SBWC Steering Committee Retreat Minutes

December 17, 2020

29 participants

Attendees: Forrest Watson III, Creighton Dunlop, Thowana weeks, Frances A Russo Avena, Susan Haberstroh, Shelly Lazorchak, Sen Dave Sokola, Kathy Cannatelli, Cassandra Davis, Gloria James, Rosa Rivera, Dara Hall (Representing Liz Brown), Kristin Dwyer, D. Jana Gindhart, Cailin Thomas-Henkel, Susan Habertr, Kristin Dwyaer, Sen Dave So, Yvette Santiago, Uma Ahluwalia, Patches Hill, Priscilla Mpasi, Shannon Britzmain, Chritopher Beardsley, John Cooper, Christine Visher, Cathy ONeill, Aileen Fink, Dr. Liz Brow, Amy Burnett, Leah Woodall, Marihellen Barrett, Valerie MCCartan, Office of Senator Da. Patches Hill,

Meeting started at 9:05am, Uma presented the agenda for the day as well as the roles for HMA staff, DPH Staff and Steering Committee Members.

HMA Staff: Neutral Facilitators and Support Staff: Task is to ensure that dialog is free flowing, safe and respectful. Strive towards consensus but majority voice holds but dissent is captured and reported. Will provide additional context during discussion from workgroups and research.

DPH Staff: Observers & Responders: Will be assigned to each breakout group to be observers. At the end of each deliberation period, they will provide feedback and clarify swim lanes or regulatory framework as needed.

Steering Committee Members Deliberators and Deciders: Deliberate on proposed recommendations and reflect on what DPH offers in comments and context as responders. Will finalize recommendations after all input is received.

Uma presented the shared agreements to make sure there is good communication during the day.

Stakeholder Interview and Focus Groups

Diana presented the Research Data and Findings. Drew asked the group if there were any comments or questions about the materials presented by Diana. Eileen asked if there were any discussion of peer support as part of BH services approach. Diana answered that there was no discussion about peer support, and she was surprised about it.

Drew presented the key findings of the Parent and Student Survey. High response rates overall. Lower response rates in Sussex County as well as lower rate from Medicaid and CHIP students. Kent had lower participating rates in terms of engagement. Majority of folks that received services, received services 1 to 2 times a year. Overall experience was good. Fair consensus that there was a positive impact on health and wellbeing. Kristin Dwyer asked if she could have information on private/Medicaid/noninsured by county. Drew will ask DPH if that data is available. Yvette Santiago indicated she wanted to learn more about the low usage of SBWC services in Kent County. Kristin Dwyer asked if visiting 5 or more times a year impact academic performance. Drew answered there was no consensus about the usage impacting performance academically.

Aileen Fink asked if the usage was low or is it ah the representation in survey of students/caregivers from Kent County was low. Drew indicated HMA could try to get the information from DPH and compare to see if this is the case.

Aileen asked about the type of services are provided fro those who get 5+ would assume behavioral health? Drew answered that indeed that is the mostly use service was BH services

14% using contraceptives and education on contraceptives.

Marihelen Barrett asked SBWC if research found that SBWC as a valued based care as an entity or component of the valued based care. Diana clarified context about people's perceived value of the SBWC. Marihelen asked the group to think that SBWC are components that delivers care coordination and continuation of care and partners of primary care providers as a valued based care as a component not as an individual entity.

Cathy ONeill noted that increased use of WC improves academic performance by keeping students in school and using WC for support throughout the school day with referral out as needed for behavioral health

Forrest Watson: Asked if this was based on data from high school respondents specifically and he understands where comes to academic performance noted Medicaid 32% on average SBWCs participation yet Medicaid revenues represent the line share of third party revenue for sustainability yet the majority we have a higher utilization of private insurers in the access of services. Drew indicated that was correct based on survey findings. Forrest noted that it was important to know that if this is the case it is important to explore how SBWC are sustained. Drew added Finance and Sustainability workgroup gathered that information.

Drew also mentioned that the survey showed that birth control or contraceptive services should not get parent consent.

Aileen asked if for or Telehealth, is that finding consistent with the providers experience or an artifact of who was interviewed. Drew indicated that during the break there will be discussion by providers. It could be data was lost in the noise.

Available in all school levels, parents and students were in support of having them at all levels to have continuum of care across ages and levels creating a gap in services.

Criteria for Evaluating Recommendations

Jon Cooper thanked the group for all the work done and the time devoted to the services that impact families and children in Delaware.

