Council on Advancement of School-Based Health Centers

Annual Report
Health – General § 19-22A-05
HB 221, Ch. 199 (2017)

December 2019

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Council on Advancement of
School-Based Health Centers

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Council on Advancement of School-Based Health Centers
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Abbreviations

BAA: Business Associate Agreement
Blueprint: Blueprint for Maryland's Future
CRISP: Chesapeake Regional Information System for our Patients
CHRC: Community Health Resources Commission
Council: Council on Advancement of School-Based Health Centers
Community Health Resources Commission: CHRC
EHR: Electronic Health Record
ENS: Electronic Notification System
FERPA: Family Educational Rights and Privacy Act
FQHC: Federally Qualified Health Center
HEIDIS: Health Effectiveness Data and Information Set
HIPAA: Health Insurance Portability and Accountability Act
Kirwan Commission: Kirwan Commission on Innovation and Excellence in Education
MASBHC: Maryland Assembly on School-Based Health Care
MHBE: Maryland Health Benefit Exchange
MCO: Managed Care Organization
MDH: Maryland Department of Health
MOU: Memorandum of Understanding
MSDE: Maryland State Department of Education
PCP: Primary Care Provider
SBHA: School-Based Health Alliance
SBHC: School-Based Health Center
SHIP: State Health Improvement Process

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Executive Summary

The Council on Advancement of School-Based Health Centers (the Council) works to improve the health and educational outcomes of students who receive School-Based Health Center (SBHC) services by advancing the integration of SBHCs into the health care and education systems at the State and local levels. The Council is staffed by the Community Health Resources Commission, an independent commission operating within the Maryland Department of Health (MDH).

School-Based Health Centers are health centers, or clinics, located in a school or on a school campus that provide comprehensive health care and are most often staffed by a Nurse Practitioner or a Physician. The SBHC serves as a healthcare resource in the school setting for the diagnosis and treatment of acute illness. The focus of the SBHC is to supplement the school health services program and to provide services to students whose access to quality healthcare is limited and/or students whose health problems are barriers to learning. Students must be referred to the SBHC program by the school nurse and parents must consent to the program.

There are currently 84SBHCs across 12 jurisdictions in Maryland. A portion of these SBHCs receive funding from Maryland State Department of Education (MSDE) from the general fund allocation of $2.5M annually. These monies are administered through grant funding. Diagram 1 illustrates the distribution of SBHCs across Maryland. Jurisdictions indicated in green are where SBHCs are located.

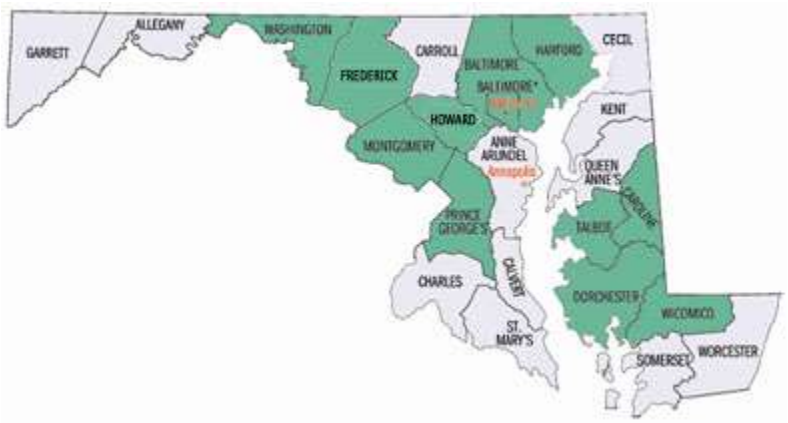


Diagram 1: SBHC distribution across Maryland

The Council made important progress on its mission in 2019. Key accomplishments are outlined below.

1. **The Council publicly released and evaluated the White Paper by Harbage Consulting and made 8 recommendations for the advancement of School-Based Health Centers.** Key categories of recommendations adopted by the Council include infrastructure, care coordination, data, quality, and population health goal alignment. The recommendations adopted by the Council reflect priorities of urgency, feasibility, and impact for the value of SBHCs in Maryland. A copy of the White Paper is included in Appendix 1.

2. **In response to a request by the Kirwan Commission on Innovation and Excellence in Education, the Council provided subject matter expertise on SBHC sponsorship models.** The Council developed an ad hoc workgroup and officially responded to the Blueprint's mandate for the Council's consultation to MDH and MSDE on sustainable sponsorship models for SBHCs. A copy of the Council's communication to the Agencies is included in Appendix 2.

3. **The Council issued recommendations for changes to the School-Based Health Center Annual Survey which were accepted by MSDE**. The Council's recommendations added additional questions to the 2018-2019 SBHC Annual Survey that better capture information about services provided, enrollees served, and SBHC operations, including billing, operating costs, and revenue. The Council provided expertise to expand the data definitions to better support SBHC Administrators in their ability to complete the Annual Survey.

4. **The Council issued recommendations that are guiding the process for the revision of School-Based Health Center Standards.** The Standards are overseen by MSDE. The Standards provide guidance on the operation of a School-Based Health Center, including levels of service, facility requirements, sponsoring agencies and medical sponsors, and maintenance of medical records. The Council's Quality and Best Practices workgroup developed a matrix of recommendations to support the revisions to the Standards.

5. **The Council provided strategic guidance to Wicomico County School-Based Health Centers.** The Council recommended strategies to improve enrollment by leveraging managed care organization capabilities.

6. **The Council staff organized presentations to key stakeholders:**
    a. **Maryland Assembly on School-Based Health Care Annual Conference.** The presentation was a partnership between the Community Health Resources Commission, Frederick County Local Health Department, and Wicomico County Local Health Department. The presentation took place on May 16, 2019.

    b. **Maryland Rural Health Association Annual Conference.** The presentation was a partnership between the Community Health Resources Commission, LUMA Health Consulting, Frederick County Local Health Department, and Wicomico County Local Health Department, demonstrating the value of SBHCs in rural Maryland. The presentation took place on October 21, 2019 at the Maryland Rural Health Annual Conference.

The Council on Advancement of School-Based Health Centers looks forward to a successful 2019. For more information about the Council, please contact Mark Luckner, Executive Director of the Community Health Resources Commission and staff to the Council, at (410) 260-6290.

Council on Advancement of School-Based Health Centers
Health – General § 19-22A-05
2019 Annual Report

I. Council Activities in 2019

The Council was established in 2015 to improve the health and educational outcomes of students who receive services from SBHCs by advancing the integration of SBHCs into the health care and education systems at the State and local levels (Health – General § 19–22A–02(b)). It is comprised of 15 members appointed by the Governor and six ex-officio members from across state government. The Council is chaired by Dr. Katherine Connor, who serves as the Medical Director of the Johns Hopkins Rales Health Center at KIPP Baltimore. Barbara Masiulis, CRNP, Supervisor of the Office of Health Services at Baltimore County Public Schools, served as Vice Chair through August 2019. After Ms. Masiulis' retirement, Dr. Patryce Toye was elected as Vice Chair in November 2019. The full Council met five times in 2019.

Appointments. 12 of the Council's 15 appointed seats are currently filled or in the process of being filled. The Council is recruiting a 1) a representative of the Maryland Assembly on School-Based Health Care (MASBHC), and 2) a principal of a secondary school with a school-based health center to fill the open slots. A second representative from MASBHC is pending gubernatorial confirmation.

During 2019, several previously vacant positions were filled, including a representative of the Public Schools Superintendents Association of Maryland, a parent/guardian of a student who receives SBHC services, a representative of the Maryland Association of Elementary School Principals, a representative of a Federally Qualified Health Center (FQHC), and a representative of the Maryland Assembly of School-Based Health Care (MASBHC). A roster of Council members is included at the end of this report.

Council Meetings. The Council met five times in 2019. At its March meeting, the Council reviewed the Harbage Consulting Report and workgroups were assigned recommendations to evaluate for calendar year 2019. Legislative and policy updates were provided by Delegate Cullison and Senator Lam. At its June meeting, each Council workgroup presented recommendations of priority for the Council to consider. In June, the Council also advanced discussions in preparation for responding to their mandated deliverable outlined in the Blueprint for Maryland's Future. At its July and October meetings, the Council further refined their official school-health advancement recommendations, reflecting those of priority, urgency, and impact. These recommendations were officially adopted via virtual poll on October 26, 2019. At its November meeting, the Council reviewed the 2019 Annual Report and elected the Chair and Vice Chair for the November 2019 - November 2021 term. Meeting minutes from each of the 5 Council meetings are included in Appendix 3.

Workgroups. Much of the Council's work is conducted by its three workgroups, which meet approximately every 1-2 months. The workgroups were each assigned recommendations to evaluate and refine for further consideration and adoption by the full Council. Each workgroup critically considered approximately 15 recommendations each.

***Data Collection and Reporting (Data) Workgroup*.** The Data Collection and Reporting Workgroup was chaired by Barbara Masiulis, the Council's Vice Chair. Ms. Masiulis retired in August 2019. Joy Twesigye, WHNP-BC, a MASBHC nominee to the Council and Director of Health Program Planning and Evaluation for School Health at Baltimore City Health Department took over the Data workgroup Chair role in September 2019. The Data workgroup is charged with making recommendations for the SBHC Annual Survey and recommending opportunities to advance school health through data collection, reporting, and evaluation. In the first quarter of 2019, the Data workgroup continued developing recommended changes to MSDE's annual survey of School-Based Health Centers. These include additional and refined questions that better capture information about services provided, enrollees served, and SBHC operations, including billing, operating costs, and revenue. The Council provided expertise to expand the data definitions to better support SBHC Administrators in their ability to complete the Annual Survey. The workgroup presented the survey changes to the School-Based Health Center Administrators in May 2019 and worked closely with MSDE to systematically update survey questions. MSDE has worked with their Information Technology Division to translate the paper-based survey into an electronic tool. The on-line tool has logic capabilities, such as skipping questions not applicable to the respondent. The respondent will also have the capability to save the survey and return to it later for completion. In addition, capabilities to allow for auto-population of previously year's entered data is being developed for future surveys. The 2018-2019 Annual Survey will be disseminated to SBHC Administrators in winter 2020.

Modifications to the survey require thoughtfulness by the Data workgroup to ensure SBHC Administrators are equipped with the resources and data to respond to the survey questions. As an example of how readiness is assessed, the Data workgroup disseminated and synthesized findings around patient experience and patient satisfaction data collection in June 2019. 27% of respondents indicated they currently collect patient experience and/or satisfaction surveys. 13% of respondents indicated these types of surveys are under development. The Data workgroup found these responses to indicate a medium level of readiness for SBHC Administrators to report on this question and the Data workgroup will work on this survey change in 2020.

In the second and third quarter of 2019, the Data workgroup was focused on evaluating their assigned recommendations produced from the Harbage Report. The recommendations they evaluated focused on data collection, reporting, and evaluation. Examples of the types of recommendations the Data workgroup evaluated include adding educational outcome measures in the SBHC survey, adding client experience measures to the SBHC survey, streamlining data requests, and developing an annual report and other data products for broad stakeholder consumption.

***Systems Integration and Funding (SIF) Workgroup*.** The Systems Integration and Funding Workgroup is chaired by Dr. Maura Rossman, representative of Maryland Association

of County and Health Officers and Local Health Officer for Howard County Health Department. The SIF workgroup is charged with recommendations to streamline and improve financial sustainability and care coordination for SBHCs. During the first quarter of 2019, the SIF workgroup was engaged with legislative updates, including House Bill 681, State Department of Education and Maryland Department of Health – School-Based Health Centers – Ombudsmen. This legislation's primary objective was increased Agency resources to support school health advancement. The SIF workgroup was also engaged in discussions related to the Kirwan Commission legislation, The Blueprint for Maryland's Future, particularly as it relates to sustainable systems of care and expanded opportunities for entities to provide sponsorship of SBHCs.

The second and third quarter of 2019, the SIF workgroup evaluated their assigned recommendations from the Harbage Report. The recommendations they evaluated focused on financial sustainability and care coordination. Examples of the types of recommendations reviewed by the SIF Workgroup include developing contracts with Managed Care Organizations (MCOs) to enable information sharing, modifying consent forms to include permission to enable bi-directional information sharing for their child, and integrating school-based health care into broader state population health goals.

***Quality and Best Practices (QBP) Workgroup*.** The Quality and Best Practices Workgroup is co–chaired by Jean-Marie Kelly, Maryland Hospital Association representative and Community Benefits and Government Relations at Union Hospital of Cecil County, and Dr. Patryce Toye, MASBHC representative and Medical Director for MedStar Family Choice Managed Care Organization. The QBP workgroup continued collaboration with the School-Based Health Center Administrators group and MSDE on revisions to the SBHC Standards. The SBHC Administrators group is comprised of representatives from each jurisdiction that SBHCs reside in. The Administrators are experienced professionals with management over SBHCs. MSDE convenes the SBHC Administrators on a quarterly basis for a two-hour meeting.

The SBHC Standards provide guidance for the operation of a School-Based Health Center. This process marks the first time that the Standards have been revised since 2006. The QBP workgroup developed a matrix of recommendations to support changes to the Standards. Examples of updates to the Standards included mission and vision, levels of service, facility requirements, sponsor requirements, scope of services, and medical records requirements. The QBP workgroup continues to advise MSDE on the Standards revision. MSDE is responsible for updating the Standards.

In the second quarter of 2019, the QBP workgroup, in addition to other Council members, made strategic recommendations to the Wicomico County SBHCs. The Wicomico County Health Department was awarded a three-year grant for $425,000 in FY2016 to open a second SBHC in Wicomico County. This award was received from the Community Health Resources Commission. Enrollment of students into SBHCs is a priority and measure of productivity for SBHCs. The QBP workgroup provided strategic guidance to the Wicomico County Health Department to improve enrollment through MCO beneficiary outreach.

The second and third quarter of 2019, the QBP workgroup evaluated their assigned recommendations from the Harbage Report. The recommendations they evaluated focused on quality standards, quality measurement, and best practices. Examples of the types of recommendations reviewed by the QBP workgroup include the use of technical assistance to drive quality improvement, insure MSDE review the SBHC Standards on a bi-annual basis with revision as needed, and coordinate student outreach to enroll them into SBHCs.

Blueprint ad hoc (Blueprint) Workgroup. During the 2019 Legislative Session, the Kirwan Commission's instrumental leadership for educational reform produced, amongst many formative transformations, a critical deliverable for the advancement of school health, "The Blueprint for Maryland's Future". Section 18 of the law states that the MDH and MSDE shall consult with the Council and other interested stakeholders on a plan to build a sustainable sponsorship model by expanding the type of organizations that can sponsor school-based health centers. MDH and MSDE's findings and recommendations are required to be delivered to the Governor and General Assembly on or before November 1, 2019. In response to this legislative assignment, the Council convened an ad hoc Workgroup. An official communication was provided to the Agencies in September 2019. The Council's letter emphasized the importance of both long-term sustainability of existing SBHCs and expansion of the number of SBHCs in the State. The Council noted that funding for infrastructure support and SBHC operations should be commensurate with these goals. The Council believes the types of sponsoring agencies for SBHCs should be expanded beyond those currently allowed. The Council noted that expansion of sponsorship models alone cannot insure sustainability and/or expansion of Maryland SBHCs. Further consideration of increased Agency staffing resources and infrastructure is a critical component of SBHC support. Additionally, funding for SBHC operations from other public and private sources must be explored. A copy of the letter is included in Appendix 2.

II. Council Recommendations and Planning for 2020

The primary activity for 2019 was developing strategic recommendations for the advancement of school health in Maryland. In 2018, the Council hired an independent consulting firm, Harbage Consulting, to write a White Paper demonstrating the value proposition of SBHCs in Maryland. The White Paper, titled *Demonstrating the Value of School-Based Health Centers in Maryland: A Roadmap* included 1) a review of Maryland SBHC infrastructure, 2) a review of SBHC literature and existing data, 3) identification of important measures and outcomes, and 4) recommendations about data, quality, and systems integration approaches towards demonstrating the value of SBHCs.

Key recommendations put forward by Harbage Consulting include **enhanced data collection, data reporting and measurement, and care coordination data sharing practices**. Additional recommendations include **increased funding** for MSDE, MDH, and SBHCs to support complex technical assistance needs and resource requirements of individual SBHCs. Recommendations on quality and best practices were offered to support SBHC Standards, communications, and improved enrollment of clients into SBHCs. Harbage Consulting provided a total of 42 recommendations.

