White Paper

The SMART Student Health and Wellness Approach
A Holistic Model for Achieving Health and Education Outcomes in Support of Diverse Communities

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PREFACE

CVS Health is proud to be a sponsor of the SMART Student Health and Wellness active engagement model. The impact of health on one’s ability to learn is firmly embedded in our company’s purpose of helping people on their path to better health. Without good physical and mental health, you can’t learn. And if you can’t learn, you can’t earn. To that end, as a country, we spend a significant amount of time and resources at local, state, and federal levels assessing how we can better educate our youth, enabling them to engage in the pursuit of happiness as productive citizens in society. To further advance this dialogue, we need to frame it in the context of where education, health, and workforce intersect. The SMART model does just that.

SMART Student Health and Wellness, at its very core, completely disrupts the usual approach to student health services by integrating health and wellness, education, and work readiness with the primary objective of each student reaching grade-level competence in their education. Throughout many of our communities, it’s clear that we have significant skills shortages that are often only being addressed with short-term approaches, which are simply not adequate in meeting the contemporary workforce needs of employers. SMART is leveraging an active access strategy that is having a direct, measurable, and lasting impact on exponentially increasing educational outcomes even in the face of a host of negative factors outside of the school environment. At CVS Health, we believe that every young person has unique potential waiting to be unleashed. SMART collaborates with educators to help put every student on a solid foundation and enables them to determine the path they will choose to walk.

We didn’t know where this journey would take us as we embarked upon this partnership four years ago. With our collaborating partner Ginn Group Consulting, the Chicago pilot brought together our unique public-private partnership—Sullivan High School, Kilmer Elementary School, the Hispanic Heritage Foundation as our multicultural advisor, and our current medical partner, Heartland Health Centers. We truly couldn’t be more excited or proud of where we’ve come thus far. We hope to build upon the momentum of these results, bringing even more stakeholders to the table in the spirit of replicating the model and committing to continuous improvement for the sake of our young people, who are the very fabric of our nation’s future.

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The SMART Student Health and Wellness Approach\textsuperscript{1}: A Holistic Model for Achieving Health and Education Outcomes in Support of Diverse Communities

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"Education is the most powerful weapon which you can use to change the world."
—Nelson Mandela

Supporting our nation’s children to be able to live healthy, successful, and productive lives remains a priority for all our communities. Much of this work rests on the opportunities and resources provided in schools, where health and educational programs and interventions are interwoven through a complex and ever more diverse system to support the needs of students. Yet, despite major efforts in schools across the country to improve school outcomes, persistent and significant gaps remain across almost every indicator of school success. For children at risk, those living in poverty or under-resourced areas and who have disabilities, these health and educational disparities are quite stark (Children’s Defense Fund, 2017).

Significant research over several decades has shown that comprehensive school health programs can be a means for efficiently improving the health and education of all Americans (Kolbe, 1993; Blum et al., 2004; Bond et al., 2007). However, traditional school-based health centers have not always been effective in reaching a significant majority of students for the provision of care, nor in directly and positively impacting student academic outcomes. Furthermore, as a result of certain constraints in service delivery systems, these traditional school-based health centers have had a limited impact in reaching a wider group of students in the schools in which they are embedded (McNeely et al., 2002; Keeton, et al., 2012).

This white paper describes the development and evolution of a highly promising and effective new model, SMART Student Health and Wellness (SMART), that explicitly focuses on positively influencing student academic outcomes, particularly in urban and rural schools serving low-income communities, while delivering financially sustainable, cost-effective services and resources for schools and communities. The SMART

\textsuperscript{1}SMART\textsuperscript{™} Student Health and Wellness Model was developed by Ginn Group Consulting, with thought-leader collaboration and funding support from CVS Health ©2017.
approach has reimagined and reconstructed a new model built on research-proven, data-driven, and effective practices. This paper draws from a qualitative study undertaken through interviews, observations, and analyses of primary documents, metrics, utilization data, testimonials, and resources shared with the research consultant (the author of this white paper).

**The SMART Student Health and Wellness Model**

Strategies that integrate health and education to Maximize and improve Academic success, Reaching all students to ultimately impact the Trajectory of lives.

The SMART approach and model was developed by Melanie Ginn, of Ginn Group Consulting, and born out of a thought leader partnership and long-term collaboration with CVS Health Workforce Initiatives. This interdisciplinary team of experts was asked to intervene and save a traditional school-based health center slated for closure at Sullivan High School, a public four-year high school located in the Rogers Park neighborhood on the north side of Chicago, Illinois. Sullivan is a part of the Chicago Public Schools district. The partners’ goal was to address the critical problem of poor health outcomes, which adversely affect academic achievement and graduation rates, and in turn affect a young person’s ability to meaningfully participate in workforce opportunities.

The SMART model was intentionally designed as an entrepreneurial solution to strategically solve this problem and create value in an area (traditional school-based health), where many programs have not only failed in reaching a significant percentage of the school population, but have also failed to manage costs, and deliver outcomes (as opposed to activities). At its heart, the Ginn Group entered this work with the following critical questions:

1. What problem are we trying to solve?
2. What business are we in?
3. What outcomes are we delivering—cost to whom and benefit to whom?
4. How can we ensure sustainability?

This approach created a clarity of purpose and a business/entrepreneurial mindset that imbues everything about the way SMART operated and measured its success from early start-up to this day.

The SMART model was developed as an innovative clinical, operational, and entrepreneurial solution, with the explicit aims of integrated care, broader reach, and impact on more students, for lower costs and with better outcomes. While the traditional school-based health clinic, co-located in the school in a reactive stance, was only primarily meeting the acute needs of a small percentage of the population (less than 15–20% on average), SMART set out with purpose and intention to proactively ensure the wellness of every child in the building, and then developed engagement and
consenting strategies and tactics to fulfill that promise. The results were immediate and extraordinary. By year one, the SMART clinic had consented 76% of the building and cared for 88% of these students. By year three, it was 92% consented and 92% consented seen (see attached SMART Summary Report Card Metrics in Appendices).