Jon mentioned it was important to think that the whole idea is to know there are constraints on the recommendations and the group relies to evaluate the constrains and manage the selection process with the hope that this will advance the work and move things forward. Jon added this is a great opportunity to move things forward. Move to valued based care and how the SBWC can capitalize on that to contribute in Children's health and to be integrated in as system where the program is sustainability. It is also important to note that during these difficult times it is important to provide trauma informed care and SBWCs are major providers under this framework.

Jon clarified that the Steering committee will oversee choosing recommendations based on the following: if they are feasible, equitable, scalable/replicable, evidence research informed, sustainable and impactful.

Yvette Santiago noted that under equitable "need care/receive care" when they need it is an important component of equitable.

Gloria James reminded the group that the future focus from the state will be to support expanding SBHCs to implement them in high needs elementary and middle schools.

Jon Cooper added that the work of SBWC will reduce the likelihood of need for chronic care.

Drew opened a poll asking if members agreed to adhere to the guiding principles. 100% of the participants agreed.

Break started at 10:00am to 10:15am

Workgroup Presentations

Infrastructure, Policy and Operations-Forrest Watson III mentioned that children re 100% of our future. This workgroup came to the agreement that SBWCs are a good thing for children. The group designed the infrastructure.

I. **Infrastructure and Operations Workgroup Recommendation**s: Forrest Watson provided the workgroup recommendations for the infrastructure workgroup.

1) Recommendation #1: Kristin Dwyer asked if everyone knew what a hub and spoke modelwas. Just want to make sure there is a common understanding. Hub and spokes model the hub is the full center unit where all services are done, medical facility outfitted with the appropriate space for lab, medical rooms, clinical delivery system and they have entrance from outside other sites have a step down approach BH there and rotating medical presence. This is classified as not having the higher required by SBWCs. Cost 500,000 to develop the hub. New SBWC in highest need schools must be a full-service model hub. The costs for SBWC infrastructure and upfront costs are high. If we replicate all services it is costly.
    - With a hub model districts can concentrate the full services and offer complementary services. Then this will allow other SBWCs that may not need the full array. The hub would have full services.
    - The other sites have a rotating medical presence. We classify it as a spoke as it doesn't have higher level of services. The cost of the hub is about $500,000. The spokes are less costly.
2) Uma mentioned that the hub and spoke is a spread and scale approach within a certain geographic focus. She noted the workgroups will discuss the approach during the workgroup meetings.
3) Recommendation #2: SBWC will not serve as student primary medical home unless necessary. Forrest noted some challenges and gave the example of Sussex where there is lack of access or not enough providers for students to receive care. The idea of SBWCs is to connect students to primary care and link where they can get medical services. SBWCs provide array of services like BH and other social supports, health insurance navigation. Forrest indicated that the problem he

experienced 1. Coordination of services, immunizations, danger of duplicate immunizations and the other problem following the same immunization problem is that if providers see that immunizations are already provided by the SBWC encourage communication if there was collaboration with providers. SBWC will not serve as the student's primary medical home, unless necessary. Forrest noted that the law supports this and SBWC also support this approach.

- There are cases where there may not be a high concentration of primary care, or barriers- then the SBWCs can step in. Forrest noted that the idea for the SBWC is a stop gap care.
- They are not set up to provide 24/7 on call care. SBWCs connect and link students to primary care. If we link with communication and coordination then that is ideal. The SBWCs provide more services such as behavioral health and social component – health insurance navigation support.

Leah mentioned integration, linkage and coordination with primary care is essential. Leah asked clarification on the term incentivize maybe for this one the group must think about different staffing for this type of collaboration for example CHWs who could contribute and support those linkages and referrals. Forrest Watson clarified that his was more revenue sharing and cross sharing of staff fro instance if a primary care is responsible for certain targets and objectives, they may have difficulty to get those outcomes, BH and mental health is one. SBWCs can fulfill that gap and provide supports at school setting and report back to primary care about progress.

Frances Russo asked the group to students and families who are often transient from school to school and/or district to district due to housing insecurity. They often fall through the gaps in education and healthcare.

Kristin Dwyer indicated she was having trouble understanding this recommendation- as a non-health policy person

Aileen Fink asked if the recommendation highlights that care coordination services between SBWC and community providers aren't being reimbursed and supported Leah's as determining what types of staff would best fill this role.

Frances A Russo-asked if nurses be the bridge and coordinate services

Priscilla Mpasi asked if the payment is incentive to the PCP or the SBWC or both? And based on RVU services or outcomes?