The Council sought an independent external body, Harbage Consulting, to ensure objective representation of recommendations. The Council believes the Report is a comprehensive and highly instructive deliverable. Over the course of 2019, the Council thoughtfully and critically considered each of the recommendations provided in the White Paper. During the second quarter of 2019, each workgroup refined the recommendations they were assigned. At the June 2019 Council meeting, each workgroup presented their recommendations. After Council comments were collected based on the June 2019 meeting, the recommendations were consolidated into a synthesized document. The Council refined the recommendations over the course of July, August, and September 2019. In October 2019, **a block of 8 total recommendations were adopted**. The recommendations adopted are organized to reflect priorities of urgency, feasibility, and impact. *Future work of the Council in 2020 will involve further consideration of resource requirements, implementation planning, timelines, and priorities.*

The following is a summary of key recommendations adopted. These recommendations are not presented in order of priority.

Recommendation #1: Promote and create systems to support reciprocal sharing of protected health and educational information, including but not limited to, SBHCs, Primary Care Providers (PCPs), other health providers, Health Plans, and schools to improve student care coordination:

Recommendation 1A*. Develop methods, including but are not limited to, consent form modification, Business Associate Agreements (BAAs), Memorandums of Understanding (MOUs), and contracts with Medicaid Managed Care Organizations (MCOs) and Health Plans. CRISP connectivity may be considered as a health information sharing platform.*

A preliminary step towards establishing MOUs with MCOs is to create a unified MOU document. Substantial resources are needed from the Agency level (i.e., MDH and MSDE) to create a template MOU, including Medicaid and Public Health policy analysts, and Agency legal staff. The MOU then needs to be examined by the MCOs.

In consideration of using CRISP as a health information sharing platform, a detailed 'use case' needs to be developed that defines the specific objectives for health information sharing for SBHCs. CRISP Electronic Notification System (ENS) is a service which enables real time alerts to professionals on the patients care team in addition to medical personnel. This includes payers, health departments, and care coordinators. CRISP operates on an opt-out model and allows sharing of ENS information to patient's care teams without explicit parental consent. If the SBHC has the authority to receive the protected health information, there is not a requirement for parental opt-in for CRISP. Before CRISP capabilities, such as Electronic Notification System alerts can be established, SBHCs need to submit panels of SBHC enrollees to CRISP. CRISP expertise is required to facilitate this process. The Council has recruited a CRISP employee to participate as a public member in Council meetings and serve on the Systems Integration

& Funding workgroup. CRISP's participation in Council activities are necessary to move these steps forward.

Recommendation 1B. *Define the minimum set of necessary data for collection on consent forms and modify the consent forms to include permissions to enable bi-directional health information sharing. Consent forms used in other states should be evaluated to provide a model for consideration. The recommendation is to change the form in the beginning of a school year.*

A preliminary step towards consent form modification is to research consent forms used in other states. Best practices for facilitating the completion of consent forms needs to be discussed with the SBHC Administrators before further Council recommendations are made.

Recommendation 1C. *Develop a MOU(s) with specific data sharing objectives between the Council and MSDE to support more expeditious data sharing, including but not limited to, annual survey data. The Council recommends such MOU(s) consider legal sufficiency, relevant data use objectives, privacy considerations, including Health Insurance Portability and Accountability Act (HIPAA) and Family Educational Rights and Privacy Act (FERPA), and leadership approval.*

Developing MOUs with data sharing objectives is a highly complex process. Dedicated legal resources are needed to accomplish this, including but not limited, resources of the MDH, MSDE, and Community Health Resources Commission (CHRC).

Recommendation 1D*. Work collaboratively with stakeholders, including but not limited to MCOs, to develop strategies to increase enrollment and utilization of SBHCs to improve access to services.*

Best practices for enrollment should be researched. In addition, SBHC Administrators play a vital role in providing successful enrollment strategies for elementary, middle, and high school students. SBHCs should collaborate with MCOs to leverage their care coordination capabilities, including communication and outreach mechanisms to beneficiaries. Outreach to students' parents to promote the use of their child's SBHC can be a tool to promote improved enrollment.

Recommendation 1E*. Ensure partnership and communications between SBHCs and student's primary care provider.*

Care coordination between the SBHC and primary care provider can be improved through leveraging CRISP functionalities. CRISP ENS alerts can be received by the student's primary care provider (PCP) as part of their treatment relationship. The Council recommends SBHCs also receive ENS notifications to enable PCP and SBHC communication to improve care coordination for students. The Council recommends consideration of Electronic Health Record

(EHR) capabilities of SBHCs and the percentage of pediatric practices with CRISP connectivity and utilization. Pediatricians need to be educated about CRISP resources and tools to increase uptake.

Recommendation #2: Analyze MDH and MSDE Agency resource requirements for oversight and SBHC operation to support advocacy for additional State General Fund resource requests for SBHCs. Collect and summarize financial information in 2019 to support policy initiatives to advance SBHCs. Each Workgroup should continually analyze the resources to successfully carry out recommended activities. Including but not limited to:

- Infrastructure and staffing resources to support improved data sharing, including MOU construction, software requirements, statewide SBHC needs assessment, and policies and procedures;
- Development of data reporting capabilities and public facing dashboards;
- Continual review and revision of the Standards including creation of the revised document;
- Review of the Annual Survey at least every two years and more frequently if needed;
- Continual adaptation of the Survey as needed with input from the Council's Data Workgroup;
- MSDE and MDH staffing resources to support SBHC grant administration;
- Additional infrastructure and staffing to support SBHC applications, financial management, and annual SBHC reporting;
- Provision of technical assistance to SBHC Administrators for establishing a new SBHC, adherence to SBHC standards, provision of high-quality care in the school setting, data collection, and administrative requirements. The technical assistance could be provided through consultation or contract with organizations with appropriate expertise such as the MASBHC;
- Collaboration with MCOs and other key stakeholders.

Recommendation # 3. Explore <u>additional funding opportunities</u> for SBHCs, including but not limited to state general funds through legislative action, grants, philanthropic and nonprofit organizations, and hospitals.

The Council recommends opportunities with hospitals should be leveraged through community benefit support and other means where applicable. The Council recommends that the impact of Local Health Core Funding dollar reductions be analyzed to assess the impact on school health funding. The Council recommends engagement with the Annie E. Casey Foundation, the Association of Baltimore Area Grantmakers, and the Community Health Resources Commission. In addition, the Council recommends exploring Federally Qualified Health Center (FQHC) capability to apply for federal funding for SBHCs. FQHCs are safety net providers that provide comprehensive services, including preventive health services, dental services, mental health and substance abuse services, transportation, and hospital and specialty care.

Grant researching and writing is a time intensive process. Resources to support seeking additional funding opportunities requires dedicated Agency and SBHC staffing. Existing Agency and SBHC staffing currently cannot support the researching and writing of grants to advance school health.

Recommendation # 4. SBHC Data Planning, Collection; Analysis and Reporting; and Evaluation to support value proposition of SBHCs

Recommendation 4A. SBHC Data Planning and Collection:

Recommendation 4A-i. Program Planning: Facilitate on-going considerations of additional appropriate measures, how they would be gathered, feasibly collected, and prioritized. Data Workgroup will recommend new measures, in addition to the2019 adopted measures, to be collected for the Annual Survey. Measures will support performance demonstration and value proposition of SBHCs.

MSDE currently does not have information technology resources dedicated towards school health. Therefore, the modification of survey questions is an extended process that is reliant on the MSDE Central Administration Office. The Council recommends additional information technology resources be devoted to MSDE's school health staff.

In addition to the resources required to accomplish the electronic survey dissemination, Agency staffing resources are required to coordinate with the SBHC Administrators and Council members to continually update the survey. The Council recommends that in addition to new questions being integrated, the MSDE SBHC survey managers consider the volume of questions; as new questions are added, older and less relevant questions are removed. Continual survey review, integration, and management of survey size require dedicated Agency resources. Funding should be commensurate with this need.

Recommendation 4A-ii. Measures: Recommend collection of measures from School Based Health Alliance's (SBHA) National Quality Initiative (i.e., annual risk assessment, depression screen and follow-up, client experience / satisfaction measures, and test measure classroom seat time saved.) Continually examine SBHA quality measures and engage SBHA on quality measure outcomes. SBHA measures are recommended to enable consistent data collection at state and national levels and demonstrate how the school-based health care system is improving the health and educational outcomes of those being served. Additional key benchmark measures to be considered outside of SBHA measures include Health Effectiveness Data and Information Set (HEDIS) – like and other outcome measures to support the development of a matrix of measures with electronic health record (EHR) readiness, existing reporting capabilities, and resource considerations. Include process, education, and outcomes-based data for collection.

Implementation steps towards the recommendations as outlined above require two

distinct levels of effort to accomplish. The first is convening leadership resources and the second step is organizing analytic and technical specialist resources. The Council recommends close collaboration with the School Based Health Alliance affiliate, MASBHC, so that leadership identifies measures that are broadly aligned to national benchmarking. The Council recommends close collaboration with the SBHC Administrators to assess their level of readiness to respond to new questions. For example, some SBHCs still maintain their health records through paper and therefore may require more resources to prepare data for reporting. The Council recommends the Maryland Health Benefit Exchange (MHBE) and MDH's State Health Improvement Process (SHIP) prepare a presentation to the Council that includes processes for creating large frameworks for data collection and public engagement. Both data collection and reporting tools have infrastructure considerations that provide insight into the resources needed to accomplish a sophisticated data collection and reporting process for school health. For example, the SHIP pulls from over ten different data sources and requires a full-time senior data analyst to ensure quality data collection and reporting. School health reporting has similar complexities in that, in order to accomplish the recommendations above, data needs to be collected for both clinical and educational measures.

Recommendation 4A-iii. Fiscal Operations: Recommend collection of operating income and revenue for each SBHC to understand the portfolio of funding and revenue requirements to support sustainability, including grants, in-kind, billing reimbursement, and analysis of sponsor type as it relates to revenue. The SBHA has identified sustainability measures (utilization, reimbursement, and efficiency) as the most meaningful and reliable markers for SBHC business performance[11]. The Council recommends a demonstration of this tool to the SBHC Administrators to assess feasibility for implementation.

Recommendation 4A-iv. SBHC Annual Survey: Continually adapt the Annual Survey to include technical specifications, questions, definitions, and instructions for completing the Annual Survey. Add additional questions based on SBHC readiness to collect. Implement a biennial process to review the Survey.

For the 2018-2019 SBHC Annual Survey, MSDE developed an on-line survey tool with user experience as the focus of the product. The on-line survey tool has smart logic capability, enabling an automatic feature to skip through not applicable questions. It also has the capability to save the survey to be completed later. Future work will continue to allow users' historical data to auto-populate from previous years' responses.

The on-line survey tool took MSDE Information Technology 6 months to complete because MSDE does not have Information Technology staff dedicated to school health.

[1] School Based Health Alliance: Sustainable Business Practices https://tools.sbh4all.org/s/sustainable-business-practices/

The Council recommends resources be devoted to maintaining this new platform and to continually advance its capabilities in line with Council recommendations and SBHC Administrator needs. Additional resource considerations for continual adaption of the SBHC Annual Survey is outlined in Recommendation 4A-i.

Recommendation 4B: SBHC Data Analysis and Reporting:
Recommendation 4.B.i. Identify and extract key data elements from the SBHC Annual Report to enable data reporting on consistently collected data.

Recommendation 4.B.ii. Develop a process to streamline data requests to MSDE from SBHC Administrators, the Council, and SBHC community stakeholders to support access to annual SBHC survey data.

Recommendation 4.B.iii. Develop a MOU between the Council and MSDE to support data sharing.

Recommendation 4.B.iv. Develop public facing data portals for key SBHC measures. The reporting may be modeled after the MDH SHIP and MHBE Data Reporting. Key considerations for a public facing portal include: (1) MSDE's SBHC Annual Report to stakeholders, (2) Capacity to respond to Public Information Act and Inter-Agency data requests, and (3) Technical portal capability and sophistication for public accessibility.

Key considerations for implementing the above recommendations align with 4A-ii.

Recommendation 4C. Data Evaluation: *Assess current baseline for each SBHC on recommended SBHA measures and other key measures, and compare to statewide and national SBHC averages, to inform individual performance improvement and technical assistance.*

The Council recommends dedicated Agency staff to support the evaluation of SBHCs on recommended SBHA measures and other key measures. In lieu of dedicated Agency staff, the Council recommends the use of graduate-level students and academic partners to support the evaluation of SBHC data. Agency staff resources to support the mentorship and preceptorship of graduate-level students to accomplish evaluation activities are required. MDH has existing relationships with the Johns Hopkins Bloomberg School of Public Health. MSDE has existing relationships with University of Maryland Medical System. The Council notes that use of graduate students in lieu of dedicated Agency staff is not ideal because of requirements to train and precept students. Moreover, graduate student turn-over is a challenge for evaluation continuity.

Recommendation # 5. Ensure continuous quality improvement for standards and best practices for SBHCs.

Recommendation 5A. Review SBHC Standards at least every two years. Update more frequently and as appropriate based on practice, legislative mandates, regulatory or

other relevant changes. Considerations for resources should be analyzed and considered to rewrite and then maintain the Standards.

The Council made recommendations to update the Standards. In order to rewrite the existing Standards, the Council recommends a competitive procurement of a one-year Contractor. The proposed Contractor shall be required to research how Standards have been developed, adopted, maintained, adapted, and executed in other states. In addition, the proposed Contractor shall be required to convene stakeholders to ensure alignment with SBHC Administrators, Managed Care Organizations, school systems, MDH, MSDE, clinical expertise, FERPA, HIPAA, architectural/engineering codes, laboratory regulations, and other subject matter expertise. The proposed Contractor shall be required to develop the Standards as a living document and identify sections with a higher likelihood of remaining static, and those sections more vulnerable to future change. Expanded funding will be required to support the financing of a Contractor. The Council estimates after the one-year contract is completed, the living document can be maintained with 120 hours every two years. The Standards revision is the responsibility of MDH and MSDE. The Council will continue to provide a consultative role for continuous quality improvement of the Standards.

Recommendation 5B. Performance goals and performance measurement incentives should be considered for the Standards revisions to drive accountability and value payment.

The Council recommends considerations of funding sources that could support quality payments, such as through MCO value-based payment and alignment with Maryland's population health goals. An additional opportunity is to leverage the MDH Diabetes Action Plan and identify incentives as part of the Plan and other public health initiatives as outlined by the Maryland Health Secretary.

Recommendation 5C. Leverage sponsoring agency relationship for improved SBHC billing capacity, data sharing, and enrollment of members.

The Council recommends expanded sponsorship models to promote the advancement of school-based health center sustainability. The sponsoring agency types should not be restrictive if the standards of being a safety net provider are met. The Council provided an official communication to MDH and MSDE on this topic in June 2019. The document can be found in Appendix 2.

Recommendation 5D. Create site-specific SBHC unique identifiers for both on-site and telemedicine, including but not limited to National Provider Identification (NPIs).

SBHC Administrators apply for NPIs for each of their sites. Medicaid is not able to distinguish services being done at the school (e.g., services billed by a speech therapist at the school site as part of a student's Individualized Education Plan (IEP) mandated services) versus the SBHCs and sometimes between SBHCs with the same operator. Therefore, the goal of unique SBHC identifiers is to be able to collect detailed data for

each site of delivery. This ability to collect site-specific data becomes increasingly important as telehealth takes a more active role in the delivery of SBHC services. Resources from MDH and MSDE would be required to develop unique site identifiers for SBHCs.

Recommendation 5E. Advocate for Explanation of Benefits (EOB) suppression to ensure confidentiality of services for all relevant Health Plans.

Maryland Medicaid requires their MCOs to send an EOB when enrollment is not active for beneficiary on data of service, there is a loss of coverage, and/or the claim is denied. The Council recommends discussions with Maryland Medicaid (MDH) to discuss the implications of sending EOBs for confidential services received by students at their SBHC.

Recommendation # 6. Ensure SBHCs are included in the strategic approaches to achieving Maryland's population health goals.

The Council recommends Maryland's population health goals be expanded to include a focus on the pediatric population through the promotion of funding, accountability, and support for children's care in hospital systems. Diabetes is a population health goal of Maryland's and there is opportunity to integrate focus on childhood obesity and the prevention of type II diabetes.

Recommendation # 7. Continue expansion of school-based health care models through telehealth.

There are existing telehealth programs in Baltimore City and Howard County. These programs should be consulted for their expertise. A statewide needs assessment needs to be performed to evaluate where telehealth would be most impactful and optimally implemented based on SBHC readiness.

