Advancing the Health and Well-being of Delaware Students

A STRATEGIC PLAN

FOR SCHOOL-BASED HEALTH CENTERS IN DELAWARE

June 2021

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

Table of Contents

_Toc72486507

Acknowledgements from the Steering Committee

The Delaware Department of Health and Social Services (DHSS) is committed to improving the quality of the lives of Delaware's citizens by promoting health and well-being, fostering self-sufficiency, and protecting vulnerable populations. School-based health centers (SBHCs) are key components of our strategy for meeting the physical and behavioral health care needs of our youngest residents so that children are healthy and ready to learn. Over the past three decades, DHSS' Division of Public Health (DPH) has focused on advancing best practices and ensuring the delivery of high quality, person-centered care through 39 SBHCs. The SBHCs are located in 32 public, non-charter high schools and seven middle schools affiliated with high schools. In 2020, the Delaware General Assembly included language in the FY2020 Budget Epilogue to establish new SBHCs in high needs elementary schools across the state.

To achieve this vision and develop a comprehensive SBHC Strategic Plan, DPH and DHSS established a Steering Committee comprised of 21 diverse stakeholder groups. By charter, the Steering Committee directed and reviewed all research and stakeholder engagement activities to develop key recommendations, which included:

1. Minimum standards for the provision of high-quality services in SBHCs
2. A selection process for expansion of SBHCs in high need elementary schools
3. Recommendations and a roadmap to advance the integration and sustainability of SBHCs as part of the continuum of care that supports the health and well-being of youth.

Changes in the school-based health care system require flexibility and local customization, integration with primary care, fiscal flexibility and stability, and a concentrated effort to serve the most underserved and those that have the poorest health outcomes. The strategic planning process was guided by the following guiding principles:

1. Allocation of services must take into account those who are most underserved, or "high needs", or have the poorest health outcomes.

Figure 1. Components of the strategic planning process for school-based health centers, Delaware, 2021.

Strategic Planning Process Components

1 Steering Committee

3 multi-sectoral strategic workgroups

3 multi-sectoral implementation workgroups

1 literature review of current and best practices

24 interviews with **51** stakeholders

2 surveys conducted for parents/caregivers and students

1 inventory of current services offered by Delaware School-based Health Centers

1 scorecard to assess high needs schools

2 virtual town halls for community input

Source: Delaware Department of Health and Social Services, Division of Public Health, 2021.

2. Services must be delivered in partnership with the local community, health, and education system.
3. A base service menu model is needed that includes physical and behavioral health services and supports for healthy lifestyle choices (i.e. physical activity and nutrition). Other services should be based upon specific needs and resources of the community being served.
4. The system must be self-sustaining and leverage a diverse funding base.
5. A core set of measures must be developed to demonstrate value and impact.

In addition, the SBHC Strategic Plan was developed using a rigorous, year-long planning process through: literature review; workgroups; key informant interviews; focus groups; parent, caregiver, and student surveys; the development of a service inventory matrix and high needs scorecard; as well as conducting town hall meetings. All information is archived and available on the 2021 SBHC Strategic Planning webpage. As part of the strategic planning process, multi-sector implementation workgroups met to develop detailed implementation and evaluation plans that ensure the five-year plan operates with fidelity.

We thank the members of the Steering Committee and several stakeholders, including DPH; the Delaware Department of Education; the Delaware Department of Services for Children, Youth, and Their Families; the DHSS Division of Substance Abuse and Mental Health; the Delaware Department of Insurance; the DHSS Division of Medicaid and Medical Assistance; private insurers; school districts; school boards and parent teacher associations; community primary care physicians; community behavioral health providers; school-based health consumers; legislators; current SBHC medical sponsors; and other payers. All gave input and contributed their subject matter expertise, served on workgroups, completed surveys, participated in focus groups, and attended town hall meetings. Their contributions will influence the improved access and quality of health care that children receive through Delaware's SBHCs. We are excited and proud to present the 2021 SBHC Strategic Plan.

Sincerely,

Aileen Fink, PhD
Co-Chair, Steering Committee
Director, Division of Prevention and Behavioral Health Services
Delaware Department of Services for Children, Youth, and Their Families

Jon Cooper, EdD
Co-Chair, Steering Committee
Director of Student Services
Colonial School District of New Castle, Delaware

Leah Woodall, MPA
Ex-Officio Member, Steering Committee
Section Chief, Family Health Systems
Division of Public Health
Delaware Department of Health and Social Services

Executive Summary

SBHC History and Purpose

School-based health centers (SBHCs) have existed in Delaware since the 1980s and have expanded to 39 sites, with one in every public, non-charter high school. SBHCs, also referred to as school-based wellness centers or student wellness centers, are a type of health care delivery model that provides school-aged youth with comprehensive physical, behavioral, and preventive health services delivered by qualified medical and behavioral health providers in school settings.

SBHCs often operate as a partnership between the school and a community health organization, such as a community health center, hospital, or local health department, which serves as the medical sponsor for the SBHC to provide appropriate physical and mental health services. Specific services provided by SBHCs are determined through collaborations between the community, school district, and health care providers. Nearly 2,500 SBHCs operate nationwide, according to the 2016-2017 National Assembly on School-Based Health Care census. Delaware's SBHCs are operated by multi-disciplinary teams of health professionals who use a holistic approach to address a broad range of health and health-related needs of students. Delaware SBHCs are funded through a combination of state funds, Medicaid reimbursement, and reimbursement from commercial insurance, but also rely on community partnerships and in-kind support from schools and medical sponsors. In Delaware, all SBHCs operate under statutory regulations 18 Del. C. §3365 and §3571G. Service components are reviewed by the Delaware Department of Health and Social Services' Division of Public Health (DPH) and the local school board based on the needs of the student population as identified through a needs assessment or a statement of need based on school data analyzed specifically for each center.

Figure 2. Number of school-based health centers, Delaware, 2021.

School-based Health Centers in Delaware by the Numbers

39 total SBHCs

32 SBHCs operate in high schools (all public high schools)

7 of the SBHCs operating in high schools also serve middle schools

7 SBHCs operate in elementary schools

25 SBHCs operate in New Castle County

6 SBHCs operate in Kent County*

9 SBHCs operate in Sussex County*

6 medical sponsors operate SBHCs

*Milford High School's SBHC operates in Kent and Sussex counties.

Source: Delaware Department of Health and Social Services, Division of Public Health, 2021.

Plan Development

Over the past three decades, DPH has focused on advancing best practices and ensuring the delivery of high quality, person-centered care by SBHCs. In 2020, the Delaware legislature included language in the FY2020 Budget Epilogue to establish new SBHCs in high needs elementary schools across the state at a rate of two per year, as well as to reimburse districts that already established SBHCs in high need

elementary schools for expenses associated with establishing them. High needs elementary schools are defined as elementary school that have greater than 90 percent of its student population classified as low-income, EL, or underrepresented minority, or is in the top quartile in three or more of the following: percent low-income students, percent English Learner students, percent students with disabilities, or percent underrepresented minority students This language served as a catalyst to reaffirm and strengthen DPH's commitment to ensuring that SBHCs serve as an integral component in supporting the health and well-being of young Delawareans. This plan takes the intent of the epilogue language and lays out a strategic roadmap to help operationalize the vision for expanding SBHCs in high-needs communities. It offers detailed recommendations on infrastructure, staff competencies, service menu, and data and evaluation. It also identifies the necessary components, costs, and financing strategies, anchored in best practices and promising approaches, to support and sustain SBHC expansion

To create a more coordinated and equitable system of SBHCs across the state, DPH convened a multi-disciplinary strategic planning Steering Committee that researched best practices for SBHCs and reviewed the current SBHC systems. This 12-month strategic planning process included extensive community and stakeholder engagement through various forums. The invaluable work of the steering committee and all involved with the process resulted in 13 goals that reflect priority areas to achieve effective and equitable operations and sustainability of SBHCs through partnerships and person-centered care (Table 1).

Next Steps

As part of the strategic planning process, multi-sector implementation workgroups met to develop detailed implementation and evaluation plans to ensure that the plan is operationalized with fidelity by 2025. The Steering Committee and DPH are currently exploring options to develop a governing body, as described in Goal 1, that will oversee see plan implementation and chart future priorities for Delaware's SBHCs.

Table 1. 2021 Delaware School-based Health Center Strategic Plan goals.

1	Create an independent body with representation from the Division of Public Health (DPH), Department of Education, Department for Services for Children, Youth and Their Families, Division of Substance Abuse and Mental Health, Medicaid, private insurers; as well as school districts, school boards, parent teacher associations, community Primary Care Providers, community behavioral health providers, School-based Health Center (SBHC) consumers, and legislators from each county with the authority to: • Assist in recommendations for future SBHC site locations identified through community needs assessment • Recommend additional service options to SBHCs based on community need (including minor oral health care and screenings, vision and hearing, prescription and medication management, social service navigation, evidence-based interventions, and reproductive health care) • Decide on and annually track/update statewide measures submitted by SBHCs • Recommend state and federal funding resources/grants to medical sponsors and school districts to cover additional services.
2	Encourage new SBHC sites for school districts to be in highest need schools and consider a base-service hub model. If a school district decides to expand SBHCs beyond this original site, additional sites must be state-recognized by DPH and are encouraged to follow a hub-and-spoke model where feasible.
3	Allow siblings who are enrolled in the same school district and who do not have a SBHC in their school to enroll in a sibling student's SBHC, as long as it is serving like-aged students and is cost-recovery authorized.
4	Encourage SBHCs to use the following model as a suggested guide for new SBHC set up and existing SBHC renovation: **Hub:** converted classroom, minimum 900 square ft. • 2 exam rooms (with ability for mobile dental unit) – 100 square ft. each • Waiting/reception area – 200 square ft. • Bathroom – 100 square ft. • Counseling room – 150 square ft. • Prep area/wet space (only needed if exam rooms do not have sink and running water) – 100 square ft. • Medical office – 100 square ft. • Storage (records, medication, immunizations, may require refrigeration) – 50 square ft. • Secure external and internal entrances **Spoke:** Designated space for SBHC, minimum 400 square ft. • Exam room (with sink and running water) – 100 square ft. • Storage area (records, medication, immunizations, may require refrigeration) – 50 square ft. • Waiting area – 200 square ft. • Bathroom (if possible, could share with nurse's office) – 100 square ft. SBHCs are recommended to be Joint Commission compliant.