The model embodies the following characteristics:

- Proactive (active care, delivered through active access)
- Preventive
- Population-focused (ensure wellness of all, rather than reacting to acute needs of a few)
- Integrative
- Grounded in behavioral change theories (health belief, risk reduction, stages of change, and theory of reasoned action)
- Behavioral health focus on preemptive screening
- Brief treatment and solutions-based care that builds resiliency and self-care
- Data driven, in real-time
- A continuous quest for improvement

The opportunity to design and implement the SMART model initially came in the form of a request to save a failing, existing school-based health clinic at Sullivan High School. Rather than providing significant financial resources just to keep the clinic operational, a public-private partnership was developed between CVS Health, Ginn Group Consulting, and representatives of Chicago Public Schools, with the recognition that an investment to innovate in this area would ultimately result in meaningfully meeting the needs of students, the school, and the larger community, and be worthy of replication. As one CVS leader commented, “Building stronger communities is and should be part of outcomes for corporations like CVS.”

Ginn was funded by CVS to work on the ground to perform due diligence on the clinic’s failing status, and she was given the mandate to find a way to keep the school-based health clinic at Sullivan High School open for at least one more year. A health system group was recruited as the initial medical provider partner, and the Hispanic Heritage Foundation joined as an advisor on culturally responsive community practices. Thus, a close-knit group of local stakeholders was formed, including the principal of Sullivan and the principal of an adjacent elementary school, Kilmer. Once this partnership was formed, the work “to crack the code on school health viability and sustainability,” as Ginn puts it, began.

The result today is a thriving flagship SMART Student Health and Wellness Center that has also included the adjacent Kilmer Elementary School (PK–8) with Heartland Health Centers currently serving as the medical provider partner executing and maintaining fidelity to the model, with Ginn as the pioneering architect, and CVS Health as the funder. The purpose of SMART is to improve student academic performance and school climate and culture through the proactive provision—named active access—of preventive and integrative physical and emotional health care—deemed
active care—of students attending Sullivan High School and Kilmer Elementary School (see Appendices for more detailed definitions of active access and active care). The SMART process is one that promotes individualized and aggregate care, informed by relevant data at each step, which ensures continuity of care and timely treatment and follow-up (see Figure 1 for SMART Student Health and Wellness Model Process).

Ginn and her team had a very short timeline to design and implement the model (less than five months), and the results came just as quickly. Within the first few months, they had broken traditional consent and utilization records, and within the first year, the school experienced dramatic increases in attendance, academic achievement and school ratings, and reductions in disciplinary incidents.

**Figure 1. SMART Student Health and Wellness Model Process**

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**Essential Factors for SMART Model Efficacy**

The SMART Student Health and Wellness Center has a team of critically engaged professionals, who are trained not only to deliver health care to students, but also comprehensively trained in the SMART model approach, so that daily practices and interactions with students, families, school staff, and relevant stakeholders are informed by a deep understanding of the SMART characteristics as described above. Indeed, the team’s unique abilities to embody these characteristics in their daily interactions is a critical strength and essential pillar of the SMART model.
Another critical aspect of the model is the **deep collaboration between the SMART team and the school staff**. The school administrators at Sullivan and Kilmer view the goals of the school and the SMART team as being well-aligned. There is clear visibility of the work they are undertaking together, and the relationships are robust. One school leader said, “Upon reflection on the greatest differentiators in the turnaround of this failing school, I credit the SMART clinic in having the greatest depth and breadth of impact on our ability to educate students, an impact that will last far beyond our students’ high school years.” Still another school leader, articulated that the “SMART clinic is a seamless partnership. I would not ever know that it is a separate entity. There are shared beliefs and a shared love of the students and the community.”

The **leadership and critical partners’ fidelity to the model** is also an essential driver of the effective outcomes achieved by the SMART model. The presence of visible, engaged leadership on the ground from the creative force behind the model has been essential to effective implementation of the model. The Ginn Group Consulting team has facilitated relationships and managed the public-private partnerships, stakeholders, and the resources in a shared governance model that has embedded both professional development training and support to empower all stakeholders to fulfill their roles and responsibilities. In interviews with the SMART clinic team, CVS corporate partners, health system providers, and the schools’ leaders, it was remarkably striking how the stakeholders in this public-private partnership so clearly articulated their shared goals and the deep understanding of the implications of their proactive, prevention-focused ambitions as illustrated in Figure 2.

*Figure 2. SMART Student Health and Wellness Model Impact Through the Lifespan*

![SMART Student Health and Wellness Model – Trajectory of a Life](produced_by_ginn_group_consulting_a_division_of_msa_management_llc_2016)
The SMART model is a **culturally responsive model** that honors the complexity of the diversity of intersectional identities, experiences, and circumstances of the students, the unique characteristics of the school culture in which it is embedded, and the larger community and surrounding neighborhoods where students live. The culture in which one lives impacts one’s attitudes, thoughts, feelings, and actions—whether one has a developmental disability or not. Being able to bridge the gap between those who serve students and the cultural background of the students served will strengthen, support, and facilitate the well-being of students as they plan their academic and future life goals. There are many benefits in being culturally responsive. Among the benefits are the abilities to:

- Facilitate a more nuanced and comprehensive understanding of the individual and how they live their daily life
- Convey to people that they are thought of as individual human beings with unique experiences
- Effectively communicate culturally responsive choices and their consequences for the individual and the community
- Be cognizant of the many circumstances and contexts, with the goal of responding nimbly and appropriately

The sum of these positive benefits is the ability to be responsive to the needs of individual students and their families as they make choices and plans, which are based on a framework influenced by their cultural background and life contexts (Hanson & Lynch, 1992; Kalyanpur & Harry, 1997; Bruns & Corso, 2001; LeRoux, 2002). The SMART team has embedded culturally responsive practices at every level of their work with students and with the schools. This is exemplified through the unique customization of the SMART model as it enters new schools and new geographic regions. The SMART team’s approach to engagement, needs identification, and intervention design intentionally considers cultural contexts, while maintaining fidelity to the core principles of the model’s purpose and approach.

