. SBHCs are a unique way to deliver health care that emphasizes:

- **Enhanced access** by bringing health care directly to where students and families are and engaging the school community as the "eyes and ears" of the health care system.
- **Stronger prevention** by going beyond a traditional doctor's visit to integrate prevention throughout the school.
- **Intensive support for the highest need students** by being present on a daily basis to manage chronic disease, deal with crises, and help families access resources.
- **A shared mission with the school to improve academic achievement** by working together to address absenteeism, school climate, classroom behavior and academic performance.

Beyond SBHCs, many schools in California offer others types of health services to students. These might include school mental health programs, school nursing, preventive dental programs or services through a mobile dental van, or asthma programs.

At the California School-Based Health Alliance, we believe that comprehensive SBHCs are the optimal model for meeting the health needs of students, but that even when an SBHC is not feasible, all schools can implement other school-based health models to ensure that health needs are not a barrier to learning.

Key Issues in School-Based Health in California

The number of SBHCs in California has been growing consistently but is far from adequate to serve all of the children who could benefit from them.

SBHCs provide benefits to children, families, and communities at all socioeconomic levels, however, we know that there is a particular need in low-income areas. An abundance of research connects poverty to poor educational and health outcomes, high rates of teen pregnancy, and greater risk of dropping out of school. SBHCs can significantly impact children living in the state's most distressed neighborhoods where children and families are uninsured, experience barriers to accessing preventive health care, have high rates of emergency room visits, obesity, asthma, and exposure to violence and trauma.

- **There are approximately 10,000 schools in California, of which 2151 could immediately benefit from a school-based health services due to the high concentration of poverty among their students** (75% or more eligible for free lunches).

The primary obstacle to expanding school-based health is financial. Unlike some other states, California has no dedicated funding stream for SBHCs--every school or medical provider that wants to start an SBHC has to put together a creative patchwork of grants, insurance payments, subsidies, in-kind contributions, and donations. This process usually takes several years. In addition, California ranks near the bottom in

terms of funding for school nurses and other support personnel. Beyond state funding, a number of issues pose challenges to the sustainability of SBHCs:

SBHCs serve many uninsured children. SBHCs are generally located in low-income communities where there are high numbers of uninsured children for whom reimbursement sources are limited. In many other states, state grants help SBHCs fill this gap.

SBHCs' open door model runs counter to the managed care system. Today, most children in California are enrolled in some type of managed care plan. They pick a "primary care provider" (PCP) who is paid for their care. SBHCs open their doors to any student at the school. When SBHCs serve students for whom they are not the PCP, they are typically not reimbursed.

SBHCs provide services that are not covered by insurance. The services provided in schools are not the same as the typical office visit. Many SBHCs provide a wide range of additional services including: health education, case management, outreach for health insurance, obesity prevention, coordination with parents and teachers, and troubleshooting referrals. These services are not covered by health insurance and are typically funded through grants, making them unstable.

Current State and Federal Statute

Unlike many states, California does not have any official certification, funding, or program for SBHCs. We have passed two bills that create the infrastructure for an SBHC program, but neither has been funded.

AB 2560 (Ridley-Thomas) was passed and signed by Governor Schwarzenegger in 2006. It created a "Public School Health Center Support Program" to collect SBHC data, facilitate the development of SBHCs, and address the programmatic, clinical, finance and policy needs of California's SBHCs.

SB 564 (Ridley-Thomas) The School Health Centers Expansion Act, was signed by Governor Schwarzenegger in September 2008. SB 564 creates a grant program for SBHCs administered by the Public School Health Center Support Program. This bill amended the Health and Safety Code (Section 124174) to create a basic definition of an SBHC (referred to here as "school health center"):

> "School health center" means a center or program, located at or near a local educational agency that provides age-appropriate health care services at the program site or through referrals. A school health center may conduct routine physical, mental health, and oral health assessments, and provide referrals for any services not offered onsite. A school health center may serve two or more nonadjacent schools or local educational agencies.

