Recommendation 2: New school based-wellness centers sites for school districts will be in highest need schools and are strongly encouraged to be a full-service hub model. If a school district decides to expand the school-based wellness center beyond this original site, additional sites should follow a hub and spoke model where feasible.					
Activity	**Target Date**	**Key Implementers**	**Milestones**	**Process Measures**	**Outcomes Measures**
State funding sent to DPH		General Assembly, DPH			
Provide technical assistance on where to situate hub and spokes, with hubs needing to be high-needs schools as designated by Department criteria		DPH/DOE/School District			
DPH issues Request for Proposals (including process measures)		DPH			
Determination of siting hubs and spokes • Full menu of services available in the HUB • Partial services in SPOKE centers - Determine staffing & hours of operations at spokes (2-5-day staffing with NP/PA and BH professional, rotating) • 2-mile radius for spokes in urban/suburban, 5-7-mile radius for spokes in rural		DOE/DPH, School Districts			
Award contract		DPH			
SBHC Medical Sponsor application to become a State Recognized Provider of SBHC Services		Medical Sponsor/DPH			
Medicaid - Cost Recovery		Medical Sponsor and Medicaid Agency			

Sites awarded a SBWC Medicaid rate		Medicaid Agency			
Sites begin third-party billing		Medical Sponsor			
Operating model implementation		Medical sponsors			
Determination of siting hubs and spokes (if any changes since earlier in the process) • Full menu of services available in the HUB • Partial services in SPOKE centers - Determine staffing & hours of operations at spokes (2-5-day staffing with NP/PA and BH professional, rotating) • 2-mile radius for spokes in urban/suburban, 5-7-mile radius for spokes in rural		DOE/DPH, School Districts			
Sites become 340b pricing entities - not sure how this works in the districts - who pays for the meds once 340b approved					
Data Reporting - secure shared data agreements with districts and standardized reporting		DPH/Medical Sponsors			
Resources Needed: • Sustainability questions – startup costs and wrap-up need to be calculated in order to attract new providers. There's no subsidy until you're up and running. • Because high-need school districts may not have the fiscal capability to finance and stand up a SBWC and the legislature has made it clear that they want 2 in high-need districts each year, that identification should carry with it the needed resources. • Sustainability right now is based on FFS, mostly Medicaid; probably the most reliable reimbursement under the current model. Have a real dilemma with commercial carriers, for whatever reasons relating to sustainability. SBWCs have provided litany of services to all high schools based on the Medicaid model supporting it. If you have a combo of high and lower-need schools, effectively the poorer Medicaid reimbursement has been spread throughout. Now we're saying high-need schools need access to these models, access to prevention. What we have seen is the Medicaid model carrying these services. At elementary level, carries reimbursement to more affluent schools. Want a model that (vs current model putting burden on high-need schools)					

Commented [DR1]: I'm not sure where this actually fits in the order here

Commented [UA2R1]: I think the potential site will have to think this through to put in an application. So it makes sense to have it here but may need to repeat after certificating and billing and put another row for operating model implementation. Does that make sense?

transforms this model (1) like the recommendation that funding goes along with high-need designation (2) FFS unfairly burdens high-need districts and that financing for services should look different (3) if we know impact is positive, be bolder in delivering services to high-need schools

- Higher-need areas may need more spokes, which also increases the need for resources
- Recommend that all payers recognize and pay the Medicaid rate. Private carriers are paying much less currently and Medicaid is sustaining the model.

Foreseen Challenges:

- Wide variation in school districts' ability to fund new SBWCs, with highest-need districts having the fewest resources; this inequity needs to be addressed or it will be carried through in SBWC siting and access.
- Currently don't charge for confidential services to prevent EOBs from being issued (other group addressing this and how Medicaid can influence this). This affects a lot of other things.
- There's a base model for the hub - who determines what is layered on? That hasn't been determined in a concrete way. Need to ensure that staffing supports are built in.

Implementation Considerations

- Modify enrollment form to allow for receipt of services in all SBWCs in district (hub and spoke area)
- Provide technical assistance on where to situate hub and spokes, with hubs needing to be high-needs schools as designated by Department criteria

Future Recommendations

When developing implementation plans for this recommendation, please keep in mind potential application of these future recommendations.

Recommendation 3: Siblings who are enrolled in the same school district and who do not have a SBWC in their school, may receive services from a sibling student's SBWC, as long as it is serving like-aged students. Parents and caregivers, however, may not receive services from a SBWC.

Recommendation 4: Use the following model as a suggested guide for new SBWC set up and existing SBWC renovation:

Hub: converted classroom, minimum 900 square ft. (Infrastructure)

- 2 exam room (with ability for mobile dental unit) – 100 square ft. each
- Waiting/reception area – 200 square ft.
- Bathroom – 100 square ft.
- Counseling room – 150 square ft.
- Prep area/wet space – 100 square ft.
- Medical office – 100 square ft.
- Storage (records, medication, immunizations, may require refrigeration) – 50 square ft.
- Secure external & internal entrances

- Spoke: Designated space for SBWC, minimum 400 square ft
  - Exam room – 100 square ft.
  - Storage area (records, medication, immunizations, may require refrigeration) – 50 square ft.
  - Waiting area – 200 square ft.
  - Bathroom (if possible, could share with Nurse's office, etc.) – 100 square ft.

SBWCs are recommended to be Joint Commission compliant.

Recommendation 5: Develop data collection and analysis infrastructure that meets the needs of SBWCs and stakeholders by:

- Standardizing data collection and reporting across SBWCs
- Information technology departments need to be at the table as part of this process
- Encouraging SBWCs to adopt electronic health records (EHRs)
- Developing the ability for DPH, and possibly SBWCs themselves, to generate annual reports showing a dashboard of metrics, including but not limited to:
- Utilization and performance measures, payer mix, financials
- Qualitative input from users of SBWCs that convey the value of SBWC services to the legislature and other stakeholders, and to support grant-seeking by SBWCs

Ensure that data collection and reporting tools are able to capture and track data recommended by oversight body as outlined under recommendation 1.