Recommendation #8. Interpret data sharing barriers as they related to FERPA and HIPAA.

Interpretation of FERPA and HIPAA law is complex and requires dedicated legal resources from MDH and MSDE. The attorney needs to be briefed on the activities of the Council and SBHCs in Maryland, how their oversight is regulated and operationalized, and how Standards are maintained. After understanding the landscape, barriers as they relate to contracting issues and data sharing need to be enumerated. An attorney's resources are then devoted to issuing legal interpretations of FERPA and HIPAA as they relate to the objectives of school health advancement.

**

The Council is confident the adopted recommendations will support SBHC advancement in Maryland. *The Council believes that in order to pursue sustainable expansion of SBHCs, there*

must be further consideration of increased and dedicated Agency staffing resources and infrastructure. The Council will continue to offer its expertise and guidance during the 2020 General Assembly session as it relates to SBHC resource policy, systems integration, data priorities, and quality and best practices. The Council will continue to partner with the Maryland Assembly on School-Based Health Care through the provision of subject matter expertise and leadership to support their advocacy efforts for school-health advancement. The Council looks forward to developing implementation plans for these recommendations that further support sustainability.

The Council on Advancement of School-Based Health Centers looks forward to a successful 2020. For more information about the Council, please contact Mark Luckner, Executive Director of the Community Health Resources Commission and staff to the Council, at (410) 260-6290.

NOTE: There was a delay in the survey distribution and data collection because the SBHC Annual Survey was developed as an on-line tool this year. The following information will be delivered to the General Assembly during 2020 Legislative Session as an addendum to the 2019 Annual Report.

1. The total number of visits for mental health, somatic, and dental in 2018-2019;
2. The levels of service designated for each SBHC in 2018-2019;
3. The number of SBHCs using telehealth.

III. Roster of Council Members

Appointed by the Governor

Dr. Katherine Connor, Chair
Maryland Assembly on School-Based Health Care (The Johns Hopkins Rales Health Center, KIPP Baltimore)

Uma Ahluwalia *(through 9/19)*
Maryland Assembly on School-Based Health Care (Montgomery County Dept. of Health and Human Services)

Cathy Allen
Maryland Association of Boards of Education (St. Mary's County Board of Education)

Sean Bulson
Public Schools Superintendents Assn. of Md. (Harford County)

Jennifer Dahl
Commercial Health Insurance Carrier (CareFirst)

Dr. Diana Fertsch
Dundalk Pediatric Associates (Pediatrician)

Jean-Marie Kelly
Maryland Hospital Association (Christiana Hospital)

Dr. Arethusa Kirk
Managed Care Organization (UnitedHealthcare Community Plan)

Dr. Patryce Toye
Maryland Assembly on School-Based Health Care (MedStar Family Choice)

Barbara Masiulis(through 8/2019)
Maryland Assembly on School-Based Health Care (Office of Health Services, Baltimore County Public Schools)

Kelly Kesler
Parent/guardian of a student who receives services from SBHC (Howard County Health Department)

Meredith McNerney
Md. Assn. of Elementary School Principals (Gaithersburg Elementary School)

Dr. Maura Rossman
Md. Association of County Health Officers (Howard County Health Department)

Joy Twesigye
Maryland Assembly on School-Based Health Centers (Baltimore City Health Department)

VACANT
Secondary School Principal of a School with an SBHC

VACANT
Maryland Assembly on School Based Health Care

Ex Officio Members

Senator Clarence Lam
Maryland State Senate

Delegate Bonnie Cullison
Maryland House of Delegates

Dr. Cheryl De Pinto
Designee of the Secretary of Health
Director, Office of Population Health Improvement

Mary L. Gable
Designee of the State Supt. of Schools
Assistant State Supt., Student, Family, and School Support

Andrew Ratner
Chief of Staff, Maryland Health Benefit Exchange

Mark Luckner
Executive Director, Maryland Community Health Resources Commission

Demonstrating the Value of School-Based Health Centers in Maryland: A Roadmap

Prepared by Tanya Schwartz, MPP, MSW and Megan Thomas, MPP
Harbage Consulting

for

The Maryland Community Health Resources Commission and the Council for the Advancement of School-Based Health Centers

November 1, 2019

Disclaimer: Report was developed in Calendar Year 2019

HC HARBAGE CONSULTING

Table of Contents

Executive Summary

The Maryland Community Health Resources Commission and the Council on the Advancement of School-Based Health Centers (Council) partnered with Harbage Consulting to develop a white paper on demonstrating the value of school-based health centers (SBHCs) in Maryland. To complete this paper, Harbage Consulting reviewed publicly available information on SBHCs in Maryland, conducted a series of stakeholder interviews, interviewed national experts and SBHC administrators in other states, and reviewed state and national information.

Findings

Harbage Consulting found that SBHC stakeholders are committed to providing high quality services to children and reducing barriers to care. SBHCs fill a critical role in the health care system by providing needed acute and ongoing physical and mental health services to children in Maryland schools, particularly in underserved areas.

However, the state is not collecting the data it needs to adequately describe the demographics of its enrollees, measure health outcomes, or demonstrate the overall value of SBHCs. This lack of information can be attributed to limited state capacity and resources, inadequate data collection tools, and insufficient collaboration between state agencies and SBHCs, health plans, and primary care providers.

Recommendations

Harbage Consulting recommends that the state and the Council develop a data reporting process with the ultimate goal of having comprehensive state-level information on SBHC enrollees, operations, services, health and education outcomes, and cost savings. We recommend implementing the data reporting process in three phases:

- **Phase 1 – Data Reporting Plan and Performance Measures Collection**
- **Phase 2 – Data Analysis and Dissemination**
- **Phase 3 – Data-Driven Decision-making and Technical Assistance**

It will take time, effort, and collaboration to fully develop and implement this data reporting process. However, the end result of having information about the care provided in SBHCs and using it to drive decision-making and SBHC improvements will be critical to ensuring that SBHCs are maximizing their impact on children's health and education and reducing costs across the state.

We recommend that the state establish a School-Based Health Center Program Office that would be responsible for administering and overseeing all aspects of SBHCs. The state and the Council should identify which entities have the expertise, resources, and the capacity to lead each element of SBHC administration, including the data reporting process. State and Council efforts should continue to improve the value proposition for SBHCs by helping ensure that the data findings accurately reflect SBHCs' contribution to a high-quality system of care for children.

Introduction

The Maryland Community Health Resources Commission (CHRC) and the Council on the Advancement of School-Based Health Centers (Council) partnered with Harbage Consulting to develop a white paper on demonstrating the value of school-based health centers (SBHCs) in Maryland. This includes the role that SBHCs play in improving children's health and educational outcomes, and in achieving cost savings.

To complete this effort, Harbage Consulting reviewed all publicly available information on SBHCs in Maryland and conducted a series of stakeholder interviews. Interviews were conducted with:

- Maryland SBHC Administrators from two counties, one Federally Qualified Health Center (FQHC), health plan staff, SBHC health care providers, Council leadership, Maryland Assembly for School-Based Health Care (MASBHC) board members, and Maryland State Department of Education (MSDE) and Maryland Department of Health (MDH) representatives;
- National School-Based Health Alliance (2 interviews);
- Michigan Department of Health and Human Services; and
- Seattle & King County (Washington State) Health Department.

We also attended two Council meetings. We were unable to interview additional SBHC Administrators or students (and/or their parents) served by SBHCs.

Our team reviewed literature from state and national studies on the impact of SBHCs on health outcomes, education outcomes, and cost savings. Additionally, we researched publicly available information on various websites, including the SBHA, states, and state school-based health alliance chapters regarding state SBHC data, administrative structures, and funding.

Background

SBHCs have long played a critical role in providing a comprehensive array of health care services to children in Maryland schools. SBHCs are "health centers, located in a school or on a school campus, that provide onsite comprehensive preventive and primary care health services. Services may also include mental health, oral health, ancillary, and supportive services."[i] SBHCs are staffed by a range of health care providers, such as pediatricians, family practitioners, nurse practitioners, physician assistants, registered nurses, mental health providers, and/or other provider types.

There are currently 84 SBHCs located in 12 of Maryland's 24 jurisdictions. During the 2017 – 2018 school year, 40,551 students were enrolled in 86 SBHCs. SBHCs provided services to 15,081 of these students over the course of 52,254 visits.[ii] More than two-thirds of the visits were for somatic health care, nearly one-third for behavioral health, and other services including dental care, substance use, and case management.[iii]

Administration and Oversight

The Maryland State Department of Education (MSDE) Division of Student Support, Academic Enrichment, and Educational Policy oversees the administration of $2.6 million in state grant funding to 72 of the 84 SBHCs,[iv]. SBHCs that receive MSDE funding submit application budgets, quarterly financial invoices, and interim and final reports. It is very important to note that the $2.6M does not fund the 72 SBHCs in full; these monies support a portion of the 72 SBHC's overall budget. MSDE also oversees the administration of the SBHC program, which involves reviewing and approving new and ongoing SBHC applications; responding to SBHC questions; conducting site visits; providing technical assistance; and consultation to MSDE School Facilities Branch for architectural plan review of new and existing SBHCs.

The Maryland Department of Health (MDH) provides clinical and subject matter expertise on SBHC applications, attends telehealth site visits and some SBHC site visits when needed (primarily to new sites), approves SBHCs for the purpose of receiving Medicaid reimbursement, provides consultation to MSDE School Facilities Branch for architectural plan review of new and existing SBHCs, and receives health care encounter data for Medicaid enrollees from Medicaid managed care organizations (Medicaid MCOs) and Beacon Health Options (the state's behavioral health administrative services organization).

The Council on Advancement of School-Based Health Centers, herein referred to as the Council, was established by the state legislature in 2015 to "improve the health and educational outcomes of students who receive services from SBHCs by advancing the integration of SBHCs into the health care system and the educational system."[v] The Council's mandate is to facilitate collaboration between state entities and other stakeholders that play a role in administering SBHCs and provide advice and recommendations on improving and advancing the role of SBHCs across the state.

A key partner in the advancement of school-based health care is the Maryland Assembly on School-Based Health Care (MASBHC). The Assembly is a non-profit advocacy organization that promotes school-based health care as a means to advance the belief that all Maryland children and youth have a basic fundamental right to access and receive comprehensive, quality health care. MASBHC is committed to advocacy, facilitating professional learning, providing technical assistance, and ensuring quality school-based health care in Maryland. MASBHC has advanced local, state, and federal legislation to better support school-based health centers. For the past twenty years, MASBHC has been a critical partner to the advancement of school-based health in Maryland.

As specified in COMAR 10.09.76.03, Medical Care Programs: School-Based Health Centers, Conditions for Participation, SBHCs must have a sponsoring agency, which have Memorandums of Understanding (MOUs) with the school system to provide funding, staffing, medical oversight, and/or liability insurance and are responsible for developing and overseeing the SBHC's policies and quality improvement activities. According to Maryland COMAR regulations,

sponsoring agencies can be Local Health Departments, Federally Qualified Health Centers (FQHCs), and General Clinics as defined in 42 CFR §440.90. Local Health Departments are the sponsoring agency for approximately 70 percent of SBHCs, FQHCs represent 24 percent, and General Clinics represent 6 percent.[vi]

All SBHCs must meet state-established minimum requirements and are then designated as Level 1, 2, or 3 based on the variety of service types that are provided and hours of operation.[vii] In 2016 – 2017, nearly two-thirds of SBHCs were designated as Level 1, and the remaining SBHCs were split nearly evenly between Levels 2 and 3.[viii]

Funding

The state annually provides $2,594,803 in funding to 72 of the 84 SBHCs.[ix] MSDE reported that this funding level has largely remained the same over the last ten years, which translates into an effective decrease of funding over time. It is important to note that this $2.6 million in state funding only covers a portion of the costs of the 72 SBHCs. Additional funds for SBHCs are received from Medicaid reimbursement, county government, federal grants, private, commercial plan reimbursement, and in-kind donations. SBHC Leadership are developing mechanisms to bring more clarity to the breakdown of respective funding to describe the overall operating budgets.

Medicaid Reimbursement

SBHCs are required to be approved by MDH to receive Medicaid reimbursement. During the 2017 – 2018 school year, MDH Medicaid reported that 78 out of 86 SBHCs submitted claims for Medicaid reimbursement.[x] According to Maryland Medicaid requirements, only FQHCs, Local Health Department clinics, and general clinics are permitted to receive Medicaid reimbursement as SBHCs. Maryland Medicaid regulations do not allow for hospitals to receive reimbursement as sponsoring agencies of SBHCs[xi] It is important to note that Medicaid reimbursement only covers a small portion of SBHC operating costs.

Maryland regulations require Medicaid reimbursement to SBHCs for specified self-referred services that SBHCs provide to students enrolled in Medicaid and MCHP.[xii] Medicaid reimburses SBHCs when they provide the following services, as specified in COMAR 10.09.76.04 Medical Care Programs, School-Based Health Centers Covered Services:

- Comprehensive well-child care, including immunizations in accordance with the Maryland Healthy Kids Preventive Health Schedule according to Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standards; follow-up testing and treatment based on EPSDT screenings; preventive and primary health services, including acute and chronic care management (not related to EPSDT screening),[xiii] certain dental services; certain family planning services; and specialty behavioral health services.

Medicaid MCOs do not provide Medicaid reimbursement for mental health and substance use disorder services – these services carved out of the MCO benefit package in Maryland and are billed directly to Beacon Health Options, the contracted behavioral health entity for Maryland Medicaid (and are incorporated into the MDH claims system).

Under Maryland regulations, Medicaid reimbursement for SBHC services is only available for students. However, since FQHCs have contracts with Medicaid MCOs, they can be reimbursed for services provided in SBHCs to other Medicaid-enrolled individuals. In some states, Medicaid reimburses for SBHC services provided to other groups of people, such as teachers, school employees, and other community members. Maryland would need a regulatory change in order for Medicaid to reimburse for SBHC services provided to non-students.

Despite the state funding provided to SBHCs through state General Funds, Medicaid, and commercial health plans, there is limited information publicly available about the quality and quantity of care provided in Maryland SBHCs. The data presented above is primarily from the Council's Annual Report. The Council has identified the need to collect more useful and outcomes-based data on SBHC performance and to share more information with stakeholders to demonstrate the critical role SBHCs play for children and families in Maryland.

Maryland Data Collection and Analysis Findings

Harbage Consulting found that stakeholders that play a role in SBHCs are committed to providing high quality services to children and reducing barriers to care. SBHCs fill a critical role in the health care system by providing needed acute and ongoing physical, mental, and oral health services to children in Maryland schools, particularly in underserved and rural areas. They are a common sense and convenient solution to improving access to care by bringing services to where children are; enabling parents to stay at work; identifying health issues early and connecting them to services; decreasing the amount of class time missed; and keeping children out of the emergency department by managing chronic conditions. On a daily basis, SBHC administrators and providers see the positive impact they have on children's health and lives.

> "SBHCs improve health and education outcomes for students, particularly vulnerable students, by keeping them in the classroom and improving their attendance and participation in school. They increase children's receipt of preventive services and keep children out of the emergency room, thereby saving the health care system money and helping children be more productive and engaged adults." - SBHC Provider

However, the state does not currently have the data it needs to adequately describe the demographics of its enrollees, measure health outcomes, or demonstrate the overall value of SBHCs. This lack of information can be attributed to limited state capacity and resources, inadequate data collection tools, and insufficient collaboration between state agencies and SBHCs, health plans, and primary care providers (PCPs), among other challenges. There has also not been a systematic way for all stakeholders – the Council, SBHCs, health plans, PCPs – to engage on data collection and data sharing issues.

All the stakeholders we interviewed commented that they are interested in developing the infrastructure for collecting, analyzing, and sharing data to show the value of SBHCs, including their impact on children's health outcomes, education outcomes, and the resulting cost savings that can be achieved.

Infrastructure and Capacity

A key theme throughout all the interviews was the lack of state infrastructure, resources, and collaboration for administering SBHCs across the state. Currently, one staff person at MSDE serves as the liaison to the 84 SBHCs, in addition to serving as the liaison to the 24 jurisdictions for school health services (school nursing) and other special projects. This position is overseen and supported by one other staff person who also has other job responsibilities. Currently, one staff person at MDH serves as the clinical director to the 84 SBHCs, in addition to serving many other duties. Both positions are funded with state General Fund dollars that are separate from the state's $2.6 million SBHC grant funding.

