Visioning the Future: School-Based Wellness Centers in Delaware: the Next 25 Years

A report from the George Washington University School of Public Health and Health Services at the request of Nemours Health and Prevention Services in Partnership with the Delaware Health and Social Services Department, Delaware Division of Public Health and the Delaware Department of Education

In 2008, the Delaware Division of Public Health and Delaware Department of Education joined Nemours Prevention and Health Promotion in sponsoring a project to review 23 years of Wellness Center operations with the goal of identifying future directions for the program. The project was undertaken with a view towards determining what is the best health system and most effective wellness center strategies to support Delaware's children. To assist with this work, the Center for Health and Health Care in Schools at George Washington University was asked to examine wellness center history, interview key participants in program and policy development, and facilitate a statewide summit on school-based wellness centers attended by individuals and state agency representatives with close knowledge of the wellness center program. The following pages include recommendations from the summit that propose 'next steps' in wellness center development as well as the issue brief that summarizes the program's history and presents commentary on critical issues offered by the 25 key informants.

December 2008

Visioning the Future: School-Based Wellness Centers in Delaware -- the Next 25 Years

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RECOMMENDATIONS AND COMMENTARY FROM A LEADERSHIP FORUM TO EXPLORE A FUTURE VISION FOR SCHOOL-BASED WELLNESS CENTERS (SBWC) IN DELAWARE

NOVEMBER 17, 2008, THE BUENA VISTA CONFERENCE CENTER, NEW CASTLE, DE

The context for this forum was a recognition that studies continue to reinforce the importance of student health for successful academic performance. Delaware has committed to achieving world-class schools by the year 2015. For past 20 years the Delaware wellness centers, located in 28 of the state's 33 high schools, have contributed to the health of the state's high school students and, in turn, to their capacity to succeed in school. As the centers move into their next 20 years, 45 community and state leaders gathered at the Buena Vista Conference Center to consider how the wellness centers might be positioned to meet the changing health and education needs of the state's young people. The conference itself built on the issue brief prepared for meeting participants. This memorandum summarizes the recommendations and background discussion from the November 17 meeting.

A Call to Action

In summing up the import of this day-long meeting, Paul Silverman, associate director of the Division of Public Health, noted that the most important result of the day-long forum was the universal enthusiasm participants expressed for moving forward with a new agenda that focused on future priorities for the wellness centers. Participants also agreed that it was vital to quickly establish a planning committee or task force that would meet soon to plan for the work ahead. On behalf of the Division, Dr. Silverman volunteered to bring that group together to launch the process.

Next steps While acknowledging that the current economic climate might incline some to look for survival strategies rather than build a bigger vision, Dr. Silverman noted that given the overwhelming support of the very smart people in the room, the proposed school-based wellness center task force should step out boldly. Challenges to be undertaken should include examining infrastructure needs; assessing service expansion possibilities – including opening wellness centers in middle schools and adding reproductive health care to the wellness center service package; looking at new service delivery models; exploring potential partnerships to support the wellness centers; developing supportive communications strategies, and working more closely with communities.

Short-term, long-term With Governor-elect Jack Markell scheduled to be sworn in on January 20, there was consensus that follow-up to the Buena Vista forum must be fast-tracked with a planning group in place and a strategy for the next 12 – 24 months under development as soon as possible. Suggestions for components of this strategy include:

- **Begin the conversation with the new administration as soon as possible**: Identify a visible and well-known spokesperson to present the idea of a renewed focus on the wellness centers to the Governor-elect's transition team
- **Do some homework:** Research how the wellness center initiative dovetails with the Vision 2015 education agenda that commits the state to creating a world class school system for all Delaware children. Review the outcomes data, documenting the effectiveness of the wellness centers. Document the numbers of uninsured adolescents served by the wellness centers.
- **Explore the idea of creating an advocacy group for the wellness centers.** In other states such groups have helped educate both community members and legislators about the work of the centers.

Conference Commentary of Key Topics

Three state leaders –Valerie Woodruff, Secretary of the Department of Education, Dr. Paul Silverman, Deputy Director of the Division of Public Health, and Marihelen Barrett, head of the Children's Center at Nemours Health and Prevention Services -- led off with stories of how the centers came into being and issues that had emerged as the wellness centers grew from a small handful in the late 1980s to a statewide network serving more than 80% of the state's adolescents in the first decade of the 21st century. The remaining agenda focused on four key topics: the assets and strengths of the Delaware model; the current Center service and staffing model; possibilities for service expansion, and potential new directions in advocacy and technical assistance. Recommendations and advice that emerged from the six hours of conversation are summarized below.

OPPORTUNITIES TO BUILD ON

Policy environment and priorities are congruent with SBWC goals.

Federal policies encourage services close to communities; State Medicaid supports maximizing resources; and the Delaware Health Information Network facilitates patient information exchange among providers and insurers. These policies are consistent with SBWC goals.

Strengths of school-based wellness center program offer a platform for continued growth.

Multiple features of SBWCs provide a solid foundation for continued program growth. These include on-going collaboration between school nurses and the wellness centers and similar collaboration between school guidance counselors and administrators with the SBWC mental health professionals. Delaware has had a longstanding school nurse program that places a nurse in every school. When SBWCs were developed, they were intended to expand and enhance health services in school in cooperation with school nurses. They were not intended to replace school nurses.

Several centers have also piloted strategies to serve younger teens in middle schools and their experience can inform new discussions about SBWC expansion into the middle schools. For example, in Cape Henlopen High School, the SBWC has established a satellite office at the 9th grade academy that is located within the high school.

Timing may be right to consider expanding reproductive health services.
One participant commented that 'short memories' provide the greatest opportunity for moving forward in this arena. Old battles don't necessarily need to be re-fought and there is nothing in statute or regulation that prohibits reproductive health services within the wellness centers. Dover High School wellness center provides HIV testing – a service whose addition was discussed and approved by the school district. A large number of participants noted that given the level of sexual activity among high school students, persistent high rates of sexually transmitted infections (STIs) and the numbers of unintended pregnancies, expanding reproductive health services should be a priority.

Potential strategies for opening this topic for consideration include:

1. Engaging the school-based wellness center advisory board members to reach consensus on the topic and carry the SBWC views to the district school boards.
2. Basing the conversations on adolescent health data

PRIORITY STRATEGIC ISSUES

Mental health services in SBWCs should be increased.
Priorities should include cross-system collaboration. The Department of Education, school districts, the Department of Services for Children, Youth and Families, the Department of Health and Social Services need to clarify their roles and responsibilities. Private insurers should be included in the mix as well. Paying attention to the needs of middle school students may reduce the need for services at the high school level. Collaboration also should be fostered at the local level, with community-based agencies – schools, community-based mental health agencies, wellness centers and others – coming together to identify what services are available locally and to build trust among the providers. There was a strong consensus on three points: local treatment capacity needs to increase, workforce development is an essential component for overcoming the shortage of services, and reimbursement for mental health promotion services is critical for assuring the availability of a full continuum of care.

More attention to health promotion/disease prevention as well as chronic disease management would add value to SBWC services.
Participants agreed that it was time to reaffirm the role of the wellness centers in promoting "wellness". It was also agreed that chronic disease management was an essential component of the SBWC service package. In terms of both health promotion and disease management, the service/program model should be based on an understanding of desired outcomes.

Adding dental health services to the SBWC service package would meet a critical need for many low-income adolescents.
While this topic was not discussed in depth, there was agreement that oral health is often not available in a timely way for low-income children and youth. Participants recommended that consideration be given to how the SBWC may be utilized to promote oral hygiene and reduce dental disease among adolescents.

Opening school-based wellness centers in middle schools as well as alternative schools, charters, and other locations would enable the centers to target particularly needy populations.
The value of making SBWCs universally available to high school students was recognized but participants acknowledged that, going forward, identifying outcomes to be achieved would be essential as would tracking progress once the new centers opened. There was also a sense that the new SBWC models, such as those opened in middle schools, might be jointly sponsored by community partnerships so that some services provided in the SBWC would be offered by other community agencies. Partnerships may be a key strategy for expanding the resources at the centers.

Increased public investments in SBWC will require documentation of their outcomes and effectiveness.
During the Summit, public officials emphasized that if increased funding is to be secured for additional services at the high school level or for new centers at the middle schools, then advocates must document the benefits associated with the wellness centers. Among the recommendations: It's essential to link or coordinate existing databases from the Department of Children Youth and Their Families , the Department of Education and the Department of Health and Social Services. It is also essential that the SBWCs gather data that describe which populations use the centers, eg. foster kids, ESL, uninsured. Another priority is to explore linking educational outcomes to SBWC usage. Graduation rates, attendance, early dismissals, teacher evaluations of student behavior in class etc were mentioned as possibilities. Health outcomes data to be tracked might include immunization rates, referral rates, and health status associated with better management of chronic diseases.