The SMART model is a **cost-effective and financially sustainable solution.** CVS Health invested in providing business expertise via the Ginn Group, and Ginn, in turn, treated CVS cash commitment as an investment in producing a working model, not a grant that when exhausted, leaves operations in jeopardy. In maintaining a commitment to preserve fidelity, Ginn’s priority was to imbue the model with recognized key business fundamentals and a day-one goal of creating sustainability. Adhering to her “de-siloing” approach, Ginn recognized that in any operationalized model, the concepts of “purpose” and “financial sustainability” were inextricably linked. This entailed a two-step process: (1) prioritizing the investment of resources in academic purpose (cutting costs, eliminating waste, and appropriating resources in activities that deliver key outcomes), (2) meeting the goal of “wellness of every student in the building” (increased productivity, increased billing revenue, and increased outcomes to more stakeholders).
The Kilmer-Sullivan SMART clinic immediately tripled the number of students receiving care (from 128 to 358 students, representing a 180% increase) through renewed focus on its daily purpose, while reducing costs on many levels. These increases have continued significantly to this day, proving the new model’s capacity to do more with less. Over its first three years as a start-up operation, the Kilmer-Sullivan SMART clinic remarkably increased productivity through the number of students served (288%), quantity of encounters provided (197% increase), and efficacy of care delivered. In doing so, it also dramatically increased reimbursement revenue. Its flexible staffing model cut overhead by 20–35%. Additionally, financial sustainability was improved through a variety of other business and entrepreneurial strategies and practices, including “growing the business prior to increasing overhead,” investing in engagement and marketing, and innovatively utilizing existing spaces to reduce capital and facility costs. The model emphasizes daily performance and impact fueled by the real-time collection and reporting of data to improve student outcomes and accountability.

Prior to commencing a SMART start-up operation, Ginn’s team works closely with health care providers, conducting due diligence on the reimbursement systems in that state/region to maximize all potential revenue sources. Furthermore, they consider more effective approaches to lowering costs, while increasing quality and impact in meeting the needs of students. During the initial years of operation, they continue to work closely with their medical provider partner(s) to ensure that the most comprehensive and accurate coding and billing practices are consistently deployed to capture maximum revenue. Determining and maximizing reimbursement during a particularly unstable period within the health care landscape continues to be one of the greatest challenges. Ginn’s message to payers, public and private, is that models that deliver maximum benefit to large populations at lower costs should be rewarded with expedited and adequate reimbursement.

Finally, from the macro view, Ginn draws upon several key principles, (1) *silos solutions add unnecessary cost, waste, and duplication of service*, (2) *serious problems call for swift solutions; too much time is a momentum killer that adds costs and lowers accountability*, and (3) *SMART does not need “new money” or complex policy “add-ons” to be successful*. There are copious amounts of resources currently appropriated for the purposes of providing health care and educational supports to at-risk and vulnerable populations. The SMART approach and model works to ensure that existing dollars reach the largest percentage possible of their intended target population for the best outcomes. Ultimately, by stating academic competence as its purpose, SMART delivers health care that has the greatest statistical capacity to affect long-term socio-economic status and related health status as adults. This will save system costs and is the very definition of “breaking the cycle of poverty.” From the beginning, this was the shared vision of Ginn and CVS Health.

**Landscape for Traditional School Health Programs**

The SMART Clinic and school health programs in general operate in a landscape where approaches to educational outcomes and health outcomes are often implemented in silos, indifferent to the interconnectedness of the problems as illustrated in Figure 3.
Research has indicated a number of barriers to the means by which traditional school health programs have attempted to collectively address the problems identified in Figure 3. These barriers have included:

1. Lack of administrative support
2. Local obstacles
3. Limited governmental support
4. Conventional patterns of funding education and health promotion programs

*Figure 3. Problems Pertaining to Education, Health, and Workforce Issues*

Too often, there is skepticism about the merits of such comprehensive programs, as school stakeholders see health issues as not central to their goals, and health programs are not sufficiently knowledgeable about how to directly influence school outcomes within a complex web of medical care providers and social services agencies (Allensworth & Kolbe, 1987; Symons, et al., 1997; Lister-Sharp et al., 1999).

From its earliest inception, the SMART purpose, approach, and model systematically addressed these barriers through the buy-in of critical public-private partners, who all recognized that education, health, and workforce problems are all enmeshed and interconnected and must be addressed collectively. This was achieved within the SMART model at the Kilmer-Sullivan Center by focusing on addressing the key drivers of these problems in students' lives, as seen in Figure 4, and then, distilling down to specific physical, mental, and behavioral areas identified in Figure 5.
Figure 4. Key Drivers of Problems Impacting Students’ Lives

Research-Proven Connections Between Education, Health, and Workforce

- High Disciplinary Referrals
- Poor Attention Span and Focus
- Poor Attendance
- Risky Behaviors
- Chronic Disease
- Poor or Lack of Family Supports

KEY DRIVERS OF THESE PROBLEMS

Figure 5. Student Physical, Mental, and Behavioral Areas to be Addressed

Research-Proven Connections Between Education, Health, and Workforce

- Lack of Sleep
- Physical and Emotional Abuse
- Violence
- Physical Inactivity and Unhealthy Eating
- Early Sexual Initiation, Teen Pregnancy and Childbearing
- Substance Abuse
- Mental Health
- Poor Communication and Problem Solving Skills

WHAT FUELS THE DRIVERS?

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The school environment is pivotal in addressing the intersection of health promotion to ultimately affect academic outcomes for students (Blum et al., 2004). Roughly 56 million children in the U.S. are enrolled in public schools and spend about half of their waking hours in school (Center for Education Statistics, 2010). Thus, the impact of creating an effective infrastructure like the SMART model could have wide-ranging positive effects in improving the short-term and long-term consequences of low or poor academic achievement (see Figure 6).

