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SCHOOL-BASED HEALTH ALLIANCE

House Energy & Commerce Health Subcomittee Hearing: *School-Based Health Centers Reauthorization Act of 2019*

Written Testimony Submitted for the Record

Robert Boyd
President, School-Based Health Alliance
July 29, 2020

SCHOOL-BASED HEALTH ALLIANCE
Redefining Health for Kids and Teens

We are

The national SBHC advocacy, technical assistance and training organization based in Washington DC, founded in 1995

Our Mission

To improve the health status of children and youth by advancing and advocating for school-based health care

Our Goals

1. Support strong school-based health care practices
2. Be the national voice
3. Expand and strengthen the SBHC movement
4. Advance policies that sustain SBHC

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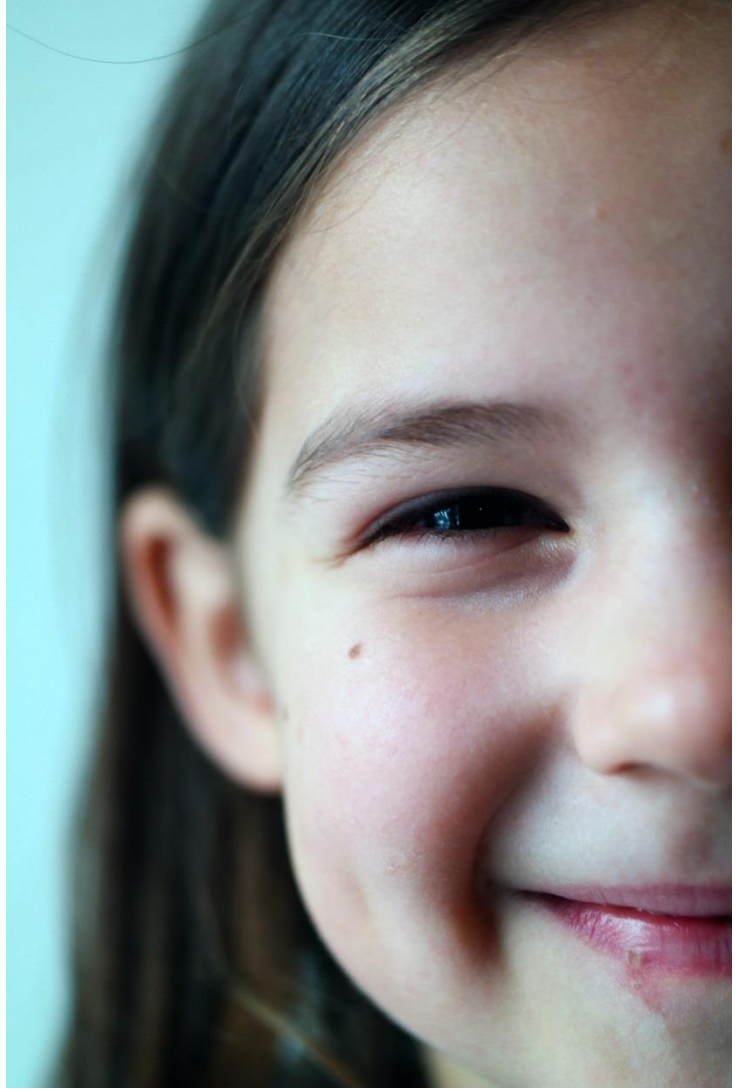
We Believe…

In the transformational power of the health and education intersection



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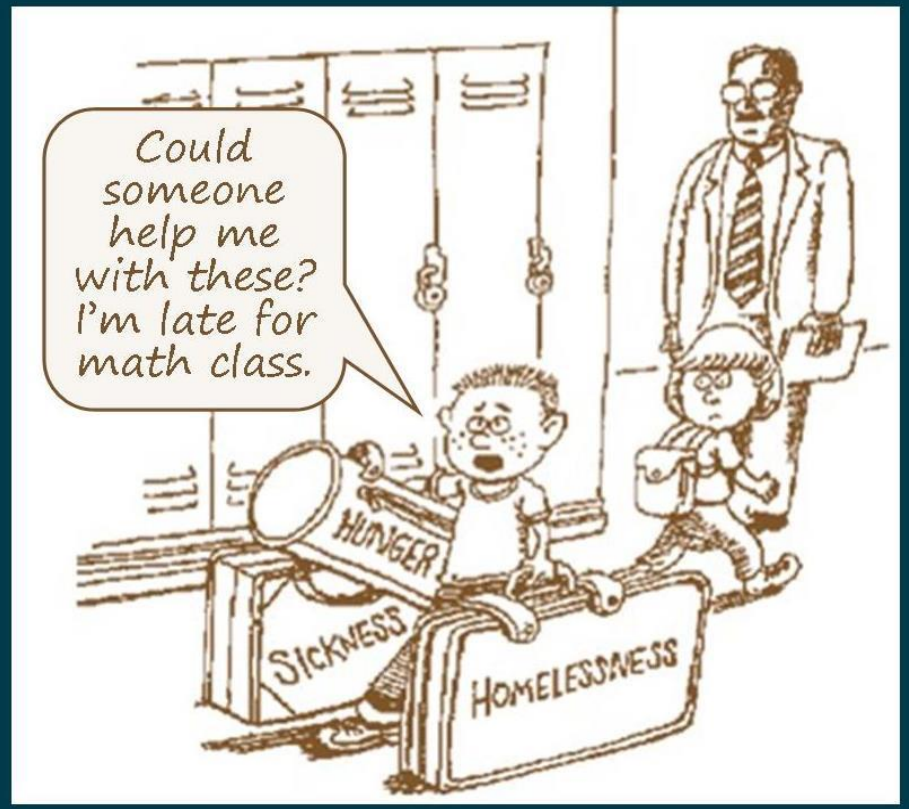
Only when we meet our most vulnerable young people where they are...



...do we afford ALL children the opportunity to thrive

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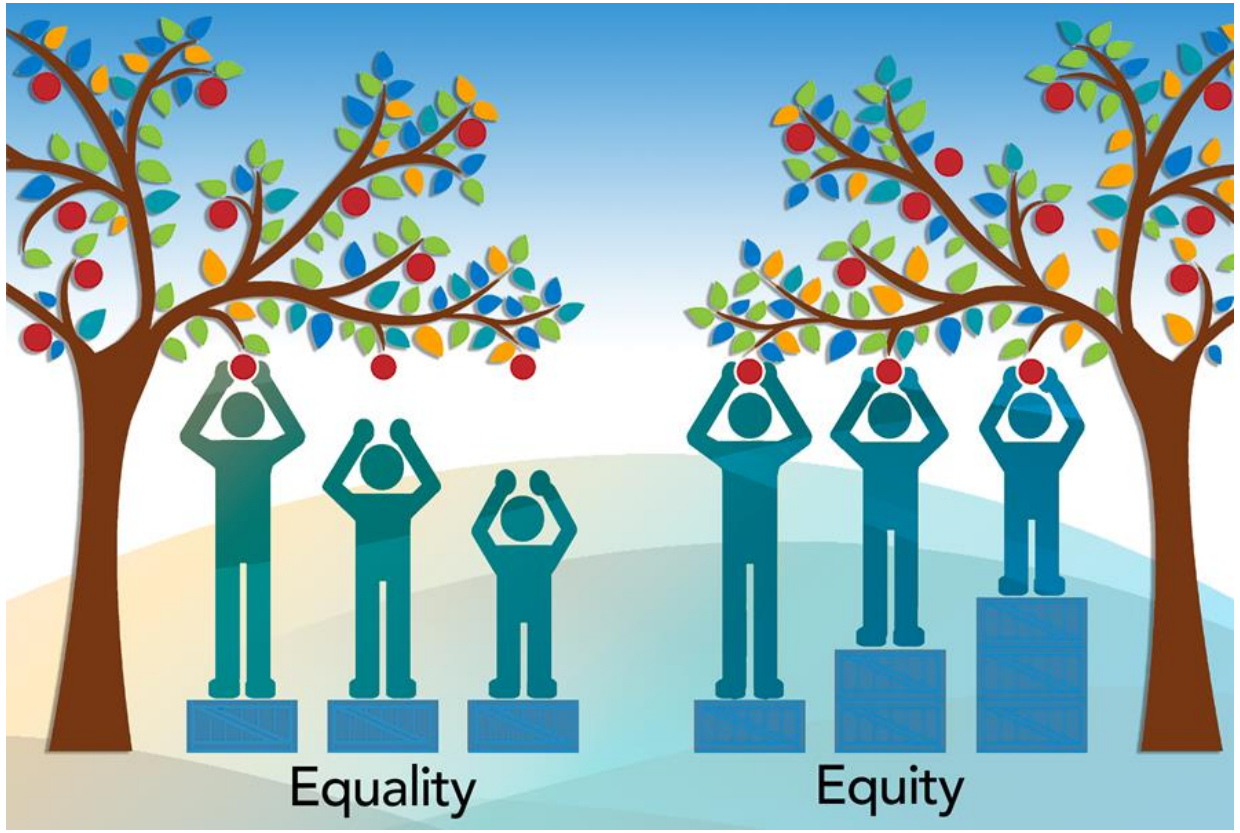
Equity is moving health resources into socially disadvantaged schools and communities so school aged youth can access medical, behavioral and oral health care.