Overtime staffing resources for SBHC Agency oversight have been decreasing. There are currently no dedicated staff for SBHC oversight. All the stakeholders commended the work of the two MSDE staff and one MDH staff but noted that this level of staffing is inadequate for handling the required workload.

Similarly, individual SBHCs face staffing challenges. This makes it difficult to find time to collect and report program information to the state, and SBHCs often do not have the staff to support this effort. However, as previously noted, FQHCs have greater infrastructure, capacity, and expertise for collecting and analyzing data since they conduct these activities for other purposes.

Most of the stakeholders identified the need for greater interagency collaboration between MSDE and MDH to improve and advance SBHCs in Maryland. Many stakeholders noted that SBHCs present an underutilized opportunity to improve health outcomes, play a larger role in the health care delivery system for children and other populations, and support Maryland's ongoing population health initiatives. Therefore, greater public health and clinical expertise is needed at the state level to support planning and the administration of SBHCs.

Finally, stakeholders were positive about the Council and believe that it plays an important role in facilitating collaboration among stakeholders and providing recommendations to advance SBHCs in Maryland. Given the limited state capacity to move SBHC planning forward, the Council has sometimes been placed in the role of doing the actual work of the program, but that is not the intended function.

Data Collection and Reporting

This section summarizes the data that is being collected by SBHCs and reported to MSDE, shared between SBHCs and health plans, reported to MDH, and other data collection activities that are underway. SBHCs, Medicaid MCOs, and Beacon Health Options are all collecting information about SBHC clients and submitting information to MSDE and/or MDH through various vehicles and information technology systems. Commercial health plans also collect information about the services their members receive.

SBHCs are required to submit information to MSDE and MDH at their initial application to become an SBHC and provide information annually to MSDE. This includes information on their administrative structure, enrollment, and utilization. MSDE-funded SBHCS also submit financial invoices and reports to receive state grant funding. Other information must be submitted at other frequencies. Table 1 below outlines the SBHC information submission requirements:[xiv]

Table 1. SBHC Submission Requirements
Initial Requirements
• Initial MSDE SBHC Application • MDH SBHC Application for Medicaid Reimbursement • Process Evaluation (prior to SBHC opening) • Outcome Evaluation (within 5 years of SBHC opening)
Annual Requirements
• Continuing SBHC Application • Clinical Quality Improvement Objectives (including follow-up responses from previous year and current year projections) • Interim Report • Annual School-Based Health Center Outcome Report Survey • Final Report
Other Frequency
• Invoices for MSDE-funded SBHCs (quarterly) • Site Visit Self-Evaluation (no frequency requirement) • Needs Assessment (every 3 – 5 years)

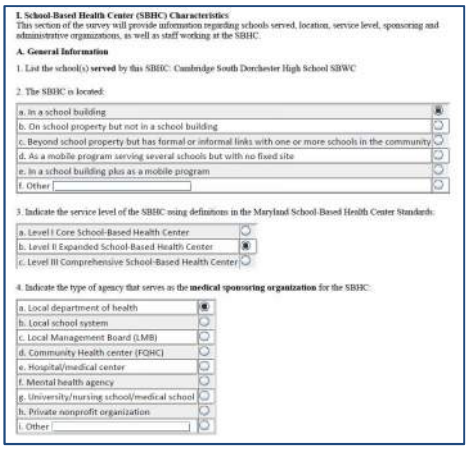
Currently, SBHCs submit a Word version (or sometimes a PDF version) of the new and continuing application by email and mail a hard copy to MSDE. The electronic applications are stored in a folder and paper applications are stored in a filing cabinet. The Annual School-Based Health Center Outcome Report Survey (Annual Survey) is submitted through a web-based tool.

SBHC Annual Survey

Despite the extensive efforts SBHCs are undertaking to collect and submit the required information to MSDE, the state is not currently requesting the data it needs to describe the demographics and insurance status of its enrollees, understand the health outcomes of clients, and demonstrate the value of SBHCs. The Annual Survey – the primary tool used to collect information about SBHCs for the past 12 years – largely focuses on describing the SBHC structure, staffing, and the number and type of services provided. While this is useful information, the Council identified that the Annual Survey questions were not helpful in fully telling the story of SBHCs and made recommendations to MSDE for ways to improve it. The Council, MSDE, and SBHC Administrators have been collectively working to revise the Annual Survey.

SBHCs noted that it is time-consuming and labor intensive to pull the information and produce the reports needed to complete the Annual Survey. One SBHC sponsoring agency we interviewed that has infrastructure and capacity for data analysis noted that their team spends six weeks putting together the required data.

While the latest draft of the Annual Survey is a major improvement over the previous version, our review of the tool found that it still focuses largely on health care utilization and less on the quality of care provided to children and health outcomes. We also found that some of the language in the revised survey needs to be clarified, and that detailed instructions are needed. Otherwise, the state risks collecting non-standardized information across the 84 SBHCs, which can lead to poor data quality and the inability to make conclusions about the performance of SBHCs.



I. School-Based Health Center (SBHC) Characteristics
This section of the survey will provide information regarding schools served, location, service level, sponsoring and administrative organizations, as well as staff working at the SBHC.

A. General Information

1. List the school(s) **served** by this SBHC: Cambridge South Dorchester High School SBWC

2. The SBHC is located:

a. In a school building	☒
b. On school property but not in a school building	○
c. Beyond school property but has formal or informal links with one or more schools in the community	○
d. As a mobile program serving several schools but with no fixed site	○
e. In a school building plus as a mobile program	○
f. Other	○

3. Indicate the service level of the SBHC using definitions in the Maryland School-Based Health Center Standards:

a. Level I Core School-Based Health Center	○
b. Level II Expanded School-Based Health Center	☒
c. Level III Comprehensive School-Based Health Center	○

4. Indicate the type of agency that serves as the **medical sponsoring organization** for the SBHC:

a. Local department of health	☒
b. Local school system	○
c. Local Management Board (LMB)	○
d. Community Health center (FQHC)	○
e. Hospital/medical center	○
f. Mental health agency	○
g. University/nursing school/medical school	○
h. Private nonprofit organization	○
i. Other	○

While we recognize that SBHCs across the country struggle with assessing SBHC costs, the information being collected on the Annual Survey is insufficient for purposes of illustrating the cost of administering SBHCs as well as the total revenue. This makes it impossible to develop even a cursory estimate of SBHCs' return on investment. For example, the revised Annual Survey asks about the category of services SBHCs bill for, the amount billed, and the amount of reimbursement received. While this provides some information about revenue, it does not provide the full revenue picture, nor does it provide insight into the costs of administering an SBHC – including salaries, equipment and other supplies – and how these costs compare to revenue.

It is our understanding that some SBHCs may be collecting additional data beyond what is required by MSDE, but this varies by SBHC and depends on their capacity and the information they are required to submit for other funding sources.

Data Sharing Between SBHCs and Health Plans

Most children who get services from SBHCs are low-income and have public health coverage or are uninsured. Although state-level data is not publicly available on the insurance status of children who receive care in SBHCs (referred to as "clients" in this paper), in one county we interviewed, 73 percent of students who are served in its SBHCs have Medicaid coverage. Most children in Maryland who are enrolled in Medicaid have coverage through a Medicaid MCO.

Maryland's self-referral Medicaid model makes it administratively easier for SBHCs to receive Medicaid reimbursement, since most of them do not meet Medicaid PCP standards (e.g., operating hours). However, this structure has obviated the need for SBHCs to have formal relationships with Medicaid MCOs so very few SBHCs contract with Medicaid MCOs and private health plans. FQHCs are more likely than Local Health Departments and clinics to have formal relationships with health plans due to their connections in other programs.

Data Analysis

Because most SBHCs do not contract with Medicaid MCOs (or private health plans), SBHCs only have information about the services they provide – they do not have information on the services children receive from other health care providers. This limits the SBHC's and state's ability to collect comprehensive utilization data and performance measurement information.

Stakeholders shared that there are a couple of health plans that are particularly proactive in working with SBHCs (i.e., FQHCs) when they have a contract in place on providing information panel management and population health information, but staff turnover at the health plans can hinder this progress. It was also noted that some health plans have pushed back on sharing data due to Health Insurance Portability and Accountability Act of 1996 (HIPAA) concerns when they do not have contracts with the SBHCs.

Care Coordination

With respect to sharing information at the client level, once an SBHC submits a Medicaid reimbursement claim to a health plan, the SBHC and the health plan can share information about that child. Maryland regulations require SBHCs to fax a health visit report to the child's Medicaid MCO and PCP within three business days of the health visit for inclusion in their medical record. If follow-up care is needed, a health visit report must be faxed within one week to the child's Medicaid MCO and PCP.[xv] SBHCs continually seek to establish improved bi-directional data sharing with MCOs to facilitate effective care coordination.

Based on our interviews, it appears that communication between the SBHCs and health plans occurs to varying degrees. In some cases, the health plans actively review the SBHC's notes and follow up with clients who have received care but appear to have unmet health needs. However, SBHCs and health plans are currently not permitted to share information about children who have returned an SBHC enrollment form but have not received services (referred to as "enrollees" in this paper). Nor are health plans permitted to obtain information from schools/SBHCs on whether their members are enrolled in a school that has an SBHC. Therefore, for the majority of SBHCs that do not have contracts with Medicaid MCOs and private health plans, they cannot encourage SBHCs to outreach to children who need services.

Both SBHCs and health plans expressed frustration about their inability to share information and believe that this is a major barrier to improving care coordination across health care provider settings as well as to demonstrating the value of SBHCs. The SBHCs and the health plans we interviewed expressed strong interest in improving their organizational and data sharing connections.

Medicaid MCO Data Reporting to MDH

SBHCs submit Medicaid claims to Medicaid MCOs (and to Beacon Health Options) to receive reimbursement for covered services provided to SBHC clients. Medicaid MCOs then provide information on claims paid to MDH. The claims include the:

- SBHC National Provider Identifier (NPI);
- Place of Service Code of "03" (block 24B); and
- SBHC Name and Address (block 32).

However, the "03" service code is for *all* services provided in a school setting, including those provided by a school nurse not employed by an SBHC. Analyses would have to be conducted to understand which services are specifically provided by SBHCs. Additionally, according to MDH, SBHCs bill Medicaid for services using the NPI and Medicaid provider number of their sponsoring entity. Some SBHC sites do not have a site-specific NPI or Medicaid provider number, but rather use the same sponsoring agency (Local Health Department or FQHC) number across all their locations. In other counties, each SBHC has a unique identifier. All FQHCs enrolled in Maryland Medicaid are collapsed under one NPI number per organization, which makes it difficult to drill down to the school level based on claims data alone.

Therefore, MDH indicated that that they do not have all the data SBHCs may be interested in and that Medicaid MCOs may be better positioned to provide some of this information. There should be further discussion with the appropriate MDH data staff on what data is collected by MDH and how it could be used to help demonstrate the value of SBHCs.

Other MSDE Data Collection

MSDE is collecting some data that could be useful in analyzing the impact of SBHCs on education outcomes. For example, they have been collecting school-level information on chronic absenteeism, but the definition is being revised this year to align with the federal definition. As of next year, it will be included on every school's MSDE Report Card. There will be associated performance goals and schools will have to report what they are doing if not meeting the goals. MSDE also noted that they think SBHCs are collecting information about whether students are returning to class after they visit the SBHC. Additionally, MSDE will be collecting information about school climate.

Data Analysis, Dissemination, and Technical Assistance

Many stakeholders commented that SBHCs are currently submitting a substantial amount of information to MSDE, which could be more fully utilized to help inform SBHC programming and operations and to demonstrate the value of SBHCs. Some stakeholders reported that they submit information but do not receive any feedback or recommendations based on that information. It also appears that the state is not regularly consolidating or analyzing the information submitted by SBHCs. For example, SBHCs annually undertake a required Clinical

Quality Improvement (CQI) effort, but they do not receive feedback on it, and there is no sharing at the state level about these efforts, lessons learned, or best practices. It appears that MSDE staff are reviewing the information SBHCs submit and asking SBHCs questions as needed, but their lack of staff and capacity makes it impossible to comprehensively review SBHC information and share that information with other SBHCs.

Data Analysis

Data from the Annual Survey is housed at The Hilltop Institute (Hilltop). However, it appears that Hilltop's contract is only to serve as the data repository and does not require them to analyze the data. MSDE has two staff members who have administrative rights to the Hilltop's SBHC data, as well as another data person in a separate branch. However, these staff members have a range of data analysis responsibilities within MSDE. This spring, MSDE is bringing on two students from Stevenson University to support these efforts, and they hope to have an ongoing relationship with the University.

Some SBHCs conduct their own data analyses, but this varies by SBHCs and their capacity to do this is very limited. FQHCs have greater capacity to conduct data analyses and are required to do this to fulfill other program requirements.

Dissemination

All the stakeholders interviewed noted that state-level data on SBHCs is not publicly available. Many noted that the only way to obtain this information is to make a special data request to MSDE by email, which is then run through MSDE's internal approval process. Some stakeholders mentioned that people have asked for reports and they have been told that there is not staff to analyze the data and produce the requested report. However, MSDE said they have not received data requests for state-level information from individual SBHCs. Another stakeholder reported that they were told they would have to pay $10,000 to obtain access to Medicaid data that is housed at Hilltop.

Technical Assistance

Based on feedback received from SBHCs on their technical assistance needs, the state and the Council have been trying to bring in state experts to present at the regular SBHC Administrators meeting (e.g., on Medicaid billing). MSDE reported that it is planning to continue to try to leverage various state agency staff to support SBHCs. MSDE also provides individualized support to SBHCs as needed. However, the state does not have a formal process for identifying trends in technical assistance needs nor for providing technical assistance to SBHCs. There are informal vehicles for SBHCs to share technical assistance needs, including at SBHC Administrator meetings and MASBHC's annual conference.

National School-Based Health Center Literature and Data

Many of the challenges that Maryland faces in demonstrating the value of SBHCs are shared by states and SBHCs around the country. However, the national SBHA and some states are increasingly focused on improving SBHC data collection, analysis, and dissemination to further the evidence base for SBHCs. In 2015, the SBHA began an initiative to collect performance measures from SBHCs to demonstrate their value. Michigan and Oregon are two of the states leading the way on improving data collection and analysis to assess the impact and value of SBHCs. (See Appendix A for summaries of the SBHA, Michigan, and Oregon performance measurement efforts.)

Literature on the Value of SBHCs

As states and the SBHA seek to expand data collection and analysis, research continues to be conducted on the value of SBHCs. Michigan and Oregon are primarily focused on how individual SBHC performance compares to statewide performance, as well as on year-to-year performance improvements. Many of the existing studies on SBHCs have been conducted by academic researchers using complex methodologies. These studies show that SBHCs improve health care utilization, health care outcomes, education outcomes, and cost savings.

Utilization and Health Outcomes

Studies show that SBHCs lead to increased health care utilization[xvi] and primary care,[xvii] including recommended immunizations[xviii] and other preventive services.[xix] SBHCs have been found to reduce emergent care visits[xx] including emergency department use,[xxixxiixxiii] and result in fewer hospitalizations,[xxivxxv] particularly for children with asthma.[xxvixxvii] SBHCs have also been shown to provide benefits to students with asthma, including reductions in symptoms and incidents.[xxviii] Additionally, studies show that SBHCs reduce illegal substance use and alcohol consumption. They also increase contraceptive use among females and increase prenatal care.[xxix]

Michigan found that SBHC clients reported significantly better health outcomes and behaviors after three years than non-SBHC clients. This included greater satisfaction with health, greater self-esteem, less physical discomfort, engaging in more physical activity, eating more healthy foods, greater family involvement, and more active social problem-solving skills.[xxx]

Finally, SBHC health education and promotion activities also benefit other students in the schools even if they are not enrolled in SBHCs.[xxxi] Michigan found that the presence of SBHCs in schools was associated with health benefits for the entire student population, such as less physical and emotional discomfort, higher self-esteem, engaging in fewer individual risk behaviors, fewer threats to achievement, and fewer negative peer influences.[xxxii]

Education Outcomes

Studies show that SBHCs have a positive impact on educational outcomes. In a review of the literature, Knopf et al. (2016) found that SBHCs are associated with substantial educational

benefits including "reductions in rates of school suspension, high school non-completion, and increases in grade point averages and grade promotion."[xxxiii] Research also demonstrates the positive relationship between SBHCs and attendance, drop-out rates, and school tardiness.[xxxiv]

A Michigan study found that 95 percent of students were sent back to class after visiting the SBHC.[xxxv] The Oregon student satisfaction survey found that more than half of SBHC clients reported missing less than one class while accessing care at their SBHC.[xxxvi]

Cost Savings

> "SBHCs are an effective and cost-beneficial setting for health care delivery….With moderate costs, SBHCs have generated considerable savings to society, especially to the Medicaid program." – Ran et al.