At the federal level, SBHCs are defined in the Child Health Insurance Plan Reauthorization Act passed in 2009. The Affordable Care Act of 2010 included $200 million in one-time funding for capital and facilities in SBHCs. California secured $30 million of these funds which will lead to the opening of 44 new SBHCs. Also included in health care reform was an *authorization* for a federal SBHC grant program. Unfortunately funds were not appropriated for the program and it will sunset in 2014.

Accomplishments from the 2011-2014 Strategic Plan

Priority 1: Maximize the opportunities provided by health care reform.

What we accomplished

- Helped get $200 million in ACA by working with the national Alliance and secured $30 million for California SBHCs.
- Obtained a designation of SBHCs as "essential community providers" in the Covered California regulation and had SBHCs and schools recognized in Covered California's outreach and marketing plan.

- Raised the engagement of schools/SBHCs in outreach and enrollment by securing a Covered California grant to fund 10 agencies working in schools, creating an innovative youth leadership program for peer insurance outreach, and helping to spearhead "All In" which is getting more schools involved in outreach.
- Increased the number of FQHCs running SBHCs from 35 in 2010 to 55 today.
- Produced and disseminated resouces on policy or practice issues relevant to health care reform. These include: SBHCs and health care reform, payment reform opportunities for SBHCs, SBHCs and patient-centered medical homes, electronic health records, and measuring adolescent patient experience.
- Helped ten SBHCs expand nutrition and fitness programs which are the type of preventive services emphasized in health care reform.

Implications for the next two years

Health care reform continues to be an important context for our work, but the opportunities are changing. The policies of Covered California are set; outreach money has been allocated; federal SBHC capital grants are finished. The greatest opportunities are now connected to "delivery system reform" to strengthen prevention, improve outcomes, lower costs, and increase patient engagement and satisfaction. These changes present an opportunity for SBHCs but necessitate addressing some hard questions.

- What is the competitive advantage of SBHCs (e.g., obesity prevention, immunizations, expanded access, case management)?
- Are payers willing to pay for these services?
- How can payment for these services be structured to work for both the payer and the SBHC?
- What proportion of SBHCs are ready to embark on demonstration projects with new partners and payers?

2. Make SBHCs and school health services a higher priority for K-12 educators and policymakers.

What we accomplished

- Increased the number of school districts with an SBHC from 61 to 80.
- Increased our communication with school personnel by increasing the school district contacts in our database from 402 to 933 and presenting at various education conferences.
- Increased our connections in education by working with advocates and TA providers in the fields of community schools, chronic absence, and school climate.
- Passed an Assembly resolution by the chair of the education committee supporting SBHCs.
- Capitalized on the new opportunity of the Local Control Funding Formula by producing a policy paper, sharing talking points, hosting a training and a webinar to help local stakeholders advocate for expanded health services.
- Began exploring the role of SBHCs in health care workforce and career pathways.

Implications for the next two years

The failure of the federal government to reauthorize the Elementary and Secondary Education Act reduced our emphasis on this priority. However, we recognize that it is important for the long-term success of our work for school-based health to be a priority in more school districts. This past year California changed its funding formula and accountability system for school districts such that lower income districts will receive increased funds, some of which could be used for health services. As a result, it is a strategic time to strengthen our efforts to share information with more school districts about how school-based health services can help improve attendance, school climate, student behavior, and academic performance.

3. Improve SBHCs' use of information technology to gather, utilize and report data on services and patient outcomes.

What we accomplished

- Provided support to help SBHCs adopt electronic health records and get federal incentive payments.
- Created a set of SBHC performance measures and a guide to evaluating the impact of SBHCs on academic outcomes.
- Played a role in strengthening evaluation of SBHCs in LA, Alameda and San Diego, including sharing information between these regions and exploring IT systems/vendors.
- Worked with two SBHCs in LA to analyze the data from their EHRs.
- Launched our "quality improvement leadership initiative" which will encourage SBHCs to collect more data.