*Figure 6. Consequences of Low Academic Achievement*

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<th>Implementaiton of SMART Model: Lessons from the Trenches</th>
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<td>The collective work of communities, as defined by the U.S. Departments of Education (ED) and Health and Human Services (HHS) should be about “working each day to help children grow into healthy and well-educated adults.” They go on to say that “this work depends on strong sustainable partnerships and commitments between health and education agencies at the local, state and federal levels... Being able to provide wraparound services benefit students, especially those who are low-income, chronically absent, homeless or otherwise are at risk of falling behind in school.” (Health and Human Services and Education Department Joint Letter to Chief State School Officers and State Health Officials, 2016).</td>
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<td>Implementation of the SMART model and the business/entrepreneurial approach of the collaborating partners (Ginn and CVS) has illustrated the critical need for these</td>
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partnerships to engage private entities (corporations), non-profit health care agencies, insurers/payers, families, and community groups in a cohesive and comprehensive manner. For such partnerships to be truly successful, they require **focused leadership, training, and regular facilitation and monitoring** to ensure alignment of practices, metrics, and communication of shared values.

The Ginn Group Consulting team worked directly with Sullivan High School and the medical provider to implement the SMART model. CVS provided the funding to facilitate the implementation of the model into an operationalized entity and continued to remain engaged as a supporter and thought leader partner. The existing, traditional school-based health clinic was disbanded, and the SMART model operational plan was executed, with particular attention paid to the following:

- Re-imagined purpose, linking health and educational goals
- Development of an operational business/entrepreneurial model
- Buy-in from school leaders and teachers to achieve integration within the school
- Aligning practices to metrics and outcomes
- Active system for consenting of and access to students
- Hiring the SMART team with capacity and experience to execute goals, and providing ongoing professional development
- Development of a customized database/information system for tracking and reporting on outcomes
- Building an accountability plan for stakeholder partners

When taken together and built into the operational plan, these areas are key differentiators in the successful application of the SMART model.

Over three years out from implementation of the model in Sullivan High School, interviews have indicated a seamless integration of the SMART Center into the daily lives of students, faculty, and school leaders. Clarity of purpose fueled the building of strong relationships and community-building that have been at the heart of its success.

School administrators and teachers have found the SMART team to be accessible and increasingly essential partners in facilitating improved student outcomes. The SMART team has won the hearts and minds of staff and parents by being present and open to ideas for collaboration, creating new resources and support for the school, screening for early identification and intervention on problems, and being willing to problem solve through issues that are brought to their attention. As one school leader indicated, “The SMART model helps keep kids in school and embodies the importance of supporting the whole child to have impact.” He goes on to say that “the public-private partnership is essential—for support and accountability. The SMART model is committed to meeting academic benchmarks and is focused on student outcomes. At the core are relationships and the ability to listen for the stories (transcend trajectories). They (SMART team members) understand what we all want this school to look and sound like.”
Students comment about the importance of the SMART team in navigating health and educational challenges. They say that the “clinic is helpful to all students and helps them deal with personal issues. When they needed additional support, they started a support group for them.”

One of the students shared their narrative and indicate the type of support they have received by articulating, “It helps me a lot; makes me feel comfortable. The anger management group released tensions, and I learned to pay attention and listen.”

The SMART Clinic has also been instrumental in helping students manage academic work and prevent or get ongoing treatment for health care issues.

The comments from the students, as shared below, illustrate the depth of their connection to the SMART staff:

“A thousand words would never be enough to explain what the clinic means to me. Over the past three years, I have worked with some amazing women, who have taught me how to be a woman. I love the staff in the clinic because they know how to make you feel welcome. They always were honest and loving no matter what the situation was. I was treated as if I was their child, as if they watched me grow up right in front of their eyes. My sophomore year at Sullivan I had a lot of doctors’ appointments that I occasionally missed school for, until I found out about the Kilmer-Sullivan SMART Health Center. At first, I was not comfortable going because of the past nurse we had freshman year here at Sullivan. She was not the worst nurse, but she was not the best either. Walking into the clinic was a new and improved environment that we never had here at Sullivan. My junior year of high school I only missed four days because all of my appointments were here at the Kilmer-Sullivan SMART Center, which was better than missing seven or more days. The clinic has changed the way I look at my health; now I am more aware of what my body is telling me. I used to say if it is not hurting me, I am healthy. I am entirely grateful to the clinic not only because they have increased my knowledge about my health, but they helped me grow as a person. Without the clinic, I would not be the person I am today; I would not be able to say I accomplished so much without their help.”

“It (the SMART Clinic) has really made an impact on my outlook on what I accomplished through my overall health and ability to stay in school and get good grades by personal counseling. Counseling has helped me understand where I used to stand and made me realize where I stand now because any problems or decisions that I had, I could simply make an appointment and just discuss what I believed was right, which then afterwards made me realize that perhaps I wasn’t so right with my decisions or that I had to improve with my lifestyle. My lifestyle impacted me to change and improve on my schoolwork and try my hardest to get good grades, so that I would be able to satisfy my family and myself. It has also helped me in maintaining my attendance and academic goals and achievements based on the decisions that were agreed would help me in succeeding through high school. Back to the learning of how to control my asthma—that has helped me to be healthier—since before I was simply too afraid to run or exercise, and mostly my fear was from
suffering an asthma attack, but as I was taught these methods in being able to control my asthma, then that lessened the fear that I had. It even encouraged me to try sports, so that I can lose weight and build my body up, so that it matched with my height, which I did through cross-country and wrestling. Though at first it was very hard, but practice after practice I was mostly getting the hang of it. Yet, at the end I did suffer a few minor asthma attacks. But I would have never known of what I was capable of doing if I had never stepped foot into the clinic and had the opportunity to talk with the nurses and discuss methods that would control my asthma. So I’m really appreciative for all the things that they have done to secure that students like myself are in good hands and get all the necessary treatments that we require.”

Another positive impact has been the students’ view of SMART staff as role models and mentors. A number of the students indicated that because of their exposure to the kinds of health care work done by SMART staff, they began to see themselves in these types of careers in the future (e.g., counselor, physical therapist, nurse practitioner).

For students, the SMART Clinic has been a special place. They comment “SMART has been a family—like a HOME. SMART is comforting, peaceful—a place to get suggestions and advice.”