Table 1. 2021 Delaware School-based Health Center Strategic Plan goals (continued).

5	Develop data collection and analysis infrastructure that meets the needs of SBHCs and stakeholders by:
	• Standardizing data collection and reporting across SBHCs
	• Including information technology departments as part of this process
	• Encouraging SBHCs to adopt electronic health records
	• Developing the ability for DPH, and possibly SBHCs themselves, to generate annual reports showing a dashboard of metrics, including but not limited to:
	  ○ Utilization and performance measures, payer mix, financials
	  ○ Qualitative input from users of SBHCs that convey the value of SBHC services to the legislature and other stakeholders, and to support grant-seeking by SBHCs
	Ensure that data collection and reporting tools are able to capture and track data recommended by the governing body as outlined in recommendation 1.

6	Establish a base service menu model that includes: • Sports physicals (only physicals for those who need it/linkages to primary care providers for physicals) • Minor acute care • Immunizations (only for those who need it/linkages to primary care providers for immunizations) • Reproductive health for middle and high school (Sexually Transmitted Infections and HIV testing, contraceptives, pregnancy testing, birth control pills) • Behavioral health (counseling, substance use screening for middle and high school) • Nutrition counseling • Health education • Insurance navigation
7	Ensure approaches to care are aligned and comprehensive across all SBHCs, especially for behavioral health care and trauma-informed care – including trauma-informed treatment – utilize school and state resources/tools, and are consistent with Culturally and Linguistically Appropriate Service standards.
8	Ensure SBHCs serve as a part of a seamless continuum of care to meet the needs of students by collaborating with primary care providers and other community providers where there is a medical home or connect a child to an available medical home where appropriate. SBHCs will only serve as a student's primary medical home if all other options are exhausted.
9	Ensure that existing telehealth service delivery and billing flexibilities continue and that SBHCs are brought up to speed in telehealth service delivery and new/emerging technologies, especially of behavioral healthcare, through encouraging adoption of electronic health records.
10	Increase access to discretionary funding to cover the cost of non-billable services and children who are uninsured at the time of services, at an adequate annual amount.

Table 1. 2021 Delaware School-based Health Center Strategic Plan goals (continued).

11	Increase efficiencies in credentialing and contracting with payers so that SBHCs can be credentialed as a practice rather than as individual providers.
12	Explore creative solutions with commercial payers that adequately compensate SBHCs for services provided and protect student privacy.
13	Maximize third-party billing and certified coders in SBHCs.

Source: Delaware Department of Health and Social Services, Division of Public Health, 2021.

Introduction

Background on SBHCs in Delaware

Delaware's first SBHC was established in 1985 at Middletown High School in the Appoquinimink School District under Governor Michael N. Castle. In the more than 30 years since then, SBHCs have provided physical, behavioral, and preventive health services in Delaware schools and improved health outcomes for young people. Recognizing and addressing barriers to care and elevated rates of teen pregnancy was the impetus for establishing SBHCs. Since their inception, SBHCs have received a majority of their funding from DPH using Tobacco Settlement and General State funds through the Bureau of Adolescent and Reproductive Health. As part of this funding, DPH established program standards and operation procedures with input from the Delaware Department of Education (DOE).[1] These standards and procedures have evolved over time but remain centered on DPH's primary goal of providing school-aged children with access to preventive and comprehensive care.

In 2012, the Delaware legislature formalized the authority of DPH as the regulating body for contracted SBHCs in Delaware by passing House Bill 202 and adding SBHCs to Title 18 of the Delaware Code.[2] After Governor Jack Markell signed HB 202 into law, DPH was given the authority to recognize sites as SBHCs based on their offering of minimum services specified in legislation and determined by DPH. Recognition of SBHCs by DPH is required for SBHCs to collect billing reimbursement from Medicaid. However, just because a SBHC is recognized by DPH does not mean that it must contract with DPH and thereby receive state funds. Schools and school districts may choose to work with a medical sponsor on their own to build a SBHC and have it recognized by DPH. Under this method, school districts may or may not apply for state funds to support SBHC operations. The three processes for establishing a SBHC are explained in Table 2.

Table 2. Processes to establish school-based health centers in Delaware, 2021.

Division of Public Health-Contracted, State-Funded SBHCs:

1. School district approaches DPH with desire to establish an SBHC.
2. DPH releases equal opportunity Request for Proposals (RFP) for medical sponsors to bid on contracting.
3. Medical sponsor is selected and contracts with DPH to receive state funds and ensures policies and procedures consistent with DPH regulations.
4. Medical sponsors contract with school districts on SBHC operations and agreements.
5. DPH recognizes and regulates SBHC to allow for SBHC to receive Medicaid. reimbursement

[1] https://udspace.udel.edu/handle/19716/24912#files-area
[2] 18 Del. C. §3571G.

Table 2. Processes to establish school-based health centers in Delaware, 2021 (continued).

Non-Contracted, State-Funded SBHCs:

1. School district receives state funding to establish an SBHC.
2. School district releases equal opportunity RFP to medical sponsors to bid on contracting.
3. Medical sponsor is selected and contracts with school district to receive state funds.
4. DPH recognizes and regulates SBHC to allow for SBHC to receive Medicaid reimbursement.

Non-Contracted, Non-State Funded SBHCs:

1. School district approaches medical sponsor to establish SBHC in school.
2. Medical sponsors contract with school districts on SBHC operations and agreements but does not receive state funds.
3. DPH recognizes and regulates SBHC to allow for SBHC to receive Medicaid reimbursement, but does not supply state funds.

Source: Delaware Department of Health and Social Services, Division of Public Health, 2021.

There are currently 39 recognized SBHCs in Delaware operated by six medical sponsors: Bayhealth, Beebe, ChristianaCare, La Red Health Services, Life Health Center, and TidalHealth.[3] Thirty-two of these SBHCs are contracted with DPH and operate in high schools, with seven of these sites also offering services to attached middle schools. As the SBHC model grew, schools and school districts across the state recognized the value SBHCs brought to the continuum of support for children's health and well-being and opened seven new SBHCs by elementary schools in 2018. These SBHCs in elementary schools are not contracted with DPH.

By legislation, Delaware SBHCs must provide the following services (with slight variation across sites):

- Preventive care (physicals, sports physicals, immunizations, screenings, etc.)
- Diagnosis and treatment of minor, acute, and chronic medical conditions
- Mental health and substance use disorder assessments
- Crisis intervention
- Individual counseling
- Referrals and connections to primary care, specialty care, oral health care, and behavioral health care.

[3] TidalHealth was formerly Nanticoke Health.

All SBHCs must receive school board approval prior to applying for DPH approval to become a recognized state SBHC and before implementing such services. With school board approval, the following services may also be provided:

- Testing and treatment for sexually transmitted infections (STIs)
- HIV testing and counseling
- Pregnancy testing
- Limited reproductive health services (counseling, education, birth control pills, condoms, Depo-Provera, and other contraceptives).

While all SBHCs must offer the services specified in legislation, a majority of SBHCs operating in Delaware have added the following additional services with approval from the medical sponsor, the local school board, and DPH:

- Family and group counseling
- Prescription and medication management
- Nutrition counseling
- Health promotion education
- Insurance navigation
- Social service navigation and linkage (food assistance, family income assistance, etc.).

Students must be enrolled in SBHCs by their parent or caregiver to receive services. At the time of enrollment, parents and caregivers can specify any services offered by SBHCs that they do not consent to their child receiving. However, health care providers in Delaware are permitted to accept the consent of minors 12 years and older for treatment of pregnancy and STIs under 13 Del. Laws, c. 7 § 710. Under this legislation the provider has discretion to provide information to, or withhold information from, the minor's parent or legal guardian on the consultation, examination, and treatment of the minor in connection with an STI. Additionally, per 16 Del. Laws, c. 50 § 5003, a minor between 14 and 18 years of age can give consent to receive behavioral health treatment. As specified in the 2012 legislation establishing SBHCs and through subsequent DPH regulations, SBHCs do not substitute for students' personal physicians or medical homes but rather act as a source for referral to outside medical care and additional points of contact for supportive services along a continuum of comprehensive health care.[4]

The Value of SBHCs

Acting alongside Delaware's Road to Value that reimagines health care, SBHCs can serve as an innovative health care delivery model proven to enhance population health and reduce long-term health care costs.

From national studies, SBHCs have a documented positive impact on students' physical and behavioral health. A 2016 systematic review of 46 studies on SBHC's impact on academic and health outcome across SBHCs in K-12 schools catalogues this impact:

- A median reduction of 51.6% in non-asthma-related hospitalizations[5]
- A median reduction of 40.0% in teen pregnancy among females[5]

[4] 18 Del. C. §§3571G.
[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5759331/pdf/nihms931248.pdf

- A median reduction of 5.7% in self-reported mental health problems[5]
- A median reduction of 15.7% in any reported substance use (including tobacco and alcohol)[5]