Studies have also been conducted to analyze the cost savings of SBHCs for the Medicaid program and for parents. SBHCs have been found to reduce inpatient, non-emergency department transportation, drug, and emergency department Medicaid expenses.[xxxvii] SBHCs also help parents avoid productivity loss and income reductions from taking time off work to take their child to the doctor and to care for them at home.

In a review of the literature on cost savings, Ran et al. (2016)[xxxviii] found:

- The calculated annual benefit of <u>each</u> SBHC to society ranges from **$15,028 to $912,878**; and
- SBHCs lead to a positive net savings to Medicaid, ranging from **$30 to $969 per visit** and **$46 to $1,166 per user**.

This cost savings is largely due to averted emergency department use, ongoing support for children with asthma, and increased contraceptive use among females and therefore decreased teenage pregnancy. The variation in the large ranges presented above is attributed to including different benefit components and assumptions about the number of emergency department visits that were avoided due to the use of SBHCs. Additionally, all the studies reviewed by Ran et al. incorporate annual SBHC operating costs, but only a couple of studies factor in start-up costs.

Another study by the Hispanic Heritage Foundation and MSA Management, LLC on SBHCs in East Baton Rouge, Louisiana found that for every $1 annually invested in SBHCs, there is a return on investment of $3.28 (annual savings of $5.3 million on an annual investment of $1.6 million).[xxxix]

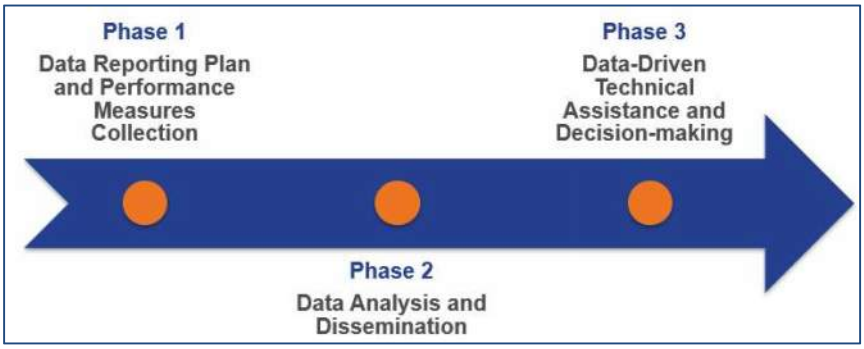
A firm in Michigan is about to release a comprehensive study on the cost savings of SBHCs in the state. Although there is movement toward analyzing the impact of SBHCs, more state data and research is needed to determine the impact on health and education outcomes, and particularly on the cost savings that can be achieved.

Recommendations

Based on Harbage Consulting's findings on SBHCs in Maryland and nationally, this section provides a roadmap of recommendations for developing a data reporting process. The ultimate goal is to have comprehensive state-level information on SBHC operations, services, health and education outcomes, and costs/savings that can be analyzed and used for effective program management, SBHC improvement, and to demonstrate the value of SBHCs in Maryland. This includes information that identifies health care disparities that may exist in order to help move toward health equity. The data reporting process should be guided by the following principles:

- State Investment – The state, including MSDE and MDH, must invest in, prioritize, collaborate in, and lead the development and implementation of, a comprehensive data reporting process;
- Data Sharing – All involved partners must be willing and able to share data, and in accordance with applicable federal and state laws;
- Minimize Burden – Data collection efforts should be streamlined, and technology leveraged, to minimize the burden on SBHCs and partners;
- Transparency – Program information should be analyzed and provided to the full range of stakeholders, recognizing that the level of information needed varies by stakeholder; and
- Actionability – Data should be used to drive improvement and ensure accountability of individual SBHCs, inform state-level SBHC planning and decisions, and demonstrate the value of SBHCs in Maryland.

We recommend developing a comprehensive long-term plan and implementing it in three phases. This will ensure adequate time to create the data reporting process and obtain internal stakeholder buy-in; and to be realistic about the practicality of implementing these changes given the infrastructure, additional resources, and collaboration required. Stakeholders should be prepared for this process to take time to develop and implement.



Phase 1. Data Reporting Plan and Performance Measures Collection

The first phase would involve developing a reporting plan and timeline for establishing the data reporting process through systematic engagement of stakeholders. Achieving stakeholder buy-in on the performance measures and the process for obtaining them will be critical. Below are recommended steps for completing the activities in this phase – these steps should be taken concurrently.

Step 1: Develop Data Reporting Plan, Including Technology Options

The State of Maryland must be willing and able to take on a leadership role in developing a data reporting plan and obtaining buy-in from frontline staff and other stakeholders. The state will also need to dedicate additional resources and staff to strengthening the infrastructure for data collection, reporting, analysis, and dissemination. In the last section of this paper – "Improving the Value of School-Based Health Centers" – we recommend the state create a School-Based Health Center Program Office composed of MSDE and MDH staff with the expertise to oversee all aspects of SBHC administration.

> "Having staff has enabled us to do performance measurement and site reviews – if we didn't have the staff, we wouldn't be able to do all of this."
> – Michigan Dept. of Health & Human Services

The first step is to create a "Data Reporting and Analysis Plan" (Plan) and timeline for developing and implementing a comprehensive data reporting process. This Plan should be developed and monitored by the Council and the Data and Reporting Workgroup, potentially with support from the Commission's part-time contractor or another vendor. A key part of the preliminary meetings should focus on which data outlined in this paper can be shared among partners in accordance with state and federal requirements and whether any immediate contract/MOU additions/revisions are needed. The full Plan should be discussed with all the stakeholders to obtain their input and buy-in, approved by the Council, MSDE, and MDH, and then finalized and distributed.

- *Leverage Technology*

The Plan should include an approach for leveraging existing technology to both store and analyze the data while exploring opportunities to implement a system with additional capabilities. Ideally, SBHCs would be able to leverage their electronic medical record (EMR) systems to pull the required data, and all information that SBHCs submit to the state would be housed in one location. However, it is very important to note that not all Maryland SBHCs have EMRs.

We recommend that the state and Council explore an online database software, Knack,[xl] that is used by Michigan. After years of trying to develop their own database, Michigan decided to

have Knack develop their database, but they can make modifications to it. They reported that Knack is affordable, provides the database structure they need, and produces reports.

Step 2: Determine Performance Measures and Develop Student Satisfaction Survey

- *Collect Additional Performance Measures*

Harbage Consulting recommends adding eight performance measures to the revised Annual Survey. These recommended measures include health and educational outcomes, as well as revenue and costs, and have detailed measure technical specifications that allow for data to be collected and reported in a standardized way. Most of the recommended measures are currently part of, or adapted from, established quality measurement and reporting efforts, including the:

- HEDIS,[xli] from which many of the Centers for Medicare & Medicaid Services (CMS) Child Core Set measures were adapted;
- CMS Child Core Set,[xlii] from which many of the SBHA measures were adapted;
- SBHA, which is encouraging voluntary reporting of five clinical performance measures;[xliii] and
- The California School-Based Health Alliance (CA SBHA).[xliv]

To implement the recommended performance measures, SBHCs, Medicaid MCOs, and private health plans will need to share information and leverage the Chesapeake Regional Information System for our Patients (CRISP) health information exchange. Each of these partners has a piece of information on children's health care utilization and health care quality. In some cases, SBHC partners (Medicaid MCOs, private health plans, MDH) are already reporting on these measures (e.g., to the state and/or CMS). By putting the full picture of information together, the state will be able to show that children who receive SBHC services are receiving needed, appropriate, and comprehensive care.

We recommend starting by assessing the current baseline for each SBHC on the recommended measures and comparing it to the statewide SBHC average. In subsequent years, the state and SBHCs could measure year-to-year improvements. Over time, individual SBHC performance and the Maryland state average could be compared to other states, national benchmarks, and across payers. For example, SBHCs could compare the percentage of children they serve who have had a well-child examination to state and national percentages.

Table 2 below lists the recommended performance measures; sample findings that could be achieved for each measure; and the potential sources of data for each measure. Appendix B includes the definition, rationale, quality measurement reporting efforts each measure aligns with, and links to the measure technical specifications.

Table 2. Recommended Performance Measures		
Measure Name (measure steward)	**Sample Measure Findings**	**Potential Data Sources**
Primary and Preventive Care		
Annual Risk Assessment (SBHA)	X% of MD SBHC clients who had an annual risk assessment, regardless of where the assessment was conducted	SBHCs, Medicaid MCOs, MDH, Private health plans, CRISP
Depression Screening and Follow-Up (SBHA modification of CMS)	X% of MD SBHC clients who were screened for clinical depression and had a follow-up plan, regardless of where the screening was conducted	SBHCs, Medicaid MCOs, MDH, Private health plans, CRISP
Care of Acute and Chronic Conditions		
Asthma Action Plan (N/A)	X% of MD SBHC clients with asthma who have a documented asthma action plan in their health record, regardless of which provider developed it with the client/parent	SBHCs, Medicaid MCOs, Private health plans
Asthma Medication Ratio (NCQA/HEDIS)	X% of children served in SBHCs with persistent asthma had a ratio of controller-to-total asthma medications that signaled their asthma was in control	SBHCs, Medicaid MCOs, MDH, Private health plans, CRISP
Emergency Department Visits (Modification of NCQA/HEDIS)	There were X emergency department visits per 1,000 member months among children in Medicaid/MCHP private health plans who were enrolled in SBHCs There were X emergency department visits per 1,000 member months among children enrolled in Medicaid/MCHP/private health plans in schools with an SBHC compared to Y visits among children in non-SBHC schools	Medicaid MCOs, MDH, CRISP, Privat health plans
Care Coordination		
Timely Transmission of Health Visit Report (N/A)	X% of SBHC clients who needed follow-up care with their PCP had their health visit report transmitted to the PCP within 7 days of the SBHC health visit	SBHCs, Medicaid MCOs, Private health plans

Table 2. Recommended Performance Measures		
Measure Name (measure steward)	**Sample Measure Findings**	**Potential Data Sources**
Education Outcomes		
Classroom Seat Time Saved (SBHA test measure)	X% of MD SBHC client visits resulted in sending students back to class versus their homes, a hospital, emergency room, or external provider	SBHCs
Cost and Budgets		
Operating Income (California SBHA)	MD SBHCs have an average of $X in operating income available after operating expenses are accounted for MD SBHC annual revenue ranged from $X to $Y MD SBHC annual costs ranged from $X to $Y	SBHCs, MSDE

- *Calculate Cost Savings*

  The state could use the data results from some of these measures to develop cursory estimates of cost savings. For example:

  - Emergency Department Visits: MDH could calculate the average cost per emergency department visit for all Medicaid/MCHP enrollees up to age 19; private health plans could also be asked to do this calculation. Using data on emergency department utilization, the state could multiply the difference in the emergency department visit rate for SBHC clients versus non-SBHC clients by the average emergency room cost to identify SBHC-related cost savings.
  - Parent Productivity Time and Income Saved: SBHCs could calculate the difference in the average amount of time to visit an SBHC versus the average amount of time it would take students to seek care from an external health care provider based on data from the Classroom Seat Time Saved performance measure. Multiplying this figure by the number of students seen each year and the median income of parents in the jurisdiction would provide a general estimate of the annual cost savings to the state resulting from the SBHC.

  Later, the state could partner with a local university to develop more thorough analyses of cost savings that incorporate other factors and examine cost savings resulting from specific SBHC services (e.g., asthma care).

- *Develop Client Experience Survey*

  In addition to collecting data on children's access to, and the quality of SBHC services, it is also important to measure clients' experiences receiving those services. Therefore, we recommend that the state implement a client survey. Survey questions could address issues such as communication with providers, the ability to get appointments and needed care, missed class time reduced due to visiting the SBHC instead of going home or to see an external provider, what students would have done if their school did not have an SBHC, and general SBHC satisfaction. To develop the client survey, the Council could leverage surveys that are already being used at some Maryland SBHC sites, as well as those developed by the SBHA, Oregon, and Connecticut.[xlv]

Step 3: Modify, Streamline, and Provide Support on MD SBHC Annual Survey

While we recognize that the revised Annual Survey is still a draft, Harbage Consulting has specific recommendations for opportunities to improve the survey. Appendix C includes detailed suggestions for modifying some data elements to align with technical specifications of measures used in national performance measurement programs. We are also separately providing to the Council suggestions for refining some of the other Annual Survey questions, such as defining each question (as Michigan does)[xlvi] and developing instructions for completing the Annual Survey.

In addition to these detailed suggestions, we recommend streamlining data requests, developing an ongoing process for updating the Annual Survey, and providing technical assistance to SBHCs in completing the Annual Survey.

- *Streamline Data Requests*

  It is important to strike a balance between collecting information and ensuring SBHC accountability while not overwhelming SBHCs with data requests. This balance is particularly important for SBHCs that do not receive state funding. To avoid burdening partners with duplicate reporting requests and reducing the risk of introducing error into the data collection process, every effort should be made to streamline data collection and reporting to the maximum extent possible (e.g., on the application, Annual Survey, site visit self-evaluation, etc.). However, this requires the state to have the capability to analyze all SBHC information – regardless of the data collection vehicle and where the information is housed.

  The Council and MSDE should also review the SBHC Standards and determine whether all the reporting requirements will continue to be needed once the comprehensive data reporting process is in place (e.g., the Outcome/Impact Evaluation). Additionally, the state could also standardize the frequency of site visits so that SBHCs know when to expect them, based on the state's capacity to conduct them.

- *Provide Technical Assistance on Survey*

  To support SBHCs in understanding how to collect, report, and analyze the measures and use the data to improve access to and the quality of care for children, we recommend that Maryland launch a technical assistance program in the year prior to collecting SBHC data on the revised Annual Survey. Technical assistance should be made available through a variety of vehicles, including webinars, one-on-one technical assistance calls, reporting guidance, and in-person data workshops. Additionally, SBHC sponsoring agencies should be encouraged to collaborate on the survey responses when appropriate. Technical assistance should be provided by people who have expertise in the survey data elements, such as state Agency staff and MASBHC, as appropriate. It is important to note that adequate resources are needed to support Agency staff and MASBHC.

  In the first year, technical assistance would primarily be designed to help SBHCs understand the measure technical specifications, including the data elements and/or codes needed to calculate the measures. Since the recommended measures are part of, or adapted from, established quality measurement and reporting efforts, the state can leverage existing technical assistance resources, some of which are specifically developed for SBHCs (e.g., SBHA Technical Measure Specifications, SBHA quality webinars, SBHA tips).[xlvii] In subsequent years, technical assistance should be largely tailored to SBHC needs. Access to certain SBHA resources is available through membership.

- *Create Survey Update Process*

  To help improve and expand data collection and reporting over time, Harbage Consulting recommends that three years after the implementation of the revised Annual Survey, the state and the Council in concert with MASBHC, implement a biennial process for updating it. This would include making decisions about revising and/or removing the data elements that are no longer providing value to the state and adding at least one performance measure for future collection. This will help ensure that the reporting program continues to evolve in a consistent way and is responsive to programmatic changes.

Step 4: Enhance Relationships with Health Plans

Harbage Consulting recommends that SBHCs and health plans develop contracts and a process for sharing information about SBHC enrollees for the purpose of ensuring that children receive needed care, and for demonstrating the value of SBHCs. Given that most children served in SBHCs are Medicaid enrollees, the logical first step is improving connections with Medicaid MCOs; the second step is improving connections with private health plans. It is valuable that health plan representatives sit on the Council and that health plans are sometimes invited to SBHC Administrator meetings, but these meetings need to be more regular.

- *Show Value Proposition for Health Plans*

  The state and the Council should make the case to health plans about the value of collaborating with SBHCs across the state. SBHCs provide health care services to children who are enrolled in health plans and they have information about utilization and quality that health plans and PCPs should want. Health plans have extensive information about children's health utilization and health outcomes that would help SBHCs provide appropriate and non-duplicative care to children, and that would help demonstrate the value of SBHCs. Therefore, the health plan-SBHC relationship can bring mutual value to each entity.

