Best Practices and Data Workgroup Notes

10/6/20

To support development of the strategic plan, what data do we want to capture?

What do we want to capture? Is this about what the medical sponsors would capture? Participants spoke about absenteeism, educational performance. If a student is seen multiple times at a SBWC is there an individualized count of the number of times a student was seen? They can look at unduplicated raw data to look at this information. They separate the data by primary and secondary diagnosis.

- Laura- what components would drive an evaluation of SBWC. Students and engagement in SBWC- look over time at their attendance, grades, etc.
- Gloria- the data access would require each of the schools to allow cross pollination from schools. Primary diagnosis vs. secondary diagnosis. Wanted to see if there are other underlying conditions. How many students are we serving? Enrollment projections.
- Patches- HIPAA is to promote the sharing of information. Limitations of FERPA, HIPAA
- What's the difference between the data provided at the center versus the aggregate? If a child provides consent. Khaleel- from the perspective of data sharing to provide data it is part of their contractual agreement. HIPAA is part of the purposes of reporting for evaluation. FERPA- several states have made Business Associate Agreements- for sharing of information to use these for tracking key performance measures and use of evaluation. There are state examples that can be drawn from for these purposes.
- What we need to understand- what data at a minimum do we need to answer the questions?
- Educational data we could use the data twice a year populated if there's a BAA in place to use the data to answer the questions. The consent that matters is the parent's consent. If they signed consent to access services.
- BAA with DOE and the medical sponsors would be important to establish.
- Patches- we don't own the data. Unless we know what we can share/ we need to understand what we're legally capable of sharing.
- Policy changes- necessary steps around the data.
- Want to capture financial data. How are they funded? What's the funding mix? What's coming in from insurance? Number of employees, staffed up at the level they need to perform? Think longer term about the funding. Filling gaps (e.g., behavioral health) operational and management. Capital space available to accommodate a center.
- Gloria: SBWC were initially started due to infant mortality. They originally started based on the school population. If the population increased they did not receive additional funding. Look at what it takes to operate a SBWC.
- What's the demand and need: is that based on PCPs, uninsured students, number of low income students?
- Gloria- it is in the DOE regs that what defines a high need elementary schools per year. There is a list of those schools. There is an issue with the language of the budget epilogue. DOE has a list of the schools. Find out the list of high need schools?

- Hub and spoke model- can this be replicated? Prioritizing this as a potential model. Could this be something to explore across district lines. In the City of Wilmington; should we think about going across districts.
- Would there be governance issues that would need to be addressed? School boards? Is there data that could support that type of model?
- Recommendations for the strategic plan?
- What about potentially including academic outcomes? We may need additional information and data to look at outcomes. Could be self-report data that could be reported.
- Health outcomes we're looking to capture and evaluate- should not be constrained to just academics. If a child has been depressed how to look at those measures. Rate of vaccination, reproductive health, lowering pregnancy rates, well child visits.
- How to capture attendance and engagement. Looking at discipline as an indicator
- Gloria- referred the group to the CA document on data to review.
- Discipline is a factor and different school boards establish their own factors. Some schools offer PBPS which is an intervention program that can influence factors.
- Colonial looked at discipline and baseline including the number of referrals and looked at the decrease over time.
- Number of kids who are supposed to be enrolled in a school versus those that opt out/ stay in feeder pattern. How to capture the school climate aspect.
- What we currently capture for Public Health is process measures. Others- attendance (not for HS) data services and the MOU provides it to Christiana from Red Clay.

What gaps are in data collection and reporting? Some centers do not report to DHIN, some do not report all of the elements. It varies by medical sponsor. Would it help if all reported? Is it expensive to be a part of DHIN? Confidentiality was cited as an issue.

What is currently available?

What data do medical sponsors provide? A monthly report that is provided by visits, aggregate data, diagnosis. They provide a template with ICD 10s and when they moved from a centralized data base included a demographic data base. This is raw data that is provided by the medical sponsors. There are 14 different indicators: contraceptive use, types of services; quarterly data for Title X program.