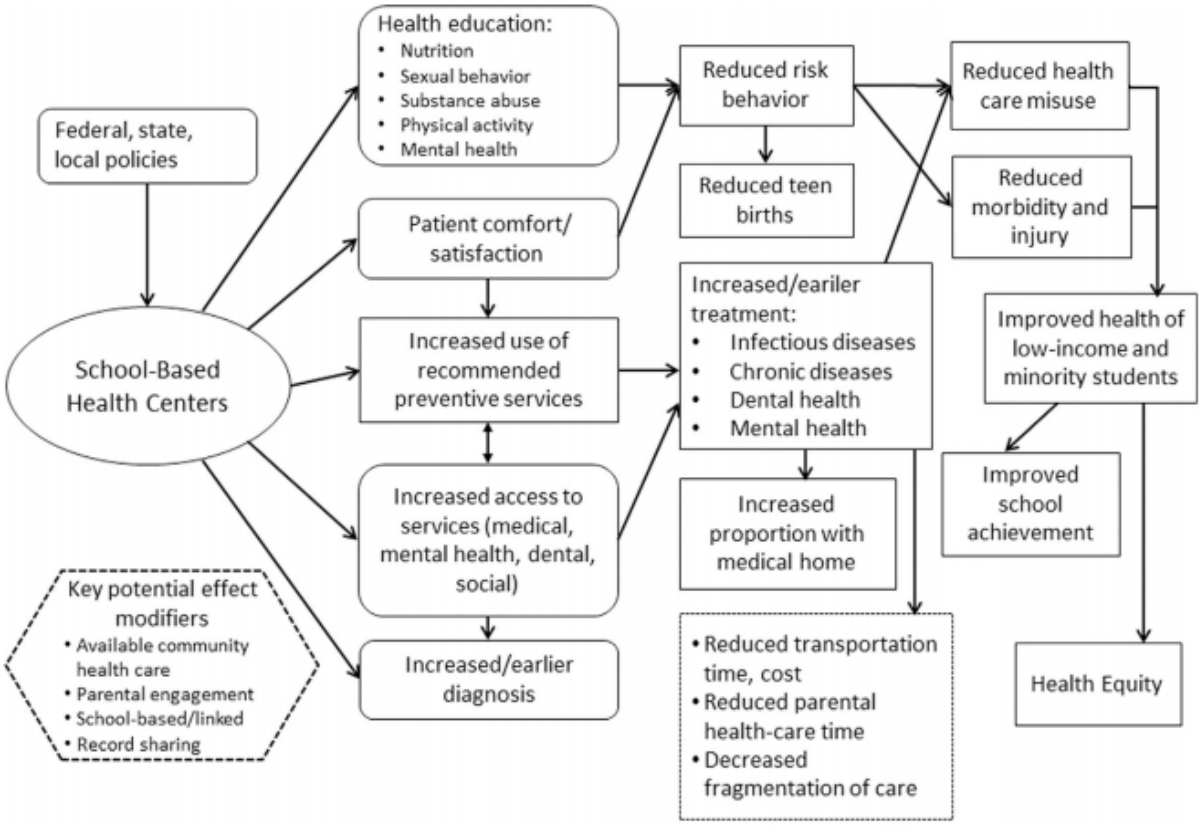
Primary care and behavioral health care delivered in SBHCs also helped to reduce disparities in health care access, utilization, and costs, as well as health outcomes, for racial and ethnic minority populations, even more so than care received in other clinical settings.[5,6] One 2016 review of SBHC approaches by the Brookings Institute reported that students were 10 times more likely to utilize SBHC services for behavioral health needs than other clinical sites or community health centers.[7]

SBHCs are also associated with substantial education benefits, including reductions in rates of school suspension and high school non-completion and increases in grade point average and grade promotion.[5] Behavioral health services offered through SBHCs are credited with reducing violent student behaviors and absenteeism and improving school achievement, attention, and social skills.[8] Additionally, easy and close access to physical and behavioral health services through SBHCs has improved more proximal educational measures, such as student seat time[9] (Figure 3).

With a focus on primary and preventive care, SBHCs have significant cost benefits. One 2016 systematic review of 22 studies found that that SBHCs have a total net savings to Medicaid ranging from $30 to $969 per visit and $49 to $1,166 per student.[10] A different systemtatic review of 46 studies estimated total annual savings from SBHCs to be $15,028 to $912,878 for communities as a whole due to reductions in emergency visits and other healthcare utilization.[5] The financial impact of SBHCs was found to be particularly strong in underserved communities, given SBHCs' unique impact on health disparities, with one study estimating a net social benefit of $1.35 million over three years.[2]

[6] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2920971/pdf/1617.pdf
[7] https://www.brookings.edu/wp-content/uploads/2016/07/Price-Layout2-1.pdf
[8] https://escholarship.org/content/qt6th2r852/qt6th2r852.pdf?t=oupznn
[9] https://files.eric.ed.gov/fulltext/ED539815.pdf
[10] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6173311/pdf/nihms-989612.pdf

Figure 3. Analytic framework: School-based health centers to promote health equity.[11]



Source: Knopf et al. (2016): School-based health centers to advance health equity: A community guide systematic review.

[11] The "Key potential effect modifiers" listed serve to strengthen or weaken the pathways illustrated in the framework. For example, if there is good record sharing, then increased/earlier treatment will better lead to reduced health care misuse. However, if there is not good record sharing, then increased/earlier treatment may effectively reduce health care misuse.

Though not captured through formal research and evaluation, SBHCs also can also provide vital health and social resource navigation and care for students and their families. Depending on their service model, SBHCs may use community health workers or partner with community-based organization (CBO) partners to address upstream social determinants of health (SDOH) for students and their families, including food insecurity, housing assistance, income assistance, and other benefits programs. Additionally, SBHCs commonly assist students and their families navigate insurance enrollment options like Medicaid or publicly subsidized health insurance and can help refer and link students to pediatricians and other providers within the community for care.

In addition to enhancing the value of health care, the unique setting and services provided by SBHCs strongly align to enhance the five priority areas of Delaware's State Health Improvement Plan (SHIP) – Chronic Disease, Maternal & Child Health, Substance Use Disorders, Mental Health, and System-Wide Recommendations – by providing care that targets the health needs and SDOH impacting Delawareans during childhood and adolescents. The work of this strategic plan will uplift and strengthen these SHIP priorities.

FY20 Budget Epilogue

Given individual school districts' motivation to establish SBHCs in seven elementary schools in 2018, the Delaware legislature moved to further expand SBHCs in high-need elementary schools across the state to support efforts in building strong foundational health and well-being for the state's youngest students. It did so by including $340,000 in the FY2020 Budget Epilogue allocated to the DOE and flowing to DPH to establish new SBHCs in high need elementary schools and reimburse the seven existing, recognized, non-contracted SBHCs in high need elementary schools for costs related to their establishment.

Catalyzed by this language, DPH and stakeholders embarked on a planning effort to develop a clear strategy for establishing new SBHCs in elementary schools, while also enhancing the larger SBHC system and model to ensure alignment, promote sustainability, and maximize SBHCs benefits to the health and well-being of K-12 students in Delaware.

Vision for Delaware SBHCs

Under the stewardship of Division Director Karyl Rattay, MD, MS, FAAP and Ms. Leah Woodall, Section Chief, Family Health Systems, DPH convened a strategic planning Steering Committee to develop a plan to help execute the goal of expanding SBHCs in Delaware. This strategic plan, developed by DPH and stakeholders, serves to actualize the vision of an equitable and accessible system of care for children and youth enrolled in Delaware public and charter schools with the goal of supporting improved health and well-being outcomes for children and closing the educational opportunity gap for at risk children. The strategic plan recognizes that SBHCs are an important part of the health care and social services safety net. While the plan prioritizes high need schools in its early roll-out, the vision is to build SBHCs as part of a larger ecosystem of value-based health care – one made up of pediatricians, specialists, behavioral health providers, and other health care providers and that is responsive to the needs of all students in public and charter schools and strives for the Quadruple Aim for improved health.[12] A key component of this strategic plan and resulting activities is to engage and lift up the voices of youth and families to ensure that SBHCs remain sustainable, accessible, and impactful.

Figure 4. Quadruple Aim for improved health, 2014.

Source: Health Information, Technology, Evaluation, and Quality Center (HITEQ).

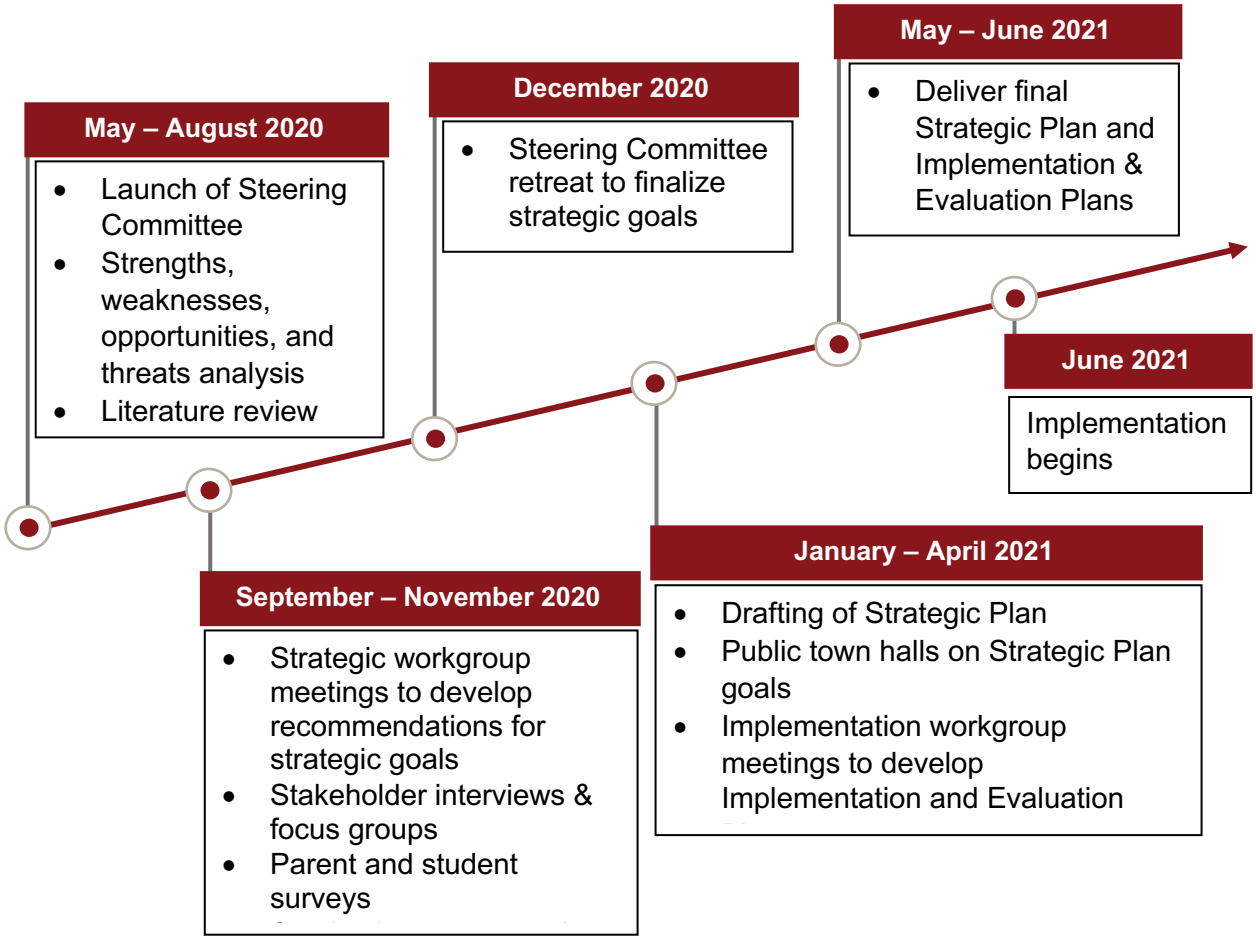
Strategic Planning Process

Process

In the spring of 2020, DPH contracted with Health Management Associates (HMA), a national health consulting firm, to facilitate multi-sectoral stakeholder engagement and assist in developing this strategic plan for SBHC improvement. The year-long strategic planning process consisted of three main components: 1.) Research and Data Collection, 2.) Strategic Planning, and 3.) Implementation and Evaluation Planning (Figure 3).