  Medicaid MCOs are required to report HEDIS measures to MDH – not achieving performance measure goals has financial ramifications for them. Medicaid MCOs are also focused on value-based purchasing efforts, such as adolescent well-child visits. Subject to resource availability, MASBHC may be able to offer their expertise in demonstrating to Medicaid MCOs how SBHCs can serve as partners and help them meet their performance goals and save money.[xlviii] Additionally, MASBHC and SBHCs could support Medicaid MCOs with other population health efforts that are underway in Maryland.

  > "If you as an SBHC can help any health plan improve their HEDIS scores, that's value. There are dollars on the line for HEDIS measures and sometimes health plans just fall short of meeting the goals. A couple extra well-child visits can make the difference in paying a chunk of money back to the state or not."
  > – Health Plan Representative

- *Share Information on SBHC Clients*

  We recommend first ensuring there is consistency across the state in the level of information that is being shared between health plans and SBHCs for students that have received services at SBHCs and for whom a reimbursement claim is submitted to their health plan.

  To streamline the Medicaid MCO-SBHC connections across 12 jurisdictions and 84 SBHCs, it would be logistically easier if the state required Medicaid MCOs and SBHCs to share certain information. This could be done by requesting that MDH add language to COMAR regulation 10.09.67.28(C) related to the information that Medicaid MCOs must provide to SBHCs on clients. An alternative is for the state to develop a Business Associate Agreement (BAA) template that could be used by SBHC administrative sponsors and Medicaid MCOs (such that each administrative sponsor, rather than each SBHC, would need an agreement with each MCO). The state should also explore creating connections with private health plans.

However, in order to receive information from Medicaid MCOs, SBHCs must be willing and able to provide information to them. It would be administratively simpler for SBHCs to provide information on a panel of clients (rather than on individual clients). We also recommend exploring the role that CRISP – the state's health information exchange – currently plays and could play in improving care coordination and reducing duplicative services for SBHC clients.

- *Share Information on SBHC Enrollees*

We recommend that the state and Council work with health plans, particularly Medicaid MCOs, to enable the sharing of information about SBHC enrollees (children who are enrolled in an SBHC but have not received services). This practice would be consistent with New York's requirement that Medicaid MCOs and SBHCs share information to improve enrollee health outcomes (see best practices example box). During the 2017 – 2018 school year, 40,551 students enrolled in Maryland SBHCs but only 37 percent received at least one SBHC service. Creating a policy that permits data sharing between SBHCs and health plans about enrollees would likely improve access to, and coordination of, care for approximately 25,470 additional students.

New York Best Practice

In New York, MCOs are required to work with SBHCs to improve enrollee health outcomes. This includes requiring MCOs to use rosters provided by SBHCs to identify enrollees that need comprehensive exams or other services. MCOs are required to provide data to help SBHCs target enrolled children who have not had an annual history and physical exam, and/or other well-child services.

To enroll in a SBHC, parents of children must sign a consent form, which is developed by each county/SBHC. We recommend the development of model language to be added to consent forms, giving permission for SBHCs to inform health plans that their member is enrolled in the SBHC and giving permission for SBHCs and health plans to bi-directionally share information for the purpose of identifying the child's PCP and ensuring their child receives any needed services and treatment. This would enable the health plan to inform the SBHC of which services students need but have not received (e.g., well-child visit, flu shot, etc.) – the SBHC could then conduct targeted outreach to the student to facilitate the provision of these services. Once the health plan is informed that their member is enrolled in an SBHC, they can also proactively reach out and educate their member/their family about the available SBHC services. MASBHC has the appropriate expertise to serve as lead agency for this project. MASBHC or other lead agencies will require adequate financial resources to support such projects.

Since we envision the consent form as the primary way for SBHCs and health plans to be able to communicate about enrollees, SBHCs should work with the schools to enhance their outreach efforts and to encourage people to return the consent form (see additional marketing and outreach recommendations in the last section of the paper – "Improving the Value Proposition for School-Based Health Centers).

- *Share Information on Children Enrolled in Schools with SBHCs*

  Based on our analysis of the Family Educational Rights and Privacy Act (FERPA) and New York's practices (see New York best practice box), we believe that it may be possible for schools to share the name and date of birth of its students with health plans. Under FERPA, schools may disclose without parental consent 'directory' information such as a student's name and date of birth, among other information[xlix] if the school has notified parents that it may do so according to the requirements.[l] Schools with SBHCs would need to revise their annual FERPA public notice to explain which directory information would be shared with health plans for the purpose of treatment and connecting students with needed services.

  Health plans could use the list of children's names and their date of birth to try to identify their members who attend schools with SBHCs. From there, health plans could work with SBHCs to simultaneously outreach to students to encourage them to enroll in the SBHC, and then to support the receipt of needed services and care coordination.

  However, we understand that the state is rightfully concerned about protecting children's privacy. The state would need to decide about whether sharing children's information with health plans meets the public health goals of increasing children's access to needed services. If the state decides not to pursue this strategy, health plans could proactively send communications to their members who are likely in schools that have an SBHC, leveraging member information on their members' age and zip code.

Step 5. Collectively Address Student Information Privacy Concerns

We recommend addressing two key student information privacy concerns – one related to the need to suppress Explanation of Benefits (EOBs) for confidential services and the other related to sharing and disseminating data.

- *Suppress Explanation of Benefits for Confidential Services*

  Recently revised Maryland regulations require Medicaid MCOs to send an EOB to parents when their child's SBHC claim is rejected. This presents a challenge for students who are being seen for confidential services, such as a sexually transmitted infection (STI) or for contraception. Some stakeholders noted they are no longer submitting claims for those services because they do not want to risk an EOB being sent to parents – however, not submitting for reimbursement could hurt the SBHC's revenue. In many other states, including Michigan and New York, Medicaid MCOs are required to suppress

denial notices and EOBs in accordance with the state's policy on confidential health information for minors. The Council and MASBHC should advocate to MDH to make this policy change immediately. This issue needs to be separately addressed with private health plans.

- *Share and Disseminate Data*

  The state and other stakeholders must ensure that data are shared in accordance with all state and federal health and education laws in a manner that appropriately safeguards clients' protected health information (PHI) and education records. This includes adherence to HIPAA, FERPA, where applicable.[li] The lawyers from MSDE, SBHC Administrative sponsors, and Medicaid MCOs (as well as private health plans) need to agree on an approach for ensuring that all requirements are followed. There should be written policies to dictate the access to, and use of, SBHC data.

  Additionally, when publicly disseminating quality measures, stakeholders should be mindful of protecting the confidentiality of clients, particularly in small SBHCs/counties where small numbers are likely. To this end, the state should adhere to guidelines for the release of information with small numerators and small sample size. Additionally, in sharing health and health care data for the purposes of producing aggregate statistics – such as the recommended performance measures – the process of de-identification should be applied to reduce the risks of compromising patients' privacy.[lii]

Phase 2. Data Analysis and Dissemination

Once the data has been collected, Phase 2 involves analyzing the data to produce results that can be used to drive program improvements and to demonstrate the value of SBHCs, and then sharing the findings with the appropriate stakeholders.

Step 1. Consolidate and Analyze the Data

The data collected through the reporting effort will only be as powerful as the states' ability to analyze it, monitor it, and act on the findings. Appendix C lists examples of the types of data results that could be produced based on the recommended and modified performance measures and other Annual Survey questions.

In the short term, Maryland should begin producing baseline performance rates for each MD SBHC and at the state level. Since the data for this reporting effort will likely be housed in different systems, analyses may involve combining datasets to form a more complete dataset to support data analysis. For example, to compare health and educational outcomes at SBHCs versus non-SBHCs, data from the Annual Survey, MSDE, and MDH may need to be analyzed together. Ideally, there would be one system/database that would store all the SBHC data that is reported to MSDE.

The state and Council in concert with MASBHC need to identify who has the expertise, resources, and capacity to conduct this analysis – MSDE, other state staff, the Hilltop Institute,

university researchers, or others – and ensure that the appropriate resources are dedicated to support data analysis and the production of data products. Regardless of which office is responsible for conducting the analyses, they must have staff dedicated to this effort. It would be ideal for the state to be able to conduct the analyses since they understand the context of the program. Alternatively, the state could explore opportunities to leverage local universities to conduct rigorous analyses using all available data sources, but some funding would likely be required to do this (see Maryland best practices box). Currently, the most robust studies on the value of SBHCs in individual states have been conducted by academic researchers.

Maryland Program Best Practice

The Vision for Baltimore (V4B) program is a public-private partnership that provides vision screenings to all children in the Baltimore City School System, and follow-up eye examinations and glasses (as needed) through mobile clinics at schools. V4B partnered with Johns Hopkins University to evaluate the program model and its impact on children's academic performance.

Since our recommended and modified survey performance measures are all currently used in other reporting initiatives, analyses should eventually include comparisons to other states' SBHC initiatives, national benchmarks, and across payers, such as Medicaid. This will help SBHCs and other stakeholders understand current performance and for the state to begin identifying trends, potential quality and access concerns, as well as SBHCs that might have best practices to share with others.

The state should also stratify existing measures by SBHC population subgroups, including demographic characteristics such as race/ethnicity and age. This would allow SBHCs greater insight into their client base to identify and address health disparities that may exist within the population served and move toward health equity.

To facilitate analyses at the state level, MDH should explore whether SBHCs could be given a dedicated site of visit code that could be separate from general school health services and any other services that may be provided in the school setting.[liii] Additionally, Maryland should explore whether its all-payer claims database (APCD), which includes enrollment, provider, and claims data for Maryland residents with private insurance, enrolled in Medicare, and Medicaid MCOs, can be leveraged to compare SBHC costs and performance to other SBHCS, other payers, and across states.

Step 2. Disseminate Data Results

It is important to recognize that the data emanating from the reporting system will serve different purposes for different parties (i.e., SBHC Administrators, MASBHC, the state, Council, state legislature, clients/parents, and the public), and that these purposes may change over time. Although the state should develop a reporting system that can fulfill the full range of data

needs, the information dissemination strategy should be designed to account for the level of information that is appropriate to share with each party.

It will also be important to appropriately frame the data results and to be prepared that the results may not demonstrate the value stakeholders are hoping they will show. It should be made clear that SBHCs are not singularly responsible for the health outcomes and educational outcomes of the children they serve; Children also receive care from PCPs and in other settings, and there is a myriad of other demographic factors that contribute to these outcomes. Therefore, some of the performance measures seek to capture whether children are receiving appropriate health care services, regardless of where the service is provided. Additionally, performance measurement requires reviewing results and making modifications as needed to improve outcomes.

> "Even ugly data is better than no data, and ugly data is more helpful than pretty data."
> – SBHC Stakeholder

We recommend a two- to three- year approach for disseminating the data results to provide time for reviewing the data and handling any data collection, consistency, and/or data analysis issues that may arise. The first year of the enhanced data collection and analysis should be viewed as a learning year and results should only be distributed to MSDE, MDH, MASBHC, SBHC Administrators, and the Council. It should also be accompanied by a webinar that focuses on framing the findings and any data limitations. Once the Council is comfortable with the data, it should work with MSDE and MDH to determine which data should be shared with which stakeholders. MASBHC could play a key role in disseminating this information.

Step 3. Develop Annual Report and Other Data Products

Once the state and SBHCs have confidence in the data analysis results, we recommend that data displays and other products be circulated more widely. The data could be disseminated in the form of fact sheets or reports that provide information and data on key SBHC performance indicators that best demonstrate the value of SBHCs.

Given that it will take some time before the state has information on quality and outcomes, we recommend starting with a simple one-page "Maryland SBHC Fact Sheet" that highlights the information that is already known in order to start marketing the program. It could also highlight data from individual SBHCs that currently exists (but may not be reported to MSDE). Assuming adequate resources can be provided, MASBHC could take an ownership role, in partnership with SBHC Administrators and CASBHC, to develop.

Over time, the document could be expanded to include additional information, year-to-year comparisons, and ultimately become a report. Examples of other state reports that could be leveraged include: Oregon Status Update, Michigan report

Total vaccines given per year in SBHCs (Data source: ALERT IIS)

Target	2014	2015
25,000	20,742	23,340

card, and the Connecticut student satisfaction survey report.[liv] Appendix D includes elements that could be included in a report. SBHC information should also be incorporated into other MSDE and MDH reports.

Phase 3. Data-Driven Technical Assistance and Decision-making

Phase three involves using the data findings to drive technical assistance for SBHCs and decision-making at the SBHC and state levels.

Step 1. Use Data to Drive Technical Assistance, Quality Improvement, and Decision-Making

The results of the data analyses should be used to drive technical assistance and training for SBHCs as well as MSDE, MDH, and SBHC decision-making. Although MSDE currently tries to address issues that are raised by multiple SBHCs by tapping into resources and presenting at SBHC meetings, these efforts could be expanded with the appropriate infrastructure. Technical assistance efforts could be led and/or supported by MASBHC, with considerations for resources needed to provide these efforts. Additionally, data could be used to identify areas of support needs for SBHCs rather than relying solely on individual SBHCs making requests. Elements of a technical assistance approach could include:

- Ad-hoc technical assistance calls/webinars for all SBHCs to address specific issues based on the data trends and SBHC feedback;
- Issue-specific affinity groups that give groups of SBHCs opportunities for technical assistance and to work together toward performance improvement, sharing challenges and best practices;
- Statewide training on issues that are pervasive across many SBHCs; and/or
- Individualized technical assistance to support individual SBHCs on specific issues.

For example, the current CQI Objective requirement could be leveraged to support SBHCs through issue-specific affinity groups. The state and Council could work together to identify a list of areas where quality improvement is needed, and then groups of SBHCs could work toward the same objective. Technical assistance sessions could facilitate dialogue among the SBHCs and include national experts. Maryland could also leverage SBHA and other states' materials on best practices, such as The California SBHA Best Practices Checklist.[lv]

Step 2. Establish Performance Goals and Consider Performance Measurement Incentives

Once there is an understanding of how individual SBHCs and the state are performing, the state and Council should set realistic, but aspirational performance goals for SBHCs. This could include minimum thresholds, year-to-year improvements, and target goals on certain measures, as used in Michigan and Oregon. For example, in Michigan, each SBHC sets a goal for the number of children it will provide services to during the year and at the end of the year they evaluate whether they reached that goal. Michigan also has "threshold goals," which are developed based on a review of the SBHC median score, HEDIS goals, national goals, the state's experience, and efforts to push SBHCs to improve at a realistic rate.

Once performance goals are established, we recommend exploring ways to create performance incentives to encourage and recognize higher performing SBHCs. This could include creating a culture of friendly competition between SBHCs and presenting an award or certificate to the SBHCs that are performing well on or have the greatest improvement on certain metrics. This recognition can be important in fostering a culture of performance measurement and improvement.

PREVENTION AND DISEASE CONTROL QUALITY MEASURES			
METRIC (all values represent the median across CAHCs)	FY 2017	FY 2016	Threshold
Percent of clients with:			
An up-to-date, documented comprehensive physical exam, regardless of where exam provided (n=66)	71%	67%	Reasonable Percentage
An up-to-date risk assessment (n=66)	90%	90%	90%
Complete immunizations for age on date of service, using ACIP recommendations (n=66)	47%	N/A	60%
A diagnosis of asthma who have individualized care plan (n=65)	89%	77%	100%†

Step 3. Incorporate SBHCs Into State Quality Improvement Efforts

The quality of care should be addressed from a state-level perspective, but also from levels that can address the needs of subpopulations within the state. It appears that SBHCs have been incorporated into some MDH population health goals, but MDH should continue to incorporate SBHCs into state quality improvement efforts, such as the State Managed Care Quality Strategy.

This section of the white paper outlined a myriad of opportunities for creating a data reporting process to demonstrate the value of SBHCs in Maryland. While it is important to collect, analyze, and disseminate information, the goal is for the data to show that SBHCs are making a significant and positive impact on children's health and education outcomes. In the next section, we provide recommendations for how the state can improve the actual value proposition for SBHCs by helping to ensure that the data findings accurately reflect SBHCs' contribution to a high-quality system of care for children.

Improving the Value Proposition for SBHCs

Developing a comprehensive data reporting process is critical to being able to demonstrate the value of SBHCs and to use data to inform technical assistance and drive decision-making. The Council, in collaboration with MSDE and MDH, has been working to improve many areas of SBHC operations and performance. These efforts should continue to be made to improve the actual value proposition for SBHCs. Based on our interviews with stakeholders and our experience working on SBHC issues, children's health issues, and delivery system efforts across the country, below are general recommendations for improving the value proposition for Maryland SBHCs.