Implications for the next two years

Our work on EHRs was most useful for a handful of SBHCs run by school districts. We helped these sites understand the federal incentives for EHRs and evaluate their options. A few sites actually obtained federal incentive payments. On the other hand, SBHCs run by community clinics did not need our assistance, and we see our future role in EHR rollout as fairly limited. However, the broader issue of data collection to document patient outcomes is still very important to the future growth of SBHCs, and we will be working on this in the context of demonstration projects on delivery system innovations (priority 3).

4. Expand mission of the organization beyond SBHCs to encompass other forms of school health services.

What we accomplished

- Evaluated school-district needs and identified mental health as our first area of focus.
- Hired a new staff position to focus on school mental health and began providing assistance to school districts in improving mental health services for students.
- Added content to our website and conferences that is relevant to school health personnel even if they do not have an SBHC.
- Changed our name and branding to reflect a broader mission than just promoting SBHCs.

Implications for the next two years

We have made very significant strides in this direction and continue to see this as a strategic priority for the organization. Our enhanced capacity in the area of school mental health now puts us in a good position to address the needs of many more schools—schools that want to expand health services but are not in a position to open an SBHC.

5. Increase awareness and support for SBHCs/SHS within the general public and corporate sector.

What we accomplished

- Achieved greater print and social media presence.
- Launched several new partnerships with corporations.
- Positioned ourselves for more successful communications by rebranding with our national organization and eight other states.
- Developed a cause marketing campaign to expand our corporate partnerships.

Implications for the next two years

We have achieved tremendous growth in our communications capacity during the past three years which as increased the "assets" that we have to offer a corporate partner (e.g., the number of people we reach or the number of events we have). The next step in this work is to focus our communications in a more targeted way through our cause marketing campaign which is a priority for our development program.

California School-Based Health Alliance Strategic Framework

MISSION: To improve the health and academic success of California's children and youth by advancing health services in schools.

NEEDS

The rationale for our work

1. Many children and youth have **unmet health needs**, which directly affect learning and success in and out of school.
2. There are **insufficient health services offered in schools**—where kids are—to meet the level of need.
3. Decision makers have **limited understanding** of the need for and importance of school-based health services.
4. There is **lack of sustainable financing mechanisms** for the essential elements of school-based health services.
5. School-based health providers **need more capacity and proven care delivery models** to succeed in the reformed health care system.
6. Many school-based health providers **need stronger linkages to host schools** to maximize health and educational outcomes.

STRATEGIES

What we do to achieve our intended outcomes

1. Legislative and administrative **public policy and advocacy**.
2. **Training and technical assistance** to support the start-up and implementation of school-based health services (e.g., toolkits, webinars)
3. **Outreach and communications** to generate awareness, interest and support for school-based health services.
3. **Resource cultivation** for school-based health services among private funders and industry partners
5. **Annual conference and other initiatives** to connect school-based health stakeholders and generate engagement and leadership for the statewide movement to bring health care to schools.
6. **Shaping the conversation** about school-based health services within the context of health and education reform.
7. **Generating evidence** to promote successful care delivery models in schools

OUTCOMES

What we seek to accomplish

1. An **increasing number** of SBHCs and school health services in California.
2. Adoption of a **school-based health model** that takes advantage of the unique collaboration between a school and health care provider to impact to students' health and educational outcomes in a way that no other model can.
3. **Public policies** that support the delivery of health services in schools and promote the school-based health model.
4. Greater integration of school-based health services into the **health care delivery system**.
5. Greater **school/district** commitment to expanding and sustain health and mental health services.

ULTIMATE IMPACT: Increased access to effective school-based health services that contributes to all children and youth in California being healthy and achieving at their full potential in school and beyond.

Strategic Priorities 2014-2016

Over the past decade the number of SBHCs in California has almost doubled. There has been great interest from schools, health care providers, policymakers, and many community and advocacy organizations. Health care reform and changes in California's school financing open possibilities for further growth and, ultimately, a chance to make school-based health an integral part of both health care and education. Our strategic priorities for the next two years build on the successes of our past strategic plan and address the challenges of scaling up school-based health, maximizing its unique value-added, and ensuring its sustainability.