[12] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4226781/

Figure 5. Strategic planning process for school-based health centers, Delaware, 2021.



Source: Delaware Department of Health and Social Services, Division of Public Health, 2021.

Steering Committee

The entire strategic planning process (Figure 5) was overseen by a Steering Committee comprised of 21 members that were selected by DPH leadership and represented diverse stakeholder groups. This Steering Committee was headed by two co-chairs and included one ex officio member representing DPH. Full Steering Committee membership is listed in the Appendix. By charter, the Steering Committee directed and reviewed all research and stakeholder engagement activities to develop:

1. Minimum standards for the provision of high-quality services in SBHCs
2. A selection process for expansion of SBHCs in high-need elementary schools
3. Recommendations and a roadmap to advance the integration and sustainability of SBHCs as part of the continuum of care that supports the health and well-being of youth

As part of its work, the Steering Committee conducted an analysis of the strengths, weaknesses, opportunities, and threats (SWOT) of the current programming and climate for SBHCs in Delaware. The Steering Committee convened for an all-day retreat in December of 2020 to review all draft recommendations from the strategic workgroups and finalize the strategic goals of this plan.

Strategic Workgroups

Three workgroups met weekly between September and November 2020 to review research and data and develop draft recommendations of strategic goals for consideration by the Steering Committee. The strategic workgroups were titled Infrastructure, Policy & Operations; Data & Best Practices; and Finance & Sustainability (Figure 6). Membership for these groups was recommended by the Steering Committee and is shown in the Appendix. Each workgroup was charged with a specific set of topics to address through their recommendations.

Figure 6. Strategic workgroups for school-based health centers, Delaware, 2021.

Source: Delaware Department of Health and Social Services, Division of Public Health, 2021.

Implementation Workgroups

Three workgroups met between February and April 2021 to develop plans on how to operationalize the final strategic goals developed by the Steering Committee and attach process and outcome measures to activities as part of evaluation and monitoring of plan implementation. All members of strategic workgroups were invited to participate, and additional membership was recommended by members of the Steering Committee. The implementation workgroups were titled Infrastructure, Delivery, and Finance & Sustainability. Membership is shown in the Appendix. Subject matter experts were brought in on an ad hoc basis to assist in developing implementation plans for specific recommendations.

- Infrastructure – Goals 2-5
- Delivery – Goals 6-9
- Finance & Sustainability – Goals 10-13

The Steering Committee served as the entity responsible for drafting an implementation plan for Goal 1. The Implementation & Evaluation Plans for each goal are separate companion documents.

Literature Review

Prior to convening strategic workgroups, HMA conducted a literature review that synthesized over 80 sources of existing research on SBHCs and current Delaware practices and policies to identify insights about potential models, opportunities, gaps, and barriers in programs and policies. Key findings from the literature review are listed :

- Telehealth is an increasingly integral element of SBHC service delivery and supports financial sustainability.
- SBHCs are encouraged to be incorporated into patients' primary care medical home (PCMH) by linking students with community providers and providing more routine health monitoring and management.
- Adoption of electronic health records (EHRs) in SBHCs is critical to building data infrastructure and evaluation capacity.
- SBHCs should be incorporated into the school culture and coordinated with the larger school provider ecosystem.
- SBHCs have a positive impact on students' health and well-being and more proximal academic factors, like seat time.
- Suppressing Explanation of Benefits (EOBs) for SBHC services is important to offering and ensuring confidentiality of sensitive services like behavioral and reproductive health care.
- There is evidence that SBHCs show cost savings for Medicaid and the larger health care system because of their ability to provide early preventive care that is accessible to high-need, low-resource populations.
- Given barriers to third-party billing, SBHCs use diversified funding strategies, including maximizing Medicaid billing, local, state, and federal funds, grant funding, and collaborative financing strategies to ensure financial sustainability.

Key Informant Interviews and Focus Groups

The HMA team conducted 24 interviews with 51 individuals by video conference or phone, including two focus groups with pediatricians across the state. Interviewees were identified collaboratively by the Steering Committee and strategic workgroups and represented a broad range of public, private, and community stakeholders, as well as state and national experts. Interview questions were tailored to stakeholder groups and touched on SBHC practices, policies, operations, infrastructure, partnerships, data and evaluation, and finance and sustainability. Key findings for each section are listed :

- **Practices:** SBHCs have strong value for students, parents/caregivers, and school staff by providing accessible care and expanded services. SBHCs also serve to bridge students to medical and behavioral health services to ensure a continuum of care.

- **Policies:** There is a need for more streamlined and aligned policies and agreements between DPH, school districts, and medical sponsors. There was interest in SBHCs incorporating more policy that addresses health equity, alternative discipline, and trauma-informed care.

- **Operations:** The hub-and-spoke model was noted as a good option to ensure care across schools and ages and enhances operational efficiencies. SBHCs should ensure that hours of operation and engagement opportunities are aligned with student needs. SBHCs should also have strong connections with school support staff.

- **Infrastructure:** EHRs are important tools for SBHCs but need to be interoperable with school and other medical records. Since there are challenges with capital financing for SBHC construction, medical sponsors should work closely with school districts to determine effective siting and construction.

- **Partnerships:** Collaboration and two-way referrals between SBHCs and community providers is essential, but good communication channels, financial incentive models, and interoperable data systems do not exist currently.

- **Data and Evaluation:** Current measures focus on process and there are limitations on linking and synthesizing data to show outcomes. Leveraging interoperable EHRs or statewide data systems may help to overcome some barriers but requires all SBHCs to participate.

- **Finance and Sustainability:** Ninety-five percent of SBHC operating costs are on personnel. Establishing new SBHCs requires capital investment to outfit a physical space within a school setting. Even with public funding and Medicaid reimbursement, SBHCs face large spending deficits. There was interest in SBHCs serving as a component of value-based care models in tandem with other community providers, but this would require restructuring of financial models, billing, and incentives. Maintaining telehealth billing flexibilities was seen as essential for sustainability.

See here for a detailed summary of all focus group and key informant interview findings.

Parent/Caregiver and Student Surveys

HMA surveyed parents, caregivers, and students to assess their experiences with SBHCs in Delaware. One survey was for parents and caregivers; the other was for students. The surveys were available in English, Spanish, and Haitian Creole. They were disseminated by SBHC coordinators and public information officers for school districts via the DOE, including its social media channels. At the time the surveys closed, the survey for parents and caregivers received 437 responses and the survey for students received 212 responses. For reference, there are 1,268 students enrolled in elementary school SBHCs and 24,872 students enrolled in middle and high school SBHCs. Key findings from both surveys were:

- Uninsured students had a higher percentage of SBHC enrollment.
- Students covered by Medicaid and uninsured students had a higher percentage of SBHC usage.
- The most common reason why students were enrolled by their parents/caregivers in a SBHC was because of its accessibility and ease of enrollment.
- The most common reason why students were not enrolled by their parents/caregivers in a SBHC was because they received services from an outside primary care physician.
- Most students enrolled in a SBHC received services one to two times a year.
- Most students and parents/caregivers of students enrolled in a SBHC reported having very positive experiences with SBHCs.
- Most students enrolled in a SBHC reported believing their physical and mental health was better because of the services offered by SBHCs.
- The most common SBHC services used by enrolled students were mental health counseling, sport physicals, annual physicals, and contraceptives.
- Students and parents/caregivers overall felt that SBHCs were important because they allow students to receive confidential health services, are compatible with students' schedules, and provide health care to students who may not otherwise have access.
- A majority of students and parents/caregivers overall believed that SBHCs would be useful at every level of school (elementary, middle, and high school).

See here for full results of the parent/caregiver survey and student survey.

Service Inventory Matrix

To better understand the current menu of services offered at each SBHC in Delaware, HMA worked with the coordinators of all 39 SBHCs, contracted and non-contracted, to compile an inventory of services offered. This inventory was then analyzed in a matrix to show service offerings across county, medical sponsor, and school level. Distinctions were added to show services that required additional parental consent, like birth control prescriptions or vaccinations, and services offered via telehealth. The full matrix is available here.

High-Needs Scorecard

The language included in the FY20 and FY21 Budget Epilogue defines the initial criteria for "high-need" elementary schools eligible for SBHC siting, based on the DOE's definition. Through conversations with stakeholders in both the strategic workgroups and key information interviews and focus groups, an additional tool was developed to prioritize elementary schools meeting these criteria. This "scorecard" methodology is adapted from a model used in Montgomery County, Maryland to guide SBHC siting and converts a set of measures agreed upon by the Steering Committee into points based on schools' values. Schools can then be scored and ranked across four domains: Physical Health, Behavioral Health, Healthcare, and Social Need. (See the 2021 SBHC Strategic Planning webpage for this scorecard.) The measures in this scorecard provide an initial, standardized assessment of need but cannot be used as performance indicators of SBHC outcomes. Once schools are scored, additional information, including capital costs, school readiness, and community readiness and interest can be used to determine SBHC siting.

Town Halls

Once all strategic goals were confirmed and implementation plans for each goal were adequately scoped out, DPH and the Steering Committee held two public, virtual town halls on April 19 and 20, 2021 to present the goals of the plan and receive community feedback. Both town halls were held virtually over Zoom and had simultaneous live interpretation in Spanish and closed captioning in English. Steering Committee members publicized the events to stakeholder groups through social media channels, paper flyers, and email lists. Combined, the two town halls had 51 attendees. Each attendee received a follow-up survey to indicate their level of support for each goal and provide additional comments and 27 individuals responded. Survey responses are shown in the next section alongside each goal.

Strategic Goals

The following strategic goals were developed by the strategic workgroups and voted on by the Steering Committee. For each goal, the supporting evidence base from research and data collection is identified. The 2021 Strategic Plan is not an inventory of all objectives DPH and other stakeholders will pursue or all actions that they will undertake related to SBHCs. Instead, the Plan presents *priority goals* reflecting best practices and promising approaches that DPH and stakeholders hope to achieve, and the rationale for establishing these goals. The Plan is a dynamic document and will change as DPH adjusts to new circumstances while keeping its focus on meeting the needs of the children and youth SBHCs serve and ensuring effective use of taxpayer dollars. The order of the strategic goals does not signify an order of importance or priority; rather, the goals are ordered around the types of target areas (governance, policy, infrastructure, service delivery, financing, etc.).

