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| Data, Evaluation and Best Practices | |
| Date: | 9/29/2020 |
| Time: | 1-2pm |
| Location: | |  |  | | --- | --- | | Meeting URL: | <https://healthmanagement.zoom.us/j/91271393398?pwd=ZlhQTC9qYnB3aklhU3NWZWFVTjFJQT09> | | Meeting ID: | 912 7139 3398 | | Passcode: | 894728 | |
| Facilitator: | DIANA RODIN |

**Agenda**

* **Welcome and Call to Order**
  + Are participants comfortable with meetings being recorded?
    - Yes, recorded
* **Timeline/Process Update from the Co-Chairs**
* **Literature Review Reminder** 
  + Full literature review available in the [digital binder](https://dethrives.com/sbhc). For next week:
    - Please review pages 16-19 on best practices
  + Best practices matrix (to be emailed in follow-up)
    - Please review the best practices and competencies tabs
* **Brainstorm in Response to Research Questions** 
  + Research questions include:

**Data Questions**

* + - SBWCs are providing both behavioral health and physical health services – what is the impact of those services on attendance, behavior? (Christiana has examined this for Red Clay and Nemours for Colonial)
      * When talking about attendance and behavior, are we talking about before and after metrics?
        + For Warner Shortridge (?) we do have a baseline, and they do have a baseline for the Colonial schools. Wouldn’t be able to get baseline for HS unless you built a new school
      * Each HS is different in how they refer to behavior specialist. Need to be careful in counting referrals
        + In Colonial, they looked at referrals at Eisenberg for discipline and the fact that they went down—one school’s rules
        + Good Point: it will differ from school to school what it means
      * Data that links students participating in interventions and outcomes – Christiana works with the Data Service Center to get this
        + Christiana analysis—any other findings to highlight?

Warner is the first year, second year haven’t done bc of COVID so really cant make any comparison or share anything other than anecdotally they are thrilled to have SBWC

Colonial does have solid data—**who has? Can we get it?**

It would be helpful to know how Colonia collected the data, for how long, etc.

* + - * Make sure attendance means the same thing across districts—may have some discrepancies there
      * Behavior- they were looking at suspensions and expulsions and seeing ties to SBWC. They have to have PBS in place to help kids mitigate some of these consequences. If suspensions and expulsions get too high, they have to have a plan to minimize them.
        + 1) How is behavior related to SBWC, 2) and are administrators and teachers recording the behavior issues?

Districts aren’t always honest so that their numbers aren’t so high

Underreporting/no reporting

* + - * + A better question might be how does the teacher believe the student is behaving in the classroom from the start to end of the year?

Anecdotal, but if student is seeing SW on ongoing basis how has their behavior improved?

* + - * Academic data: Colonial was looking at test scores. Trying to make a correlation, but how do you capture that data with integrity? Is test scores the way to measure (and if no, how?)
        + Don’t want to act like if you open a SBWC you’re going to have huge academic outcomes
      * Causal pathways argument is problematic, more like unintended outcome **(Note: hard to hear everything Khaleel said here)**
      * Faulty to show causal relationship between contact with SBWC and increase in grades, but using ABCs is a method of early screening in schools for youth who may be in need of services in lieu of a formal tool – these are the measurements that schools are interested in. How can this be integrated to data conversations?
      * If we don’t look at try and figure out potential correlations we’ll never know. Don’t necessarily need to report out
    - Can data shed light on the impact on emergency visits, medical aid unit types of visits for certain populations?
      * ER visits for asthma – challenging to make connection because kids who access SBWCs are “sicker” kids. They are starting off at a higher level.
        + When you find no difference, people would assume there is no benefit of SBWC. But no difference could be a good thing—it means rates have not increased (although lower level would be ideal)
    - Is it possible to do some data mapping to see what instruments are used across SBWCs and whether they’re similar, current expectations and how data flows?
      * Policy subcommittee – all use different billing systems and EHRs (Bay Health, Christiana etc.) and these systems do not communicate effectively to pediatricians
        + Have something standardized across the board. How can you get good data if everyone is doing their own thing?
      * Transferring of data is also concern among medical sponsors
        + Had centralized database, as they transitioned, they wanted to be able to capture all the same data from the tables in that database.