Priority 1: Engage more school districts in expanding a variety of school health services, especially mental health services.

There are 226 SBHCs in the state and 10,000 schools. While the growth in SBHCs has been impressive, they are not feasible for every school. However every school has children in it with health needs, and every school can do more to address those needs. We can have a bigger impact by promoting models, in addition to SBHCs, that are feasible for more schools. Our initial focus for this work will be on school mental health.

Outcomes

1.1. 250 schools, districts or county offices of education will use the Alliance's tools or trainings to strengthen their health or mental health programs.

1.2. 80,000 children and youth will have better access to mental health services at school as a result of the Alliance's efforts to help schools establish more comprehensive mental health programs.

Action Steps

- Develop assessments, trainings, and other resources on mental health for schools that do not have plans for a full SBHC.
- Provide direct outreach and assistance to schools to help 20 districts conduct an assessment to map their existing mental health programs and make plans for expansion.
- Develop expertise in policy related to financing and delivery of children's mental health services.
- Develop a stronger connection with the CDE and county offices of education to gather information on school health and mental health and to provide assistance in strengthening these services.
- Conduct outreach to develop a broader network of school district contacts and develop a better understanding of their needs.
- Provide hands-on training/support to schools through a small group learning collaborative model to help them implement mental health programs.
- Explore new options or business models to facilitate expansion of school mental health (e.g., USC intern program, telehealth).
- Offer models and tools to schools that want to expand health services but have no FQHC or county health partner able to operate a permanent SBHC.

Priority 2: Increase the number of SBHCs that are well-integrated with the school to maximize their impact on student health and learning.

The number of SBHCs has grown in California, but with that growth has come wide variation in practices, such that some sites are serving the entire community and have little connection to their host schools. While serving the entire community can be a strength, it is important to ensure that these sites continue to focus on the health of students. Although it has not been explicitly defined in California, the school-

based health model is characterized by a number of principles and practices that make this model different from health care in other settings. An SBHC takes advantage of its partnership with the school to deliver a level of access to care, prevention, and individualized support that makes a unique contribution to children's health and educational outcomes. Over the next two years, our goal is to see more SBHCs in California work closely with their host schools and implement the principles of school-based health that make it a unique model for serving children and youth.

Outcomes

2.1. Sixty of the state's SBHCs will seek to maximize their impact on children's health by using the Alliance's school-based health principles and indicators checklist to identify areas for quality improvement.
2.2. Thirty of the state's SBHCs will become more connected to their host schools to increase access to care, deliver stronger prevention programs, and/or provide greater individualized support to high-need students.

Action Steps

- With input from a wide range of stakeholders, develop a statement of 3-5 principles that define the school-based health model and a checklist of specific practices that serve as indicators of the principles.
- Set up a data system to enable SBHCs to assess their performance on the checklist and record the data in SalesForce.
- Collect data on how 60 of the state's SBHCs perform on this checklist.
- Conduct site visits with SBHCs to help them assess their performance and identify areas for improvement.
- Develop tools, trainings, and resources to move more SBHCs towards implementation of the school-based health principles. (e.g., resources on working with chronically absent students)
- Provide hands-on training/support to SBHCs through a small group learning collaborative model.
- Help SBHCs obtain grant funding to implement aspects of the school-based health model.
- Partner with our Affiliates to advance their work that is focused on similar goals.

Priority 3: Advocate for health care financing for the key elements of the school-based health model that are not currently reimbursed.

The unique preventive, outreach, and support services that SBHCs provide are exactly the type of patient-centered services emphasized as part of heath care reform to achieve the "triple aim" of better health, better patient experience, and lower costs. However it is difficult for SBHCs to fully implement these services because many of them are not reimbursable. For example, there is no sustainable source of reimbursement for the prevention activities that characterize the school-based health model, such as running peer health programs or conducting health education in classrooms. To take the school-based health model to scale, it needs to be integrated into a broader delivery system and funded as part of that delivery system, rather than through special grants and budget line items. Our goal is to integrate school-based health into the new delivery and payment models that are emerging as part of health care reform.