Uma clarified that this idea was mostly about payment incentives. Ways to incentivize the reimbursement methodology and asked members not to do deep on analysis as we would do this later and vote on each recommendation.

Dr. Liz Brown added that she would be happy to discuss more during the deliberation, but she thinks the only way this is doable would be voluntarily in the newly developed ACOs contracting with the MCOs.

4) Recommendation #3: Explore payment models that incentivize collaboration between SBWCs and community providers.

- Two paths: the coordination of services if the child has been immunized and there is a danger of duplicate immunizations. The other issue is that there are certain carrots that draw families sin such as immunizations and sports wellness physicals. This could reduce the incentive for kids to present to primary care. Eliminate barriers between SBWCs and PCPs.
- Leah had a question as it relates to the term incentivize. She asked should we be thinking about different types of staffing to help with this collaboration. Does this mean utilizing a CHW at SBWCs that could continue and support these linkages between SBWCs and PCPs.
- Forrest noted we were looking more about revenue sharing for a provider. If a PCP is responsible for certain metrics, they may have challenges providing the services such as BH and how SBWCs can play a role. If there is an early development assessment that a PCP scores and provides, then that individual is noted as needing developmental services. A referral could be made to a school based wellness center to provide those supports and services. Then the SBWC would report back to the PCP on the development and progress.
- Collaboration if shared with the insurance company or with a primary care practice.
- Uma noted the payment that the payment MCOs are providing could incentivize the collaboration between PCPs and SBWCs and the value in that collaboration. Uma spoke with Liz Brown from DMMA.
- This issue needs further discussion. There was a general sense in the workgroup that PCPs and SBWCs were not coordinating enough. Could payment be used to incentivize closer coordination. This isn't about a specific individual, but more around payment incentives.
- Leah noted she is having difficulty with this one. She noted the principals what is the most actionable and feasible politically. If it is a discipline that there is evidence behind.
- Uma noted it is important that people add in their comments and we discuss this in terms of deliberating. If we determine that this is not feasible at this time we will discuss later.

5) Recommendation # 4: Siblings enrolled in a school district and who do not have a SBWC in their schools, may receive services from a siblings student's SBWC, as long as it is serving like-aged students. Parents, however, may not receive services.
    - We note that there is often a need but we are currently unable to do so.
    - Dr. Mpasi asked a question in chat: for this rec would the child travel to the siblings school to access the SBWC? This would then require the parent to transport the child to the other school. Why would the sibling not go to the PCP
6) Recommendation #5: Establish a base menu model that includes: sports physicals, minor acute care, immunizations for linkages to PCPs
7) Recommendation # 6: Appoint an independent legislatively appointed council with representation from DPH, DOE, DSCYF, School District, Parent teacher Assoc and Community PCPs and legislators to assist in recommending future SBWC siting and additional service options for SBWCs based on community needs and resources.

8) Recommendation # 7: Recommend a staffing model. NP/ PA, rotating RD, MA every 1,000; physician and rotating dental hygienist and hearing and vision specialist for hub and spoke for every 2500 students.
9) Recommendation # 8: Recommend hours of operation: August-June, 9-5; once a week until 6:00pm; If hub has external entrance, can do some weekend/holiday office hours.
    - Uma noted questions in chat: previous discussion regarding payment incentive and all the recommendations. We need to focus on finalizing recommendations in the break outs but these need to be deliberated in the future in terms of how to implement. These are all questions that can be resolved in the future.
    - In chat Dr. Brown noted: Don't schools have very different operating hours based on their grade level? Rather than standard 9-5, what about in relationship to the school day?
    - Leah in chat: I would echo Dr. Brown's comments....we need the sbhc hours of operation to be more flexible and driven by the local needs/resources
10) Recommend the following SBWC set up: Hubs classroom 900 sq ft; exam, waiting, bathroom, counseling; prep area, medical office, storage; secure external entrances. Spokes less as they do not need to more intensive service delivery spaces.
11) Recommendation 10: Recommend add'l factors to consider for future school-based wellness center siting factors.
    - Aileen in chat: We have some data around prevalence of exposure to adverse childhood experiences (ACE hotspots)- would we consider that as a criteria?
    - Uma noted that the access issues were ones that we spent considerable time deliberating. Uma noted that folks should review the virtual binder and we need to figure out how to craft some of the context during lunch.