Goal 1

Create an independent body with representation from DPH, DOE, DSCYF, DSAMH, Medicaid, private insurers, as well as School Districts, School Board, Parent Teacher Association, Community PCPs, Community Behavioral Health providers, SBHC consumers, and legislators from each county with the authority to:

- Assist in recommendations of future SBHC siting through community needs assessment
- Recommend additional service options to SBHC based on community need (including minor oral health care and screenings, vision and hearing, prescription and medication management, social service navigation, evidence-based interventions, reproductive health care)
- Decide on and annually track/update statewide measures submitted by SBHCs
- Recommend state and federal funding resources/grants to medicals sponsors and school district to cover additional services.

EVIDENCE BASE

SBHCs require oversight and investment into infrastructure and staffing. A state-level independent entity can provide oversight and recommendations that are equitable, informed by stakeholders across the state, and support the sustainability of the SBHC program.

Individual school board input on service provision can create inequitable disparities driven by political rather than public health considerations. Consistent assessment of needs would help to identify barriers and drive policy change to address them.

Other states, including Maryland, have developed governing entities to oversee SBHC operations and decision-making for the state.[13]

PURPOSE

An independent council can assist in examining the needs of students and families in high-needs areas and recommend additional services based on needs and community resources.

Town Hall Survey

65%
STRONGLY SUPPORT

27%
SOMEWHAT SUPPORT

8%
NEUTRAL

0%
SOMEWHAT DO NOT SUPPORT

0%
STRONGLY DO NOT SUPPORT

[13] https://health.maryland.gov/mchrc/Pages/Maryland-Council-on-Advancement-of-School%E2%80%93Based-Health-Centers.aspx

Goal 2	Strongly encourage new SBHC sites for school districts to be in highest need schools and consider a base-service hub model. If a school district decides to expand SBHCs beyond this original site, additional sites must be state recognized by DPH and are encouraged to follow a hub-and-spoke model where feasible.

EVIDENCE BASE

The staffing model for a SBHC depends largely on the types of services offered and the operational model, but may include:

- One nurse practitioner (NP) or physician's assistant (PA) per 700-1,500 students with a supervising physician accessible to the NP or PA
- One full-time licensed behavioral health provider per 700-1,500 students
- A medical or health assistant on site who schedules appointments, conducts data entry, and assists the NP and PA in patient care
- One full time dental hygienist per approximately 2,500 enrollees
- Expanded centers may also have a health educator, a community outreach worker, registered nurses, and/or a nutritionist[14]

Colonial School District instituted a hub-and-spoke model for its elementary school SBHCs where services and staff are available at one centralized school (hub) and rotate on regular basis to other elementary schools within the district (spokes). This is different than the standard model, where staff and services only serve one school, and has shown to improve SBHC financial sustainability and increases access to services for student across the district.

PURPOSE

Highest need schools in school districts must allow for a greater range of services and consistent staffing and operations to support their students. However, school districts may choose to expand SBHC services beyond that individual hub to have rotating service availability at other schools in the district, which operate as stand-alone spoke sites. The hub-and-spoke model brings greater capacity to serve students and allows for all students to receive enhanced services at the hub. All sites–hubs and spokes–must still be certified by DPH.

Staffing should be determined through student ratio. The ratio should be based on the number of students enrolled in the school rather than SBHC so as not to limit staffing based on enrollment numbers. Staff may rotate between spoke sites. Specialty staff (dental, hearing, vision) may be available on a quarterly basis.

Town Hall Survey

54%
STRONGLY SUPPORT

34%
SOMEWHAT SUPPORT

8%
NEUTRAL

4%
SOMEWHAT DO NOT SUPPORT

0%
STRONGLY DO NOT SUPPORT

[14] https://nyshealthfoundation.org/wp-content/uploads/2017/12/school-based-health-centers.pdf

Goal 3

Allow siblings who are enrolled in the same school district and who do not have a SBHC in their school to enroll in a sibling student's SBHC, as long as it is serving like-aged students and is cost-recovery authorized.

EVIDENCE BASE

Offering the option of SBHC services to siblings who are enrolled in the same school district but do not have an SBHC at their school is a common approach to increasing access to SBHCs. Given resource constraints on the number of SBHCs that can be established, it is a viable approach to maximizing the benefits of SBHCs.

PURPOSE

Allowing siblings to access services at SBHCs enhances equitable access of services and allows for students to receive needed services. SBHCs are not equipped to serve as medical homes for patients given their staffing and operations, or to serve parents, and therefore should assist in linking patients to PCPs. However, it is feasible for them to serve siblings, and they should do so when this helps address health care access barriers for families.

Town Hall Survey

69%
STRONGLY SUPPORT

19%
SOMEWHAT SUPPORT

8%
NEUTRAL

4%
SOMEWHAT DO NOT SUPPORT

0%
STRONGLY DO NOT SUPPORT

Goal 4

Encourage SBHCs to use the following model as a suggested guide for new SBHC set up and existing SBHC renovation

Hub: converted classroom, minimum 900 square ft. (Infrastructure)

- 2 exam rooms (with ability for mobile dental unit) – 100 square ft. each
- Waiting/reception area – 200 square ft.
- Bathroom – 100 square ft.
- Counseling room – 150 square ft.
- Prep area/wet space – 100 square ft.
- Medical office – 100 square ft.
- Storage (records, medication, immunizations, may require refrigeration) – 50 square ft.
- Secure external and internal entrances

Spoke: Designated space for SBHC, minimum 400 square ft

- Exam room – 100 square ft.
- Storage area (records, medication, immunizations, may require refrigeration) – 50 square ft.
- Waiting area – 200 square ft.
- Bathroom (if possible, could share with Nurse's office, etc.) – 100 square ft.

SBHCs are recommended to be Joint Commission compliant.

EVIDENCE BASE

There is general consensus on the space and equipment needs of SBHCs based on other models:

- Two exam rooms
- Counseling room(s)
- Reception area
- Professional office space
- Storage area and locked space for medical records and pharmaceuticals
- Bathroom(s)
- Infirmary area
- Clean and dirty prep areas
- Hand washing sinks
- Laboratory area
- Two entrances (inside the school and an external one).[15,16]

School districts are responsible for providing SBHCs with adequate physical space and office supplies and the medical sponsor is responsible for suppling medical equipment needed.

PURPOSE

Hubs should be more expansive in their space requirements so that they can account for the additional services offered. Spokes do not need the space of a converted classroom but must ensure that no other entity uses the space.

Town Hall Survey

58%
STRONGLY SUPPORT

31%
SOMEWHAT SUPPORT

0%
NEUTRAL

11%
SOMEWHAT DO NOT SUPPORT

0%
STRONGLY DO NOT SUPPORT

[15] https://nyshealthfoundation.org/wp-content/uploads/2017/12/school-based-health-centers.pdf
[16] https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2016.1234

Goal 5

Develop data collection and analysis infrastructure that meets the needs of SBHCs and stakeholders by:

- Standardizing data collection and reporting across SBHCs
- Including information technology departments as part of this process
- Encouraging adoption of electronic health records (EHRs)
- Developing the ability for DPH, and possibly SBHCs themselves, to generate annual reports showing a dashboard of metrics, including but not limited to:
  - Utilization and performance measures, payer mix, financials
  - Qualitative input from users of SBHCs that convey the value of SBHC services to the legislature and other stakeholders, and to support grant-seeking by SBHCs.

Ensure that data collection and reporting tools are able to capture and track data recommended by the governing body as outlined in Goal 1.

EVIDENCE BASE

Currently, DHSS and DMMA require certain sets of outcome measures to be tracked related to the individual annual goals of SBHCs. Each provider has flexibility to develop quality assurance activities to meet their needs. There are challenges in evaluating and comparing individual SBHCs due to differences in patient populations and operations. Evidence suggests that evaluations should be statewide to increase the data pool and examine population-level trends, allowing for adjustment in differences in service delivery models and patient populations.[17] Data should be stratified by race and ethnicity wherever possible. Evaluations should follow a specific, pre-defined theory of change that emphasizes proximal outcomes.

The most prevalent infrastructure issue SBHCs face is ensuring interoperability and maximizing functionality for EHRs. While there are privacy and confidentiality laws that govern data sharing across agencies and platforms, SBHCs need to select and develop EHRs in tandem with the agencies with which they partner, including school districts, medical sponsors/hospital systems, and local departments of public health. Equally as important in the EHR development process is for SBHCs to understand the documentation and reporting needs of MCOs and third-party insurance to ensure proper billing and quality reporting according to the metrics required. To maximize efficiency, it may be advantageous for SBHCs to explore integrating EHRs with practice management (PM) systems. SBHCs and school districts can partner with web and application development businesses to help construct these.

PURPOSE

Data collection and analysis infrastructure is necessary to enable DPH, SBHCs, and other stakeholders to understand the services needed and provided by SBHCs, and their value, in a standardized and actionable way. The recommended measures should reflect the input of the workgroup as well as stakeholders and are intended to reflect a combination of utilization and outcomes measures that will be meaningful and actionable to a broad range of stakeholders. They should also be aligned with national SBHC association best practices and other state efforts to enhance their SBHC performance measurement efforts.

Town Hall Survey

81%
STRONGLY SUPPORT

12%
SOMEWHAT SUPPORT

7%
NEUTRAL

0%
SOMEWHAT DO NOT SUPPORT

0%
STRONGLY DO NOT SUPPORT

Goal 6

Establish a base service menu model that includes:

- Sports physicals (only for those who need it with linkages to PCPs for physicals)
- Minor acute care
- Immunizations (only for those who need it with linkages to PCPs for immunizations)
- Reproductive health for middle and high school (STI & HIV testing, contraceptives, pregnancy testing, birth control pills)
- Behavioral health (counseling, substance use screening for middle and high school)
- Nutrition counseling
- Health education
- Insurance navigation

Identify grants and resources from federal and other state agencies to support this base service menu, if necessary.

