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Connecting Kids to Care: Developing a School-Based Telehealth Program

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A B S T R A C T

School-based telehealth is an efficient and effective way to overcome barriers to care and improve health equity for children in rural and underserved communities. Empowering health care providers, such as nurse practitioners, to develop successful, sustainable programs may contribute to improved access to care and improved health outcomes for the children served. Using a structured framework for program development is essential to successful implementation when connecting school-age children to care through a school-based telehealth program. The Telehealth Service Implementation Model provides a robust structure with requisite components to develop and implement a successful school-based telehealth program.

Introduction

Establishing a statewide school-based telehealth (SBTH) program extends the reach of health care to students who otherwise face barriers to care. SBTH can increase the efficiency of care delivery by allowing one provider to serve multiple schools on the same day, overcoming many of the sustainability barriers to in-person school-based health programs, particularly for smaller and more rural schools.[1]

After a review of SBTH and program operation, this report describes the development and implementation of a successful SBTH program in South Carolina (SC) that includes collaboration with local nurse practitioners (NPs) and physicians. The interprofessional SBTH leadership team responsible for program development and expansion consists of the lead NP, a pediatrician, and 2 public health professionals. The intent is to highlight lessons learned and best practices on the development and implementation of a successful SBTH program established using the Telehealth Service Implementation Model (TSIM) framework to empower others to do the same. One caveat readers must consider is their own local contexts, laws, and regulations.

School-Based Telehealth

Although health care services for children from early Head Start through high school are available in many locations, significant health care disparities exist with regard to health care access and quality of care.[2] Barriers to accessing health care services include geographic distance, transportation, poverty, inadequate health insurance coverage, and a lack of providers in a community.[1] In SC, a lack of access to health care is evident, in that 44 counties, or 95.6%, of SC's counties, are designated as full or partial Primary Care Health Professional Shortage Areas (HPSAs).[3] Additionally, the poverty rate is the ninth highest in the country,[4] with more than 20% of children living in poverty.[5] Individuals who live in poverty are less likely to have access to health care compared with high-income individuals.[2] Specifically, low-income families may experience stressful circumstances that lead to difficulties in receiving regular preventative and primary care such as financial difficulty, job instability, and an inability to manage stress.[6]

One of the most obvious places to address access barriers for children is through the school system. It is well documented that healthier students are better learners and that health factors have effects on educational outcomes.[7,8] School-Based Health Centers (SBHCs) serve an essential role in providing access to high-quality care to underserved students in more than 2,500 schools across the United States[9] and have been established since the late 1960s.[10] SBHCs have been shown to improve academic outcomes, reduce student absences,[11] decrease hospitalization and emergency department (ED) use for children with asthma,[12] and improve adherence to guidelines for managing attention deficit hyperactivity disorder (ADHD).[13]

Despite the numerous benefits of SBHCs, some programs struggle to continue to offer services due to a lack of sustained funding.[1] Telehealth offers a solution to improve efficiency and potentially sustainability. Multiple schools can be served on the same day, by the same provider, allowing for resourceful use of the provider's time. For example, one NP can conduct telehealth visits to any participating school on the same day. This maximizes the NP's capacity because the number of referrals at a given school may range from few to many. An NP may be physically located in 1 SBHC providing care in person while incorporating telehealth visits to distant school sites.

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Table
Challenges and Best Practices

Challenge	Best Practice
School nurse availability	Optimize efficiency: • Limit time spent requesting and conducting visits • Easy-to-use technology • Consider electronic scheduling and request system • Ensure workflow at provider site promotes a rapid response and connection
Facilitating multiple providers serving a single school or district efficiently	• Limit school nurse time and effort to coordinate a visit • Establish an automated tiered call pool
Missed class time for students	• On-demand model allowing a rapid connection to complete the visit and return the student to class • Coordinate nonurgent visits around student class electives or breaks to avoid missing core classes
Gaining trust in new communities	• Establish a community advisory board inclusive of local stakeholders and school-based telehealth staff • Invite local providers to participate • Establish a marketing plan in collaboration with school district
School nurse adoption	• Ensure a strong education and training program • Conduct mock visits and ongoing “check ins” • Provide ongoing support and resources • Build strong relationships between providers and school nurses
Consent forms	• Include consent to treat, Health Insurance Portability and Accountability Act, & Family Educational Rights and Privacy Act • Valid the entire time student is enrolled in the district unless revoked • Ensure inclusion with student registration • Mimic district registration process (electronic vs paper) for program enrollment
Electronic health record	• Modify to ensure compliance with telehealth billing requirements and facilitate data collection • Ensure a single provider is able to be scheduled in multiple locations on the same day, if more than one school is being served
Security and privacy Secure transfer of documents between school nurses and providers (consent forms, medication order forms etc.)	• Leverage secure electronic platform to share documents with protected health information • Store consents in electronic health record or other secure location • Consult compliance team to ensure security and privacy of patient information