Outcomes

3.1. There will be greater capacity in the school-based health field to be active participants in delivery system reform and innovation.
3.2. In at least three locations in the state there will be robust demonstration/pilot projects to implement/fund a school-based health model as a health care delivery or social impact innovation.

3.3. Policymakers, health care payers and advocates will work towards financing the elements of the school-based health model (expanded access, prevention, individualized support, and integration with the school) that go beyond a traditional health care visit.

Action Steps

- Form a workgroup on delivery system reform and school-based health.
- Disseminate information on trends and funding opportunities to the field to build capacity to participate in new payment models, systems integration, HIT, health care innovation, and other aspects of delivery system reform.
- Identify the most promising areas for development of pilots for financing school-based prevention and wellness services based on local capacity and interest among schools, providers and payers.
- Conduct an assessment in the six most promising communities of opportunities to link school-based preventive services with health care payers, hospital community benefit, or new financing mechanisms such as social impact bonds, health trusts or accountable care communities.
- Catalyze the development of local pilots in promising areas of the state by facilitating the development of partnerships between schools, providers, and payers to develop pilot projects and/or apply for grants to demonstrate models for financing school-based prevention and wellness services.
- Track state policies and projects related to payment models and performance measures for prevention and wellness.
- Educate policymakers about the scope and impact of existing school-based prevention services and the need to finance services outside of a traditional office visit.
- Serve as a bridge between health and education by advocating for inclusion of school-based preventive services in state and local health care reform policies and initiatives (e.g. health home pilots, accountable care communities).
- Explore new funding strategies for school-based health including hospital community benefit, community development financing, social impact bonds, and intergovernmental transfers.

Indicators

Outcomes	Indicators
Outcome 1.1 250 schools, districts or county offices of education will use the Alliance's tools or trainings to strengthen their health or mental health programs.	• Number of school districts and county offices of education with current contact info in SalesForce. • Number of schools, districts or county offices of education where at least one staff person: o comes to conference o receives one-on-one TA by phone, in person or email o purchases a resource o participates in webinar o requests resource download o attends a coalition meeting o meets with CSHA staff
Outcome 1.2 80,000 children and youth will have better access to mental health services at school as a result of the Alliance's efforts to help schools establish more	• Estimated number of students benefiting from school mental health program and policy changes tracked in SalesForce.

comprehensive mental health programs.	
Outcome 2.1 Sixty of the state's SBHCs will seek to maximize their impact on children's health by using the Alliance's school-based health principles and indicators checklist to identify areas for quality improvement.	• The number of SBHCs that have completed the checklist (as an indication of their understanding that there is a unique SBHC model and they want to move towards it).
Outcome 2.2 Thirty of the state's SBHCs will become more connected to their host schools to increase access to care, deliver stronger prevention programs, and/or provide greater individualized support to high-need students.	• Number of SBHCs that make significant practice changes as determined by self-report or assessment of CSHA staff.
Outcome 3.1 There will be greater capacity in the school-based health field to be active participants in delivery system reform and innovation.	• Number of communications and education events for the field on delivery system reform.
Outcome 3.2 In at least three locations in the state there will be robust demonstration/pilot projects to implement/fund a school-based health model as a health care delivery or social impact innovation.	• Number of health plan contacts in SalesForce. • Number of communities where there is active dialogue between SBHCs, schools, health plans, or county. • Number of pilots launched or funded.
Outcome 3.3 Policymakers, health care payers and advocates will work towards financing the elements of the school-based health model (expanded access, prevention, individualized support, and integration with the school) that go beyond a traditional health care visit.	• Number of organizations receiving our communications that are: policy, elected, government or health plans. • Number of communications reaching these audiences on SBHC model. • Idenfication of policy options and progress moving them forward (qualitative).