TOP RECOMMENDATIONS FROM SUMMIT

1. **Stabilize the existing school-based wellness center program before moving on strategies to expand services or increase the numbers of centers.**
   There was broad recognition that the centers have a large agenda and limited resources to implement their plans. Thus participants agreed that strengthening and stabilizing the existing centers needed to take precedence over expansion at this point in time. However, there was also recognition that some high schools do not yet have wellness centers and that ensuring that all high schools that want centers should have access to those resources.

2. **Shore up financing through an exploration of cost recovery strategies via Medicaid.**
   Currently Medicaid is billed one time for each student seen at a wellness center during the course of a year. Medicaid revenues are not shared with the vendors but rather split between the Division of Public Health and the Delaware treasury. Whether more revenues, tied to SBWC productivity, might be available to the centers is a question to be explored.

3. **Improve SBWC financial stability through cost analyses of services and implementing measures to improve efficiencies.**
   In addition to expanding revenues, examining service costs and ways to reduce costs per service unit may be a strategy to increase 'bang for the buck' of dollars invested in the SBWC program.

4. **Coordinate services sponsored by state agencies.**
   The Division of Public Health and Department of Education have historically partnered in supporting the wellness centers. There was strong sentiment that the time is ripe for other state agencies to become involved in the coordination and support of the wellness centers services. The group felt there is an opportunity to increase services while containing cost through the co-location of state agency services especially mental health in the wellness centers and this option should be explored

5. **Increase communication among state agencies and between SBWC and state agencies, especially information on grants that could support health promotion and oral health services in the SBWCs.**
   In exploring new opportunities to increase the coordination of services between state agencies, increasing communications was seen as a vital step. An increase in communication between state agencies as well as between the wellness centers and the state could provide new opportunities for the state and wellness centers to partner in applying for grants and exploring other revenue generating prospects

NEXT STEPS

Long-term and short-term 'next steps' include some that are urgent and others that permit time for reflection. On the short-term list, there is the economic crisis to contend with and participants agreed that scenario planning to anticipate strategies for coping with potential budget cuts make sense going forward even as leaders move forward with recommendations from the November 17 meeting.

Priority recommendations requiring immediate follow-up:

- Summarizing the meeting's discussions and its recommendations for circulation along with the initial school-based wellness center. The George Washington University staff will provide the summary.

- Structuring a process to keep the discussion begun at Buena Vista going. Dr. Paul Silverman agreed to take responsibility for this follow-up.

- Sharing the recommendations with the new administration of Governor Jack Markel.

- Identifying outcomes that are associated with school-based wellness centers and developing a data summary that makes the evidence-based case for the centers.

Other post-meeting steps include:

- Exploring development of a Delaware-based advocacy group for the school-based wellness centers. This task should include a review of national resources to determine whether those resources would be useful to the state.
- Inviting Vice President Elect Joe Biden to visit a school-based wellness center as part of national health care reform discussions.
- Connect with the new Delaware administration in Dover.

Agenda
A Policy Forum on Delaware School-Based Wellness Centers: Exploring Future Directions

Buena Vista Conference Center, 661 South DuPont Highway, New Castle, DE

November 17, 2008

Time	Topic	Responsible party
9:30 – 10:00am	Continental breakfast	
10:00 – 10:10	Forum Overview: Purpose and Logistics	Julia Lear/Karen Finn
10:10 – 10:30	Welcome Project Description; Brief History of Wellness Centers	Paul Silverman Valerie Woodruff Marihelen Barrett
10:30 – 11:15	Introductions	All
11:15 – 11:50	Assets and Strengths of Delaware Model: -- What the key informants said -- Comment and thoughts	 Julia Lear Forum participants
11:50 – 12:30	Current Wellness Center Service and Staffing Model -- What the key informants said -- Comments & discussion -- Next Steps	 Donna Behrens Forum participants
12:30 – 1:00	Lunch	
1:00 – 2:00	Service expansion and target population expansion -- What key informants said; what other states are doing -- Comments & discussion -- Next steps	 Forum participants
2:00 – 3:00	Advocacy and Technical Assistance -- What key informants said; what other states are doing -- Comments & discussion -- Next steps	Julia Lear Forum Participants
3:00 – 3:45	Prioritizing Next Steps	Forum participants
3:45 – 4:00	Wrap up and Adjournment	Paul Silverman

A Policy Forum on Delaware School-Based Wellness Centers

Attendees

Gerald Allen	New Castle County
Lisa Barkley	University of Delaware College of Health and Public Policy
Marihelen Barrett	Nemours Health and Prevention Services
Kathy Cannatelli	Christiana Care Health Systems
Rhonda Combs	Christiana Care Home Health Services, Visiting Nurses Assoc.
Deborah Craft	Beebe Medical Services, Physicians Services
Karen Cratz	William Penn High School Wellness Center
Susan Cycyk	DCMHS, Division Director
Sonya Davis	Nemours Health and Prevention Services
Roberta Gealt	
Phyllis Hazel	Christiana Care Home Health Services, Visiting Nurses Assoc.
Gloria James	DHSS, Div. of Public Health
Lynn Jones	Christiana Care Health Services
Tyrone Jones	
Kathy Kolb	Christiana Care Health Services
Evelyn Krump	
Martha Lawrence	Wilmington Wellness Center
Fred MacCormack	DHSS, Div. of Public Health
Cindy Madden	Delmar High School Wellness Center
George Maldrom	
Cathy Mosley	DHSS, Div. of Public Health
Ana Nevins	Christiana Care Health Services
Dave Nichols	Nemours Health and Prevention Services

Alisa Olshefsky	DHSS, Div. of Public Health
Janet Ray	Delaware Department of Education
Paula Roy	Delaware Health Commission
Dennis Rozumalski	Delaware Department of Education
Dana Sawyer	DSCYF, Office of Prevention Kid's Department
Paul Silverman	DHSS, DPH, Health Information and Science
Katherine Spencer	Polytechical High School Wellness Center
Midge Taylor	
Mark Thaylheimer	Cape Henlopen Wellness Center
Doug Tynan	Nemours Health and Prevention Services
Sandy Voss	Smyrna High School Wellness Center
Ed Waples	Cape Henlopen School District
Nancy Wilson	Delaware Department of Education, Office of the Deputy Secretary
Linda Wolfe	Delaware Department of Education
Valerie Woodruff	Delaware Department of Education, Office of the Secretary

Consultants

Julia Graham Lear	George Washington University Center for Health and Health Care in Schools
Donna Behrens	George Washington University Center for Health and Health Care in Schools
Karen Finn	FinnCore Consulting

Visioning the Future

School-Based Wellness Centers in Delaware – The Next 25 Years

A report from

The Center for Health and Health Care in Schools
School of Public Health & Health Services
The George Washington University

October 2008

Julia Graham Lear, PhD
Donna Behrens, RN, BSN, MPH

About the authors

Julia Graham Lear, PhD, directs the Center for Health and Health Care in Schools at the George Washington University School of Public Health and Health Services and is a research professor in the Department of Prevention and Community Health. For the past 25 years she has worked nationally to develop state and local school-based health center initiatives.

Donna Behrens, RN, BSN, MPH, is associate director at the Center for Health and Health Care in Schools. Before joining the Center she was executive director of the Maryland Assembly on School-Based Health Care, an advocacy organization devoted to increasing health care for children in Maryland through school-based health centers. Prior to that she served as director for Health Policy and director of the Maryland school-based health center initiative in the Governor's Office for Children, Youth and Families.

Preface

Project history. Early in 2008 the Nemours Division on Health and Prevention Services (NHPS), collaborating with the Delaware Division of Public Health (DPH) and the Department of Education, asked the Center for Health and Health Care in Schools at George Washington University School of Public Health and Health Services to assist in organizing a health policy forum to discuss the future of Delaware's school-based wellness centers (SBWC). In preparation for the health policy forum, this paper provides some history and background information about the school-based wellness centers as well as poses policy questions to stimulate and guide discussion.

While states across the country have developed school-based health centers to serve *some* of their young people, Delaware is unique in that it created a universal network of high school-based wellness centers intended to serve *all* adolescents. After nearly 25 years of program growth, the state of Delaware can proudly claim that it guarantees access to comprehensive physical and mental health services through school-based wellness centers to more than 80% of its adolescents. These services are delivered through 28 state-funded school-based wellness centers located in all but four high schools across the state.[1]

With more than two decades of precedent-setting experience in wellness center development, the Nemours Health and Prevention Services, the Division of Public Health and the Department of Education concluded that it was time to open a conversation about the future of this remarkable program. As a result, leaders in those two institutions crafted a project that would review the original school-based wellness center concept, ask the question as to whether the concept was as valuable today as it has been in times past, and, in particular, generate a discussion as to whether the model might be broadened to extend it into middle schools and whether health promotion and disease prevention efforts should assume a larger role in wellness center activities.