SBTH in rural and underserved communities provides an opportunity to increase health care access[14] by offering an innovative strategy to effectively and efficiently provide access to health services. Over the last several years, the number of school-based programs serving rural communities has increased due to telehealth.[9] There are more than 260 SBTH locations across the country increasing access to health care to approximately 165,000 students.[14] SBTH can support the delivery of health care to children in the school setting without requiring parents and guardians to miss work or arrange for transportation to a provider's office.[15] SBTH programs have been shown to improve care of children with type 1 diabetes,[16] reduce student absences,[17] and reduce stress for caregivers.[18] Additionally, studies demonstrate positive outcomes among children with asthma, including improved symptoms, reduced health care use,[19] and reduced ED visits.[20] This is significant, because asthma is the most common chronic disease of childhood[21] and is associated with high rates of school absenteeism.[22]

Despite the many benefits of SBTH, providing care in an environment focused on education rather than health care presents unique challenges, as outlined in the Table. Using a framework to guide program development can ensure incorporation of best practices designed to mitigate these challenges. The Table summarizes common SBTH challenges and best practices to overcome them.

Program Overview

The Medical University of South Carolina (MUSC) SBTH program began in 2013 and has expanded to more than 70 schools statewide since its inception. In 2013, the SC Legislature appropriated funds to expand the use of telehealth statewide. The use of these funds, administered through MUSC, allowed for the creation of the South Carolina Telehealth Alliance (SCTA), a consortium of representatives from the major health care systems, state agencies, and other key stakeholders. In 2017, the MUSC Center for Telehealth (Center) was designated by the Health Resources and Services Administration as 1 of only 2 National Centers of Telehealth Excellence.

The MUSC SBTH program is a hub-and-spoke model that connects schools across the state to health care providers at the academic medical center and/or to local community providers. The interprofessional SBTH team consists of NPs, pediatricians, and public health professionals as well as nurses and a medical assistant who assist with care coordination. The program facilitates collaboration between NPs, physicians, and school nurses to extend the scope of care available to students at school. A telehealth cart with secure Health Insurance Portability and Accountability Act–compliant video conferencing and telehealth peripherals (digital stethoscope, otoscope, examination camera, and dental mirror) is placed in the school nurses' office of participating schools. The telehealth program is not a school service but rather a health care service occurring at the school. When students require care beyond what the school nurse can provide, an NP or pediatrician can be contacted to evaluate the child and determine the best plan of care.

The MUSC SBTH program networks with local private practices and health centers to provide care via telehealth to local schools and supports program development for provider groups across the state. For example, Federally Qualified Health Centers are guided through program development and receive ongoing support as needed. If requested by the local provider group, the MUSC SBTH clinical team serves as backup providers to support an efficient response to a visit request in the event the local provider is not available. The goal is to partner with the medical home to ensure children receive the care they need to remain healthy and able to learn.

Figure 1. School-based telehealth workflow: Consents are completed before the visit, the school nurse completes a nursing assessment and initiates a referral, the visit takes place, the student returns to class, prescriptions are sent to the pharmacy and the primary care provider is notified of the visit outcome.

All children in a partner school are eligible for services, provided the parent or guardian has completed a consent form. Consents may be completed at any point during the school year electronically or in paper form. The consent forms include consent to treat, Health Insurance Portability and Accountability Act consent to allow the provider to share information with the school nurse as necessary, Family Educational Rights and Privacy Act consent to allow school personnel to share information with the provider, and a demographic form. One key advantage is that MUSC SBTH consents are valid as long as the child remains in the specified school district, even if the child changes schools, unless the parent revokes it.