“The clinic had a huge effect on my success and continuing my education here at Sullivan. I was allowed to talk to the social worker about my situation at home. He didn’t only allow me to talk about my mother, but he also provided encouraging words. My health over the 3 years has changed a lot as well, but the staff in the clinic were there for everything—when I was having troubles with my knees to just having a simple headache. It truly is heartwarming to have health care officials in the building that actually care about your overall health. But the staff don’t only care about when you’re sick, but also when you’re doing well. There have been a few instances when I haven’t been down to the clinic in a while and they would stop me in the hallway to talk about school and transitioning from high school to college. They don’t only care about my health, but about my life. It truly means a lot to me knowing that I have a safe space and people in the building who I can always talk to. I’m really sad that I’ll be leaving Sullivan this year but knowing that I had and hopefully continue to have such a wonderful support system. The staff and just CVS themselves has not impacted my life and health but improved it.”

The implementation, however, has also had its challenges. School leaders noted philosophical differences at times and that the negative reputation of the previous school health team left a lot for the staff to overcome with students and teachers alike. The SMART Team understood that not all students can advocate for themselves and thus, may be reluctant to initiate going to the SMART Clinic. In addition, work still needs to be done to come to a shared understanding of how risk assessment data will be used and how the students that are now known to be at a higher risk for poor outcomes will be prioritized. There is also ongoing work to develop new programs. While school staff were initially apprehensive about the SMART Clinic’s integration in the school, that has been mostly alleviated by the daily presence of a SMART staff role, the Utilization and Engagement Manager. This person serves as a liaison between the school and the
clinic and is responsible for engaging with students, parents, and faculty, as well as ensuring all students in the building are consented and seen at the SMART clinic. There is still additional training that could be done for school staff, and that is now underway.

However, many implementation challenges ultimately resulted in better outcomes and innovations, as is the goal. For example, as Ginn’s SMART experts worked with school and health care providers to navigate the vast Federal Regulatory environment on issues such as FERPA, Section 504 of the Rehabilitation Act and new ESSA (Every Student Succeeds Act) legislation, they discovered a great capacity for SMART Centers to support improved compliance for the district and administrators for better student outcomes in these areas.

The SMART model must also continue to invest in leadership development, in order to fully provide a broad and deep understanding of risk assessment, trauma, knowledge, and critical consciousness. “We all need to continue to be educated about the issues,” according to the principal of Sullivan High School.

Other school leaders indicated that the differentiators of the SMART model included being “student-driven, culturally aware; not numbers or funding driven but somehow still achieving the outcomes we all want.” The SMART model has an “authentic presence in the school.”

Additional lessons learned include developing a better understanding of SMART operations as a complementary, yet different business unit of primary care, requiring its own unique set of operational elements, staffing requirements, and culture, in order to maximize efficacy and fulfill its academic purpose. The activities and programs of the SMART clinic continually work to be aligned with the goals of the school community. The funding is used to help the entire community. The data that is being collected is important for tracking and reporting on individual student outcomes and impact on the school and community overall. More importantly, due to its business lens, the data is entered, extracted, and analyzed in real time to assess individual and aggregate needs and design interventions and follow-up.

One of the most profound results of SMART’s intention and design to reach the entire student and school population with a goal of wellness to support education, has been a stunning and swift de-stigmatization of the seeking and receiving of physical and behavioral health care supports and interventions with the students. When over 90% of the students are receiving any number of types of care, wellness becomes an expectation and self-advocacy and receipt of care is normalized. This in turn, has fueled the model’s capacity to impact school climate and culture by maximizing the potential for prevention and the earliest possible identification of need and risk levels and delivery of interventions.

Finally, the SMART model has facilitated both climate change and culture change, empowered staff, and set concrete expectations about a sustainable student-focused, mission-driven, and financially solvent model.
Future Considerations for Scaling and Dissemination of SMART Model

The SMART Model’s initial replication is already underway. Year one of start-up operations in two rural Alabama sites is nearly complete, due diligence is in process to open sites in the Maryland/D.C. region in August 2017, and there are requests to consider other urban and rural locations. In considering the dissemination of the model, a critical challenge will be maintaining the “fidelity and flexibility of the model,” as one of the CVS leaders articulated during an interview. It is essential that the SMART model is able to adapt, while local school and medical community leadership demonstrate a willingness to change, for the sake of the evolving educational landscapes and the changing nature of student issues.

In the interviews with stakeholders at these new implementation sites, there have been high levels of enthusiasm about the SMART model because of its emphasis on prevention and the behavioral health focus. They indicate that “their students have many issues at home,” and if they could be exposed to and learn about new coping skills (such as anger management), they believe and have experienced that student outcomes can be significantly improved over a short period of time. The risk assessments conducted within the SMART model have also been a positive feature. These stakeholders have also indicated that resource-poor schools serving students who come from families with limited means will benefit tremendously from the implementation of the SMART Student Health and Wellness model. The parents will also see beneficial outcomes in this model. The cost-effectiveness and sustainability are also factors, which stakeholders in potential implementation sites saw as essential to eventual adoption of the model in their schools. In addition, the mechanism of consenting and ongoing access to patients are positive features of the model for health care providers. They see this model as providing them with more capacity to flex and pivot around the rapidly changing landscape of students’ needs and insurance/payer issues (notably changes to the Affordable Care Act, etc.)

Despite the enthusiasm of many of these new and emerging implementation sites, there are challenges in scaling. Some academics and clinical stakeholders will note their perceived need for more rigorous evaluation data to assess efficacy of the model across different sites. While the model’s creators welcome additional analysis on evaluation of impact, the foundational clinical and educational aspects of the interventions are already well documented, as are the model’s metrics by site. The SMART model is able to execute and take “the sum of the parts” to facilitate exponential gains at lower costs to more students by taking research-proven practices and carefully aligning these practices within the nested systems of school, community, cultural, and health care provider contexts in order to meet the needs of as many members of its student populations as possible. The very nature of the model, combined with the necessity for timely response to the high levels of students’ needs make traditional experimental and even quasi-experimental studies challenging. Additionally, the business/entrepreneurial thought leaders engaged with SMART have indicated that the highest priority be that new resources be invested in the delivery of more care as well as the type of real time data
collection, reporting, and performance measurement that SMART already employs to quickly support schools and students.