Project approach. While the forum is the centerpiece of this project -- enabling a critical conversation among policy, program and community members about wellness center operations, the forum itself builds on two preliminary pieces of work: (1) a review of documents associated with the development of school-based wellness centers in Delaware, and (2) a summary of insights gathered from interviews conducted with 22 key informants. Project leaders at Nemours, the Division of Public Health, and the Department of Education generously combed their files for background documents on the history and early operations of the wellness center and spent considerable time identifying interview participants. Through the spring and summer of 2008, staff from the George Washington University reviewed the documents and interviewed these key individuals. The history of the wellness centers and the perspectives of the key

informants are woven through this report. Following the forum, the report will be amended to include the vision and recommendations offered by forum participants.

Acknowledgements. The Delaware School-Based Wellness Program is firmly rooted in communities across the state. Six months of discussions and interviews made clear the depth of support and firm belief in the good work done by this program. While, as will be suggested in this report, some of the program's strongest supporters have ideas about how the program might be enhanced, their commitment to it was unwavering. And that commitment was demonstrated repeatedly by the generous commitment of time made by the many who contributed to this report.

For their work in launching this project we want to acknowledge especially Marihelen (Midge) Barrett from Nemours Health and Prevention Services, Jamie H. Rivera at the Division of Public Health (DPH) and Valerie Woodruff at the Department of Education (DOE). Their year-long discussions about the wellness centers were the genesis of this project. Ably stepping in to implement the concept was a staff team from DPH -- Alisa Olshefsky, Gloria James, and Fred MacCormack. They provided information, insight and a great deal of energy as members of the project steering committee. Representing George Washington University on the steering committee and staffing the project were Julia Graham Lear and Donna Behrens.

As noted above, the project owes a great debt to the many individuals who generously consented to hour-long interviews (and more) – providing us with background, insights and thoughts about the future of the program. With thanks, these key informants are listed in Appendix 5.

Julia Graham Lear Donna Behrens
Director Associate Director

Center for Health and Health Care in Schools
The George Washington University
Washington, DC

History of an Innovative Program

The setting

In the early 1980s, two public health issues dominated maternal and child health discussions: *teen pregnancy* and *infant mortality*. Among the high-visibility responses to these public health challenges were initiatives that increased young people's access to comprehensive care – including physical and mental health services as well as reproductive care. And, because infant mortality was linked to teen pregnancy, a program that reduced teen pregnancy was viewed as an effort that could also reduce infant mortality.

An emerging strategy for expanding adolescent access to care that came to national attention at the time was a new school-based health care model, the school-based health center. The centers, numbering no more than a hundred in 1985, had been piloted in several states and a number of cities. The centers were establishing a track record for achieving the result that policymakers wanted -- easily accessible, comprehensive care for adolescents. As Delaware considered how it might reduce teen pregnancy and infant mortality, school-based health centers became the focus of interest and state action.

How the wellness centers got started

In *Remembering: The Influence of School Nurses on Delaware's School Health Services* Edith Vincent writes that the idea for school-based health centers had its genesis in both the Department of Public Instruction (now the Department of Education) and the Department of Health and Social Services. According to Vincent, in 1985 representatives from both agencies attended a conference in Washington DC at which barriers to teen access to health care and teen pregnancy prevention were discussed. School-based health centers were proposed as a possible solution.[2]

On returning to Delaware, those agency representatives surveyed high school students to determine where the need was greatest, looking particularly at which high school had the highest number of teen pregnancies. In addition, the project leaders sought the views of parents and community leaders as well as conducted detailed needs assessments in the communities. While the high school survey responses pointed to Wilmington and William Penn High Schools, both schools and their respective districts declined to open Delaware's first school-based wellness center. And, while the record is not clear as to how the decision was reached, those interested in the wellness centers decided that to overcome reluctance from the schools, reproductive health care would not be made available unless the local school board voted its approval. That decision, as will be evident below, solidified into a complete ban on reproductive health services several years later. With reproductive health care moved off the table, Middletown High School, with a newly appointed principal, school nurse and district superintendent, became the first to open a school-based wellness center.

For the most part wellness centers have remained out of the political spotlight. That said, elected state officials played a key role in initiating and sustaining the centers. Mike Castle, governor from 1985 – 1992, got the momentum going. As a leader of the multi-state Southern Regional Task Force on Infant Mortality, he took up the task force recommendation to increase health care access for teens as a way to reduce infant mortality. During his tenure Castle supported opening four school-based wellness centers to improve teen access to care. Castle's successor, Tom Carper, governor from 1992 through 2001, continued gubernatorial support for the centers. In a phone interview in 1999 Governor Carper said, "This is an idea that just made sense. When I ran for governor, the focus of my campaign was on strengthening families. Promoting school-based health centers tied in well with that theme."[3] Carper went on to say that financial support for the centers under his tenure was to be incremental -- each year a few more a wellness centers would be funded until there was one in every high school.

A major legislative partner to both governors, State Representative Jane Maroney, served on the advisory board of the Southern Regional Task Force on Infant Mortality and the Delaware Task Force on Infant Mortality during Governor Castle's tenure and later advised Governor Carper on teen health and the school-based wellness centers. Her sustained leadership in the legislature broadened and deepened state support for the centers.

From the beginning the wellness centers have been lodged in the Division of Public Health with the Department of Education serving as an active partner. The DPH Maternal and Child Health Bureau assumed lead responsibility for the creation of the program and articulated its standards, operating procedures, and oversight. The Department of Education provided both input and guidance. The original model was built on cooperation and coordination between education and health professionals at the state, local and school level. At the school building level, the school principals, school nurses and wellness center staff worked together to launch and sustain the centers.

While the Division has retained direct operational responsibility for the wellness center at Middleton High School; the remaining 27 are operated by 5 Delaware health services organizations that have received contracts through a state Request for Proposals process. Except for Sussex Vocational Technical High School, which received $130,000 from 1988 until 2005 from Maternal Child Health Block Grant funding, the wellness centers have been funded by state dollars through the Governor's budget

The Delaware Model for School-Based Wellness Centers

Basic elements

Fundamentals of the Delaware school-based wellness centers are found in two documents developed early in the history of the centers: the *School-Based Health Centers in Delaware Position Statement* and *Eight Goals for SBHCs*. These documents remain central to the wellness center program.

In 1988, to guide the expansion of the school-based health centers, the Division of Public Health developed the *Position Statement.* Attachment 1. The position statement outlines 8 basic principals to guide health center development:

1. SBHC goals are to provide primary prevention and early intervention for health problems among the student population. Strategies for achieving these goals are described.
2. School boards must approve the SBHCs prior to opening. All services must be approved by the local school board based on the needs of the student population as identified through a needs assessment survey.
3. Parental permission is required before providing medical services to students.
4. SBHCs do not supplant family physician and are intended to provide care for minor problems and detect and refer students with serious problem.
5. School records and center records are kept separately to assure confidentiality.
6. Centers may be funded through a variety of resources but DPH remains "the manager of the center to assure that the facility is implemented in accordance with the accepted model and standards for school-based health centers."
7. The centers may offer diagnosis and treatment for STDs and provide HIV testing and counseling as long as these services are approved by the school board.
8. "Reproductive health services (i.e., family planning, gynecological care) will not be provided at any school-based health center in Delaware."

Sometime between the opening of the first school-based health center and a major expansion of the centers begun in 1994, DPH also developed *Eight Goals for SBHCs*. (Attachment 2) Since the development of the goals, the document has been expanded to include specific data elements and measurable objectives that individual school based-health centers must report to the state. To date, the medical sponsors of the centers, known as vendors in Delaware, collect data based on these goals as part of their contractual agreement with the state. The goals and how the wellness centers will accomplish them are a required component of an annual work plan submitted by all vendors to DPH. Workplans set benchmarks for the coming year for enrollment, number of visits, prevention activities and other measurements of their success in meeting students' needs.

The model: Where Delaware is now

By incorporating the above standards and requirements into its vendor contracts, the state has achieved consistency of services, staffing and operations across all the wellness centers. However, because funding for individual centers may not have kept pace with inflation, the contracts have been challenging for the vendors in that staffing and service requirements must be met despite funding constraints.

To resolve the strain, the state encourages vendors to seek additional resources to provide additional support and to seek federal, local and foundation grants as well as in-kind community contributions. Currently, medical vendors report that they are struggling to maintain both the clinical and prevention services.

The specifics of the Delaware model are primarily found in the contracts between DPH and the medical vendors. Unlike the national custom in which most states that fund centers have established state standards as a framework under which contracts are developed, in Delaware the standards are spelled out in the contracts. See Table 1.