Workflow

When a student presents to the school nurse with a chief concern, the nurse completes an assessment following established nursing guidelines. If the nurse determines that further evaluation is needed by an NP or physician, they will contact the family to share their recommendations and offer SBTH as an option. For example, if a child presents with a sore throat and headache, the nurse would appropriately be concerned about possible streptococcal pharyngitis. If the parent or guardian is supportive, the child can be assessed through telehealth, a rapid strep test completed, and a diagnosis made without the child having to leave school. Once the diagnosis is made, the child is returned to class unless established school exclusion criteria are met. This expedites health care for the child, reduces missed class time, and supports the school nurse in determining whether the child must be excluded from school to reduce the spread of communicable disease. Visit lengths vary based on the child's condition but are typically less than 15 minutes.

This program uses an electronic scheduling platform allowing the school nurse to request a visit with the NP or physician. The platform sends a series of alerts to a pool of providers ranging from the most local to those at the distant academic medical center. This model of care allows for care to be kept as local as possible while still providing the nurse with a quick connection.

Once connected, the visit takes place as it would in a regular clinic setting. The school nurse serves as the telepresenter and operates the technology with the guidance of the connecting provider. Basic tests and medications, including rapid strep tests, albuterol, and prednisolone are provided. Following SC mandate, in

which standing orders are not to be used in school health, these are only for use within the context of a telehealth visit with a specific order from the provider. After a thorough history and physical examination, the diagnosis is made, and necessary prescriptions are sent to the local pharmacy. With an additional parental consent, delivery pharmacies are used to deliver the medications directly to the school. If the parent is not present or participating in the visit by phone or video, they are contacted afterward. A visit summary note is then sent to the medical home (Figure 1).

Care Provided

This SBTH program provides both acute and chronic care management. Acute visits include common childhood illnesses such as pharyngitis, upper respiratory infections, lice, rashes, and asthma. Other than true emergencies, referral conditions are not limited. If a visit is not able to be completed through telehealth, the provider must acknowledge the need for in-person care and connect the patient to the most appropriate care provider for their condition. Chronic care visits in this SBTH program include the management of asthma, ADHD, and specialized mental health care. These conditions were chosen based on a combination of community need, stakeholder request, and suitability for the school setting.

This SBTH program provides management of acute wheezing episodes as well as long-term management of patients with asthma who have barriers to accessing care locally. School nurses are encouraged to identify and invite students with asthma to participate in the program who may be experiencing decreased access to primary care, preventative or rescue medication, or who are unable to return completed order forms for medication administration at school. Once a child is enrolled in the program, a thorough asthma assessment is completed, appropriate controller and rescue medications are prescribed, medication administration forms are signed, and an asthma action plan is provided to the school and family along with thorough asthma education. Additional asthma education sessions through telehealth are provided by an experienced respiratory therapist asthma educator at no charge.

Throughout the program, the same approach is used to offer asthma education, ensuring consistent terminology. Simple techniques are used such as labeling inhalers as “rescue” and “controller.” In many cases, the school nurse may provide the controller medications in school, allowing for consistent administration of the medication and leading to decreased exacerbations. Appropriate follow-up appointments are then scheduled to ensure the student’s asthma remains well controlled.

Visits for ADHD are scheduled in advance with parents’ or guardians’ attendance required at the first visit each school year to ensure a thorough history is obtained. For subsequent visits, parents may be available by phone or video. Validated symptom assessment forms are provided to teachers before each visit. In many cases, medications are administered by school nurses. Therefore, a mechanism has been implemented to allow the school nurse to request a refill directly from the SBTH team. Collaboration between the NP, physician, parent, school nurse, teacher, guidance staff, and others at the school allows for a more comprehensive assessment of the student’s condition. This facilitates interprofessional communication leading to a comprehensive approach to managing a student’s ADHD to achieve the best possible outcomes for the student.

This program also offers a specialized type of mental health care in select schools that is limited in availability across the state, trauma-focused cognitive-behavioral therapy.[23] This type of therapy addresses symptoms of posttraumatic stress syndrome in children and involves weekly telehealth visits for 16 to 20 weeks with a psychologist or licensed clinical social worker.

