Infrastructure, Policy, and Operations Workgroup

Meeting Minutes from October 29, 2020

Attendees: Uma Ahluwalia, Drew Hawkinson, Kristin Dwyer, Nick Conte, Susan Haberstroh, Cathy Zorc, Cassandra Davis, Joanna White, Forrest Watson III, Jordan Weisman, Joyce Hawkins, Rob Walter

Agenda Item	Discussion	Action Items
Welcome	• Uma welcomed everyone.	
Recap Previous Weeks	• Uma reviewed the previous weeks' discussion. There is agreement on methodology for picking services based on need, with representation from DPH, DSAMH, DOE, DSCYF, School Districts, community providers, and parents determining service menu.	
Research Questions	• Uma overviewed some information on the cost impact of service array and staffing. Most uncompensated care is reproductive health or behavioral health and compensation lost from not charging patient fees. Biggest cost benefit was a decrease in teen pregnancy, ED utilization and asthma treatment. Salaries are main driver of operational costs. Capital costs vary based on siting of SBWC. Hub and spoke approach is also a way to pull cost down. • Forrest: Eisenberg's operating cost is around $500,000 - $600,000 overall for 5 schools. Elementary SBWCs are not part of state (non-contracted providers), still go through authority of DPH, but not obligation to report informational things to DPH, report to school district instead. • Forrest: Our largest driver is physical health cost. Hub and spoke approach this helps us figure out baseline and disperse costs. • Drew: According to the literature staffing should be on full time NP or PA to 700-1500 students, on full time behavioral health counselor to 700-1500 students, and one dental hygienist to 25000 students. Average cost per student is $147-$450 depending on number of services provided. • Susan: I think we need to look at the costs as a ratio of student size rather than SBWC size, it is a better fit that way. **Breakout Groups**	• Forrest: Send Drew the square footage of Eisenberg and spokes.

	• Joanna: Have to have exam room, depending on model, need an exam for dentist with specialized rooms, 1-2 offices for staff, bathroom right in center, because other bathrooms might not be confidential. Hub model might need more space in bigger office. • Uma: Are there square footage recommendations for hub and spoke? • Forrest: The district took a large classroom at Eisenberg and other sites have other standard classrooms. • Uma: We can look at square footage requirements that other states put in requirements, potentially 1100 sq ft. There is usually a standard. • Nick: For a hub and spoke model, I don't think that dental requires a specialized room, but more of a nonlimiting room just with space to work. A nicely equipped dental laboratory may be more expensive and more limiting. Almost everything is portable now for dental. • Joanna: Cost varies over time, first year is more expensive and then decreases over time until the need for more tech improvements, as more kids are enrolled, there may be more cost. We also talked about incentives for enrollment to make sure that SBWCs are being used to their full capacity. School nurse being able to assist SBWC but not employed by vendor. Dental hygienist would increase budget, but is worth it. Medical vendors, DPH, and other partners (dental, optometry, PCPs involved). • Susan: Talked about hub and spoke model. We suggest that it is opt-out enrollment so that we could increase access. It would be up to parent to opt-out and also opting out of some services. Look at research for square footage. • Jordan: With opt-out, there could be a larger base menu of services. One new model could be a per-member per-month model (PMPM), this may balance out high and low utilization and make things more sustainable, allows for predictions. Would develop an appropriate ratio for providers. Could build in value incentives/options, pay for performance (ex: how often they visit their PCP, screening for diabetes) this then helps incentivize partnerships. • Uma: Would PMP come out of state dollars? • Jordan: It is hard to make this the full way that a SBWC is reimbursed because there are many different payors. Medicaid and state could serve this way. It may be harder to convince private payors, but it is better for them too	

	because they know that for one fee a month, the patient gets more for their dollar. • Uma: This PMPM could land between $127 to $450. • Jordan: This is why it makes sense for base menu to be bigger. • Joyce: How would this affect the other providers in the school who would be providing other and potentially similar services? • Forrest: With value added approach, then it makes sense to collaborate with everyone because it is incentivized. It would create a stronger continuum of care. • Joyce: I just would be concerned about having too many providers in the parents and children's lives addressing similar issues.	