II. **Data and Best Practices Recommendations:** Kristin Dwyer and Kathy Cannatelli

1) Recommendation #1: Address existing gaps in behavioral health capacity by: validated tools for SUD and BH specific to SUD
    - Jon Cooper had a question about SUD- if that's substance use disorder?
    - Kristin noted how critical it is to integrate services between SBWCs and the community. Looking at clinical and non clinical. There are several different professionals in schools and the role that SBWCs play is one component of a larger system. Kathy shared Warner Elementary School that all students are looked at, all BH services are coordinated.
2) Recommendation # 2: Est a statewide standing work group. Dove tails with the infrastructure recommendation.
    - This would replace the local school board decision-making process. There was an understanding that oftentimes the local decision is politicized and not based on the need. There is a critical need for these services. This workgroup would examine evidence base and the feedback.
    - Could examine specific issues such as the suppression of EOBs. Kristin noted that this would eb geographically diverse and representation in the types of professionals tat sit on this workgroup.

- Yvette noted in chat: Will need to engage DE School Boards Association on recommendation #2; perhaps the recommendation from the standing group to the School Board may be a good compromise or intermediary.
- Kristin noted that school board members could be part of the committee to ensure that there is still an effort to include the voice from the education community local and otherwise.
- Leah noted that the word "replace" School Boards would be problematic. That whatever process we use with training and educating school boards and think through what this process would ook like. That this would inform the school boards.

3) Recommendation 3: Align approaches and enhance provision of trauma informed services.
    - Kathy noted we need to align and ensure that we wrap around each child.
4) Recommendation #4: Ensure SBWCs have the ability to provide ongoing telehealth services consistent with DE, federal ethics, client confidentiality and CLAs.
   Kathy noted BH represents the majority of telehealth services. Certainly in the hub and spoke model it is important. Continue to grow and expand telehealth to improve access.
   Aileen noted: CLAS= culturally and linguistically appropriate services
5) Recommendation 5: Explore the feasibility of expanding access to preventative dental services and ophthalmology. Kristin noted you heard from Diana and Drew.
    - Forrest noted in chat: Certainly support dental and vision inclusion in the prevention model at SBWCs. Very important!
    - Uma noted that Dr. Conte served on the infrastructure, policy and operations workgroup.
6) Kristin noted the school nurse screens and then this typically falls outside of typical insurance takes time to get to these services. Being able to see is a big issue with engagement. Vision to Learn van is critical and is something that is not necessarily relied upon as it is community based.
7) Recommendation #6: Develop a data collection and analysis infrastructure that meets the needs of SBWCs and stakeholders.
    - Kathy noted that the medical sponsors and DPH need resources to assist with this process. We need support, guidance.
    - Kathy noted we had APEX present to see what a data hub would look like. DPH had good questions. We need to collect it, we need to centralize it and we need support to be able to make this happen.
8) Recommendation 7: Track the following recommended priority measures (noting those that are already required by DPH).
    - Are any of the measures currently collected still need to be collected? The proposed additional measures were based on survey of members, literature reviews and surveys. We want feedback from the members to ensure we are accurately capturing.
    - Kristin noted that the performance measures. Need to develop an annual report to accurately capture the document. Kristin noted this is on the service delivery side. Look at list what should be continued, removed.
    - Asked members to review and see what they agree with. Kristin wanted to discuss the academic measures. Everyone will want to jump to the academic measures to draw causality.

- Kristin noted - is there a critical mass to make that correlation to overall academic performance. Looking at drilling into students who utilize SBWCs and to see what the effect of utilization would have on their individual outcomes. Overall effect on the community. It is an exception to the rule. Spikes in performance happen.
- Aileen Fink noted in chat: if we use diagnoses as a measure, we'll need a mechanism to update the data collection since diagnoses can change over time.

Uma noted that these need to be refined and asked for people to hold these ideas to deliberation.