Table 1. Delaware Division of Public Health – Vendor Contract Provisions

Staffing and operations requirements*

- Center staff must include a full time provider who also serves as center coordinator and a full time administrative assistant
- At centers where the medical provider is the coordinator, mental health staff must provide a minimum of 30 hrs per week for 40 weeks during the school year or a total of 1200 hours
- Where the mental health provider is the coordinator, the medical provider must provide a minimum of 30 hrs per week for 40 weeks during the school year or a total of 1200 hours.
- A minimum of 6 hrs per week for 40 weeks for a registered dietician during the regular school year
- A minimum of 2 hrs per week for 40 weeks for a physician during the regular school year
- In the summer, a minimum of 10 hours per week for 8 weeks for the administrative assistant and the medical provider or mental health provider (or a combination of both)
- At least one health provider at each site during the center's regularly scheduled hours during the school year

* These standards are for schools with student enrollment of 1,000 or less. Schools with larger student enrollments have both additional hours of service and more funding

Required policies include:

- Standing orders to be implemented
- Confidentiality procedures
- Hours of operation
- Vetting requirements for staff applicants
- Procedures for handling clinical preceptorship requests and placements

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At a minimum the policies and procedures must address:

Consent for treatment
Emergency care
Emancipated minor designations
Informed consent
Consent for specific services including those needing parental consent
Liability of school and contractor
Financial and/or legal responsibility for referral/treatment
Standing orders or collaborative agreement
Coordination/communications with primary care providers

Policy and procedures manuals must be submitted to DPH annually.
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Other contract requirements:

Center coordinator to meet at least quarterly with the school principal and/or school district superintendent with written reports of these meetings to be submitted to DPH
Mandatory attendance at statewide school based coordinator and administrative assistant meetings
Submission of standardized monthly statistical reports, quarterly reports on center goals and objectives; annual reports; and documentation of quality assurance activities

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The model: Thinking about the future

Targeting *– who is to be served?* The Delaware model is unique among all state programs in that its objective since the program was launched 20 years ago is to provide universal access to the wellness centers by *all* adolescents attending public schools. Central to the increased access to medical care and mental health services was the delivery of this care in a setting uniquely designed to accommodate adolescents. Currently the program maintains wellness centers in 28 of Delaware's 32 high schools. While some states have had a preference for serving adolescents, other states have been inclined to focus on low-income or uninsured students. Across the country, 20% of centers are located in elementary schools; 15% in middle schools, and 29% in high schools. Thirty-seven percent describe themselves as serving "mixed grades".[4]

The Policy Question: The central question concerning Delaware's targeting strategy is should Delaware continue its policy of building a high school-only network of school-based wellness centers or should it expand the centers into lower grades, particularly middle or junior high schools. The benefit of the high school-only strategy is that the state is creating guaranteed universal access for all high school students thereby completing a public health network that could serve multiple adolescent-targeted public health and health promotion purposes; the benefit for expanding into middle schools will be to increase the possibility of prevention efforts targeting teen smoking and chewing tobacco use, alcohol and drug use, early mental health interventions as well as healthy eating and physical exercise promotion. Middle school wellness centers would allow for greater prevention efforts that target lifestyle choices, allow early detection and

management of chronic diseases and the promotion of healthy choices. Expanding into middle schools has obvious funding implications but depending on the outcomes desired from the program, the expansion may help achieve a different set of outcomes than those targeted by a high school initiative.

Interview Comments: The interviewees unanimously supported expansion of the centers to middle schools or, at a minimum, to reach out to 7th and 8th graders. There was agreement that the middle school students were in great need of both medical and mental health services. One respondent noted that "by the time they are in high school, their habits are set." Because a significant number of students are beginning to experiment with high-risk behaviors in middle school, several interviewees were concerned that younger adolescents had little in the way of guidance or prevention programs.

Elementary school expansion received less support among those interviewed. There seemed to be consensus that this age group has better access to primary care and that there are better mental health service supports in the elementary schools.

A number of respondents were cautious about expanding the Wellness Centers into new populations. They were concerned that current programs needed to be fully funded and needed to meet the needs of the high school students before the target population was increased. "We need to do a good job with the programs we have and then expand to the middle schools". Others cautioned that any expansion should be data driven and include the opinions and input of families and local communities.

***Services and staffing model** – should new services be added or the care team expanded?*
From the beginning, the Delaware school-based health center service package has had strong similarities to centers across the country. The model provides physical and mental health services, utilizes at least one administrative support staffer, and draws, part-time, on the resources of dietitians and nutritionists. While, nationally, mental health services are not provided in all centers; Delaware has understood the critical value of emotional and behavioral health services for teens from the beginning and those services are mandated under the state contract. The model also includes both collaboration and coordination with school health services and the school principal.

A number of the Delaware centers include a part-time health education or health promotion staff person, frequently funded through private foundation grants or grants from public agencies. The health education/health promotion position is not currently part of the mandated Delaware model.

The Policy Questions: The history of school-based wellness centers indicates strong support statewide for a comprehensive staffing configuration and service package. However, there are two areas of specific concern:

(1) **The area of greatest controversy** is the current policy that bans delivery of reproductive health services in the centers. As noted above, the initial school-based wellness position statement published by DPH in 1988 and confirmed in 1991 categorically stated that reproductive health services will not be provided by the wellness

centers. Sexuality-related services -- diagnosis and treatment for STIs and providing HIV testing and counseling – can be provided as long as they are approved by the school board. After 20 years, the question is: have community and political attitudes changed and are there arguments for adding these services. Two large cities that provide these services – Seattle and Denver – have documented a related decrease in teen pregnancy rates.[5]

Five of the 19 states with school-based health center initiatives (Delaware, Louisiana, Michigan, New Jersey and Texas), however, prohibit grantees from dispensing contraception on site. Six additional states (District or Columbia, Georgia, Nevada, Ohio, Utah and Virginia also restrict contraception access through the centers, although those states neither fund nor oversee standards for the centers.[6]

Interview Comments: A significant number of respondents expressed their desire to see the wellness centers offer reproductive health services. "If we could give out condoms, we could reduce the spread of disease and teen pregnancies." It was strongly felt that, at a minimum, the wellness centers should be doing STI, HIV and pregnancy testing and should also be authorized to treat STIs. Some suggested that a few vocal community members have been responsible for limiting the availability of reproductive health services. Some said it was time to "be brave" and re-open the issue of current limits on reproductive health care.

(2) A second, less controversial issue is the expansion of the model to include – either as a mandated or optional service – health promotion and disease prevention initiatives. This might involve either a full-time or part-time health educator or health promotion expert as part of the health center team. Given the growing awareness that the health and lifestyle choices in youth can lead to chronic diseases of adulthood, all those interviewed want to see strong and robust health promotion and disease prevention programs in the schools.

Interview Comments: Some informants expressed concern that the original intent for the centers was to focus on early intervention and disease prevention and that this intent had not been maintained. It was thought that this lack of time and focus on prevention services has been influenced by (1) the need to provide medical and mental health services at a level that meets a contractually obligated standard based on school and wellness center enrollment, and (2) level-funding of the centers over the past several years. Some commented that the need to see kids for higher-level clinical problems (those generating ICD-9 or DSM-IV diagnoses) have hampered the ability of the wellness center staff to provide some of the value-added prevention and early intervention services. Some of these non-diagnostic services included participation in health education classes, offering "lunch and learn" opportunities, health fairs and other group classes to students on health and wellness issues.

(3) A third and also less controversial issue is the possible expansion of mental health services. This might involve either the co-location of community based mental health providers in the schools or increasing the funding and staffing of the school-based health centers to address mental health.

Interview Comments: Uniformly across those interviewed expressed their desire to have more mental health services in existing wellness centers. Many felt that mental health services are limited, hard to access, and not available for addressing crisis situations. It was reported that families have difficulty accessing community-based services and have come to rely on the school based wellness centers as the main source of mental health services. "The wellness centers are the first line of defense in counteracting the growing problems brought about by poverty and violence".

Final comment on service and staff expansion. It should be noted that although most centers have a full-time mental health professional on-site, the majority of those interviewed felt that more mental health services were needed in existing wellness centers. Community-based mental health services are seen as very limited, hard to access, and not available for addressing crisis situations. Families are reported to have difficulty accessing community-based services and have come to rely on the school based wellness centers as their main source of mental health care for their children. Commented one interviewee, "The wellness centers are the first line of defense in counteracting the growing problems brought about by poverty and violence."

Program Partnerships. The Delaware Department of Health and Social Services has assumed the lead in policy, technical support and monitoring the wellness centers through its Division of Public Health. The Department of Education (DOE) has been a strong collaborator and historically instrumental in the success and growth of the centers. The current Secretary of Education, Valerie Woodruff was principal of Middletown High School when the first wellness center opened in 1985. In a July 2008 interview, Secretary Woodruff spoke of her role in launching the first wellness center in the state and her continued support of the partnerships between health and education to continue to grow the centers. She remembers being a part of a few dedicated people in the state that went in person to school districts, school boards, parents and legislators as they worked to dispel fears and myths about the centers and explained what would and would not be done in them. She described her work as going "up and down the state" talking to people and helping them to see that the wellness centers would be a good thing. Now as then, she continues to feel the role of the school, school districts, communities and parents as central in defining the future of the wellness centers.