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STATE AFFILIATES
21 and growing

- Arizona School-Based Health Alliance
- School-Based Health Alliance of Arkansas
- California School-Based Health Alliance
- Colorado Association for School-Based Health Care
- Connecticut Association of School-Based Health Care
- Delaware School Based Health Alliance
- Georgia School-Based Health Alliance
- Illinois School-Based Health Alliance
- Louisiana School-Based Health Alliance
- Maryland Assembly on School-Based Health Care
- Massachusetts School-Based Health Alliance
- School-Community Health Alliance of Michigan
- Minnesota School-Based Health Center Alliance
- Show-Me School-Based Health Alliance of MO
- New Mexico Alliance for School-Based Health Care
- New York School-Based Health Alliance
- North Carolina School-Based Health Alliance
- Ohio School-Based Health Alliance
- Oregon School-Based Health Alliance
- Washington School-Based Health Alliance
- West Virginia School-Based Health Assembly

Emerging Affiliates

Florida, Hawaii, Indiana, Kentucky, Pennsylvania, Virginia, DC

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SBHC 101

- A **school-based health center** is a shared commitment between a school, community, and health care organizations to support students' health, well-being, and academic success by providing preventative, early intervention, and treatment services where students are: in school.

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• School-Based Health Centers

- Primary care
  - ✓ Preventive services
  - ✓ Acute, and chronic care
  - ✓ Immunizations
- Oral Health
- Vision Services

- Behavioral health (mental health and substance abuse)
  - ✓ Screening, assessment, and early intervention
  - ✓ Group and individual counseling

- **Financing**
  - Local school district
  - Community organizations
  - State grants and appropriations
  - Federal grants
  - Tax levies
  - Public health funds
  - Foundation grants
  - Medicaid reimbursement

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SBHCs: The Evidence Base

- Health of communities *(an evidence- based intervention per the CDC & US Preventative Service Taskforce Taskforce Community Guide)*
- increased access to care → decreased health disparities
- use of primary care (better care coordination)
- improvements in social competency, behavioral and emotional functioning
- inappropriate emergency room use
- hospitalizations

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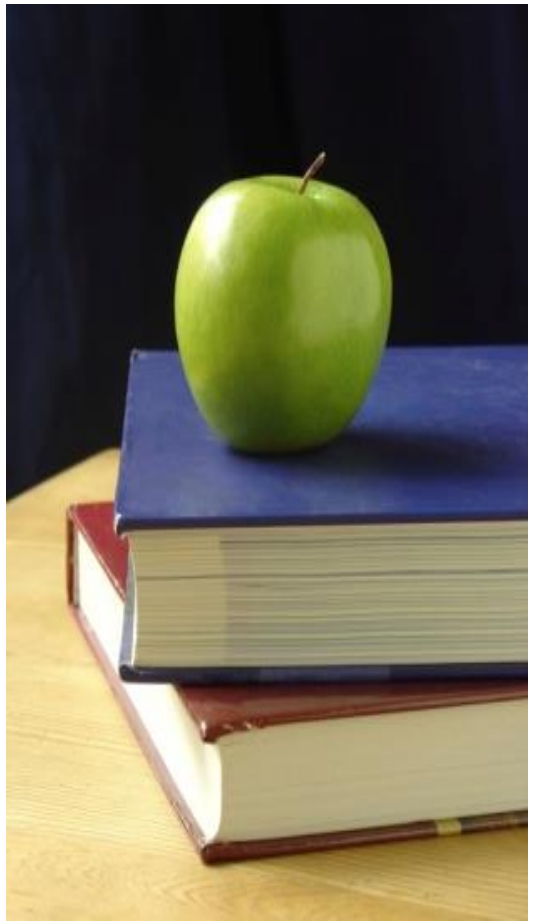
SBHCs & Academic Improvement

- academic expectations, school engagement, and safety and respect
- improvements in academics (GPA, test scores, attendance, teacher retention)
- absenteeism and tardiness
- increase graduation rate



ABC's for Education

2016-17
National School-Based Health Care Census

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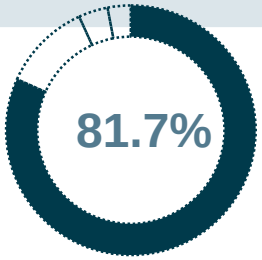
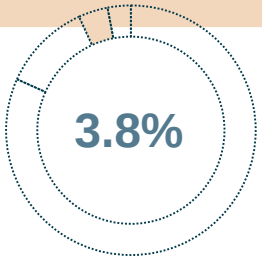
The Census identified 2,584 School-Based Health Centers in 48 of 50 states

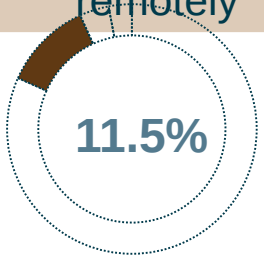
and in the District of Columbia and Puerto Rico.

SBHC Delivery Models

	Traditional	School-Linked	Mobile	Telehealth Exclusive
Location where a patient accesses care	A fixed site on school campus	A fixed site near school campus	Mobile van parked on or near school campus	A fixed site on school campus
Location where providers deliver care	Physically onsite, and remotely for some services	Physically onsite, and remotely for some services	Physically onsite, and remotely for some services	All primary care delivered remotely and other services may be available onsite or remotely