The importance of the model should also continue to be examined through the lens of a public health perspective. New implementation sites also need to consider the facilities/space issues for ensuring the integration of a SMART clinic into a school. There are territorial staff issues that must also be systematically addressed among the school staff. In considering new sites, SMART leadership must continue to work on the multiple competing agendas within different school systems, reimbursement policies of individual states, and assess differing fiscal viability of the model within certain communities.

As the SMART leadership looks forward to scaling and dissemination, they are mindful of the possible threats to successful adoption and sustainability of the SMART model. These threats may be categorized as follows:

- Institutional barriers—groups/individuals have differing views of the benefits
- Primary care framework—access issues
- Payers/insurance providers—reimbursement structure
- Entrenched thinking from different stakeholders, existing silos and territorialism
- General apathy among relevant stakeholders
- Stakeholders viewing change as a critique rather than a way to continue to thrive

Mindful of these threats, Ginn Group Consulting has undertaken and will continue to push for comprehensive needs assessments and ongoing discussions with stakeholders at implementation sites to ensure that these potential threats are addressed and consensus on mutual benefits is built.

**Summarizing Impact of the SMART Model**

Extensive interviews with the SMART leadership and staff revealed a number of critical differentiators of the model:

1. This is a win-win model that yields critical short-term and long-term benefits for multiple stakeholders.

2. The model is designed for speed of execution and delivery of outcomes.
   a. Quickly reduces barriers and threats to implementation
   b. Achieves momentum by providing visible benefits to stakeholders
   c. Ongoing due diligence and assessment of practices

3. The model has built-in flexibility, which allows for timely adjustments, so that a site can change course immediately with minimal interruption or harm.

4. There are visible and quantifiable lower costs of implementation and a higher return on investment (ROI).
5. The SMART leadership team is always questioning and critiquing the model’s practices, activities, metrics, and outcomes in a quest for continued improvement.

6. Each SMART model site is designed to be an entrepreneurial entity.

7. There is a focus on “investment thinking” (rather than grant-thinking) in the context of all resources, including cash, time, and staffing. There is a real understanding of risk reward ratios and the limited window to achieve return on investment.

8. Using relevant research and data from sites, the SMART model was ahead of the curve in implementing effective practices across the intersections of population health care, reimbursement models for prevention activities, and the ESSA (Every Student Succeeds Act). However, now the model sometimes has to wait for systems to “catch up.”

9. The SMART leadership team has been fearless and untiring in thinking about possible solutions, as well as sufficiently persistent in getting to the right approach to achieve outcomes.

10. The SMART model is a pragmatic model that positions itself as able to adapt within a changing landscape, and it is also able to assess what constitutes real success even as it recognizes when to cut its losses.

In summary, the SMART model has been able to demonstrate a cost-effective, outcomes-based, student-centered, integrated school health solution that consistently promotes health and learning outcomes as inextricably tied and synergistic. With the support of the public-private partnership and Ginn’s intentional prioritization of academic outcomes within a traditional medical model, the SMART model has leveraged the expertise and resources of its stakeholders to develop and sustain a comprehensive and holistic array of health and educational services centered on students’ needs, while also meeting the larger needs of the school community. As education reform and health reform debates continue, it is vital for all advocates for youth well-being (especially those from under-resourced communities) to develop broader public-private partnerships, which can cultivate inclusive health and education practices in a nested system of wraparound services, which will allow us to achieve our collective goal of delivering quality health care and education for every young person in this country.

“All young people who have utilized or been touched by the SMART model have been given an opportunity to more fully explore their capacities and potential to become the next generation of leaders in our society. We can do no less than to invest in resources aimed at supporting all of them on their journeys.” —SMART Student and Health Center partner stakeholder
References


SMART™ Definitions:

SMART’s Active Access is only deployable when care is embedded within a location in which a given population is during most of their daily lives (e.g. a school for children between the ages of 4 and 18).

Active Access leverages the real-time availability to see a student/patient due to geographic location within their school, combined with the intention, strategies, and tactics to do so through (1) the proactive messaging of purpose, (2) normalizing wellness, (3) engaging and partnering with school administrators, (4) collecting parental consents, and (5) proactive scheduling of preventive care and screenings to ensure wellness. Active Access places the responsibility on the providing organization to possess a purpose, initiative, and engagement, as well as to effectively brand, communicate, and market that purpose, secure consents, and initially drive utilization.

Active Care (AC) is the ongoing engagement, the drive of utilization levels, and the follow-up for the provision of proactive, integrative, physical and behavioral care—both preventive and acute. Active Care operates with the purpose of ensuring wellness and preventing illness and negative outcomes, resulting in the reduction of barriers to academic achievement. The hallmark of Active Care is the continuous leveraging of the daily physical proximity of patients to drive in-depth student relationships, the identification of needs, high compliance and adherence levels, and appointments and follow-up for care. Successful delivery of Active Care involves establishing (1) clinical needs, (2) follow-up for chronic diseases and/or acute needs, (3) continued efforts in contributing behavioral health interventions, (4) continuous focus on breaking down barriers to academic achievement for every student, (5) provision of preventive and urgent care for school faculty, staff, and families to support students, and (6) intentional building of increased levels of health literacy, resiliency, and self-care to support students’ success in school and their knowledge, skills, and behaviors to continue to successfully navigate and manage health issues as adults.

Active Care, which is made possible by the initial deployment of Active Access, is fueled by a strong sense of purpose, urgency, and an entrepreneurial drive to reach more students, provide more support, care, and interventions, and deliver more outcomes. Reaching a level of 100% in every meaningful outcome metric is the goal of each, so the work is never done. Additionally, a significant outcome of the successful execution of Active Access (with its consistent average engagement level of over 90% of a given student population) is the de-stigmatization of seeking and receiving health care, which in turn increases student utilization, peer referrals, adherence, and compliance.