At the local level, Delaware institutionalized its commitment to developing strong partnerships between wellness centers and the families and communities they serve by making those relationships part of the Program's founding documents (Position Statement and Goals for SBHCs). The position statement says the local school board must approve all services offered in each school based wellness center. Optional services such as STD testing and treatment, pregnancy testing and HIV testing must be approved by the local school board before they are offered in the centers.

All wellness centers have community advisory councils although they may vary in size, composition and frequency of meetings. There is no legal requirement for these councils and *Eight Goals for SBHCs* is the only place that references these councils. Two of the

eight goals (#6 Ensuring parental involvement in the SBHCs and the Centers care of students and #8 Ensuring community awareness of and support for SBHCs) refer to the councils. Historically, the advisory councils were required to steer the initial community needs assessments. Growing out of their role in the community needs assessment process, advisory councils became institutionalized.

The Policy Question: While the wellness center advisory councils have been institutionalized, the advocacy function remains unclear and it appears that there are no organized advocacy efforts at the state level. Across the nation, 20 state associations representing school-based health centers are collaborating to assist individual centers promote standards and funding for the centers. In Delaware, would the wellness centers benefit from stronger local and state-level advocacy? And, based on other states' experiences, would the state benefit from collaboration with the National Assembly on School-Based Health Care?

Interview Comments: When asked about the current role of the Wellness Center Advisory Council, there was variability in knowledge about these councils. Some of those interviewed were very knowledgeable -- having either currently or at some point served on one. Others were not aware they existed or did not know there was one for every wellness center. Those who were knowledgeable made the following suggestions:

- Need to maximize the contribution of the advisory councils to program development.
- Would be helpful to have the advisory councils able to communicate directly with the Division of Public Health to incorporate the views and thoughts of parents into the school based wellness center planning
- The advisory councils are useful in providing input on their individual centers however they are fragmented and limited to local focus
- A few suggested that there needed to be a statewide advisory group that could act in conjunction with the local advisory councils to share data, information, procedures and "push" for more services
- Membership on the advisory councils should be standardized in order to ensure that there is diverse and good representation

Other thoughts on advocacy included the following:

- The advisory councils should work with the school nurse advocacy group that has been a strong leader and voice on children's health issues.
- Opportunities exist to inform and educate other school and community members about school based wellness centers
- Advocacy efforts by the advisory councils and other organizations have been effective in preventing erosion of the current program however have not been effective in growing the program
- Advocacy efforts in Delaware tend to be either disease specific and/or geographically limited

When asked about the national advocacy and technical assistance organization for school-based health centers, the National Assembly on School-Based Health Care, there was an overall lack of knowledge, interest or understanding of this organization. There was some support for the idea of exploring a state level organization that focused on school-based wellness centers either as an affiliate of the National Assembly or as an independent body.

The Policy Question: The Department of Education and the Division of Public Health have led the state level collaboration in support of the Delaware Wellness Centers. In light of the range of issues and interest addressed by the wellness centers, would it be appropriate to formalize the state wellness center advisory process and should additional agencies or offices such as Children's Mental Health be added to the wellness center collaboration?

Funding

In Delaware. As noted previously, Delaware school-based health centers are funded through the state general fund. Dollars flow to individual centers through contracts negotiated between the Delaware Division of Public Health and the medical vendor. The contract amount is based on the size of the student population. Currently Delaware spends about $6 million state dollars on the wellness centers.

Initially, for schools with student populations of less than 1000, each wellness center received the same amount. For schools with more than 1,000 students, the base rate reflects an additional $100 for every student over this number. A funding challenge has been maintaining funding equity among the centers as new ones are added and receive an increased base rate. This "rolling" inflationary adjustment presents difficulties in maintaining standard funding base rates across all state sites. While some contracts have been adjusted, not all have. Compounding the challenge has been the fact that centers have been level-funded for the past 4 years.

In Delaware, the medical vendors do not bill Medicaid, SCHIP or other third party insurers. Instead, Delaware has established a "bundled" billing strategy for students enrolled in state Medicaid and who are seen in the centers. This billing is done centrally through DPH. The wellness centers collect information from each student and that information is submitted to DPH. DPH then submits a one time annual bill for any Medicaid enrolled students seen in the wellness center. Of the Medicaid funds received from both state and federal sources, a portion is used to support the administrative overhead associated with billing within DPH, a portion is returned to the state Medicaid office, and the remainder goes to state general funds.[7] One result of this strategy is that individual centers do not benefit financially when their patient visits increase.

In Other States. Among all states in the United States, Delaware remains unique in its commitment to providing a school-based health center in every high school in the state.

With only four high schools lacking a health center, Delaware's goal of universal access to the centers for adolescents appears within reach.

State grant funds. While other – and somewhat larger states – have not achieved a similar degree of access for adolescents to school-based physical and mental health services, a 2005 survey by the National Assembly on School-Based Health Care reported that 19 states provide at least some grant dollars for school-based health center initiatives.[8] As indicated in Table 2 below, state general fund dollars represent about half the $55.7 million provided for SBHCs in state grant funds nationwide. Title V block grant dollars totaled $7.1 million. This survey did not collect data on Medicaid funds paid to school-based health centers for services provided to Medicaid-enrolled young people.

Table 2. SBHCs and total grant funding directed by state government (2004 -2005)

State	Number of SBHCs funded by state	Total funding	Title V MCH block grant	State general fund	Tobacco settlement	Other
Colorado	6	$240,000	$240,000			
Connecticut	63	$6,180,825	$288,096	$5,892,729		
Delaware	27	$5,399,542		$5,399,542		
Florida	2	$497,030		$497,030		
Illinois	38	$3,897,300	$1,109,200	$159,800	$1,840,000	$788,300
Kansas	5	$176,744		$176,744		
Louisiana	54	$7,736,992	$480,000		$7,160,192	$96,800
Massachusetts	49	$3,018,466		$3,018,466		
Maryland	22	$2,871,825		$2,871,825		
Maine	20	$623,000		$255,000	$368,000	
Michigan	45	$3,740,000		$3,740,000		
North Carolina	28	$1,443,044		$1,443,044		
New Jersey	6	$600,000		$600,000		
New Mexico	34	$450,000		$450,000		
New York	127	$15,514,400	$4,431,500		$1,257,900	$9,825,000
Oregon	26	$1,350,000		$1,350,000		
Rhode Island	7	$525,000	$59,500	$390,000		$75,500
Texas	6	$562,500	$562,500			
West Virginia	47	$900,000		$900,000		
Total	612	$55,726,668	$7,170,796	$27,144,180	$10,626,092	$10,785,600

SBHC = school-based health center

State Medicaid and SCHIP policies. An earlier survey by the Center for Health & Health Care in Schools reported on state Medicaid and SCHIP policies that have contributed to the sustainability of school-based health centers. While grant dollars have provided the initial kick-start for the centers, over the past few years, school-based health centers have increasingly sought to diversify their funding mix. One approach has been to secure third-party reimbursement dollars. A 2001 – 2002 survey identified the following state policies as supporting center growth[9]:

- At least seventy-five percent (n=38) of the states permitted school-based health centers to bill for services under fee-for-service (FFS) Medicaid and the State Child Health Insurance Program (SCHIP).

- Thirty-nine states reported that nurse practitioners were eligible to bill for their services under FFS Medicaid and in thirty-four states, nurse practitioners are eligible to bill for services under FFS SCHIP.

- In some states, other providers such as psychologists and social workers are also eligible to bill for services provided within school-based health centers.

- In five states, school-based health centers are required by law, managed care contracts, or regulation to be included in Medicaid managed care provider networks. In 11 states, Medicaid managed care provider networks are encouraged to include school-based health centers

- For SCHIP managed care provider networks, five states require and nine states encourage the inclusion of school-based health centers.

To the Future

In the course of our interviews with leaders across Delaware, there was unanimous agreement that the wellness centers are working well and doing good. Many echoed the idea that the wellness centers were recognized as an essential part of Delaware high schools. That said, there are some important issues that may impede continued growth of the centers and the November 17 forum will present an opportunity to open discussion of the centers and their future. Here are four issues that require attention:

1. The current concerns about under-funding of the centers are too heartfelt to be ignored. Successful accomplishment of program objectives mandate attention to this issue. And because core funding is on the table, program advocacy becomes more salient. Securing increased program dollars will require an engaged constituency at the local and state level communicating with elected officials and with each other.

2. The service issues are also important if the program is to achieve its objectives. Only one of those issues – reproductive health care -- is controversial. In a related question, there was a strong consensus that the wellness centers should pursue expansion into the middle schools. Additionally, the desire to see an increase in and strengthen of the health promotion/disease prevention services and mental health care was shared by those interviewed. There is an opportunity to move forward on most, if not all, of these issues.

3. Constraints on funding suggest that the sustainability model for the centers is insufficient to support continued growth. Revisiting the Medicaid-reimbursement

issue, examining the potential for private funding to expand the dollar base may also be critical to making progress on these matters.