Create an SBHC Vision

We recommend that the Council create a vision for the future of SBHCs and make decisions about whether and how it wants to integrate SBHCs into the broader health care system. As conversations continue to take place in the state regarding delivery system transformation, the importance of preventive services, and bringing services to people, what should the role of SBHCs be? Should SBHCs be able to serve as a child's PCP? Should SBHCs provide health care services to parents, school employees, and/or the broader community?

Invest in State SBHC Infrastructure

Maryland must invest in SBHCs to yield positive outcomes and to realize the full potential impact of SBHCs on children's lives. This includes ensuring that the appropriate levels of funding are dedicated to state SBHC administration and to individual SBHCs. Additional staff will be needed if the state decides to implement the recommendations in this report, as well as other operational and oversight tasks. Additionally, greater collaboration is needed between MSDE and MDH and with partners.

- *State Funding*

  The State of Maryland annually provides $2.6 million in state general funds to support 73 of the 84 SBHCs.[lvi] Data from the SBHA shows that state funding for SBHCs in Maryland has declined by 34 percent since FY 2002 (from $3,949,941).[lvii] This trend seems to be in stark contrast to the level of need among low-income students in Maryland and the level of demand in local communities. In fact, at least one additional county is planning to establish SBHCs next year and other counties have expressed interest to MSDE in opening new SBHCs.

  The level of state funding for SBHCs in Maryland is lower than in many other states. Table 3 below lists some of the states that provide funding to SBHCs, the number of SBHCs that are funded, the total number of SBHCs, and the total state funding.[lviii]

Table 3. State Funding for SBHCs			
State	Number of SBHCs Funded	Total Number of SBHCs	Total State Funding ($)
Michigan	111	111	22.0 million
Louisiana	64	70	8.7 million
Oregon	65	65	6.8 million
Delaware	29	29	5.2 million
Illinois	41	60	4.1 million
New Mexico	52	72	3.5 million
Massachusetts	34	52	3.0 million
Maryland	78	84	2.6 million
District of Columbia	6	6	2.0 million

If the goal is to increase the value of SBHCs to Maryland's delivery system, the state will need to invest more resources. We recommend that the Council, MASBHC, MSDE, and MDH advocate to the state legislature to create a budget line item specifically dedicated to funding SBHCs. MASBHC is ideally leveraged to advocate for increased funding because they can lobby. In seeking additional state funding, it will be critical to be specific about what the funding would be used for. We also recommend that any additional state funding be directed to improving state capacity and ensuring the financial viability of existing SBHCs before funding new SBHCs. Additionally, Maryland should also explore other funding options (e.g., health plan foundations, Health Resources & Services Administration Maternal and Child Health grant funding).[lix]

- *State Infrastructure and Collaboration*

We recommend the state establish a School-Based Health Center Program Office that would be responsible for administering and overseeing all aspects of SBHCs. Eighteen states have a School-Based Health Center Program Office that is devoted entirely to the administration of SBHCs.[lx] These Program Offices are typically administered by the state's Health, Medicaid, or Public Health Agency. This structure enables states to better integrate SBHCs with other state quality improvement and delivery system transformation efforts. Ideally, the Maryland office would be jointly staffed by MSDE and MDH with staff reporting up through their respective agency's line of authority.

We recommend that the Council facilitate the identification of all the tasks that MSDE, MDH, and the Council currently conduct in support of SBHC administration, as well as additional responsibilities the state and others identify. This list of tasks could be used to determine which state agency is most qualified to conduct each activity, which would

inform state staffing and resource decisions and ultimately improve interagency collaboration and capitalize on the full range of state expertise.

Improve the Maryland SBHC Model

We recommend that the Council further analyze opportunities for improving the SBHC model in Maryland, which differs from other states. In Maryland, Local Health Departments serve as the sponsoring agency for approximately 70 percent of SBHCs,[lxi] compared to eight percent nationally.[lxii] Nationally, 51 percent of SBHCs are administered by FQHCs and hospitals are the second most common sponsor.[lxiii] In Oregon – a state that is considered a leader in SBHCs – 77 percent of its SBHCs are administered by FQHCs.[lxiv] In New York, 40 percent of SBHCs are sponsored by hospitals.[lxv]

FQHCs are a logical home for SBHCs – they have existing infrastructures, experience serving vulnerable populations, and receive more favorable Medicaid reimbursement rates. Relying more on FQHCs to serve as the sponsoring agency for SBHCs could reduce SBHC start-up costs and be a more financially viable model in the long run. Currently, hospitals are not permitted to receive Medicaid reimbursement for SBHC services, but this is something that should be reviewed, leveraging experiences from other states.

Additionally, the Maryland SBHC standards need to be revisited since they have not been updated since they were released in 2006. The Council has efforts under way to make recommendations on changes to the standards. As part of this effort, the Council should develop standards for determining which areas of the state have the highest unmet health care needs and therefore are appropriate for housing an SBHC. Updating the standards should be informed by stakeholder feedback and the standards in other states (e.g., Oregon, Louisiana, Michigan, and New Mexico).[lxvi] The standards should identify the requirements that SBHCs in the state should meet and should not be retrofitted to meet current SBHC practices.

Improve Connections with Primary Care Providers

We recommend that the Council and SBHCs make a dedicated effort to improving bi-directional connections with PCPs to better coordinate care, reduce duplication of services, and to improve data sharing across providers. We also recommend that the state revisit the current COMAR regulations regarding SBHC communication with PCPs to assess how they are working in practice, and work with PCP associations to create a standardized process for SBHC-PCP communications.[lxvii] In New York, there are minimum requirements for SBHCs to communicate with PCPs when a student enrolls in the SBHC and requirements for policies and procedures to strengthen the services of PCPs while avoiding service duplication (see New York best practice box).[lxviii]

New York Best Practice

SBHCs must initiate a written communication process with PCPs including: Notification the student has enrolled in the SBHC; The scope of services offered by the SBHC; and a Request for the student's health records and current treatment plan.

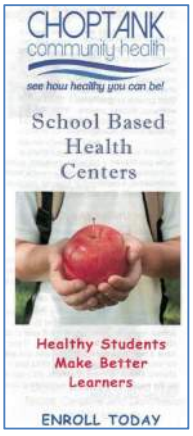
Some SBHC providers expressed that some PCPs view SBHCs as a threat to their work and revenue, particularly in small and rural counties. Michigan has faced the same challenge but found that PCPs quickly recognize how SBHCs help their practice. Michigan reported that PCPs experienced an increase in clients due to referrals from SBHCs both for students who did not previously have a PCP and for follow-up services. PCPs ended up spending less time with children whose health issues did not require their attention and more time with children who needed them. The state, Council, and Maryland American Academy of Pediatrics could conduct outreach and education to PCPs on the services SBHCs provide, how PCPs and SBHCs can coordinate, and how SBHCs can be helpful to PCPs – with the ultimate shared goal of improving children's health.

Conduct Marketing and Outreach

In addition to conducting outreach to PCPs, the value of SBHCs needs to be marketed to students and parents. Many students and parents are unaware of the services that SBHCs can offer. One SBHC sponsoring agency noted that they wished they had an outreach person to facilitate getting SBHC enrollment forms signed. Outreach strategies are key to increasing enrollment in public programs and SBHCs are no exception.

> "SBHCs are a key piece of the safety net but they are underutilized for their potential to be an access point for children who might otherwise not have access to services." -Stakeholder

During the 2017 – 2018 school year, only 37 percent (15,081 out of 40,551) of children who were enrolled in an SBHC received at least one service.[lxix] However, these statistics vary by SBHC. For example, while Montgomery County enrolls a larger number of children in SBHCs (18,422), only 15 percent of them actually received services. On the other hand, in Talbot County, 86 percent of SBHC enrollees received services[lxx] and in Dorchester County, 81 percent of the school population is enrolled in an SBHC and 47 percent of enrollees received services.[lxxi] The SBHCs we interviewed noted they have the capacity to serve more students, but some SBHCs would need additional funding to hire staff to accommodate additional clients.



Choptank Health recognizes the importance of marketing and has a series of brochures on their SBHC programs. In Louisiana and New York, SBHCs and schools are required to work together to publicize SBHC services to the student body. Some states, such as Oregon and the District of Columbia have one-page marketing materials.[lxxii] We recommend that Maryland develop similar policies and materials. The state could also identify strategies for incentivizing the return of enrollment forms (e.g., teacher competitions and rewards for most returned forms). Individual SBHCs could be encouraged to establish goals for the share of the student body who enrolls in the SBHCs.

Increase Collaboration with Health Plans to Improve Effectiveness of SBHCs

Efforts should continue to be made to ensure that SBHCs are maximizing Medicaid billing. MDH regulations should be revised to permit Medicaid reimbursement for services provided to Medicaid-enrolled teachers, school employees, siblings, parents, and members of the community. Additionally, as SBHCs start to incorporate telehealth models, MDH should work with them to ensure appropriate reimbursement (which may involve exploring revising Maryland Medicaid policies).

Efforts should also be made at the state level to try to improve connections between SBHCs and private health plans, rather than requiring each county or SBHC to separately approach each private health plan. Other states have found that it is critical to show private health plans the critical mass of their members who are receiving services in SBHCs across the state. It is also important to explain to health plans what services are provided in SBHCs, since these are services that private health plans would cover if the services were received in a different setting.

Engage Students and Parents

We recommend engaging students and their parents in SBHC strategic planning and enlisting their help in demonstrating the value of SBHCs. For example, New Mexico requires that SBHCs maintain or participate in a school or district level School Health Advisory Council that meets at least twice during the academic year and requires the membership of at least two youth. The meeting agenda must specifically address and support SBHC operations and activities.[lxxiii]

Conclusion and Next Steps

This white paper lays out a detailed roadmap for developing a data reporting process to demonstrate the value of SBHCs in Maryland. It will take time, effort, and collaboration to fully achieve this goal. However, the end result of having information about the program and using it to drive decision-making and SBHC improvements will be critical to ensuring that SBHCs are maximizing their impact on children's health and education and reducing costs across the state.

While this reporting process is being designed and implemented, the Council should work with the state to begin to tell the Maryland SBHC story using existing information and data. The Council should also continue to pursue opportunities for improving the value proposition for SBHCs to help ensure that the data findings accurate reflect that SBHCs contribute to a high-quality system of care for children. The SBHCs know that they play a critical role for children – now is the time to show that to children, parents, stakeholders, the legislature, and the public.

Appendix A. National and State Performance Measurement Efforts

The national SBHA and some states are increasingly focused on improving SBHC data collection, analysis, and dissemination to further the evidence base for SBHCs. Below are summaries of these efforts.

National SBHA Performance Measurement Initiative

In 2015, the SBHA began an initiative to collect performance measures from SBHCs to demonstrate their value. Through a multi-stakeholder review process, the SBHA selected the following core set of five standardized, evidence-based clinical performance measures for voluntary adoption and reporting by SBHCs:

- Annual Well-Child Visit;
- Annual Risk Assessment;
- Body Mass Index (BMI) Assessment and Nutrition and Physical Activity Counseling;
- Depression Screening and Follow-Up Plan; and
- Chlamydia Screening.

The SBHA set a goal of having 100 percent of SBHCs nationwide report on these measures; currently 22 percent of SBHCs are reporting at least one measure. Since these five measures also align with measures used in other national reporting efforts, including the Healthcare Effectiveness Data and Information Set (HEDIS) and the CMS Medicaid/CHIP Core Set of Children's Health Care Quality Measures (Child Core Set) for state reporting, SBHC reporting on the measures will enable comparisons to SBHCs in their own states and nationally, as well as across payers. The SBHA has also developed a wide range of technical assistance efforts around the measures, including detailed measure technical specifications, webinars, and downloadable performance measurement reports.

Other States

Below are snapshots of two states – Oregon and Michigan – that are leading the way on improving data collection and analysis to assess the value of SBHCs.

Michigan

Michigan's Child and Adolescent Health Center (CAHC) program is jointly administered by the Michigan Department of Health and Human Services and the Michigan Department of Education. The Department of Education receives state funding, but the state SBHC staff work for the Department of Health and Human Services. There are four full-time state staff dedicated to SBHC administration and six part-time consultants that provide expertise in a range of areas including clinical and evaluation support.

There are 111 state-funded CAHC sites in Michigan, serving over 30,000 children and adolescents. The program currently collects data on several standardized measures from CAHCs, including information on well-child visits, immunizations, and sexual health. Statewide results are published in an annual report card and are compared to desired performance thresholds to contextualize the findings. The state also sends each SBHC their own individualized report card, which compares their score to the statewide results. The Michigan measures appear to encompass the SBHA measures, with some variation.

Key Factors Leading to Michigan Performance Improvements

- More frequent and intensive training and technical assistance to increase provider understanding and comfort level
- Support for Michigan efforts through national initiatives and incentive programs to measure quality
- Improved familiarity for providers on the capabilities of their electronic health records systems

CAHCs are also required to implement a continuous quality improvement plan for physical mental health services, that includes a: 1) practice and record review conducted at least twice a year; 2) needs assessment conducted within the last three years; and 3) annual client satisfaction survey. The state notes that there has been a noticeable improvement in performance since the implementation of quality measurement in CAHCs.[lxxiv]

Oregon

Oregon's SBHC program is administered by the School-Based Health Center Program Office, which is within the Public Health Division in the Oregon Health Authority. There are state-developed certification standards to help reduce variability between SBHC sites across the state. While certification is voluntary, only certified SBHC are eligible for funding from the Oregon Health Authority. As of July 2018, there were 76 certified SBHCs in 25 counties across the state.

All certified SHBCs must meet five data reporting requirements: 1. Visit/encounter data; 2. Patient satisfaction surveys; 3. Billing/revenue and funding information; 4. Staffing and hours of operation; and 5. Key Performance Measures (KPMs).

Certified SBHCs must report on two KPMs – Well-Child Visit and Comprehensive Health Assessment – and one of five optional KPMs: Adolescent Immunization, Chlamydia Screening, Depression Screening, Nutrition Counseling, and Substance Use Screening. Each measure has a detailed measure technical specification for reporting, including inclusion and exclusion criteria. Like in Michigan, the Oregon measures appear to encompass the SBHA-recommended performance measures.

Appendix B. Recommended Performance Measures

This appendix provides details on the recommended performance measures – including the measure name, measure steward, definition, the rationale for collecting the measure, and the quality measurement reporting efforts with which each measure aligns. The sources for the measure technical specifications can be linked to and found in the endnotes.

Measure Name (measure steward)	Definition	Rationale	Measure Alignment
Primary and Preventive Care			
Annual Risk Assessment[lxxv] (SBHA)	Percentage of unduplicated SBHC clients with documentation of ≥1 age-appropriate annual risk assessment during the school year, regardless of where the assessment was conducted.	Children and adolescents should annually be assessed to gauge potential environmental, social, emotional, and behavioral threats to their wellbeing; create opportunities to intervene early; and organize a response for students who are at highest or immediate risk for harm	SBHA-recommended performance measures
	Percentage of unduplicated SBHC clients ages 12 and above with documentation of ≥1 age-appropriate annual risk assessment during the school year		
Depression Screening & Follow-Up[lxxvi] (SBHA modification of CMS)	Percentage of unduplicated SBHC clients aged ≥12 years with documentation of the following at least once during the school year, regardless of where the screening was conducted: • Screened for clinical depression using an age appropriate standardized tool AND • Follow-up plan documented if positive screen	The U.S. Preventive Services Task Force recommends that adolescents be screened for depression using a validated questionnaire, and only when systems are in place for diagnosis, treatment, and follow-up	SBHA-recommended performance measures; CMS Medicaid/CHIP Child Core Set
Care of Acute and Chronic Conditions			
Asthma Action Plan (N/A)	The percentage of unduplicated SBHC clients identified as having asthma who have an asthma action plan documented in their health record, regardless of which provider developed the plan with the client/parent (including non-SBHC providers).	The Centers for Disease Control and Prevention recommends that all people with asthma have an action plan describing how to control asthma long term, and that all people who care for a child with asthma know about the child's plan	N/A

Measure Name (measure steward)	Definition	Rationale	Measure Alignment
Asthma Medication Ratio[lxxvii] (NCQA/HEDIS)	The percentage of SBHC clients ages 5 to 18 who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the school year	Appropriate ratios for these medications could potentially prevent a significant proportion of asthma-related costs (hospitalizations, emergency room visits, missed work and school days)	CMS Medicaid/CHIP Child Core Set; HEDIS
Emergency Department Visits[lxxviii] (Modification of NCQA/HEDIS)	Rate of emergency department visits per 1,000 member months among SBHC clients up to age 19 who are enrolled in Medicaid/MCHP/Private health plans	Unnecessary visits to a hospital emergency department may indicate lack of access to more appropriate sources of medical care, such as primary care providers or specialists	CMS Medicaid/CHIP Child Core Set; HEDIS
Care Coordination			
Timely Transmission of Health Visit Report (N/A)	The percentage of SBHC clients who needed follow-up care with their primary care provider (PCP) whose health visit report was transmitted to the PCP within 7 days of the SBHC health visit.	Care coordination can help improve the safety, efficiency, and effectiveness of health care. COMAR regulations include standards for ensuring the timeliness of coordination between SBHCs and patients' primary care providers	N/A
Educational Outcomes			
Classroom Seat Time Saved[lxxix] (SBHA test measure)	Can be measured three ways: • The percent of SBHC visits that result in sending students back to class rather than to their homes or a hospital, emergency room, or external health care provider • The total hours of the remaining school day students save once they are sent back to class after visiting the SBHC • The average time of a visit to the SBHC versus the amount of time it would take students to seek care from an external health care provider	Students with accessible health services, can have their health issues addressed in real-time and sent back to class, rather than be sent home	SBHA test measure

Measure Name (measure steward)	Definition	Rationale	Measure Alignment
Cost and Budgets			
Operating Income[lxxx] (California SBHA)	Net annual revenue – Net annual operating costs Annual Revenue: • Federal: • State: • Local: • Foundation: • Private donation: **Net Annual Revenue** Annual Operating Costs: • Salary and Wages: • Fringe benefits: • Contracts: • Training: • Utilities & Maintenance: • Equipment: • Travel: • Supplies and Materials: **Net Annual Operating Costs**	Understanding the cost effectiveness of SBHCs can help identify SBHCs that are operating inefficiently and identify where additional investments may be needed	California SBHA

Appendix C. Recommended Modifications to Annual Survey Performance Measures

This appendix provides recommendations for modifying some performance measures that are currently in the revised Annual Survey to align with other performance measurement efforts. It includes the current Annual Survey data element (and the question number), the recommended performance measure, measure steward, definition, the rationale for collecting the measure, and the quality measurement reporting efforts with which each measure aligns. The sources for the measure technical specifications can be linked to and found in the endnotes.