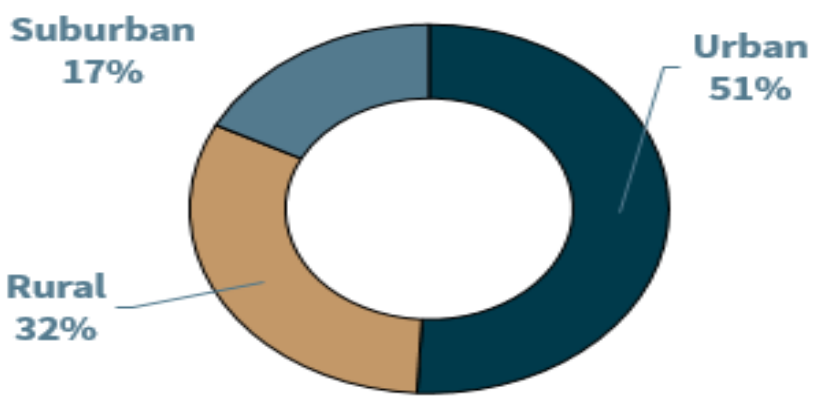




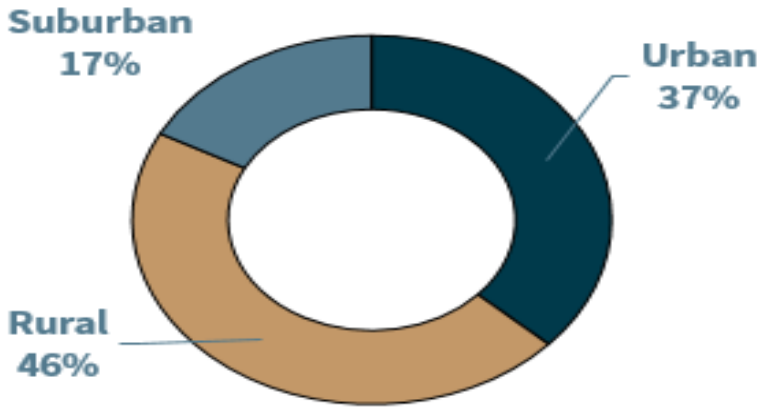


Geographic Location of Community Served, by Delivery Model

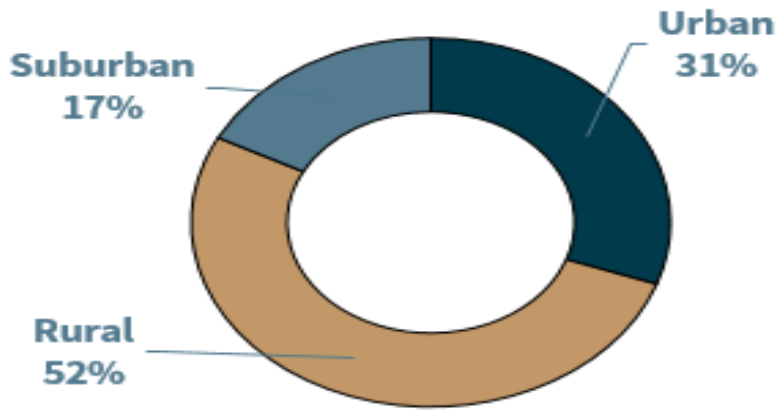
Traditional (n=1,887)



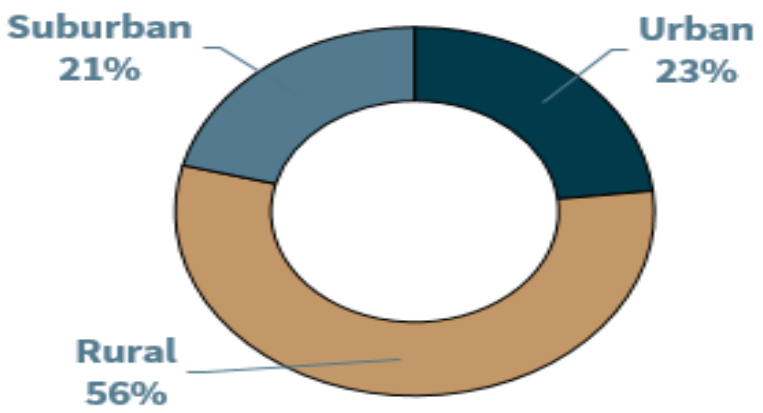
School-Linked (n=87)



Mobile (n=69)



Telehealth Exclusive (n=267)



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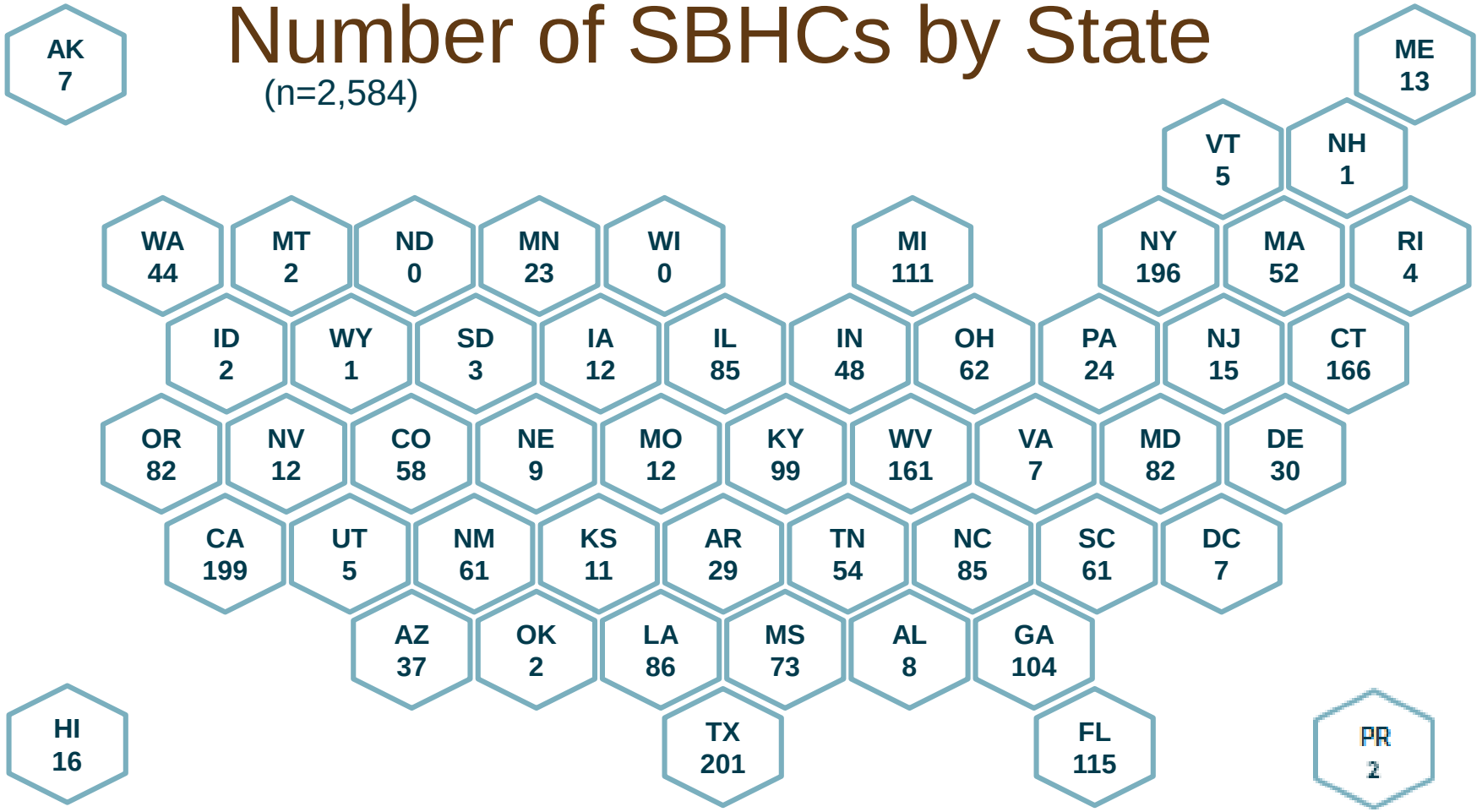
Number of SBHCs by State

(n=2,584)



Note: For the 2016-17 Census, we include only those SBHCs that we confirmed are open and include primary care. These counts include all SBHC delivery models. Telehealth exclusive SBHCs were located in Georgia (73), Indiana (3), Maryland (6), Michigan (5), North Carolina (35), South Carolina (30), Tennessee (2), and Texas (113).