4. While the current data collected from the centers says much about their ability to provide increased access for adolescents, the data do not address the issue of outcomes. It is critical that some thought be given to measurable health and prevention outcomes for wellness centers as well as some easy-to-use measures of quality. There has been a national investment made in the establishment of quality measures, outcome measures and tools to enhance the delivery of care in school based health centers. The National Assembly on School Based Health Care has made both the tools and technical support available. There is an opportunity to investigate and adapt these tools to enhance the Delaware model.

The issues suggested by people we interviewed and by research on other school-based health center program present a challenging agenda, but the success of the Delaware centers over time provides encouragement that state and community representatives have the will to address these matters. Our anticipation is that the day-long forum will provide an opportunity to begin to explore the issues and develop of the possibility of new directions.

[1] Public high schools in Delaware total 31 with enrollment reported as 36,313 in 2005. 29.724 students, or 82% of the public high school population attended schools with wellness centers.

[2] Vincent EP. Remembering: The influence of school nurses on Delaware's school health services. Processed. November 2005. Pages 29- 31.

[3] Center for Health and Health Care in Schools. From the Margins to the Mainstream: Institutionalizing school-based health centers. Making the Grade: George Washington University, 2000. Pages 7 – 9.

[4] National Assembly on School-Based Health Care. School-Based Health Centers: National Census School Year 2004 – 05. Accessed on the web October 20, 2008 at http://www.nasbhc.org/site/c.jsJPKWPFJrH/b.2716675/

[5] Ricketts SA, Guernsey B.P. School-based health centers and the decline in Black teen fertility during the 1990's in Denver, Colorado. American Journal of Public Health. 2006;96(9):1588-1592. Adolescent Pregnancy, Birth and Abortion, King County, 1980 – 2001. Seattle & King County Public Health Data Watch. June 2003. Accessed on the web at http://www.kingcounty.gov/healthservices/health/data/youth.aspx on October 20, 2008.

[6] Schlitt JJ, Juszczak LJ, Eichner NH. Current status of state policies that support school-based health centers. Public Health Reports, Nov-Dec 2008, vol. 123. Pre-publication copy.

[7] As stated in the State Plan Under Title XIX of the Social Security Act 31 Delaware Code, Section 512 (31 **Del.C.** §512): "School-Based Wellness Center Services, operated by the Division of Public Health in Delaware schools, are reimbursed a single rate once each benefit year for any client served in one of the school-based clinics. The single rate is based [~~on prior year statewide costs of all School-Based Wellness Centers.~~ cost reports for the prior year submitted in a format specified by the Medicaid agency. An interim rate is paid until the end of the reporting period when there is a retrospective cost settlement. Actual costs reported on the cost report are divided by actual encounters to determine the actual cost per encounter for the period. Actual costs will be compared to interim payments and settlements will be completed."11 DE Reg. 1477 (05/01/08) (Final)

[8] Schlitt JJ, Juszczak LJ, Eichner NH. Current status of state policies that support school-based health centers. Public Health Reports, Nov-Dec 2008, vol. 123. Pre-publication copy.

[9] Center for Health and Health Care in Schools. 2002 State Survey of School-Based Health Center Initiatives. Accessed on the web September 1, 2008 at http://www.healthinschools.org/Health-in-Schools/Health-Services/School-Based-Health-Centers/State-Surveys.aspx

Appendix 1.

SCHOOL-BASED HEALTH CENTERS IN DELAWARE

Position Statement

I. **The goals of school-based health centers in Delaware are to provide primary prevention and early intervention for health problems among the student population by:**

- Providing prevention care;
- Detecting signs of emotional stress and psychosocial problems for counseling and/or referral;
- Facilitating students' use of health care systems by establishing links with primary health care providers.
- Promoting on-going comprehensive health care for students of all ages;
- Encouraging parent involvement in the health care of their adolescents;
- Working toward the improvement of the students' knowledge of the importance of preventive health care;
- Improving (responsible) decision-making about health matters;
- Reducing risk-taking behaviors;
- Developing health promoting behaviors; and
- Providing early detection of chronic conditions and early diagnosis and treatment of minor and acute illnesses and health problems.

II. **All school-based health centers will receive school board approval prior to the implementation of the center's services. All service components will be approved by the local school board based on the needs of the student population as identified through a needs assessment survey.**

III. **All school-based health centers must receive written parental permission prior to providing medical services to students.**

IV. School-based health centers do not supplant the family physician.
The centers are intended to provide care for minor problems, detect and refer students with serious problems. The centers serve as facilitator to assure that teens and their families access to all the necessary services.

V. School records and center records are kept separately to insure confidentiality.

VI. Centers may be funded by state or federal dollars; through a community partnership; through grant sources; but also require support of the school with in-kind or actual dollars. Division of Public Health will remain the manager to assure that the facility is implemented in accordance with the accepted model and standards for school-based health centers.

VII. The following services may be offered in school-based health centers in accordance with item II:

A. Diagnosis and treatment of sexually transmitted diseases.

B. Provision of HIV antibody testing and counseling.

VIII. Reproductive health services (i.e., family planning, gynecological care) will not be provided at any school-based health center in Delaware.

Adopted: Fall 1988
Revised: Dec., 1991
DHSS, DPH

Appendix 2.
Eight Goals for School-Based Health Centers

Eight Goals for SBHCs

1. ***Reducing critical health problems of adolescents by ensuring the utilization of comprehensive health services provided by the SBHC***. (Measurable objectives for this goal shall include the percentage of student population enrolled, unduplicated total users and the total number of center visits per year.)
    - give actual number of student population, the percent and number that this percentage represents, the actual number and percent of the entire student population that you have enrolled
    - **unduplicated user objective must be at least half of the number of enrolled students at each site**
    - the number of center visits (= the unduplicated count times four)

2. ***Improving the physical health of students by providing age appropriate medical services through the SBHC***. (Measurable objectives for this goal shall include the number of physical examinations, the number of immunizations given, the number of diagnoses for acute/minor illnesses, and the number nutrition diagnoses)
    - number of physical exams
    - number of immunizations
    - number of acute/minor illnesses **(acute illnesses = "other" under all diagnosis)**
    - number of nutrition diagnoses

3. ***Reducing the incidence of high risk behaviors through health education and risk reduction efforts***. (Measurable objectives for this goal shall include specific targeted efforts and number of students obtaining assistance to prevent intentional and unintentional injuries, the number of lunch-and-learn -including the topics- presentations and the projected number of students that will be involved in the presentations, the number of classroom presentations on preventive health issues and the projected number of students that will be involved, and the projected number of sessions that staff will discuss specific safety issues with students,. and the projected number of sessions to improve dietary patterns and decrease sedentary lifestyles.)
    - number of students obtaining assistance to prevent intentional and unintentional injuries

- **the number of lunch-and-learn presentations including topics and the projected number of students that will be involved in the presentation (if applicable)**
- the number of classroom presentations on preventive health issues and the projected number of students that will be involved
- the projected number of sessions to improve dietary patterns and decrease sedentary lifestyles

4. ***Reducing the mental health and psychosocial problems of adolescents***. (Measurable objectives for this goal shall include the number of individual and family counseling visits, number of referrals for additional support services, and number of students receiving back-to-school transition assistance.)
   - number of individual and family counseling visits
   - number of group counseling visits
   - number of referrals to outside providers for additional support services
   - number of students receiving back-to-school transition assistance (if applicable)

5. ***Ensuring coordination between the SBHC and the school and school health services***. *(*Measurable objectives for this goal shall include the number of faculty receiving information about the services that are provided at the center, number of meetings with school liaisons, SBHC staff attendance at student services and family life curriculum meetings where applicable, and the number of referrals from school nurse and guidance counselor to the SBHC.)
   - number of faculty who have received information about SBHC services
   - number of meetings with school liaisons
   - the number of student services offices and health education curriculum meetings that staff have attended where applicable
   - the number of meetings that staff have attended to discuss and/or coordinate the student's care within the school setting
   - number of referrals from school nurse and guidance counselor

6. ***Ensuring parental involvement in the SBHC and Center's care of student****s*. (Measurable objectives for this goal shall include the number of parents on the Center's Advisory Council, the number of PTA/PTO meetings that SBHC staff attend, and the number of parent/student communications facilitated by SBHC.)