While Active Access is proactively driven by the provider to build relationships and initiate care, Active Care then results in an ongoing reciprocal relationship between providers and patients/students—comprised of continuous outreach, data analysis, follow-up, and availability to serve by the provider. The result is a building of the knowledge, skills, and behaviors of students/patients to continuously seek, receive, and be compliant to care plans that will improve their outcomes.
Acknowledgements from Melanie Shaw Ginn

“The only real voyage of discovery consists not in seeking new landscapes, but in seeing with new eyes” —Proust

The SMART Student Health and Wellness model was made possible by the commitment and dedication of many individuals willing to journey on the road less traveled and to see with fresh eyes. As we look to the future, working with key stakeholders in the education and clinical arenas, as well as policy makers, and corporate and community stakeholders, I would like to offer heartfelt appreciation and acknowledgement to those that played a key role in making the SMART Student Health and Wellness Model a reality:

CVS Health Workforce Initiatives—the late, and very beloved, Steve Wing, for his vision, compassion, and fearlessness; Ernie DuPont for his unwavering commitment, insights and courage; David Casey for his bold energy and support; and Irvine Porter, for staying curious and making connections.

The many educators and medical provider professionals who were willing to make meaningful changes, philosophical and operational, to pave the way for a faithful alliance in creating SMART, including Megan Erskine, Chad Adams, Jean Papagianis, Emily Rivera, Sandra Manogura, Leatrice Winslow, Mary Crang, Stephen Bord, Evan Rogers, Anne Bendik, Valerie Strattan Guerra, Augustine Emuwa, Matthew Fasana, Jennifer Foss, Noe Torres, Sarah Quintenz, Tony Smith, Julia Garcia, and the entire faculty, staff, security, engineering, and custodial teams of both Sullivan High School and Kilmer Elementary for their true partnership and commitment to kids.

The precious students of Sullivan and Kilmer, and their families, for entrusting us with their care and confidences and their willingness to embrace the active access to information, care, and counsel provided. The SMART Team adores you and will carry you in their hearts always.

The Ginn Group Consulting Team, veteran and newly joined, for their indefatigable spirit, intelligence, commitment, and joy expressed for this work—Karina Rincon, Lauren Revella, Andrew Gluck, Renee Claborn, Dr. Kori Jones, Angela Elles, and most especially my brilliant and caring husband and GGC legal counsel, Stacy R. Ginn, JD.

Special note to those who played unique and specialized roles in this process—Antonio Tijerino and the Hispanic Heritage Foundation team, Roberto Callejas, Claudia Horn, Mary Wing, and Elaine and David Wilkinson.

And those who are working to represent the current expansion and replication of SMART—Gwenn Rausch and the Heartland Health Centers team, Cara Locklin, Jeff Pyritz, Vantone Barber, Deborah Tucker, Dr. John Brandon, and Whatley Health Services, Dr. Karl Hamner and the University of Alabama, School District of Pickens County, AL, School District of Walker County, AL, Tina Stevenson, Parthenia Oliver, Letisha Scott, Ashley True-love, Jenna Corley, Teirdre Owens, Patricia Adams, Dr. Faron Hollinger, Dr. Jason Adkins, Jamie Chapman, and Terry Sterling.

And finally, to Dr. Liza Cariaga-Lo, it is our great honor for you to take the time to understand, evaluate and tell the story of the development and outcomes of SMART. Your passion for innovation, wisdom, quiet counsel, gentle spirit, and words of affirmation are gifts to be treasured.
Note: The full-time flagship (primary) site is located at Sullivan High School with a part-time extension (outreach) site located at the neighboring Kilmer Elementary School. The Kilmer extension site is not fully staffed. Beginning in March 2017, a nurse practitioner is at the Kilmer extension site 4 days/week. Prior to that, on certain days of the week, a nurse practitioner from the flagship would rotate to Kilmer for a couple of hours, or children would be walked to the flagship site across the street. We anticipate that Kilmer will become a fully staffed site for the 2017-2018 school year.

### Sullivan High School (FLAGSHIP) Demographics
- 38% Black, 39% Hispanic, 6% White, 17% Other Race.
- 87% Low Income, 33% Limited English, 26% Special Needs.

### Kilmer Elementary School (EXTENSION) Demographics
- 25% Black, 55% Hispanic, 6% White, 13% Other Race.
- 94% Low Income, 54% Limited English, 24% Special Needs.

<table>
<thead>
<tr>
<th>Kilmer Elementary (Extension) and Sullivan HS (Flagship), Comparison with School Year Prior to SMART</th>
<th>School Year</th>
<th>Year 0* 2012-2013</th>
<th>Year 1 2013-2014</th>
<th>Year 2 2014-2015</th>
<th>Year 3 2015-2016</th>
<th>% Increase Year 0 vs. Year 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unique Patients</td>
<td>258</td>
<td>472</td>
<td>712</td>
<td>828</td>
<td>221%</td>
<td></td>
</tr>
<tr>
<td>Physical Encounters</td>
<td>1,165</td>
<td>1,898</td>
<td>2,767</td>
<td>3,436</td>
<td>195%</td>
<td></td>
</tr>
<tr>
<td>Behavioral Encounters</td>
<td>388</td>
<td>899</td>
<td>800**</td>
<td>1,072</td>
<td>176%</td>
<td></td>
</tr>
<tr>
<td>Faculty Encounters</td>
<td>0</td>
<td>69</td>
<td>176</td>
<td>109</td>
<td>109%</td>
<td></td>
</tr>
<tr>
<td>Total Encounters</td>
<td>1,553</td>
<td>2,875</td>
<td>3,743</td>
<td>4,617</td>
<td>197%</td>
<td></td>
</tr>
</tbody>
</table>

*Year 0 represents the year prior to the implementation of the SMART model.