EVIDENCE BASE

A number of operating models for SBHCs exist and have evolved over time to include a multidisciplinary team that offers a combination of primary/preventive care, reproductive and sexual health care, behavioral health services, nutrition services, and oral health care. Several SBHCs also provide social resource navigation and care, either through community health workers (CHWs) or community-based organization (CBO) partners to address upstream social determinants of health for students and their families, including food insecurity, housing assistance, income assistance, and other benefits programs. Across all models, SBHCs are seen as vital providers of population-level public health initiatives and health education.

PURPOSE

Certain services must be guaranteed to students at SBHCs to ensure equity and accessibility of health care. Parents' may continue to be able to opt out of students receiving specific services, except where Delaware Code permits minor consent to services.

Town Hall Survey

81%
STRONGLY SUPPORT

15%
SOMEWHAT SUPPORT

4%
NEUTRAL

0%
SOMEWHAT DO NOT SUPPORT

0%
STRONGLY DO NOT SUPPORT

[17] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4693147/

Goal 7

Ensure approaches to care are aligned and comprehensive across all SBHCs, especially for behavioral health care and trauma-informed care, including trauma-informed treatment, utilize school and state resources/tools, and are consistent with Culturally and Linguistically Appropriate Service (CLAS) standards.

EVIDENCE BASE

While more evidence may be needed to understand the full effect of behavioral health care on students, data support an association between increased behavioral health services offered by SBHCs and positive educational, social, and emotional health outcomes.[18] However, there are significant needs associated with providing behavioral health services in SBHCs, including ensuring adequate operational accessibility, using standardized, evidence-based screening tools, and streamlining referral networks with community-based behavioral health providers.

SBHCs are an important site for providing trauma-informed care (TIC) given the patient population they serve and their potential to integrate with other social and education services for children. One way to ensure TIC for students is to develop a TIC SBHC team or comprehensive TIC plan for SBHCs that assesses students' exposure to trauma and creates policies and practices for treatment by various institutions. In identifying the need for TIC practices, especially given the hardships resulting from COVID-19 and racial injustice, it is important that SBHCs assess both students and families/caregivers. To enhance this effort, SBHC staff should explore various modalities of care for families and students that reflect and respond to unique traumas in today's climate, including virtual group discussions on racial injustice, integrated talk therapy and physical exercises, and virtual family therapy sessions. Additionally, SBHCs should invest in creating a network of services and communications across school staff, community-based behavioral health providers, and CBOs providing services. Finally, SBHCs should make an effort to staff centers with individuals who represent and are aware of the communities that they serve. SBHCs should train providers on specific gender, racial, and other identity-based differences.

PURPOSE

More standard approaches to care must be developed to ensure that all SBHCs are utilizing best practices for screening, assessing, and referring youth for behavioral health disorders, and to align and enhance collaboration among SBHC and community providers in the provision of trauma-informed services.

Town Hall Survey

92%
STRONGLY SUPPORT

8%
SOMEWHAT SUPPORT

0%
NEUTRAL

0%
SOMEWHAT DO NOT SUPPORT

0%
STRONGLY DO NOT SUPPORT

[18] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5759331/pdf/nihms931248.pdf

Goal 8	Ensure SBHCs serve as a part of a seamless continuum of care to meet the needs of students by collaborating with PCPs and other community providers where there is a medical home or connect a child to an available medical home where appropriate. SBHCs will only serve as a student's primary medical home if all other options are exhausted.

EVIDENCE BASE

SBHCs should engage with community pediatricians and behavioral health specialists early and consistently to develop strong referral/communication systems and policies around student health. SBHCs can provide linkages for students to community pediatricians during enrollment and insurance eligibly screening. Community pediatricians can outsource routine health monitoring management (nutritional management, medication management, comorbidity management) and health prevention/education to SBHC providers. However, effective and equitable compensation should be coordinated between local health care providers and SBHCs.

Several states have explored establishing SBHCs as primary care medical homes (PCMH) for their students, particularly for the uninsured, but most efforts have been unsuccessful because SBHCs are unable to function under standard PCMH requirements given that their patient population is tied to school/district enrollment. Instead, many states have encouraged SBHCs to be incorporated into patients' primary care medical homes through patient choice. Under this model, SBHCs are incentivized to work with community pediatricians to connect students to primary care doctors. SBHCs are then able to provide these students with more non-specialty care that primary care offices are not able to provide, such as routine sexual/reproductive health care, behavioral health care, nutrition services, screenings and tests, and daily monitoring for specific health needs. When developing an operating model for SBHCs, it is important that community pediatricians/hospital systems, parents/students, and school district staff are involved to determine effective models and referral systems.

PURPOSE

SBHCs are not equipped to serve as medical homes for patients given their staffing and operations, and therefore should assist in linking patients to PCPs. However, some patients may not be able to be linked to a medical home.

Town Hall Survey

77%
STRONGLY SUPPORT

15%
SOMEWHAT SUPPORT

0%
NEUTRAL

4%
SOMEWHAT
DO NOT SUPPORT

4%
STRONGLY
DO NOT SUPPORT

Goal 9	Ensure that existing telehealth service delivery and billing flexibilities continue and that SBHCs are brought-up to speed in telehealth service delivery and new/emerging technologies, especially of behavioral health care, through encouraging adoption of EHR.

EVIDENCE BASE

Telehealth is an increasingly integral element of SBHC service delivery and has been shown to increase positive physical and behavioral health outcomes and reduce disparities. There are varying services that can be offered via telehealth, including physician or behavioral health provider consultations, well visits, screenings and stabilization services, and behavioral health counseling. SBHCs should designate an in-person staff member or group of staff members responsible for facilitating virtual interaction with a patient. In previous interventions, medical sponsors have provided equipment and technology needs, while schools have stored equipment and provided a fixed, physical site for telehealth services. SBHCs and the medical sponsor must also understand and follow state Medicaid guidance on telehealth service delivery to understand state regulations and billing practices.

PURPOSE

Expansion of telehealth is a valuable tool to increase access to SBHC services and equity (though equity challenges exist in telehealth provision). Flexibilities developed during COVID-19 have ongoing value and should be extended.

Town Hall Survey

88%
STRONGLY SUPPORT

12%
SOMEWHAT SUPPORT

0%
NEUTRAL

0%
SOMEWHAT DO NOT SUPPORT

0%
STRONGLY DO NOT SUPPORT

Goal 10

Increase access to discretionary funding to cover the cost of non-billable services and children who are uninsured at the time of services, at an adequate annual amount.

EVIDENCE BASE

The main expenses for SBHCs are start-up and operating costs, which vary based on the operating model and types of services provided, personnel, and existing infrastructure in schools. A strong factor in determining SBHC sustainability is diversified funding sources (public grants, private donations, and billing capacity for commercial insurers and Medicaid). State funding and grants are the most common funding source for SBHCs, particularly in Delaware. Public funding is an important base to cover services provided to uninsured students, as well as those not able to be billed to Medicaid or private insurance. However, state funding may not be the most sustainable funding source for SBHCs. Both in Delaware and in other states, efforts have been made to enhance sustainability by finding a more consistent tax base for funding, as well as examining ways to streamline and link services offered across state agencies.

PURPOSE

In Delaware, state funding covers only about 45 to 55% of SBHC annual operating costs and billing reimbursement is not reliable, though Medicaid funding is more reliable. In total, SBHCs have over $1 million in uncompensated services because of commercial insurers' Explanation of Benefits (EOB) policies, uninsured patients, commercial insurance plan plans that don't cover services, and students covered by other states' Medicaid programs. SBHCs are an integral safety-net service provider for the uninsured population, but this can lead to challenges for financial sustainability. Discretionary funding would help to address these gaps and support sustainability of the SBHC program.

Town Hall Survey

81%
STRONGLY SUPPORT

8%
SOMEWHAT SUPPORT

11%
NEUTRAL

0%
SOMEWHAT DO NOT SUPPORT

0%
STRONGLY DO NOT SUPPORT

Goal 11

Increase efficiencies in credentialing and contracting with payers so that SBHCs can be credentialed as a practice rather than as individual providers.

EVIDENCE BASE

SBHCs serve a disproportionately high number of Medicaid beneficiaries, making billing Medicaid a valuable investment for SBHCs. SBHCs have also been proven to enhance quality of care and contribute substantial cost savings to Medicaid programs. Delaware Medicaid has specific policies on service reimbursement and required data metrics for reporting. Research has pointed to financial advantages by incorporating SBHCs into MCO contracts, which more tightly manage and distribute value-based payments.[19] While research is ongoing, initial data have shown that by incorporating SBHCs into MCO contracts, plans are better able to coordinate and account for services provided and cost savings, and SBHCs are able to cover more preventive health education interventions and initiatives. Among SBHCs participating in MCO contracts, several potential regulatory or legislative barriers have been identified in addition to a potential solution being flexibility within state and federal legislation.

SBHCs services are associated with greater Medicaid savings. A 2010 study in Ohio estimated the net Medicaid savings of SBHCs to be $1,352,087 over three years.[20] An additional 2016 systematic review of 22 studies across various states found that SBHCs could save Medicaid about $35 per student per visit.[21]

In Maryland, SBHCs can receive reimbursement from MCOs for designated services without contract or prior authorization.[22] In Michigan, SBHCs use a streamlined, centralized billing system for all billing claims, which enables them to receive payment fluidly from managed care plans.[18]

PURPOSE

To support SBHC sustainability, identify process and bottlenecking issues and potential modifications to make credentialing and contracting processes timelier and more efficient.

Town Hall Survey

61%
STRONGLY SUPPORT

15%
SOMEWHAT SUPPORT

15%
NEUTRAL

4%
SOMEWHAT DO NOT SUPPORT

0%
STRONGLY DO NOT SUPPORT

[19] https://jamanetwork.com/journals/jamapediatrics/fullarticle/189092
[20] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2920971/pdf/1617.pdf
[21] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6173311/pdf/nihms-989612.pdf
[22] https://nyshealthfoundation.org/wp-content/uploads/2017/12/school-based-health-centers.pdf

Goal 12 Explore creative solutions with commercial payers that adequately compensate SBHCs for services provided and protect student privacy.

EVIDENCE BASE

Pursuant to 18 Del. Laws c. §3365, SBHCs are prohibited from collecting any cost-sharing fees or co-payments from students. Therefore, SBHCs absorb these into their own costs. As a result, the amount of compensation SBHCs receive from commercial billing is only about 8% of the cost of care for students covered by commercial insurance. Some commercial payers and Medicaid currently use an all-inclusive rate that can be billed by SBHC providers for any services received at SBHCs. This increases reimbursement and helps to offset costs absorbed by SBHCs. Another option that has been discussed may be for commercial payers to reduce or waive cost-sharing requirements for services received at SBHCs so that SBHCs do not absorb these high costs.