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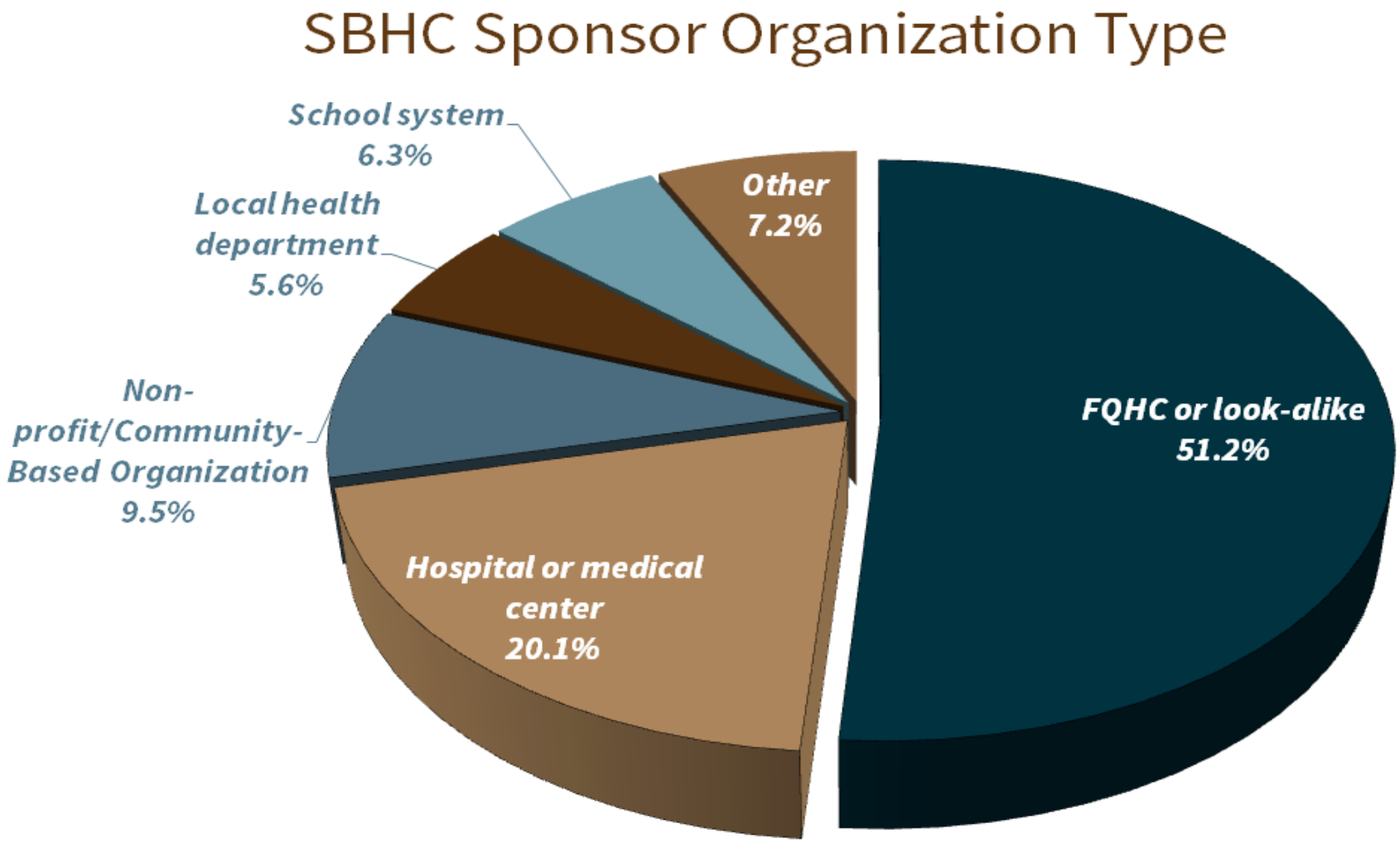
2016-2017 National School-Based Health Care Census



(n=2,305)

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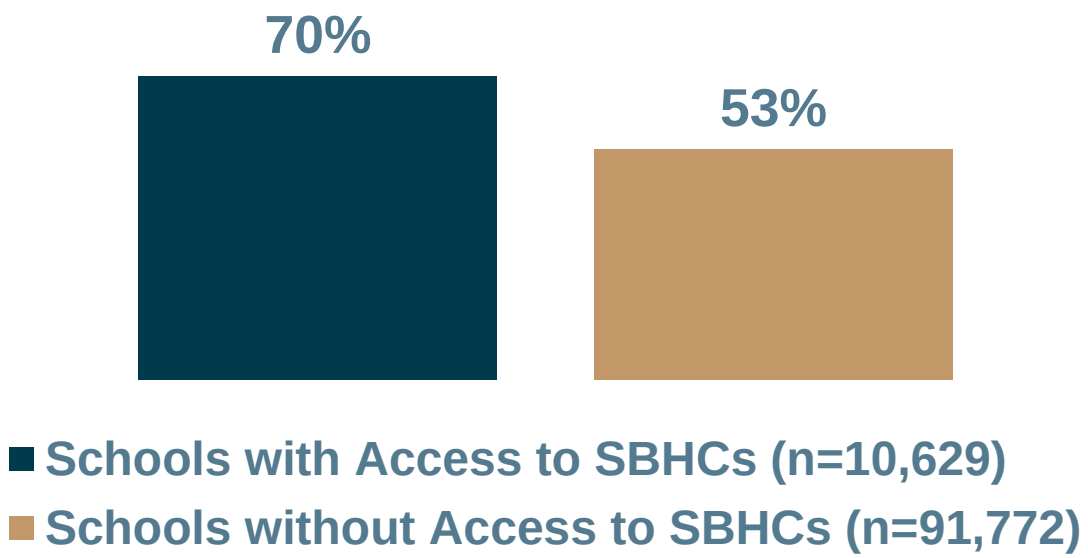
2016-2017 National School-Based Health Care Census