**In Year 2, the SMART Center was without a behavioral health provider for 3.5 months until December 2014.

### Sullivan High School & Kilmer Elementary School Population
- **Sullivan (Full-Time Flagship)**
  - Year 1: 535
  - Year 2: 560
  - Year 3: 591
- **Kilmer Population**
  - Year 1: 820
  - Year 2: 781
  - Year 3: 777

### Risk Assessments (Health Surveys)
- **Full-Time Sullivan Flagship**
  - Year 1: 90% 70% 72%
  - Year 2: 88% 90% 92%
  - Year 3: 40% 57% 72%
- **Part-Time Kilmer Extension**
  - Year 1: 6% 9% 5%
  - Year 2: 14% 39% 43%
  - Year 3: 5% 22% 31%

### Medical Encounters – Screenings/Preventive vs. Urgent/Acute Care – Year Prior to SMART vs. Year 1, Year 2 & Year

#### Medical Encounters - Screenings/Preventive vs. Urgent/Acute Care

- **Year 1 of SMART**
  - Screenings and Preventive Care: 76%
  - Urgent/Acute Care: 88%
- **Year 2 of SMART**
  - Screenings and Preventive Care: 87%
  - Urgent/Acute Care: 92%
- **Year 3 of SMART**
  - Screenings and Preventive Care: 92%
  - Urgent/Acute Care: 85%

### Note:
- During year 1, behavioral interventions were focused on conducting risk assessments in the majority of the children. In year 2, the health center was without a behavioral health provider for 3.5 months, then, one of our nurse practitioners helped the new behavioral provider conducting risk assessments, while the behavioral health provider also provided brief treatment and a few group behavioral interventions. During year 3, our behavioral health provider focused on doing several group behavioral sessions addressing issues, such as anger management, depression, grief, and refugee adjustment, in addition to conducting risk assessments.

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**Sullivan High School Academic Outcomes Comparison**

<table>
<thead>
<tr>
<th>Academic Metric</th>
<th>Prior to SMART</th>
<th>Year 1 of SMART</th>
<th>Year 2 of SMART</th>
<th>Year 3 of SMART</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>School Rating</strong></td>
<td>Level 3 (Failing School)</td>
<td>Level 2</td>
<td>Level 2</td>
<td>Level 2+</td>
</tr>
<tr>
<td><strong>Attendance</strong></td>
<td>80%</td>
<td>85%</td>
<td>89%</td>
<td>87%</td>
</tr>
<tr>
<td><strong>Freshmen On-Track Rates</strong></td>
<td>61%</td>
<td>84%</td>
<td>88%</td>
<td>87%</td>
</tr>
<tr>
<td><strong>Graduation Rates</strong></td>
<td>51%</td>
<td>48%</td>
<td>59%</td>
<td>64%</td>
</tr>
<tr>
<td><strong>College Enrollment</strong></td>
<td>47%</td>
<td>52%</td>
<td>42%</td>
<td>52%</td>
</tr>
<tr>
<td><strong>College Persistence</strong></td>
<td>70%</td>
<td>63%</td>
<td>63%</td>
<td>63%</td>
</tr>
</tbody>
</table>

**Kilmer Elementary School Academic Outcomes Comparison**

<table>
<thead>
<tr>
<th>Academic Metric</th>
<th>Prior to SMART</th>
<th>Year 1 of SMART</th>
<th>Year 2 of SMART</th>
<th>Year 3 of SMART</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>School Rating</strong></td>
<td>Level 3 (Academic Probation)</td>
<td>Level 2</td>
<td>Level 2+</td>
<td>Level 2+</td>
</tr>
<tr>
<td><strong>Attendance</strong></td>
<td>94%</td>
<td>94%</td>
<td>95%</td>
<td>94%</td>
</tr>
<tr>
<td><strong>Chronic Absenteeism</strong></td>
<td>17%</td>
<td>15%</td>
<td>11%</td>
<td>13%</td>
</tr>
<tr>
<td><strong>Out of School Suspensions</strong></td>
<td>78</td>
<td>80</td>
<td>11</td>
<td>13</td>
</tr>
</tbody>
</table>

**Out of School Suspensions**

- Year 1 vs. Year Prior: Reduced by 72% (from 472 to 134)
- Year 2 vs. Year 1: Reduced by 43% (from 134 to 76)
- Year 3 vs. Year 2: Reduced by 12% (from 76 to 67)

Reference: [http://cps.edu/SchoolData/Pages/SchoolData.aspx](http://cps.edu/SchoolData/Pages/SchoolData.aspx)

**Note:** Sullivan HS had been a failing school in a downward trajectory for over 13 years, despite having numerous changes in administration and principals, and notwithstanding having an SBHC run by a different medical provider. After only 2 years, the school was removed from academic probation and has experienced significant improvement in every academic metric, with the only variables being the implementation of our new SMART Model working in partnership to support another new incoming administrative team. After Year 3, the school is now in good standing and rated as a Level 2+ by CPS.

**Additional Note:** This report represents a work in progress and contains preliminary results, some of which may be based on incomplete information or information that is subject to change. This report is CONFIDENTIAL.

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Dr. Liza Cariaga-Lo, Vice President for Academic Development, Diversity and Inclusion

Dr. Liza Cariaga-Lo is Vice President for Academic Development, Diversity and Inclusion and a faculty member in the Education Department at Brown University. From 2007–2012, Dr. Cariaga-Lo was Assistant Provost for Faculty Development and Diversity at Harvard University. She was previously Assistant Dean at the Yale Graduate School of Arts & Sciences and the Director of the Office for Diversity and Equal Opportunity, as well as a faculty member at Yale Medical School. She received her doctoral training in Education and Developmental Psychology from Harvard University. Besides teaching courses related to developmental psychology, minority health, and health disparities, Dr. Cariaga-Lo has also taught Asian American Studies and African American Studies courses and consults widely on cultural diversity and higher education issues. She is currently a member of the National Institutes of Health (NIH) NAGMS Council and has served as Chair of the NIH--NIGMS Minority Programs Review Committee and continues to work closely with other federal agencies and foundations on broad diversity initiatives to develop and support young scholars from diverse backgrounds. She has been the Director and Principal Investigator on a number of programs to prepare students for PhD training and to consider careers in the professoriate, including the Yale Post-Baccalaureate Research Education Program and the Summer Research Opportunities at Harvard program. Her areas of research include education program evaluation, minority student development, ethnic minority health care, and public policy affecting children and families. She was the recipient of the Chang-Lin Tien Leadership in Education Award from the Asian Pacific Fund in 2014. She is currently completing work on a book about the identity development of Asian Americans. Over the past two years, Liza has provided formative evaluation on the interconnectivity of health and education outcomes and innovative models that improve outcomes for at-risk student populations.

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