Some medical sponsors are doing a good job, others aren’t able to transfer data at all because of security concerns.

Challenges—data with blanks because their systems can’t fill in the field they requested. Out of 32 sites, data collection is a mess (in terms of collection and transmittal)

* + - * Part of what this group can do is T- up what needs to be done from data standpoint so these questions can be asked on regular basis—develop data system that allows us to collect what we want (Least Common Denominator data that we need to collect that we can all agree that we need to conduct evaluations)
      * When you start talking about elementary schools and how they are funded (District or DPH)—you will have diff inputs for data which might be a concern as well.
        + Everyone will have to agree to core data sets that have both internal and external value
        + If districts want more, something additional will have to be figured out
      * Struggle that medical sponsors had: where do you go to get that data-set? DPH gets blank values because some schools can’t even pull the data requested
      * When you start working with some of the bigger health systems (e.g. Christiana), their systems can digitally map data points and integrate different data points together even without uniform data set
        + Don’t write off the ability to map if we need it (state might not have resources to come up with whole new data system)
      * When it comes to data collection, also remember insurance company and insurance codes—the following entities will want this data:
        + Health providers
        + SBWC providers
        + Insurance companies
        + Independent pediatricians
      * [Khaleel brought up Oregon example here and emailed it to us for best practices compilation]
    - Identify minimum data/benchmark performance indicators and ideal measures to track outcomes for students served by SBHCs K-12
      * Shares process indicators across levels:
        + Visits
        + Diagnoses
        + Risk assessments
        + Unduplicated users and those who’ve been seen more than once, particularly for MH visits
        + Data elements required by PH

(spreadsheet that Chris and Kathy were talking about)

* + - * + Descriptive data across all levels; characteristics of the youth served, characteristics of the services provided
        + Can you track the user to the use over time?

Kathy said somewhere you can drill down detail and get out who the kids are, but the provider knows who the kids are

* + - * + Wherever possible, they try to utilize standardized measures. Use national performance measures that span across all grades.

From literature, there are very low specific measures. Part of the challenge is that it focuses a lot on provisional services

* + - * + Types of services provided (particularly elementary)
        + Screenings
        + Asthma
        + Risk: all SBWCs do RAPS (?). Diff raps for MS than HS. Bright Futures—for elementary, if their risk is a little different, than how you address the risks would be different as well
        + Delaware School Survey

Component of how students engage with WCs and for what sort of services

* + - * + Referrals

Both external referrals and internal referrals (from the school like Resource Officer or Teacher)

Currently not required, so we don’t know how it is being captured

Physician referrals – helps tie the WC and treatment together so there is more of continuum

Referrals to MH providers

Define referrals wanted when setting up recs

* + - * + School based data (behavioral, linkage between what students are going in for and how it’s improving what is going on in the school)
      * Elementary-
        + Utilization rate
    - To support development of strategic plan and evaluation plan: Did not get to this question
* What data do we want to capture?
* What data is currently available?
* What data can medical sponsors provide?
  + - What gaps in data collection and reporting are there between medical sponsors and the state?
      * Did not get to this question
    - What models are available from wellness centers in the state and out of state that DE can learn from and apply?
      * Did not get to this question
    - How can EHRs be useful tools for data reporting & evaluation in SBWCs?
      * Did not get to this question
    - Joint application of FERPA and HIPAA – how is that working or how could it work?
      * Did not get to this question
* **Adjournment & Next Steps**
  + Be prepared to discuss lit review at next meeting
  + We will send out the compilation grid that we put together from national review of best practices/data