Average Percent of Student Population Eligible for Free/Reduced Price Lunch



2016-17
National School-Based Health Care Census

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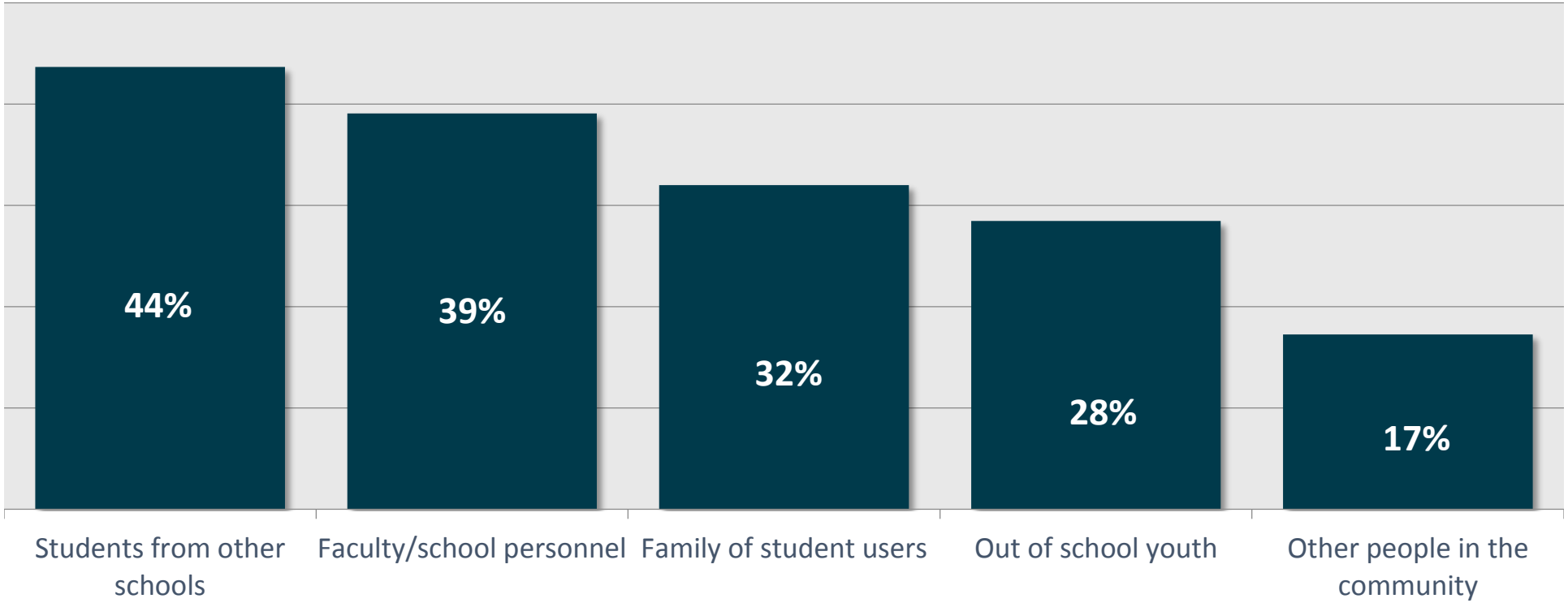
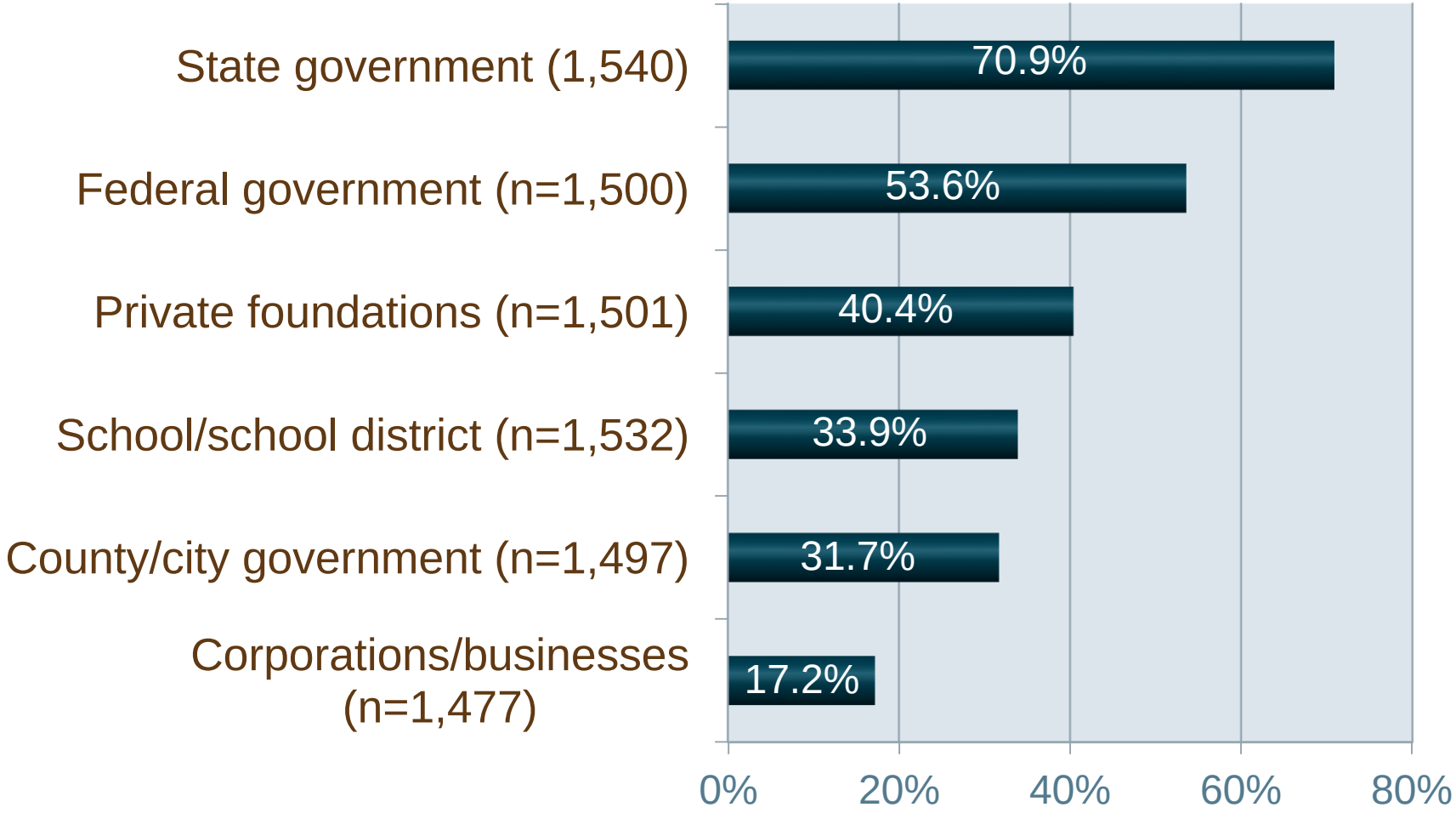
Populations Eligible to Receive Care at SBHCs

62% of SBHCs provide care to populations other than students enrolled in their schools (n=2,313)

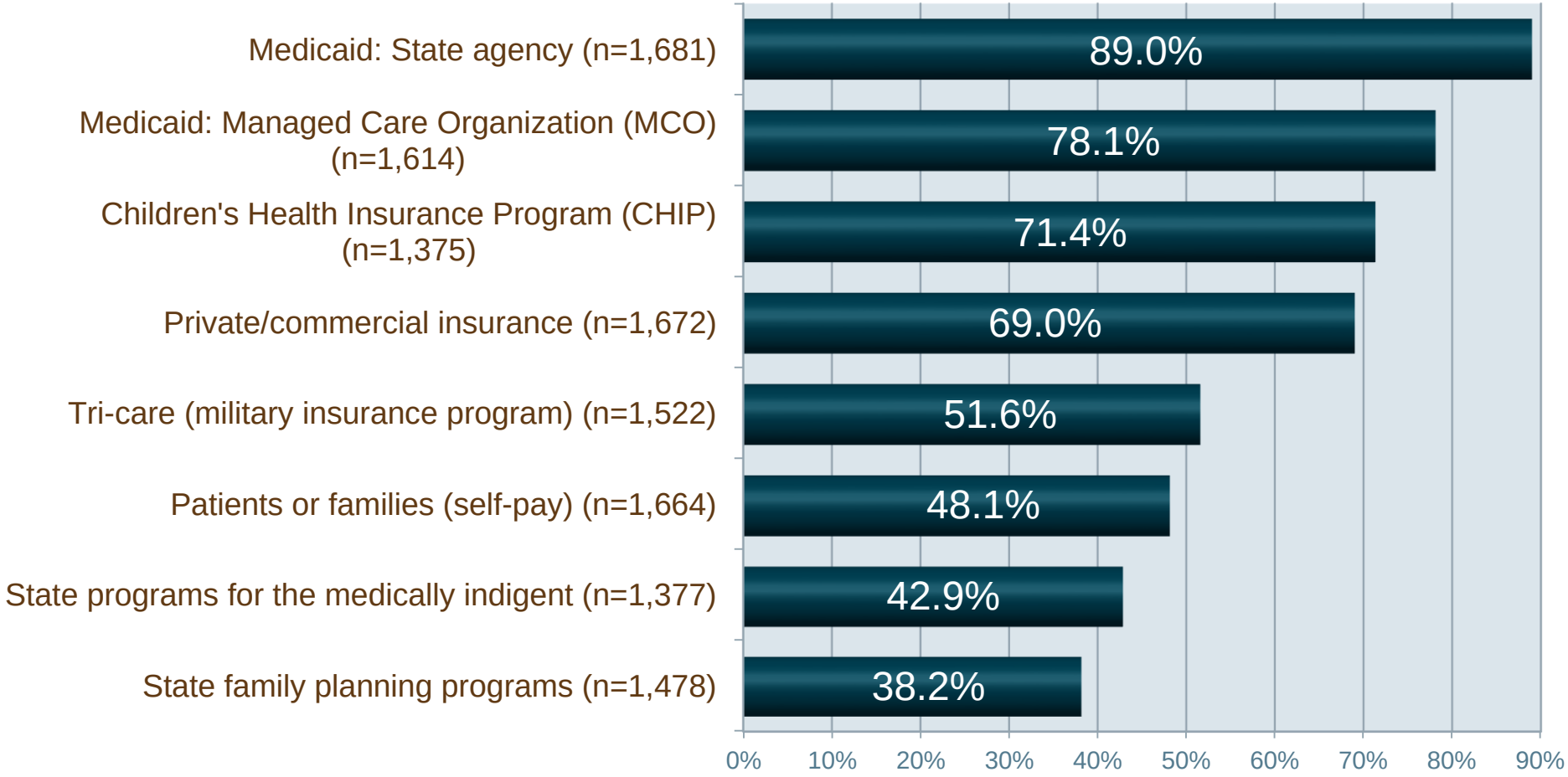
Non-student populations served by SBHCs include:



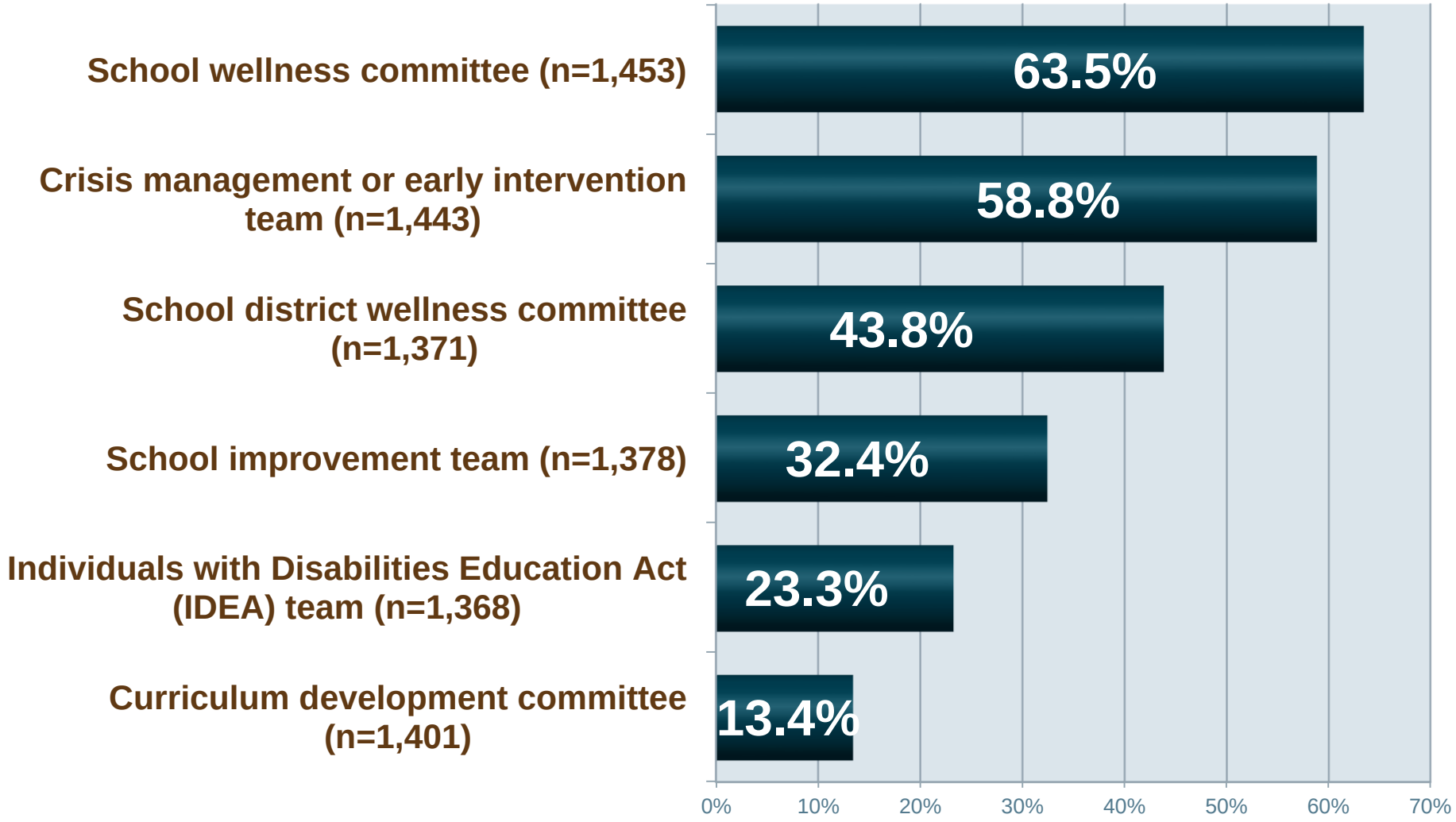
Funding Sources



Percentage of SBHCs that Bill Entities for Reimbursement



SBHC Integration and Collaboration



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SBHC State Policies and Funding, FY2017

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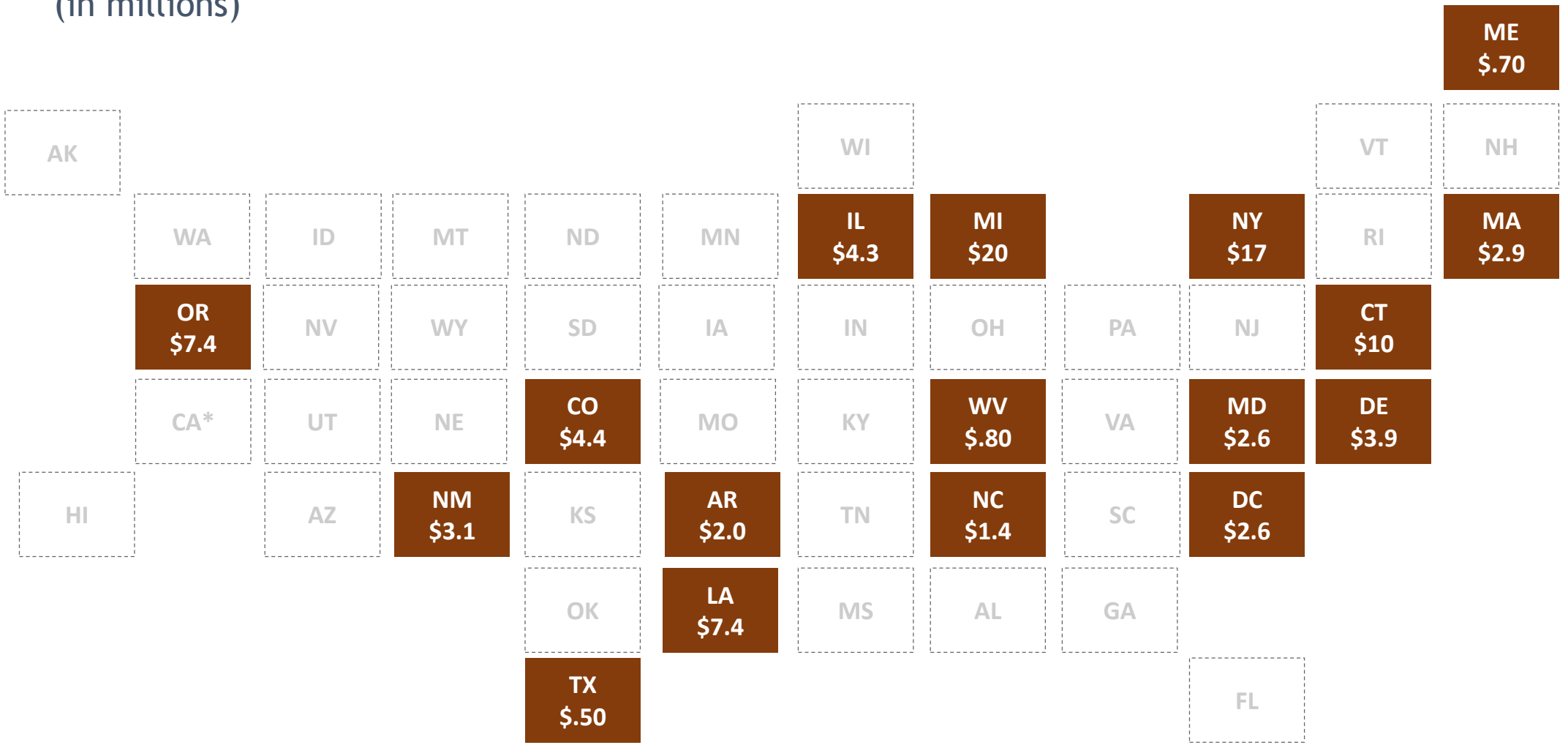
State Dedicated Funds for SBHCs, FY17
(in millions)



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SBHC Models Eligible for State Directed Funding

Model Type	#	States
Traditional *Physically located on school grounds in a dedicated, permanent space*	16	All
Mobile *Services provided on a van or other dedicated but mobile space*	5	IL, MI, NC, NM, WV
School-Linked *Located near a school and has a formal partnership to treat students*	5	DE, IL, NC, NM, WV
Telehealth-exclusive *Services provided via dedicated telehealth equipment, but not as a supplement to existing services.*	2	MD, WV

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Medicaid Policies that Work for SBHCs

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SBHCs as Provider Type

- Medicaid agencies can identify and differentiate services provided at an SBHC from services provided at their sponsoring agency
- Important for attributing quality performance and improved health outcomes to SBHCs
- DE, IL, LA, ME, NM, NC, WV

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Waive Prior Authorization for SBHCs