- the number of parents that will serve on the Center Advisory Council
- the number of students that will serve on the Center Advisory Council where applicable
- the number of faculty that will serve on the Center Advisory Council
- the number of other school staff that will serve on the Center Advisory Council
- the number of community representatives that will serve on the Center Advisory Council
- the number of School Board members that will serve on the Center Advisory Council
- Advisory Councils should meet at least twice per year, ideally quarterly
- the number of parent/student communications facilitated by SBHC staff (ex. Parent nights where adolescent topics are discussed, if parents are invited to the Heroin Alert Program, parent/student/school partnerships in a project like Christmas in April, the TATU, Kick Butt programs, etc.
- the number of PTA/PTO meetings that SBHC staff attend

7. ***Ensuring coordination with student's medical home and/or primary care provider***. (Measurable objectives for this goal shall include developing procedures for informing primary care providers of SBHC encounters, the number of collateral contacts made to the student's primary health care provider and/or the student's medical home, the number of contacts made to the student's primary health care provider via faxed encounter forms and by mail as it applies to the student's health where applicable, the number of students actually linked to a medical home that did not previously have one.)
   - number of collaterals to student's primary health care provider
   - the number of written communication to the medical home and/or primary care provider
   - the number of referrals made to primary care providers
   - the number of students referred to a medical home and/or primary health care provider who previously did not have one
   - the **actual** number of students who were linked to a primary health care provider or a medical home

8. ***Ensuring community awareness of and support for SBHC's.*** (Measurable objectives shall include the number of SBHC presentations to school board, community groups, etc, the number of articles in parent/school newsletters, the number of articles in local newspapers, etc.)
    - the number of SBHC presentations to the school board
    - the number of presentations to community groups
    - the number of health fairs if applicable
    - the number of articles in the school paper if applicable
    - the number of articles in the local paper if applicable

APPENDIX 3. SELECTED RISK BEHAVIORS AMONG DELAWARE ADOLESCENTS

Alcohol and other drug use among 8th and 11th graders

- ***Marijuana***

10% of 8th graders and 22% of 11th graders reported using marijuana during the previous month.

4% of 8th graders and 11% of 11th graders reported using marijuana more than 6 times during the previous two weeks.

- ***Alcohol***

22% of 8th graders and 41% of 11th graders reported using alcohol in the previous month

11% of 8th graders and 41% of 11th graders reported binge drinking (3 drinks at one time in the previous 2 weeks).

- ***Cigarette use***

8% of 8th graders and 17% of 11th graders reported smoking a cigarette at least once during the previous 30 days

2% of 8th graders and 5% of 11th graders reported heavy use (more than half-a-pack per day during the previous 30 days).

Source: 2007 Delaware School Survey, Center for Drug & Alcohol Studies, University of Delaware

Other risk behaviors

	Middle school	***High school***
% of students who ever rode in car driven by someone who had been drinking alcohol	29.3	28.4
% of students who have ever carried a weapon, such as a gun, knife of club	29.7	17.1
% of students who have ever been in a physical fight in which they were hurt bad & had to be treated by a doctor or nurse	9.4	4.1
% of students who have ever had sexual intercourse	23.3	59.3
% of students who have had sexual intercourse with three or more people	9.2	21.8

45.2% of all students, grades 9 – 12, reported having at least one drink of alcohol during the previous 30 days. 36.1% of 9th graders and 59.8% of seniors reported drinking at least one drink of alcohol in the previous month.

Source: 2007 Delaware/CDC Youth Risk Behavior Survey (Grades 9 – 12)

Appendix 4.
Delaware High Schools with Wellness Centers, by Opening Date

High School	Opening date	Student population[1]	Clinical sponsor
Early Adopters			
Middletown	Sep 1985	1,640	Christiana Care
Sussex Tech	Oct 1988	1,249	Christiana Care
Dover	Sep 1989	1.502	Christiana Care
Christiana	Oct 1989	1,287	Christiana Care
Mainstream			
Lake Forest	Nov 1993	946	Christiana Care
William Penn	Jul 1994	2,282	Christiana Care
Polytech	Oct 1994	1,147	Christiana Care
Delcastle	Oct 1994	1,500	Christiana Care
Concord	Nov 1994	1,180	Christiana Care
Glasgow	Dec 1994	1,193	Christiana Care
Newark	Dec 1994	1,619	Christiana Care
Smyrna	Jan 1995	1,240	Bayhealth Medical Center
Delmar	Feb 1996	592	Nanticoke Health Services
Dickinson	Feb 1996	874	Christiana Care
Seaford	Feb 1996	810	Nanticoke Health Sevices
Howard	Feb 1996	863	Christiana Care
Cape Henlopen	Apr 1996	1,198	Beebe Medical Center
Hodgson	Dec 1996	1,190	Christiana Care
Wilmington	Jun 1997	No numbers	Christiana Care
Mt Pleasant	Aug 1997	959	Christiana Care
Laurel	Sep 1997	532	Nanticoke Health Services
McKean	Sep 1997	985	Christiana Care
Woodbridge M/Sr	Sep 1997	499	Bayhealth Medical Center
Brandywine	Jul 1998	1,168	Bayhealth Medical Center
Milford	Dec 1998	1,140	Bayhealth Medical Center
Indian River	Sep 1999	861	Beebe Medical Center
Sussex Central	Sep 1999	1,268	Beebe Medical Center
Recent addition			

Caesar Rodney	Oct 2005	1,989	Bayhealth Medical Center
Without centers			
Al DuPont			
Appoquinimink			
St Georges Tech			
Conrad			

Appendix 5. List of Key Informants Interviewed by The Center for Health and Health Care in Schools for the Delaware School Based Wellness Project

Maureen Andrews
Family Crisis Therapist
Department of Services for Children, Youth and Their Families

Marihelen Barrett
Director
Center for Children's Health Innovation
Nemours Health and Prevention Services

Pat Carroll-Grant
Director of Pharmacy
Cardinal Health Care

Karen Cratz
Mental Health Provider and Wellness Center Coordinator
William Penn High School
Christiana Health Care

Steven Godowsky
Superintendent of New Castle County
Vocational Technical High Schools District
New Castle County

Bethany Hall-Long
Professor of Nursing and Public Policy
University of Delaware
Delaware State Representative for District 8

Phyllis Hazel
Manager of School Based Wellness Centers
Visiting Nurse Association

Elvina Knight
Principal
Caesar Rodney High School

Dennis Kozolofsky
Director of School Mental Health Program
Delaware Department of Education

Pam Locke
School Nurse
Hodgson Vocational Technical High School

Martin Luta
Chief of Bureau of Communicable Diseases
Division of Public Health
Delaware Department of Health and Social Services

Cathy Mosley
Director of Sexually Transmitted Diseases
Division of Public Health
Delaware Department of Health and Social Services

Janet Ray
Education Associate for Comprehensive School Health
Delaware Department of Education

Jaime Rivera
Director
Division of Public Health
Delaware Department of Health and Social Services

Dennis Rozumalski
Director of School Mental Health Services

Paul Silverman
Associate Deputy Director
Division of Public Health
Delaware Department of Health and Social Services

Martha Toomey
Director for Exceptional Children and Early Childhood Education
Delaware Department of Education

Iona Truesdale
Regional Administrator
Kent County Division of Family Services

Department of Children, Youth and Their Families

Valerie Woodruff
Secretary of Education
Delaware Department of Education

Sandy Voss
Nurse Practitioner
Smyrna High School
Center Coordinator
Bayhealth Medical Center

Linda Wolfe
Director of School Support Services
Director of Connections to Learning
Delaware Department of Education

Ed Waples
Supervisor of Alternative Programs
Cape Henlopen School District

Appendix 6

Highlights from Key Informant Interviews

Does the current model for the wellness centers still work for Delaware?
The answer to this question was a resounding yes!

"The wellness centers are more important now then when they first began"

There was unanimous agreement that the model of providing health and mental health services to adolescents through the wellness centers is working well and is good for young people in the state. One person interviewed said, "They (SBWCs) are a part of us". This statement reflected the enthusiasm and support expressed by the people interviewed.

There was greater diversity in responses when interviewees were asked about the initial goals for the school based wellness centers. While all agreed that the wellness centers were intended to increase adolescent access to health care, some felt that a secondary goal was to reduce the level of teen pregnancy. However, as one informant stated, "the intent to use the Wellness Centers to provide reproductive health care to adolescents seemed to get derailed before it even began." Reproductive health care was not part of the service package offered by first school based wellness centers in Delaware and has remained off the list. Other informants suggested a subsidiary goal was to reduce infant mortality rates by improving the health of adolescents through increased access to health services. Despite the different takes on original program objectives, all agreed that the wellness centers have provided much needed access to comprehensive health care services to adolescents in Delaware teens.

Professional Staffing Model

Does the current staffing model for the centers still make sense?
A consensus 'Yes' again.

There was also unanimous support for the current staffing model for the centers. The core clinical staff, as spelled out in vendor contracts with the Division of Public Health, are a full-time mid-level medical provider (NP or PA), a mental health provider and a part time nutritionist. One interviewee stated, "the three disciplines together are vital".

School Nurses and School-Based Health Centers

Do they get along?
Mostly.

Most reported that collaboration between school health (school nurses) and the wellness centers at community and state levels has been a consistent strength. While at the school level, some reported that the collaboration was uneven, but most felt that the school nurses and centers worked well together to meet the needs of students. Several noted that school nurses are some of the biggest advocates for the centers. For the most part, those interviewed felt that school nurses and wellness center staff work well together making the wellness centers successful at the school level. As evidence of this, someone commented that "school nurses can make or break a center".