III. **Finance and Sustainability Workgroup Recommendation**s: Yvette Santiago and Jon Cooper

1) Commercial payers should be required to suppress all EOBs for services at SBCs. These were developed from the workgroup and previous years of discussion.
   Discussed this with the Insurance Commission. Other states have accomplished this. This would eb a huge win if we're able to make it happen in the shorter term.
2) Recommendation #2: Commercial payers should provide or create an all-inclusive code for SBCWs. Aetna does this already and has provided feedback on previous workgroups as they do not know what they are reimbursing for . Yvette noted this is fertile ground and that through stakeholder engagement the insurers are open.
3) Recommendation #3: Sharing out of pocket responsibilities and not applying to SBWCs services. Payers don't see SBWCs are preventative and can be charged deductibles, co insurance.
   - Forrest asked if we are collecting from insurers or patients. Yvette noted insurers.
   - Kristin asked how many are of SBWC students are self insured? Yvette noted that she thought we had it and asked Drew.
   - Drew noted that Gloria has this data and shared it. We will send it out to the group.
   - Kristin noted building a relationship with self insureds and how to cultivate those organizations and the value of SBWCs and their return of investment. If they know employees kids are healthy then their employees would not miss work. Yvette noted engaging those groups.
   - Forrest noted in chat: to get SBWCs services to be classified as preventative, it may take a two fold effort, 1. focus at the state level, and 2. at the national level for advocacy around inclusion in the Affordable Care Act definition of prevention services.
4) Recommendation #4: Increase access to discretionary funding to cover the cost of non billable services and children who are uninsured at the time of services.
   - Yvette noted being able to leverage funding to support uncompensated care. SBWCs are a safety net for the uninsured population.
   - Kristin asked in chat is these need to be legislated. Yvette noted yes.
5) Recommendation # 5: Create a Blueprint for infrastructure needs and capital costs considerations.
   - Yvette noted that schools do not often know what is needed. This would be a great short term solution for schools to have a guide for what they need to consider, have in place as they think about cost considerations. If there is not a method in place, need to put one in place.
   - Yvette noted for the newer schools they are keeping this in mind so that schools understand the costs for information and for planning efforts.

- Kristin noted that is their a plan to pay for these costs? IS this something that could be paid for through the state planning need work? Jon noted their CFO will be providing support. There is not a great way for school districts to pay for our rehab current infrastructure.

6) Recommendation #6: Identify capital/ build or funds with matching funds required for school districts to es new sites or renovation of old sites.
7) Recommendation #7: increase efficiencies in credentialing and contracting with insurance companies.
    - Yvette and Jon did not have additional insights and noted they should skip and come back.
    - Uma noted she is doing work on this topic. You have to credential by individual provider as opposed to entity. It takes an extraordinary amount of time.
    - Forrest noted that the commercial insurers do not credential as a facility. They simply credential the individual providers. There are contracting issues as it is not recognized as a facility.
    - The rate we receive from Medicaid is as a facility.
8) Recommendation #8: Maximize third party billing and certified coders in SBWCs.
    - Yvette noted that this is an issue that SBWCs are not considered as preventative and cannot deduct co pays.
9) Recommendation # 9: Increase partnerships to improve enrollment.
    - Yvette noted early on there was a large enrollment. There were issues around charging families which decreased the number of patients seen. Parents have to give consent for kids to be seen. This varies by county and state. All kids could benefit from these services. Focusing in on how to increase the partnerships we have with various groups that could help with maximizing enrollment.
    - Midge Barrett noted in chat: I am worried about the focus on fitting SBHC into the existing third party payment system - which is too administratively burdensome. I would like to see us move to a new payor system that is not based on fee for service.
    - Jon noted how can we do a better job of communicating the value to families.
10) Recommendation #10: Identify opportunities to leverage federal grants or resources or agencies to meet the needs of the ABWS pop
    - Kristin asked about the feasibility of community service dollars from hospitals. Kathy noted there is a way to leverage that if you provide in service. Christiana uses funds to operate Shortledge. Talking to the largest hospital systems is a way.
    - Leah noted working through the Community Health Needs process to leverage those funds.
    - Uma noted that in Maryland there is no specific info about community benefit but there is a requirement to report community benefit to the state. Through the CHNA process they commit to investing in those orgs.
    - Aileen noted in chat: It will important to coordinate with the Division of Substance Use and Mental Health and DSCYF who currently receive federal funding for substance use/misuse prevention.
    - Frances A. Russo-Avena noted in chat: Can you also include DSCYF. I believe DSAMH has also provided grant funds to school districts for Wellness. A nice way to collaborate

11) Recommendation #11: Enhance technical assistance to SBWCs
    - Enhance the resources and sharing that is provided to SBWC in maintaining and sustaining.
12) Recommendation #12: Develop partnership with add'l FQHCs to serve as a medical sponsor. Yvette noted that La Red is the only one. Is there a way to coordinate and these could be optimal medical sponsors to take advantage of necessary.
13) Recommendation #12: Develop a consistent tax base for funding SBWC
    Work with legislators to identify an optimal solution.
    Kristin noted in chat: Thank you definitely worth looking into
    required vs voluntary and how to incentivize