Sustainability

To increase sustainability, a diversity of funding is warranted. Funding for the telehealth technology is provided through the SCTA, and therefore, there is no cost to the school, the school district, or the connecting provider from the local community. Support for the program is also provided through grants, community partners, and billing revenue. Services are billed by the distant site provider using the typical outpatient evaluation and management (E&M) codes with a modifier indicating that the visit was completed via telehealth. Visits are covered by SC Medicaid at the same rate as in-person care, but reimbursement by private payers varies. To ensure that claims are submitted correctly, telehealth visit type and place of service is required.

TSIM Model and Program Development

The Center created TSIM to provide a consistent framework for telehealth service development. The application of TSIM to SBTH program development will be reviewed here.

The 6 phases of TSIM include pipeline, strategy, development, implementation, operations, and continual quality improvement, as shown in Figure 2. Each phase builds on the previous.

The SBTH process begins with the pipeline. Requests to develop a new SBTH location may be initiated by local health care providers, schools, or other stakeholders.

During the strategy phase, the SBTH leadership team, school districts, and key stakeholders work together to identify common goals and keys to the success of the program in that specific community. This phase includes providing an overview of the program, determining local provider participation, executing agreements, and developing a marketing plan. Initially, the expansion of the SBTH program was based on precise public health deployment addressing health and educational disparities. To guide ongoing expansion, a statewide school-based telehealth workgroup was formed through the SCTA.

The first step in the strategy phase is to meet with school district leadership and community stakeholders, such as a local provider group, to provide an overview of the program. Often local providers have an existing relationship with a school district. This phase includes executing agreements between MUSC, the school district, and local provider group(s). The MUSC legal team worked closely with the SC Department of Education legal team to create agreements and consent forms early in the development of the program. After approval from district leadership, the SBTH team provides an overview presentation to school nurses, because it is very important to gain their support early on.

During the development phase, a telehealth network engineer connects with the school district information technology (IT) team to complete a thorough IT assessment ensuring there is a dedicated data port, space for the cart, sufficient bandwidth, and firewalls are opened to support the telehealth visits. The telehealth equipment is then ordered. If a local provider group is participating, an IT assessment is also completed for the practice. The only necessary technology on the provider end is a computer, webcam, and headphones with a microphone. A few additional business requirements are completed in the development phase such as adding the school to the program’s Clinical Laboratory Improvement Amendments (CLIA) Waiver to allow point of care testing onsite, ensuring the electronic medical record is set up to support the school location and visit type, and developing a consent form

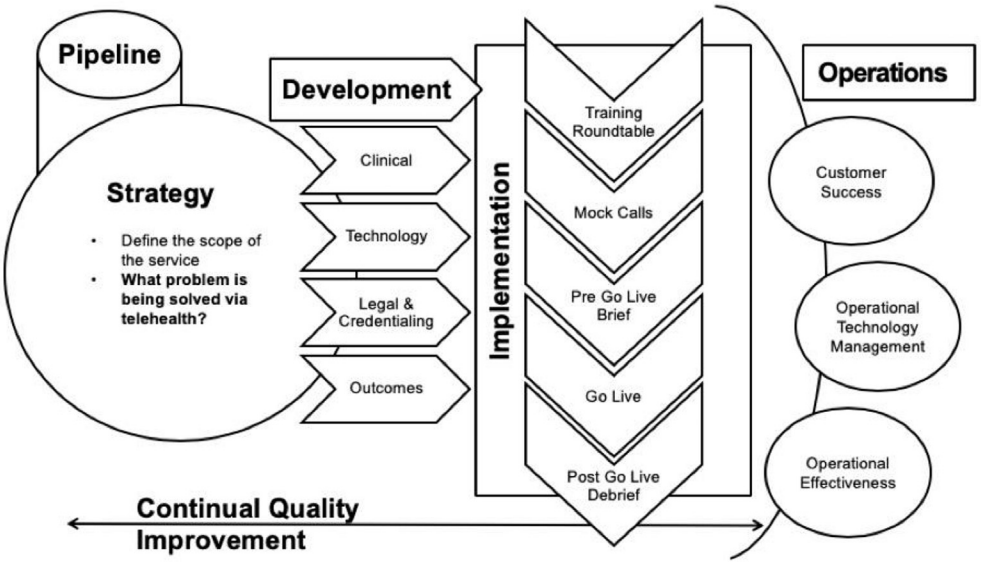

Figure 2. Telehealth Service Implementation Model phases and related domains. Copyright © 2019-2020 MUSC Foundation for Research Development, All Rights Reserved.

distribution plan. Goals and outcomes measures are also defined in this phase.