Given that most students covered by commercial insurance are dependents on parent/caregiver insurance, services that students receive at SBHCs will be listed on an EOB sent to the parent/caregiver. To protect student privacy and confidentially, SBHCs do not currently bill for certain sensitive services students may receive at SBHCs (reproductive, sexual, and behavioral health care) so EOBs detailing these services are not sent home to parents/caregivers. While this protects student privacy, it greatly impacts SBHCs financial sustainability by not being able to be reimbursed for these services. Several strategies, both legislative and regulatory, have been piloted by other states, like extending EOB suppression to services at SBHCs and establishing a public-private fund paid by commercial payers to annual reimburse SBHCs for uncompensated care costs.[23,24,25]

PURPOSE

Commercial payers and stakeholders have engaged in conversations around creative options. Given that the majority of students seen by SBHCs are covered by private insurance, adequate reimbursement of services from commercial payers is vital to ensure SBHC sustainability. Through exploring different options, like EOB suppression, all-inclusive rates with shadow billing, reducing cost-sharing, and setting up funds for annual reimbursement, commercial payers and SBHCs have multiple avenues through which sustainability is possible.

Town Hall Survey

73%
STRONGLY SUPPORT

12%
SOMEWHAT SUPPORT

15%
NEUTRAL

0%
SOMEWHAT DO NOT SUPPORT

0%
STRONGLY DO NOT SUPPORT

[23] https://nahic.ucsf.edu/wp-content/uploads/2014/06/639265-0-000-00-020-EOB-Policy-Brief_FINAL.pdf
[24] https://www.guttmacher.org/sites/default/files/report_pdf/confidentiality-review.pdf
[25] https://www.sbh4all.org/school-health-care/school-based-health-care-financing/

Goal 13

Maximize commercial billing and certified coders in SBHCs.

EVIDENCE BASE

The following best practices emerged in Colorado as keys to successful billing:

- Having a medical sponsor understanding of the SBHC model and knowledgeable about insurance billing and government regulations
- Maximizing enrollment and billing through Medicaid
- Becoming credentialed to bill private insurance, taking into account the needs of patient populations
- Closely monitoring coding and reimbursement through an EHR; educating community and providers about the importance of billing
- Connecting students to insurance options that accommodate SBHC reimbursement.

PURPOSE

A variety of barriers to billing commercial insurance for services in SBHCs should be addressed, including:

- Some types of services conducted in SBHCs are not traditionally billable to payers (consultation with teachers, classroom health education, school-wide health fairs).
- SBHC services may not be considered preventive or wellness services, and so private insurers can deduct to co-pays, co-insurance, and deductibles from reimbursement. SBHCs are prohibited from collecting these payments from clients.
- Disruption in billing for behavioral health services, which is needed for assuring continuum of care.
- Commercial insurers do not negotiate rates with SBHCs if they are already recognized by the medical sponsor and pay 80 to 90% less than Delaware Medicaid regulated rates.
- Many insurance companies do not pay more than two services per day per client.
- Self-funded plans are exempt from SBHCs code compliance.
- Many insurers do not allow SBHCs to bill for oral health services.

As the state moves to a larger vision of value-based payment for health care, SBHCs should be incorporated as integral providers in this system and adjust reimbursement practices accordingly. In the meantime, addressing these barriers through strong billing of commercial insurers will enhance financial sustainability of SBHCs.

Town Hall Survey

84%
STRONGLY SUPPORT

4%
SOMEWHAT SUPPORT

8%
NEUTRAL

4%
SOMEWHAT DO NOT SUPPORT

0%
STRONGLY DO NOT SUPPORT

Financial Analysis

Capital Budget

Currently, capital funding for SBHCs is requested by individual school districts and allocated by the legislature on an annual basis. Funding is determined by several factors, including necessary repairs and the age and condition of the facility. Capital funds are used to cover expenses like replacing or renovating a building system or element such as heating, ventilation, cooling, energy efficiency upgrades, and asbestos control.

Table 3 represents the capital budget for the most recent construction of a hub SBHC for five elementary schools in the Colonial School District during Fiscal Year 2017.

Table 3. Cost of capital project in the Colonial School District, Fiscal Year 2017.

Colonial School District Capital Projects, FY 2017	
Project/Service	**Amount Paid**
Architect/Engineer	$32,000.00
	$13,800.00
	$3,211.89
Asbestos Consultant	$252.62
Abatement Contractor	$3,186.90
General Contractor	$365,892.50
Other	$3,969.87
Door Camera and Buzzer	$1,242.50
Project Total	**$423,556.28**

Source: Colonial School District, 2018.

Using the current state funding formula for high school SBHCs, which allocates $5,000 one-time funding for SBHC start-up costs, the potential gap in capital funds for one SBHC is approximately $250,000. That gap depends on whether the $340,000 allocation from the FY20 Budget Epilogue for establishing two new elementary school SBHCs each year can be used for capital costs and will be allocated annually. This estimate uses the costs shown in Table 3 for establishing one of the most recent hub model SBHCs in an elementary school. The hub-and-spoke model requires more significant initial capital investment to construct the first SBHC (a hub) in a district. However, once each of the current school districts with high-need elementary schools has established a hub, capital expenses for future SBHC expansion in the districts will be greatly reduced due to lower construction costs of spoke SBHCs.

Careful planning of financing options at the state and local level is needed to support capital expense costs for the new SBHCs following the suggested model outlined in Goal 4. These options may include:

1. Requesting inclusion of funding for SBHC capital projects in the Governor's Recommended Budget Capital

2. Adding SBHC capital to DOE's priority list for assessing Certificate of Need requests for inclusion in the bond bill

3. Requesting that the Office of Management and Budget (OMB) create a mechanism by which unspent operating funds appropriated to DPH/DHSS and DOE can be re-programmed into capital funding in the bond bill and allocated to local educational agencies for SBHCs

4. Individual districts choosing to utilize minor capital improvement funds for SBHC projects

5. Using alternative funding mechanisms, such as Sustainable Energy Utility (SEU) Revolving Loan Fund, CARES Act funding, and other funding mechanisms to fund projects that tie in SBHC capital projects.

Operational Budget

To conduct its financial analysis, HMA gathered financial information from 21 of the 32 high school SBHCs and the seven elementary school SBHCs on their operational costs and revenue sources. Under the current state base funding formula, all DPH contracted SBHCs should receive $170,000 annual operational state funding through DPH, plus an additional $100 for every student in the entire student body after 1,000 students. However, given significant state budget cuts over the last 10 years, DPH has not been able to fund all SBHCs at this base amount and only covers about 49% of their total operational expenses.

Even with revenue from other grants, Medicaid reimbursement, and private insurance reimbursement, the average Delaware high school SBHC faces approximately $22,000 in annual net loss. Not including state funding, the average net loss for high school SBHCs jumps to $173,000 per fiscal year. These net losses are taken on by the medical sponsors. For the majority of medical sponsors who operate multiple SBHC sites, this net loss can grow exponentially due to increased service populations and decreased reimbursement. All high school SBHCs function as standard models.

Among the seven elementary school SBHCs operating in Delaware, five function a hub-and-spoke model and two function as a standard model. Operational costs differ between standard model and hub-and-spoke model SBHCs and were estimated given the financial information supplied by the medical sponsors for each elementary school SBHC. While the FY20 Budget Epilogue allows DPH to use state funds to reimburse school districts for expenses incurred when these elementary SBHCs were established, these SBHCs did not receive state operational funds for the early years of operation. The average elementary school SBHC in Delaware functioning as a standard model faces $313,500 in net loss and the average elementary school SBHC in Delaware functioning as a hub-and-spoke model faces $112,000 in net loss, with the hub site bearing a disproportionate share of the loss. These calculations are shown in Table 4.

Table 4. Operational cost comparisons by type of school-based health center, Delaware, 2021.

		Average High School SBHC	Average Elementary School SBHC (Standard Model)	Average Elementary School SBHC (Hub-and-Spoke Model)
REVENUE	Combined Medicaid Revenue	$94,368.58	$57,293.78	$57,293.78
	Combined Private Insurance Revenue	$26,266.58	$2,429.99	$2,429.99
	Self-Pay	$ -	$ -	$ -
	Other Revenue Sources (including state base funding)	$150,892.00	$ -	$ -
	Write Off Adjustments	$ -[26]	$(23,745.14)	$(23,745.14)
	TOTAL REVENUE	$271,527.16	$35,978.63	$35,978.63
EXPENSES	Total Operating Cost	$293,646.49	$349,642.00	$148,009.80
NET LOSS		$(22,119.33)	$(313,663.37)	$(112,031.17)
NET LOSS (without State funding)		$(173,011.33)	$(313,663.37)	$(112,031.17)

Source: Delaware Department of Health and Social Services, Division of Public Health, 2021.

However, most of the six SBHC medical sponsors operating multiple SBHCs across the state and calculate their losses as a whole. The two examples below illustrate this loss and demonstrate the relative financial savings of the hub and spoke model for elementary school SBHCs based on the average costs from the table above.

[26] No write off adjustments were supplied by high school SBHC medical sponsors, but likely occur.

EXAMPLE A

Provider A operates six high school SBHCs and five elementary school SBHCs using a **standard model**. The estimated revenue and costs for Provider A are shown in Table 5.

Table 5. Provider A example operational costs, Delaware, 2021.

		8 High School SBHCs	5 Elementary School SBHCs	Provider A TOTAL
REVENUE	Combined Medicaid Revenue	$471,842.91	$286,468.91	$758,311.83
	Combined Private Insurance Revenue	$131,332.89	$12,149.94	$143,482.84
	Self-Pay	$ -	$ -	$ -
	Other Revenue Sources (including state base funding)	$754,460.00	$ -	$754,460.00
	Write Off Adjustments	$ -	$(118,725.71)	$(118,725.71)
	TOTAL REVENUE	$1,357,635.81	$179,893.14	$1,537,528.95
EXPENSES	Total Operating Cost	$1,468,232.45	$1,748,210.00	$3,216,442.45
NET LOSS		$(110,596.65)	$(1,568,316.86)	$(1,678,913.50)
NET LOSS (without State funding)		$(865,056.65)	$(1,568,316.86)	$(2,433,373.50)

Source: Delaware Department of Health and Social Services, Division of Public Health, 2021.