Challenges to collaboration appear to arise when the health suite is not located near the wellness center. It seems that the closer the nurse's office is to the center, the stronger the collaboration. Although relationships are generally good, suggestions were made that there is room for more "bridge building", cross training and strengthening the relationships.

Staffing the wellness centers is a challenge for the health care organizations that manage the centers. The current state contracts require them to meet specific staffing standards. These standards have not been adjusted to account for cost of living/funding increases in the contract amounts for the past several years.

Wellness Center Expansion to Serve New Populations

Should the high school wellness center model be expanded to serve middle schools or elementary schools?
Absolutely "yes" in the case of middle schools; less enthusiasm for adding elementary schools.

The interviewees unanimously supported expansion of the centers to middle schools or, at a minimum, to reach out to 7th and 8th graders. There was agreement that the middle school students were in great need of both medical and mental health services. One respondent noted that "by the time they are in high school, their habits are set." Because a significant number of students are beginning to experiment with high-risk behaviors in middle school, several interviewees were concerned that younger adolescents had little in the way of guidance or prevention programs.

Elementary school expansion received less support among those interviewed. There seemed to be consensus that this age group has better access to primary care and that there are better mental health service supports in the elementary schools.

A number of respondents were cautious about expanding the Wellness Centers into new populations. They were concerned that current programs needed to be fully funded and needed to meet the needs of the high school students before the target population was increased. "We need to do a good job with the programs we have and then expand to the middle schools". Others cautioned that any expansion should be data driven and include the opinions and input of families and local communities.

Changing the Wellness Center Service Mix

Should the Wellness Centers Provide New Services?
It all depends on which services.

Mental health. The majority of those interviewed felt that more mental health services were needed in existing wellness centers. Community-based mental health services are seen as very limited, hard to access, and not available for addressing crisis situations. Not surprisingly families have difficulty accessing community-based services and have come to rely on the school based wellness centers as their main source of mental health care for their children. "The wellness centers are the first line of defense in counteracting the growing problems brought about by poverty and violence."

Reproductive heath. A significant number of respondents expressed their desire to see the wellness centers offer reproductive health services. "If we could give out condoms, we could reduce the spread of disease and teen pregnancies." It was strongly felt that at a minimum, the wellness centers should be doing STI, HIV and pregnancy testing and should also be authorized to treat STIs. Some suggested that a few vocal community members have been responsible for limiting the availability of reproductive health services. Some said it was time to "be brave" and re-open the issue of current limits on reproductive health care.

Early intervention and disease prevention**.** Some informants expressed concern that the original intent for the centers to focus on early intervention and disease prevention had not maintained the importance it once had. It was thought that this lack of time and focus on prevention services has been influenced by (1) the need to provide medical and mental health services at a level that meets a contractually obligated standard based on school and wellness center enrollment, and (2) level-funding of the centers over the past several years. Some commented that the need to see kids for higher-level clinical problems (those generating ICD-9 or DSM-IV diagnoses) have hampered the ability of the wellness center staff to provide some of the value-added prevention and early intervention services. Some of these non-diagnostic services included participation in health education classes, offering "lunch and learn" opportunities, health fairs and other group classes to students on health and wellness issues.

Other services. Other service expansions that were suggested included an increase in nutritionist hours to help counteract the growing problem of obesity. Oral health services continue to be missing in action for low-income kids and was also recommended as a needed service by several.

Advocacy

Do the Wellness Centers have sufficient advocacy on their behalf at the local and state levels?

There's a sense that there are opportunities to strengthen the voices that speak on behalf of the centers.

When asked about the current role of the mandated School Based Wellness Centers Advisory Councils, some were very knowledgeable due to either current or past service on one. Others were not aware they existed or did not know there was a center for every school based wellness center.

For those who were knowledgeable, some of the suggestions on the role and function of the councils included the following:

- We need to maximize their contribution and encourage their local and state advocacy efforts. Public advocacy for the Wellness Centers was not seen as highly visible or a constant in child health policy discussions.
- It would be helpful to have the advisory councils communicate directly with the Division of Public Health so that DPH could incorporate the views and thoughts of the councils into their wellness center planning.
- A few suggested that there needed to be a statewide advisory group that could act in conjunction with the local advisory councils to share data, information, procedures and advocate for more services
- Membership on the advisory councils should be standardized in order to ensure that there is diverse and active representation from the community and provider perspectives
- The advisory councils are useful in providing input on their individual centers however they are fragmented and limited to local focus

Other diverse thoughts on advocacy included:

- The wellness centers should work with the school nurse advocacy group that has been a strong leader and voice on children's health issue.
- Opportunities exist to inform and educate others about school based wellness centers as a resource.
- Advocacy efforts of the advisory councils and other organizations have been effective in preventing erosion of the current program but have not been sufficiently focused on growing the program.
- Advocacy efforts in Delaware tend to be disease specific or limited to particular communities.

- When asked about the value of the National Assembly on School-Based Health Care in supporting the Wellness Centers, few knew about it and its work in supporting the growth of centers in other states. There was some support for the idea of exploring a state level organization that focused on school based wellness centers either as an affiliate of the National Assembly or independent.

Wellness Center Assets

The overwhelming response from the interviewees was their strong belief that school based wellness centers in Delaware are a great resource for adolescents: They increase access to health care, enhance the ability to do comprehensive risk assessments and improve the connections between the students and their regular source of primary health care. They are effective at improving communications with parents, reduce the burden of chronic medical conditions, improve academic progress and school attendance and are a major source of mental health care.

Some of the specific services that were mentioned as having great value included immunizations, the ability to provide students with the yearly-required sports physicals so they can participate in team sports and the immediate access to needed medical and mental health care.

Overall, those interviewed felt that the wellness centers were well integrated into the schools and seem to have broad support among school leadership.
Some of those interviewed said that they are not sure if teens would seek or get care if not for the school based wellness centers were not there for them.

The feeling was that, overall, students believe the care is confidential and are very comfortable seeking care from the wellness centers. Wellness centers allow kids to get to know the health care system and helps them become “health literate” and learn to better navigate one they are adults. Some felt that the wellness center becomes like “moms” for the students especially those who do not have anywhere else to turn for support. One person stated, “getting services to those who are underserved is hard and the wellness centers are the first line of defense.”

Opportunities for the Future

Even with overwhelming support for the wellness centers, there were a number of areas that were identified as needing attention to strengthen the centers and move them forward.

- Many thought there was a need to increase information exchange about wellness centers among state agencies, vendors and clinicians. Routine updates would facilitate on-going program awareness.

- Many thought there was a need to strengthen the link between the school based wellness centers and academic outcomes. There are opportunities for the wellness centers to be more involved in the school improvement process and a stronger tie to academic achievement and the mission of the schools would strengthen the wellness centers.

- Some felt that there was a need to alter a perception that the wellness centers are “owned” by the DPH. Some felt this perception has led to a lack of “buy in”

from other child-serving agencies and offices. It was suggested that by creating a stronger link to other child serving agencies and departments, other state agencies responsible for children's well-being might contribute to center resources . One example cited was Children's Mental Health services. Since the need for mental health services is high and the community services have been historically difficult to access for the teen students, stronger ties could lead to co-location or other support for the mental health services in the centers.

- A few who were interviewed expressed an interest in having joint/cross training opportunities for school nurses, school-based health centers, and other school-based student support services. There was a time when these types of trainings occurred, but over time they were discontinued. There was thought that a return to these joint trainings would encourage better collaboration, joint-learning opportunities and maximize communications.

- Some felt that the State would be well served if there were some statewide organizing or oversight group for the school based wellness centers. This advisory body could provide an opportunity to bring the entire child serving agencies and offices together along with representatives from the vendors and providers, parents and community to provide oversight, input and coordination for the school based wellness program. This would allow for the flow of information from the centers and the communities to the state and vice versa. Many feel that more data and information needs to be shared in order to make informed decisions about where the wellness centers are now and where they are going in the future. Sharing of information needs to be institutionalized and standardized.

- Another theme that emerged was around parent/community engagement as well as education and outreach to the students. Some expressed concern that the families, students and communities were not as well informed about the wellness centers as they could or should be. Some felt that students might have a negative view of why or who uses the centers for medical care ("they are either gay or pregnant"). Some thought that communities, parents and school boards might be more open to discussions about the current service limitations and/or expansion of services were they more informed and received regular information and data about the services and why students come to the center.

Finally, it is important to note that the interviews did not include questions about funding. However, the topic was raised by many with whom we talked. The funding issue came up in relation to services, staffing, expansion and the future of the school based wellness centers in Delaware. There were many who thought it important to re-consider earlier decisions about Medicaid billing and other insurance billing for services provided by the school based wellness centers. There were also some who expressed a strong

desire to work with insurance companies around reimbursement for care and services. And finally, there were suggestions that, after so many years, the DPH contracts with the medical vendors should be reviewed with an eye to assessing how those contracts reflect the state's current priorities for school-based wellness centers. As one informant put it, "If not now then soon, Delaware has to be looking at the funding."