- Under many states' Medicaid managed care programs, beneficiaries must choose (or be designated) a primary care provider (PCP)
- Patient care provided by non-PCPs often requires approval–or prior authorization–from the PCP in order to provide and bill Medicaid for those services
- CT, DE, IL, LA, ME, MD, NC, WV waive prior authorization

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Then the Pandemic…
Re-imagining School-Based Health Care

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Shifting Gears and Adapting to COVID

- Schools/SBHC closures = students going without
- Schools/SBHCs provide the only source of health services and supports for many low income students
  - Medication management
  - A safe place
  - Asthma management
  - Acute care
  - Behavioral health support (acute and long term)
  - Meals

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From the Field - Innovating and Adapting

SBHCs working to keep their doors open:

Security Janitorial Prioritizing Services

Changing Adapting Connecting

Communications Continuity of Care

Creative solutions Outside doors

Figuring out new community connections

Tele-health Tweeting Creative Outreach

Legislative changes Reimbursement rates

Service Delivery Options Redeployment

School-linked Modular SBHCs

Increase trauma Re-entry planning

Tele-health and mental health

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COVID: Telehealth and Medicaid

- CMS – emergency flexibility to state Medicaid programs for telehealth services
- Audio/video communication
- FQHC sponsored SBHCs can serve as distant site provider
- CMS should make this expanded state authority and flexibility permanent

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Re-Imagining School-Based Health Care: COVID and Beyond

- Better integration with education re: school reentry plans and protocols
- Ability to pivot rapidly to telehealth-only services as necessary
- SBHCs in every Title 1 eligible school across the nation
- Integration with/expansion of community schools
- Long term impact of pandemic > increased need

Addendum to Slide Presentation – Written Testimony for the Record

SLIDE NOTES

Slide 2. The School-Based Health Alliance, is the national voice for school-based health care. Since 1995, we have focused on advocacy, policy, technical assistance and training, and growing the number of centers available to serve kids, their families, their schools and their communities.

Slide 3. We believe that all children and adolescents deserve to thrive. But too many struggle because they lack access to health care services. School-based health care is an effective and efficient solution, bringing health care to where students already spend the majority of their time: in school. We know that healthy kids learn better. Better health leads to better educational outcomes, and more education leads to better health outcomes.

Slide 4. Low-income children show up to school with various needs and challenges. There are individual, group, and systemic challenges that influence a students ability to be present and ready to learn. By working at the intersection of health and education, SBHCs can address the unmet needs that keep kids from being in school and learning. As we know, so many of these challenges shown here have been exacerbated by the current pandemic.

Slide 5. We believe strongly in the principle of equity. Children from low-income and racial or ethnic minority populations in the U.S., are less likely to have a conventional source of medical care and more likely to develop chronic health problems than more-affluent and non-Hispanic white children. They are more often chronically stressed, tired, and hungry, and more likely to have impaired vision and hearing, which are obstacles to lifetime educational achievement and predictors of adult morbidity and premature mortality. If school-based health centers (SBHCs) can help students overcome educational obstacles and increase access to needed medical services in disadvantaged populations, then they are advancing health equity.

Slide 6. At the Alliance, we have state affiliates in 21 states and leaders from many other states participating in our initiatives, in policy and advocacy efforts, and in other partnerships.

Slide 7. I am going to provide some comprehensive background to school-based health centers, including the core components, various delivery models, geographic trends, sponsor types, and financing.

Slide 8. So, what is a school-based health center? Simply, it can be described as a primary care clinic in or near a school, but it's really much more complex than that. At the core, it's a partnership between a school, community, and health care organizations to support the health, well-being, and academic success of its students.

So what does that look like? For the schools' part, utilities and the facilities are donated. The other key partner is a local health organization or organizations who bring expertise and linkages into the school – including primary medical care, mental health services, expanded services such as oral health care, vision care, nutrition education, and health promotion. The ultimate goal of the partnership is to create a culture of health within the school.

Slide 9. At the core of the SBHC model is primary care. All SBHCs have primary care as their core element, and most are also providing behavioral health services as well.

By primary care we mean preventive services, acute and chronic care, well child visits, and immunizations. These are typically beyond the scope of traditional school nursing services, although SBHCs do work closely with school nurses where there is one. Some SBHCs also provide expanded services such as oral health, vision, health and nutrition education.

SBHCs are funded through a patchwork of mechanisms, including reimbursement from Medicaid and other payers, state and federal funding, philanthropy, grants, local taxes and levies and school district funding.

Slide 10. So what's the evidence that SBHCs work? The evidence base is strong – for their impact to individual and community health as well as educational outcomes. Studies confirm that healthy students learn better.

Communities benefit as well. SBHCs have been designated as an evidence-based intervention by the Preventative Services Taskforce Community Guide. The Community Guide report provides the first quantitative, systematic review on the effectiveness of SBHCs, examining a wide array of educational and health-related outcomes.

We know that SBHCs increase access to care, especially for populations that have historically been hard to reach or faced unwelcoming health care environments, such as adolescent males and minority students. There is strong evidence that SBHCs help reduce asthma related emergency room visits. A study of SBHCs in New York City found a 50% reduction in asthma-related emergency room visits and $3 million savings in hospitalization costs for students enrolled in New York City SBHCs.

Research and references: https://www.sbh4all.org/school-health-care/health-and-learning/

Slide 11. In addition to health outcomes, SBHCs have shown to be effective at improving school climate, reducing absenteeism and tardiness, and increasing graduation rates.

The health and learning page of our website includes comprehensive academic research outcomes and references.

https://www.sbh4all.org/school-health-care/health-and-learning/

ABC = attendance, behavior and course progression

Slide 12. The Alliance conducts a national census survey of school-based health centers every three years. We were due to launch the 2019-2020 national census this summer, but will postpone until next year due to the pandemic. Our most recent data from 2016-2017 identified 2,584 SBHCs in 48 states, the District of Columbia and Puerto Rico.

Slide 13. There are four SBHC delivery models. They are determined based on the location where a patient accesses care and the location of where the providers deliver care.

Traditional SBHCs: The clients access care at a fixed site on a school campus and providers are physically onsite, and may deliver some services remotely. 81% of SBHCs fit this category.

School-Linked SBHCs: The clients access care at a fixed site near a school campus and providers are both physically onsite and remote.

Mobile SBHCs: The clients access care at a mobile van parked on or near a school campus and providers are physically onsite, and may deliver some services remotely.

Telehealth Exclusive SBHCs: The clients access care at a fixed site on a school campus and providers are available remotely for 100% of services.

Slide 14. The geographic location of SBHCs varies by delivery model.

During the 2016-17 school year,

- Among traditional SBHCs, 50.8% serve urban communities, 31.7% serve rural communities, and 17.5% serve suburban communities
- Among school-linked SBHCs, 36.8% serve urban communities, 46.0% serve rural communities, and 17.2% serve suburban communities
- Among mobile SBHCs, 30.4% serve urban communities, 52.2% serve rural communities, and 17.4% serve suburban communities
- Among telehealth exclusive SBHCs, 23.2% serve urban communities, 55.8% serve rural communities, and 21.0% serve suburban communities

Overall, telehealth exclusive SBHCs serve rural communities more than any of the other delivery model types; whereas, traditional SBHCs serve more urban communities than any of the other delivery model types.

Telehealth has many advantages. It is less costly - Requires less space, equipment and staffing. It expedites expansion, by serving as a valuable extension of health care services (physical and mental) for the medical sponsor – a federally qualified health center (FQHC), Academic Institution, Hospital System, Private Medical Providers. It works best when adjunct to comprehensive services that addresses the complex health needs of at risk students. There are limitations to telehealth, particularly the scope of services that can be provided remotely. It should not function autonomously and should be connected to larger health system

Slide 15. States with the highest number of SBHCs are Texas (201), California (199), New York (196), and West Virginia (161).

Slide 16. When I described earlier what is an SBHC, I mentioned the need for a local health organization partner, a medical sponsor. SBHCs are an outside agency coming into the school setting, and so they need to have a medical sponsor that oversees the health services provided. The most common sponsor type is the federally qualified health center or an FQHC. From our 2016-2017 census, 51 % of SBHCs reported an FQHC as their sponsor type. We know that FQHC sponsorship is increasing, as they are a more financially sustainable model – benefiting from higher Medicaid reimbursement rates and federal funding. Other sponsor types are hospitals and academic medical centers, nonprofits, local health departments and school systems.