EXAMPLE B

Provider B operates six high school SBHCs and five elementary school SBHCs using a **hub-and-spoke model**. The hub site includes a nurse practitioner and behavioral health provider at 1.0 FTE. The four spoke sites share two nurse practitioners and behavior health providers. An administrator at 1.0 FTE and overseeing physician at 0.2 FTEs support all five elementary school SBHCs. The estimated revenue and costs for Provider B are shown in Table 6.

Table 6. Provider B example operational costs, Delaware, 2021.

		8 High School SBHCs	5 Elementary School SBHCs	Provider A TOTAL
REVENUE	Combined Medicaid Revenue	$471,842.91	$286,468.91	$758,311.83
	Combined Private Insurance Revenue	$131,332.89	$12,149.94	$143,482.84
	Self-Pay	$ -	$ -	$ -
	Other Revenue Sources (including state base funding)	$754,460.00	$ -	$754,460.00
	Write Off Adjustments	$ -	$(118,725.71)	$(118,725.71)
	TOTAL REVENUE	$1,357,635.81	$179,893.14	$1,537,528.95
EXPENSES	Total Operating Cost	$1,468,232.45	$740,049.00	$2,208,281.45
NET LOSS		$(110,596.65)	$(560,155.86)	$(670,752.50)
NET LOSS (without State funding)		$(865,056.65)	$(560,155.86)	$(1,425,212.50)

Source: Delaware Department of Health and Social Services, Division of Public Health, 2021.

With or without state funding, Providers A and B face large annual net losses in operations. However, given personnel-related cost savings using a hub and spoke model, Provider B's net loss is approximately one-third of Provider A with state funding and just over one half without state funding.

Limitations

There are several limitations to this analysis, given incomplete financial information and variables, that must be incorporated into the financial assessment of SBHC operational costs. First, revenue from Medicaid and commercial billing fluctuates from year to year. Second, the payer mix of the students enrolled in and receiving services from SBHCs strongly impacts revenue obtained from billing. SBHCs in schools with a greater number of uninsured students or students covered by commercial insurance receive lower reimbursement relative to service costs, whereas SBHCs in schools with a greater number of students covered by Medicaid receive greater reimbursement relative to service costs, though still not enough to cover the full costs of services. Third, because no payer covers 100% of the costs of services, greater numbers of students receiving services at SBHCs increases the net loss for medical sponsors. Fourth, SBHCs across the state rely on generous in-kind services and operational materials -- including services not billed to protect student confidentiality and privacy -- which were not provided by medical sponsors or shown in the analysis above. These in-kind services increase net loss. Fifth, information on other operational costs, such as lab services, vaccines, and prescriptions, were not consistently supplied by the medical sponsors. This further increases operational expenses and results in an underestimate in net loss in the calculations above.

Sustainability

To encourage SBHCs in Delaware to rely on diverse funding streams, the Steering Committee was deliberate in its development of 13 strategic goals for SBHC enhancement and expansion. Having diverse funding streams allows medical sponsors to be innovative and flexible with their SBHC models, while ensuring consistent funding. Sustainability is critical to the effective operation of the proposed model. This will require:

- Fidelity in implementation of the model outlined in this strategic plan
- Identified pathways for constructing SBHCs using a hub and spoke model in high-need schools, if feasible and appropriate
- Support for district-level allocation of operational funding to medical sponsors
- Allocation of operational funding for elementary school SBHCs for start-up and subsequent years
- Promotion and advocacy to ensure SBHCs can increase revenue generated from Medicaid and commercial billing
- Application for other external funding opportunities, including other federal, state, local, and private grants.

Given the school and district-level variables described above that impact operational costs for SBHCs, a flat funding amount for state General Funds is not adequate to support SBHC operations. Instead, state funding formulas for SBHC financing must take into account not only the potential service population, but also the SBHC operational model, payer mix of students, and relative student service needs.

Next Steps

Implementation and Evaluation

Following the finalization of the strategic goals in this plan, the implementation workgroups met to develop clear, detailed plans for how to operationalize each goal and evaluate progress of plan implementation. The implementation plan specifies the following components for each goal:

- Objectives and implementation activities
- Key implementers
- Timeline
- Activity milestones
- Process measures
- Outcomes measures
- Foreseen challenges
- Resources needed

Additionally, the Steering Committee helped draft a model evaluation plan for SBHCs that includes several key process and outcome indicators by which the effectiveness of SBHCs can be measured. This evaluation plan also explains potential considerations and limitations to evaluating SBHCs in the state.

See the 2021 SBHC Strategic Planning webpage for the Implementation Plan and the Evaluation Plan.

Plan Governance and Accountability

This five-year strategic plan requires multi-sectoral engagement and ownership to ensure goals are implemented with fidelity. Through this process, the Steering Committee strategized around the development of a statewide, public-private governance entity to oversee plan implementation and hold plan implementers accountable. As described in Goal 1, this governing entity will start by assessing plan implementation and then continue to annually assess SBHC progress and chart future priorities and direction for SBHC enhancement. The entity will sponsor local county-driven collective impact efforts to ensure community-level participation and feedback. The core responsibilities of this entity will be specified in a charter and will include:

- Training and technical assistance
- Review of core services
- Education and prevention awareness
- Data surveillance and evaluation
- Annual recommendations on SBHC siting
- Review of SBHC policy
- Advocacy on best practices
- Recommendations for SBHC financing

The entity should be authorized by legislation and have staffing support contingent on funding allocation. The Steering Committee reviewed potential models, resources, and infrastructure needed to support this governance entity, which will be further developed. In the interim, DPH

is working with Steering Committee members and the Delaware chapter of the School-Based Health Alliance to kickstart initial implementation of early plan activities.

Through this immediate and sustained effort, Delaware will align, strengthen, and enhance the work of SBHCs across the state to achieve measurable and meaningful improvement in the health of its students.

APPENDIX

Steering Committee Roster

NAME	TITLE	ORGANIZATION
Jon Cooper, *Co-Chair*	Director of Student Services	Colonial School District
Aileen Fink, *Co-Chair*	Director of the Division of Prevention and Behavioral Health Services	Delaware Department of Services for Children, Youth, and Their Families
Marihelen (Midge) Barrett	Executive Director of Delaware Chapter	School-Based Health Alliance
Elizabeth Brown	Medical Director	Delaware Department of Health and Social Services, Division of Medicaid and Medical Assistance
Amy Burnett	Center Coordinator for Smyrna High School SBHC	Bayhealth
Catherine O'Neill	LCSW for Indian River High School SBHC	Beebe Healthcare
Kathy Cannatelli	Former Manager of SBHC and Juvenile Detention Center Nursing Services	ChristianaCare
Christina Crooks Bryan	Director of Communications and Policy	Delaware Healthcare Association
Kristin Dwyer	Director of Legislative and Political Organizing	Delaware State Education Association
Susan Haberstroh	Director of School Support Services	Delaware Department of Education

D. Patches Hill	Director & CIO	Delaware Department of Education
Rochelle (Shelly) Lazorchak	Prevention Unit Manager for the Division of Prevention and Behavioral Health Services	Delaware Department of Services for Children, Youth, and Their Families
Harry Lehman, III	Pediatrics Specialist	Nanticoke Memorial Hospital
John Marinucci	Executive Director	Delaware School Boards Association
Priscilla Mpasi	Pediatrics Specialist	Children's Hospital of Philadelphia
Rosa Rivera	Chief Operations Officer	La Red Health Center
Kimberly Robinson	Director of State Regulatory & Government Affairs	Cigna
Fran Russo-Avena	School Nurse/RN	Delaware Technical Community College
Yvette Santiago	Director of Operations for Delaware Valley Government Relations	Nemours/Alfred I. duPont Hospital for Children
Christine Visher	Director of the Center for Drug and Alcohol Studies	University of Delaware
Forrest Watson, III	Founder & CEO/Executive Director	Life Health Center
Leah Woodall, *Ex-Officio Member*	Section Chief of Family Health Systems	Delaware Department of Health and Social Services, Division of Public Health

Strategic Workgroup Rosters

Infrastructure, Policy, & Operations	Data & Best Practices	Finance & Sustainability
Fran Russo-Avena, *Executive Sponsor*	Kathy Cannatelli, *Executive Sponsor*	Jon Cooper, *Executive Sponsor*
Forrest Watson, III, *Executive Sponsor*	Kristin Dwyer, *Executive Sponsor*	Yvette Santiago, *Executive Sponsor*
Jandy Albury	Dana Carr	Margaret DeFeo
Nicholas Conte	Terri Cook Fasano	Connie Feeley
Sharon-Rose Gargula	Aileen Fink	Kathryn Fiddler
Susan Haberstroh	D. Patches Hill	Sandra Fox
Joyce Hawkins	Khaleel Hussaini	Tyneisha Jabbar-Bey
Cindy Madden	Parrish Kellum	Cathy Marinucci
Margaret Pisano	Chris Kelly	Dwayne Parker
Yalanda Thomas	Laura Rapp	Deanna Rigby
Rob Walter	M. J. Scales	Kimberly Robinson
Jordan Weisman	Pam Williams	Denise Watson
Joanna White		
Catherine Zorc		

Implementation Workgroup Rosters

Infrastructure	Delivery	Finance & Sustainability
Kathy Cannatelli	Terri Cook-Fasano	Connie Feeley
Nicholas Conte	Martha Coppage Lawrence	Kathryn Fiddler
Jon Cooper	Cassandra Davis	Sandra Fox
Kristin Dwyer	Aileen Fink	Tyneisha Jabbar-Bey
Emily Falcon	Sharon-Rose Gargula	Jonathan Miller
Sharon-Rose Gargula	Danielle Gumbs	Deanna Rigby
Joyce Hawkins	Susan Haberstroh	Rosa Rivera
Gloria James	Cindy Madden	Yvette Santiago
Priscilla Mpasi	Jordan Weisman	Denise Watson
Margaret Pisano		Leah Woodall
Forrest Watson, III		

SUBJECT MATTER EXPERTS CONSULTED		
D. Patches Hill	Nicholas Conte	Margaret DeFeo
Denise Hughes	Terri Lawler	Kathleen Dougherty
Khaleel Hussaini		Christina Haas
Kay McLean-Grant		Gary Kirchof
James Pennewell		Cathy Marinucci
M. J. Scales		Tanisha Merced
Katey Semmel		Dwayne Parker
Thowana Weeks		Kimberly Robinson
		Karyn Scout