Infrastructure, Policy, and Operations Workgroup

Meeting Minutes from November 12, 2020

Attendees: Uma Ahluwalia, Drew Hawkinson, Kristin Dwyer, Susan Haberstroh, Cassandra Davis, Yalanda Thomas, Forrest Watson III, Jordan Weisman, Joyce Hawkins, Rob Walter, Margaret Pisano, Sharon-Rose Gargula, Cindy Madden, Joanna White, Nick Conte, Jandy Albury

Agenda Item	Discussion	Action Items
Welcome	• Uma welcomed everyone. • Uma: Have you all heard anything about the SBWC budgeting concerns? • Kristin: We were able to switch funded SBWCs out of the tobacco settlement fund and back into the general fund at FY21 levels. Now we have to work with OMB to make sure it is included in the Governor's budget	
Recap Previous Weeks	• Uma reviewed the previous weeks' discussion. We particularly need to think about model design, how to link P4P incentives to outcomes. What is community of PCPs to be involved oversight and care. • Drew: This is what Dr. Walter had brought up last time as a potential for PCPs to be more involved in linkages with SBWCs so that cost saving of care could be funneled back into schools for operating or capital improvement costs of SBWCs. • Rob: This is about value-based reimbursement. If SBWCs helps PCPs hit measures like nutrition counseling, then cost savings could be shared. Jonathan Miller is heading this up. This is not something that it going to be in the near future. More about collaboration in care, not oversight. • Uma: Right, PCPs are not providing oversight.	
Review of Literature	• Uma: Today we are talking about partnership agreements, the ways that there is a multi-sectoral collaboration. • Drew: Case study is Maryland, they have a different structure of SBWC administration. DOE oversees administration of funding for SBWCs, application, collaboration with facilities branch for siting. DPH provides more SME and TA and are responsible for health encounter data for more evaluation. The is a joint council (CASBHC) that provide recommendations on service enhancement, siting, services array. Then a nonprofit advocacy group to provide TA and site training/capacity.	

	• Uma: It is a slightly different model than Delaware. Maryland has been more focused on SBWCs in elementary schools and following more of a community schools model. In the county I worked in, SBWCs were more adjunct to the school building so the operated as more of an independent clinic, but not available evening and weekends. There was a lot of parent engagement that happened with social services, behavioral health, food markets, etc. to strengthen community. • Drew: In Colorado they have a similar but different structure. DPH is more of the administrator of the funding for SBWCs, but have a relationship with DOE around siting, site visits, understanding the needs of sites for structure and infrastructure. They also have the CO Association for School-Based Health to provide more TA and training for the individual sites. This triad has agreements of responsibilities for administration, training, and TA/guidance. There are other types of agreements, like a shared consent form for release of information to DOH and DOE on data to protect child health and safety and for program evaluation. Signing these consents upon enrollment so that there are more data to shape quality improvement processes. • Susan: When we talk about DOE or DOH overseeing SBWCs. Do we know how oversight and administration is managed? • Uma: Initially the SBWC piece rested with MD DOH within Maternal and Child Health Bureau and would do site visits for certification and new siting would administer a small amount of grants. It was not well resourced. Then there was a change and program shifted to DOE and oversight and certification. This was difficult because DOE does not fully comprehend the SBWC and health care side. DOH may understand this better. But the better these two agencies work together, the better the outcomes. The Council as an appointed advisory body was appointed by the legislature, it was in statue. There was legislative interest in this.	
Research Questions	• Uma: These are the questions for today. Which agencies should be involved and take the lead in administration? What opportunities are there for other agencies or stakeholders to be involved? How do EHRs and IT systems work across systems? How could SBWCs leverage DHIN to work better with PCPs. Are SBWCs reporting up to DHIN?	• **Sharon-Rose & Kristin**: send breakout groups notes to Drew. • **Yalanda**: Send credentialing and sign up protocols for Medicaid

	• Cindy: No, we are not. Come July, we are changing to be on an EHR and then can report to DHIN. • Uma: I don't about other EHRs. • Cassandra: Christiana does not even have an EHR. • Uma: Mostly DHIN has been looking at labs, X-rays, etc. • Rob: If just comes to us. But everyone uses a different system and they don't talk to one another. • Uma: Thought they are supposed to be HL7 compliant so the systems should be able to talk to each other. This is the whole premise of an HIE. So what agreements and consents need to be developed across the system? And who can be involved in facilitating QA/QI process. **Breakout Groups** • Uma: The first discussion is what state agency can take the lead in this? • Susan: We suggested that lead stay as DPH, because they are the experts in this. • Cassandra: DPH is the lead, but DOE has a role to play, and anyone that may contribute funding on SBWCs. • Uma: We need to differentiate between partnership and roles. I see DPH as getting the programs a bit more, so it makes sense for you to own the contracts with providers. Need an advisory group to help this process. And DPH providing the technical assistance to a SBWC interested in becoming certified, who has mapped out these requirements, how do they become credentialed? That is a Medicaid and DPH lead with Medicaid involvement. School District plays a big role though, so does DOE play a role in providing SDs with guidance on standardization of engagement with DPH/the SBWC providers. • Cindy: We do not have MOUs or contracts with school districts. The contract is with DPH and vendor. School has buy-in so that when a contract comes up for renewal, they can provide input on selection process. • Uma: How do you decide which school district the provider is going to serve? • Cassandra: Medical vendors and schools comes to DPH to say that they would like to see a SBWC, so we have not made the decision about new siting. • Uma: How did Cindy get picked for the school she is in?	

	• Cindy: When SD decided they wanted a SBWC, they went to DPH and then DPH put out RFP and Nanticoke bid on it to meet basic criteria. • Kristin: We also discussed that DPH would remain the lead with a partnership with DOE, but there was consensus about model in MD that could provide assistance on things like system enhancements, service enhancements, etc. so it would not take up the time of DPH and DOE, other things that are blind spots for DOE and DPH. • Susan: We agreed. DOE need to be part of the conversation, we have not been at the table on SBWCs in the past. We have people that oversee school counselors and nurses, so there is an opportunity. Council model could support this. I like that it could become more legislative so that it is representative of who needs to be at the table and then there is a formal advisory to DPH as the lead entity. Running a SBWC is not DOE's expertise. • Forrest: There is a lot of confusion among the commercial carriers on SBWCs and how to credential them. Have conflicting interpretations of the code around recognizing SBWCs for commercial carriers. They don't recognize them as facility entity, they recognize them as individual licensed providers. • Uma: They don't credential the provider like Life Health System, they just individually credential the providers? This is true across the country and is a huge barrier everywhere. • Jordan: Are you able to bill under Life Health Center or bill as the individual practitioner? • Forrest: We can bill as Life Center as a group practice. • Uma: Provider credentialing is by individual practitioner. This impacts the hiring process, because credentialing takes time. • Jordan: This process is true for Medicaid as well. • Uma: We didn't get to the other questions, so send notes to Drew. • Joyce: We recommend that DPH take the lead with DOE, District and Providers be in an advisory group. The responsibilities of TA, planning, service array, training, etc. should be defined in an agreement with all parties. (Similar information should also be included in the provider's contract.) • Joyce: The agreement for data and consent should be a part of any contract, should include the specific aggregate data to be collected. The advisory group should review and recommend specific data to be collected by all SBWCs.	