Mock Recommendation Evaluation, Aileen Fink

- Dr. Mpasi noted that there were some specific recommendations such as the hours for SBWCs. And how to prioritize what services what services will the SBWC prioritize. Mental health and reproductive are finalized. But the other services are TBD. As a pediatrician I have concerns that the recommendations and model are a primary care medical home and will have tension with the community models. Equity- patient has the disparity, system creates the inequity. We want the wellness center to help create the access. Could be literacy, transportation, language. The single intervention is not addressing equity. Not sure I have a strong assessment of the strong unmet social needs that the SBWCs need to address.
- Uma noted that there is need to identify the specific services that should eb provided. We continuously want to make sure it is clear we are not building a primary care office in SBWCs. Tension between sports physicals and regular physicals. There is an inherent tension. SBWCs then lose a market share as that is how they enroll kids in the wellness centers. Medicaid is the only payer that pays for both. Do you need either or both? Kids have medical insurance. Do you deny them the ability tp participate in sports? Needs exist in all schools. Epilogue defines high need schools. Are we going with that definition or revisiting?

Each group shared how they worked on recommendations. The Steering Committee agreed to move all recommendations that have 6 stars.

Uma presented the revised recommendations and the following changes:

Kristin mentioned her concern about basing the needs on what is done in high schools and not considering what elementary and middle schools needs are.

Leah mentioned that health systems do health needs assessments, and this is a good opportunity to collaborate with SBWCs.

Kristin Dwyer asked who has the charge of the independently appointed council and who would this body report to. Leah clarified that it can be done in different ways but it could be as easy as forming a group of different stakeholders as proposed, create bylaws and later on forming membership and it does not have to be legislated.

Uma mentioned there is a lot of work to be done to identify how the council would be formed.

Get recommendation list from Drew.

Planning and Next Steps

Shannon presented HMAs timeline and how they lined up the work which showed the following:

December Finalize recommendations

January-March: Drafting of strategic plan; Implementation workgroups created to develop an action plan with evaluation components

April – May: Pubic townhalls on strategic plan-Refine Strategic plan, implementation plan and evaluation plan.

June: HMA will Deliver a final strategic plan, implementation plan and evaluation plan.

- Who owns the plan?

  Shannon mentioned it was important note this is not DPHs plan but a collaboration but it was important to know who is in charge to move things forward.

  Develop of a structure to implement and monitor the plan.
  Potential public-private governance group crated through the legislature.

- What is the role of public agencies, including DPH, DoE, DSAMH, DMMA, DSCYF in implementing the plan?
- What is the role of the providers and the advocates in implementing the plan?

Forrest Watson III suggested that this structure could be the same as the advisory independently formed council suggested in the recommendations.

Yvette Santiago mentioned that school representatives must have a voice on the plan.

Uma asked Yvette on what she would recommend in terms of a timeline.

Yvette Santiago mentioned there are many things that need to happen.

Are we still moving with two high needs schools next year. Uma asked the group that the strategic process goes through and if the Steering committee was thinking to do it next year.

Jon Cooper that in terms of timeline the existing SBWCs the question is if moratorium will be lifted what is the timeline in a school district

Frances A Russo-Avena added there may need to be meaningful and thorough education provided to the various public agencies of what a SBWC is and how it impacts school communities. She suggested to include providers as well as community members in implementing the plan. Aileen Fink suggested for the steering committee to continue meeting to move the work forward and for this committee to form the council to be able to work on both and loose momentum.

Yvette Santiago agreed with Aileen's suggestion and noted that a communication plan has to be developed as well and agreed the steering committee could look at the different tiers and identify who could catalize that information to the audience.

Susan Haberstroh asked how the group was established and is the charge only to accept the strategic plan. Shannon indicated her understanding was that the steering committee would continue to work during the implementation period. Leah clarified that the department approved it but there is shared accountability. Gloria asked for clarity as 4 of the 7 centers are in service and already operating in high needs. How does this fit it in the RFP process. In the past funding was given for 5 years but at this point we would need more clarification about what happens to those 4 SBWCs.

Kristin Dwyer mentioned her agreement with the SBWCs that are already working but is still not understanding how this relates to the recommendation of creating an independent advisory council or group.

Uma suggested to discuss about the role of the steering committee further during our next steering committee meeting. Everyone agreed unanimously.

Meeting was adjourned at 4:00pm.