During the implementation phase, the focus is on educating school nurses and providers, as well as initiating mock calls, which help ensure the equipment is working properly and that end users are comfortable conducting visits. The lead NP oversees the development and implementation of training and education for the program, which includes the consent process, technology use, workflow, documentation, billing, point of care testing training, telehealth etiquette, examination techniques, and communication and care coordination after the encounter. In addition, provider-specific training includes the importance of maintaining standard of care, communicating with the student's medical home, and reviewing laws pertaining to telehealth care. Ongoing support and training are provided along with a comprehensive manual. After training, mock calls are completed between the school nurse and participating providers. If the mock calls are successful, plans for starting the service are communicated to all stakeholders.

The operation phase focuses on launching the program. Once a school is live, the marketing strategy is implemented, which includes a range of initiatives to increase awareness and enrollment of the program through student registration, social media, and the school district's websites. For new SBTH districts, strategies include collaborating with the district to host a press conference announcing the service to the community. Attending back-to-school events, parent meetings, and sporting events is also helpful in building awareness of the program.

The continual quality improvement phase includes ongoing evaluation of the program and monitoring process measures, such as use and student enrollment, in addition to key performance indicators such as provider response time. Quality and outcomes measures have evolved as has the program.

Outcomes

Defining outcomes that are relevant to the program, its stakeholders, and its stage of maturity is an important part of telehealth program development. In the earliest stages of program development, it is important to identify the problem that the program seeks to solve and define the issue in a quantifiable way. This sets the stage for further defining process metrics that are most relevant to stakeholders such as parents, health care providers, school officials, payers, and other funders. These metrics of success can then be used to track progress and guide development, growth, and trajectory of the program. Examples of such metrics during each stage of program maturity are used to illustrate this concept here.

While this SBTH program sought to broadly combat health care disparities for children, this was narrowed further to target preventative care for asthma. Educational disparities were also considered, and when these 2 disparities were mapped they defined the footprint for program expansion, one of the earliest process metrics. This targeted approach to a public health intervention allowed resources to be used for maximum impact.

As the program transitioned to operation, further process metrics, such as counts of students who enrolled and used the program and parent satisfaction, were collected. Enrollment and use data helped refine practices for marketing and school nurse engagement. Understanding that parents felt that the program was indeed helping to overcome their barriers to care ensured that the program was also meeting the needs of this important stakeholder group.[18]

Technical and clinical quality metrics are both essential as use increases. Because technical quality and efficiency of care were important to school nurses, tracking time from request to provider connection has helped to further refine the use of call pools and local provider engagement. As the program matured and responded to stakeholder interest in the treatment of conditions such as ADHD and childhood trauma, it became increasingly important to monitor the quality of care for these conditions. Studies found that the care provided via this telehealth program achieved traditional quality metrics as well as, if not better than, in-person care.[13,23]

Most recently, as the program has reached maturity and is serving larger numbers of children, a population health approach was used to determine associated rates of ED use among children with asthma. This study determined that rates of ED use among all children with asthma and access to the program have continually decreased over the course of the program's existence. This outcome emphasizes that the association extends beyond the children

directly served, indicating a likely "spillover effect" to all children in the county.[20] In Williamsburg County, SC, there was approximately a 21% reduction in ED visits among children with asthma in the first 2 years of the program and a 35% reduction in the third year.[20] Continuing evaluation of cost-effectiveness and value-based outcomes are ongoing as the program continues to mature.

Conclusion

SBTH is an efficient and effective method of care delivery that can overcome barriers to care for many families. Ensuring a successful program requires dedicated planning, development, and implementation. Applying a standardized framework to program development may contribute to reaching established goals and outcomes. Developing a strong collaborative interprofessional network focused on achieving the same SBTH goals may not only improve patient outcomes but also contribute to improved health equity for children.

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