Slide 17. SBHCs continue to serve students with higher needs as seen by the average percent of students who are eligible for free and reduced lunch – another indicator of low socioeconomic status and

potentially lower access to health care. On average, 70% of students in schools served by SBHCs were eligible for free/reduced lunch meals compared to 53% of students in schools without access to SBHCs. 89% of SBHCs serve one or more Title 1 Schools, and we know that there will more Title I eligible schools due to the economic impact of the pandemic.

Slide 18. Who else benefits from SBHCs?

We know that nearly two-thirds of SBHCs nationwide are providing services to populations other than students in their schools. This includes:

- 44% of SBHCs that are serving students from other schools.
- 39% of SBHCs that are providing services to faculty and school personnel.
- 32% serving family of student users.
- 28% serving out of school youth, and
- 17% serving other people in the community. Those that serve the community typically have a public entrance that can be accessed by the public without having to enter the school building, and often have separate waiting rooms and hours for the community.

Slide 19. Who funds SBHCs? Most SBHCs receive funding in addition to billing revenue. From our 2013-2014 census (most recent year for which data was available), we know that 7 in 10 SBHCs report receiving state dollars for operations.Federal grants are a critical funding source for 53.6% of SBHCs.SBHCs often seek and receive additional support from private foundations: 40.4% of SBHCs receive funds from private foundations. SBHCs partner with many stakeholders to create an integrated, county-wide system of school-based health care, including schools/districts (33.9%), county/city gov't (31.7%), and corporations/businesses (17.2%).

Slide 20. While they can't rely on patient revenue alone, SBHC sustainability requires third party reimbursement. The majority of SBHCs have the capacity to and do at least some billing Medicaid (both state agencies and managed care organizations), the Children's Health Insurance Program (CHIP), private insurance, Tri-care or military insurance, and patients/families. This means they have the billing infrastructure to seek reimbursement from these different sources. The majority of students and families served by SBHCs are covered by either Medicaid or CHIP.

Slide 21. Successful SBHCs are well integrated into school programs and activities. 80.9% of SBHCs participate in at least one school team or committee, including:

- School wellness committees (63.5%)
- Crisis management or early intervention teams (58.8%)
- School district wellness committees (43.8%)
- School improvement teams (32.4%)
- Individuals with Disabilities Education Act (IDEA) teams (23.3%)
- Curriculum development committees (13.4%)

Slide 22. In addition to our national census survey, The School-Based Health Alliance surveys state public health, education, and Medicaid offices every three years to assess state-level public policies and activities that promote the growth and sustainability of school-based health centers (SBHCs).

Slide 23. The (FY) 2017 survey found that 16 states and the District of Columbia reported investments explicitly dedicated to SBHCs. Most of the state funding is from state general revenue, but funding may also come from the Title V MCH Block Grant, Social Services Block Grant and Tobacco Settlement funds. The funding is provided through a state SBHC program office, which typically sits in the state health department or sometimes the education department. In addition to providing grant funds, the SBHC program office sets standards and collects performance data.

Slide 24. This chart shows the SBHC models that are ELIGIBLE for funding in different states. In our interviews with state program offices for our state policy survey, many states expressed that while telehealth or mobile programs may not be eligible, that doesn't mean the states don't support those programs, evaluate those programs, or that those programs aren't happening. In many states, the biggest roadblock to funding telehealth exclusive SBHC programs is often the statutory definition of SBHCs being "located at" a school campus. Note - we did not receive data from TX on this question.

Slide 25. Several state Medicaid programs enforce policies that protect and promote reimbursement for services delivered in SBHCs. The School-Based Health Alliance encourages the school-based health care field to advocate for these or similar polices in their state Medicaid programs.

Slide 26. Seven state Medicaid agencies (Delaware, Illinois, Louisiana, Maine, New Mexico, North Carolina, and West Virginia) define SBHCs as a specific provider type. By assigning a unique ID number, Medicaid agencies are able to identify and differentiate services provided at an SBHC from those of its sponsoring agency. This policy is particularly important for directly attributing quality performance and improved health care outcomes to SBHCs. More info on Medicaid policies and SBHCs: https://www.sbh4all.org/advocacy/medicaid-policies-that-work-for-sbhcs/

Slide 27. Under many states' Medicaid managed care programs, beneficiaries must choose (or be designated) a primary care provider or PCP. Patient care provided by non-PCPs often requires approval–or prior authorization–from the PCP in order to provide and bill Medicaid for those services. Eight state Medicaid agencies (Connecticut, Delaware, Illinois, Louisiana, Maine, Maryland, North Carolina, and West Virginia) waive prior authorization requirements for SBHCs so they are not burdened with seeking permission from their students' PCPs in order to be paid by Medicaid.

Slide 28. When COVID hit this Spring, SBHCs quickly had to shift and adapt to meet the needs of students amidst school closures, and think long term about the future of school-based health care.

Slide 29. More than half of SBHCs had to close their doors when schools closed in March, although most pivoted to providing at least some services via telehealth. Still, we know many students have gone without regular primary and mental health care for several months now. For many low income students, SBHCs or other school health programs are the only source of health services and supports. These range from medication management, management of asthma and other chronic conditions, acute care, well visits including immunizations, mental health services, oral health and other services. And for many students, school in general is the only place they feel safe, receive regular meals and have caring, supportive relationships with adults.

Slide 30. Over the past few months, we've been listening to and learning from the SBHC field about how they are managing during this pandemic. The SBHC field has adapted and innovated during this pandemic to meet the needs of students and families. The Centers for Medicare and Medicaid (CMS) has

provided flexibility at the State level to provide Medicaid reimbursement for telehealth, reciprocity waivers for out of state licensing of providers, increasing reimbursement rates, allowing for telephone and video calls, and other policies. SBHCs continue to provide a level of care to the students to keep them out of the emergency room with primary or behavioral health crisis; finding ways to support their community by seeing the public for well visits, thereby decreasing the burden on the community health system stretched in their response to COVID. SBHC are collaborating with local food banks to distribute food to families in need, They are meeting students in parking lots to drop off meds, provide immunizations, and provide socially distanced counseling.

The SBHCs that have remained open are mostly those that have an outside door to the community, or are a school-linked or modular program and are not limited to access from within the school. Many are implementing new protocols to prevent the spread of COVID. Rather than accepting walk-ins, for example, some SBHCs now require appointments, thereby limiting and controlling the number of individuals in the center. Another approach discussed is seeing students for well-child visits and immunizations in the morning, reserving sick visits for the afternoon, and supplementing throughout the day with telehealth.

Slide 31. As I mentioned, CMS has provided state Medicaid programs with increased authority and flexibility to expand telehealth services, such as telephonic and video conference care, removal of cross state licensing requirements, and the allowance of federally qualified health centers (FQHCs) to provide telehealth services as distant site providers. While CMS has stated their actions will be temporary in order to address the pandemic, we strongly advocate for this increased state authority and flexibility to be made permanent at the federal level and that states remove as many barriers to utilization of telehealth in Medicaid as possible. More than half of all SBHCs across the country are sponsored by an FQHC and the permanent removal of this barrier to serve as the distant site provider would significantly expand health care to children and adolescents.

Slide 32. As schools plan for Fall reentry – both in person and virtual – SBHCs must be at the table with school administrators to create protocols and guidance to control the spread of COVID and also meet the increased needs for primary care and mental health among students who have been out of school for so long.

SBHCs must be prepared to pivot rapidly to telehealth only services if schools are forced to close again after reopening. Long term, we want to see SBHCs in every Title 1 eligible school in the country, and increased integration and expansion with community schools

The full impact of this pandemic to children and adolescents remains unknown. However, we do know that there was significant unmet need for services before the pandemic, and months of school closures have removed many students from the only source of health services and social supports. So many are experiencing economic insecurity due to parent's job loss, food insecurity, increased risk of abuse, anxiety and depression and grief of loved ones lost to COVID. There is no better time for a massive expansion of school health services, especially school-based health centers, in this country.