Current Survey Data Element / Recommended Performance Measure (measure steward)	Definition	Rationale	Measure Alignment
Well-Child Exams (question #25) / Annual Well-Child Visit[lxxxi] (SBHA)	Percentage of unduplicated SBHC clients 0-21 years who had at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the school year **Note:** Two percentages are calculated for this measure: 1. Well-child visits provided by the SBHC; and 2. Well-child visits provided by non-SBHC providers.	The American Academy of Pediatrics and Bright Futures recommend a comprehensive annual preventive visit at ages 3, 4, 5, and 6, and annual well-care visits during adolescence	SBHA-recommended performance measures; CMS Medicaid/CHIP Child Core Set; HEDIS
BMI >85% (question #26) / BMI Assessment & Nutrition/Physical Activity Counseling[lxxxii] (SBHA modification of NCQA/HEDIS)	Percentage of unduplicated SBHC clients aged 3-17 with documentation of the following at least once during the school year, regardless of where the services were provided: • BMI percentile AND • Counseling for nutrition AND • Counseling for physical activity Percentage of unduplicated SBHC clients aged 3-17 with BMI ≥85th percentile with documentation of the following at least once during the school year: • BMI percentile AND • Counseling for nutrition AND • Counseling for physical activity	Children and adolescents should be screened at least annually for body mass index (BMI), according to the U.S. Preventive Services Task Force. Patients with a high or increasing BMI should be counseled on nutrition and physical activity to encourage healthy weight	SBHA-recommended performance measures; CMS Medicaid/CHIP Child Core Set; HEDIS

Current Survey Data Element / Recommended Performance Measure (measure steward)	Definition	Rationale	Measure Alignment
Chlamydia/ Gonorrhea Screening (question #26) Chlamydia Screening[lxxxiii] (SBHA modification of NCQA/HEDIS)	Percentage of unduplicated SBHC clients (male or female) identified as sexually active who had ≥1 test for Chlamydia documented during the school year, regardless of where the screening was provided **Note:** Percentages are calculated separately for males and females.	The Centers for Disease Control and Prevention recommends screening all sexually active females under 25 years of age for Chlamydia and also consider screening high risk adolescent males	SBHA-recommended performance measures; CMS Medicaid/CHIP Child Core Set; HEDIS
Vaccines Given (question #26) / Immunizations for Adolescents[lxxxiv] (NCQA/HEDIS)	Percentage of adolescent SBHC clients age 13 who had documentation of one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday, regardless of where the vaccines were provided	Recommended well care for adolescents includes reviewing their immunization history to ensure they are up to date on their vaccines	CMS Child Core Set; HEDIS
Oral Health (question #31) / Dental or Oral Health Services[lxxxv] (CMS)	Percentage of unduplicated SBHC clients under age 21 who received at least one oral health service during the school year provided by either a somatic or oral health provider, regardless of where the service was provided	Untreated/undetected oral health issues can negatively affect a child's physical and social development and school performance	Form CMS-416 (Annual EPSDT report)

Appendix D. Potential Maryland SBHC Report Elements

The following elements could eventually be included in reports on Maryland SBHCs. The state and the Council would decide which data elements would be shared with each stakeholder (i.e., MSDE, MDH, Council, SBHC Administrators, legislature, the public). We recommend first focusing on individual SBHC and state year-to-year changes in performance. Over time, individual SBHC performance could be compared to the state average, national benchmarks, and across payers.

Overview of SBHCs

- Define SBHCs and identify commonly provided services and qualified providers
- Identify administration of SBHCs – % that are Local Health Departments, FQHCs, Other
- Number of SBHCs across the number of jurisdictions (identify jurisdictions)
- Number of children at schools with an SBHC to demonstrate potential access to SBHCs
- Percentage of SBHCs at elementary schools vs. junior high schools vs. high schools
- Number and percentage of SBHCs in health professional shortage areas (MDH)
- Number and percentage of SBHCs using Electronic Medical/Health Records (EMR/EHR)
- Number and percentage of SBHCs with one of the following provider types: nurse practitioner, doctor, physician's assistant, mental health provider, dental provider
- Percentage of Vaccine for Children providers that are SBHCs

Utilization of Services

- Populations served in addition to students (e.g., school employees, teachers, siblings, parents, community members)
- Percentage of the school's student population that is enrolled in the SBHC
- Number of students enrolled in SBHCs – total and by county
- Number of unique students who received care at SBHCs
- Total number of SBHC visits and average number of visits per student
- Percentage of visits that were for somatic care, behavioral health, dental health, or other services
- Emergency Department Visits: There were X emergency department visits per 1,000 member months among children in Medicaid/MCHP/private health plans enrolled in SBHCs

Demographic Information

- Insurance status of SBHC clients
- Distribution of SBHC enrollees and clients by race
- Distribution of SBHCs enrollees by age

Quality of Care

Health Outcomes

- Annual Risk Assessment: X% of MD SBHC clients who had an annual risk assessment during the school year
- Annual Well-Child Visit: X% of MD SBHC clients age under age 21 had at least one well-child visit during the school year (stratify by age); X% of MD SBHC adolescent clients had at least one well-child visit during the school year
- Depression Screening and Follow-Up: W% of MD SBHC clients who were screened for clinical depression and had a follow-up plan documented
- Asthma Action Plan: X% of MD SBHC clients with asthma who have a documented asthma action plan in their health record
- Asthma Medication Ratio: X% of children served in SBHCs with persistent asthma had a ratio of controller medication to total asthma medications of .50 or greater
- BMI Assessment & Nutrition/Physical Activity Counseling: V% of children age 3 – 17 served in MD SBHCs who had their BMI percentile, and counseling for nutrition and physical activity, documented in their medical record
- Chlamydia Screening: X% of sexually active SBHC clients who were screened for chlamydia
- Immunizations for Adolescents
    a. X% of MD SBHC clients age 13 who were up-to-date on Combination 1 immunizations compared to:
    b. Y% of MD SBHC clients that have completed the human papillomavirus (HPV) vaccine series by their 13th birthday
- Any Dental or Oral Health Service: X% of MD SBHC clients who received at least one dental/oral health service during the school year compared to Y% of children enrolled in Medicaid and CHIP

Care Coordination

- Timely Transmission of Health Visit Record: X% of SBHC clients who needed follow-up care with their primary care provider (PCP) had their health visit report transmitted to the PCP within 7 days of the SBHC health visit.

Education Outcomes

- Classroom Seat Time Saved: X% of MD SBHC client visits resulted in sending students back to class versus their homes, a hospital, emergency room, or external provider

- Chronic Absenteeism:
  a. W% of MD SBHC clients missed at least 10 percent of school days in the year compared to X% of students in the same schools who are not SBHC clients

  b. Y% of students in schools with an SBHC missed at least 10 percent of school days in the year compared to Z% of students in schools without an SBHC

Cost Savings

- Average cost per Emergency Department Visit (MDH)

Client Experience

- Results of client satisfaction survey – e.g., Estimated class time missed by students for health care appointments (SBHC care vs. non-SBHC care) (i.e., missed none or only part of a class vs. missed all day), clients' ability to get care when needed, ratings of provider communication, and client health status.

Funding and Costs

- Annual state funding amount for SBHCs
- Distribution of funding sources - % State, % Medicaid reimbursement, federal grants, local, foundation, private, in-kind, other
- Total annual Medicaid claims for SBHC services (MDH)
- Range of annual SBHC costs and revenues
- Operating Income: Average operating income across MD SBHCs
- Average cost per Emergency Department Visit (MDH)
- Cost savings associated with reductions in emergency department use
- Savings in time and income to parents of children enrolled in SBHCs

- For every state dollar invested, SBHCs leveraged an estimated additional $X from grants, billing, donations, and other sources.

SBHC Highlights

- Highlight innovative things individual SBHCs are doing (qualitative information from SBHCs)

Appendix

- List of all SBHCs by county

Endnotes

[i] Maryland SBHC Standards
[ii] Council on Advancement of School-Based Health Centers, 2017 – 2018 Annual Report.
[iii] Council on Advancement of School-Based Health Centers, 2017 – 2018 Annual Report.
[iv] Communication with MSDE on October 31, 2018.
[v] House Bill 375. Approved by the Governor on May 12, 2015. Available at: http://mgaleg.maryland.gov/2015RS/chapters_noln/Ch_417_hb0375E.pdf.
[vi] Based on Harbage Consulting analysis of MD SBHC contact information for SBHC sponsoring agencies, available at: http://marylandpublicschools.org/about/Documents/DSFSS/SSSP/SBHC/SBHCContactListFY19.pdf.
[vii] Level I: Core School-Based Health Center A Level I SBHC site must have hours that are at a minimum eight hours per week with a licensed medical clinician present and are open a minimum of two days per week when school is open. Level I SBHC staff must include, at a minimum, a licensed medical clinician and administrative support staff. There may be additional clinical support staff such as a RN, LPN, or CNA. Note: the licensed medical clinician cannot replace the school nurse.
Level II: Expanded School-Based Health Center The SBHC site must be operational (with an advance practice provider on site) a minimum of twelve hours per week, three to five days for medical care when school is in session. Mental health services must be available on site for a minimum of three days and a minimum of twelve hours per week. The SBHC staff must include at a minimum: A licensed medical clinician; Mental health professional; Clinical support staff (RN, LPN, or CNA); and Administrative support staff. Level III: Comprehensive School-Based Health Center Medical services must be available a minimum of five days and twenty hours per week. The availability of full-time services needs to be commensurate with the number of students enrolled in the school. The SBHC may rely on other community healthcare providers for 24-hour coverage.
Level III or Comprehensive SBHC is available limited hours for defined services for enrolled students during the summer hours. The SBHC is open before, during, and after school hours. The SBHC staff must include at a minimum: A licensed medical clinician; Clinical support staff (RN, LPN, or CNA); Administrative support staff; Mental health professional; and at least one additional service provider such as a general or pediatric dentist, dental hygienist, nutritionist, or health educator for a minimum of four hours per month. SBHC Standards.
[viii] Analysis of data from Council on Advancement of School-Based Health Centers, 2016 – 2017 Annual Report, p. 9.
[ix] Communication with MSDE on October 31, 2018.
[x] Communication with MDH on September 25, 2018.
[xi] Cite regulation and Maryland Medicaid School-Based Health Center Provider Manual: A Comprehensive Guide on CMS-1500 Billing Procedures for School-Based Health Centers. Updated May 24, 2018.
[xii] Maryland COMAR 10.09.76.04. Available at: http://www.dsd.state.md.us/comar/comarhtml/10/10.09.76.04.htm.
[xiii] Maryland Medicaid School-Based Health Center Provider Manual, May 2018. Available at: https://mmcp.health.maryland.gov/SiteAssets/pages/Provider-Information/SBHC_Provider_Manual_05.24.2018.pdf.
[xiv] Maryland SBHC Standards and communication with MSDE.
[xv] Maryland COMAR 10.09.76.03
[xvi]Knopf, J. et al. and the Community Preventive Services Task Force. School-Based Health Centers to Advance Health Equity: A Community Guide Systematic Review. American Journal of Preventive Medicine. July 2016; 51(1): 114-126. Available at: https://www.thecommunityguide.org/sites/default/files/publications/he-ajpm-evrev-sbhc.pdf.
[xvii] Santelli, J., Kouzis, A. Newcomer, S. School-Based Health Centers and Adolescent Use of Primary Care and Hospital Care. Journal of Adolescent Health. 1996; 19:267-275. Available at: https://www.jahonline.org/article/S1054-139X(96)00088-2/pdf.
[xviii] Knopf, J. et al., 2016.
[xix] Knopf, J. et al., 2016.

[xx] Kaplan, D, Calonge, B, Guernsey, B, Hanrahan, M. Managed Care and School-based Health Centers: Use of Health Services. Archives of Pediatric and Adolescent Medicine. Apr 2002;30(4)273-278.
[xxi] Santelli, J., Kouzis, A. Newcomer, S. School-Based Health Centers and Adolescent Use of Primary Care and Hospital Care. Journal of Adolescent Health. 1996;19:267-275. Available at: https://www.jahonline.org/article/S1054-139X(96)00088-2/pdf.
[xxii] Key, J., Washington, E., Hulsey, T. Reduced Emergency Department Utilization Associated with School-Based Clinic Enrollment. Journal of Adolescent Health. Apr 2002;30(4)273-278.
[xxiii] Knopf, J. et al. 2016.
[xxiv] Santelli, J., Kouzis, A. Newcomer, S. School-Based Health Centers and Adolescent Use of Primary Care and Hospital Care. Journal of Adolescent Health. 1996;19:267-275. Available at: https://www.jahonline.org/article/S1054-139X(96)00088-2/pdf.
[xxv] Knopf, J. et al. 2016.
[xxvi] Webber, M, Carpiniello, K, Oruwariye, T, Lo, Y. Burton, W. Appel, D. Burden of Asthma in Inner-City Elementary Schoolchildren: Do School-Based Health Centers Make a Difference? Archives of Pediatrics & Adolescent Medicine. Feb 2003; 157(2) 125-129.
[xxvii] Guo, J, Jang, R, Keller, K, McCracken, A, Pan, W, Cluxton, R. Impact of School-Based Health Centers on Children with Asthma. Journal of Adolescent Health. Oct 2005;27(4):266-274.
[xxviii] Knopf, J. et al., 2016.
[xxix] Knopf, J. et al, 2016.
[xxx] McNall, M et al., July 2008. Michigan Evaluation of School-Based Health (MESH) Study. Michigan State University. Summary available at: https://www.michigan.gov/documents/mdch/MESH_Project_Brief_Final_375932_7.pdf. Full study is available at: https://cerc.msu.edu/upload/documents/MESH_2008.pdf.
[xxxi] Ran, T., Chattopadhyay, S., Hahn, R. and the Community Preventive Services Task Force. Economic Evaluation of School-Based Health Centers. American Jurnal of Preventive Medicine. 2016;51(1):129-138. Available at: https://www.thecommunityguide.org/sites/default/files/publications/he-ajpm-ecrev-sbhc.pdf.
[xxxii] McNall, M. et al., July 2008.
[xxxiii] Knopf, J. et al., 2016.
[xxxiv] Community Preventive Services Task Force, 2015; Desocio et al., 2007; Strolin-Goltzman et al., 2014; and Walker et al. 2010.
[xxxv] Lichty, L., McNNall, M., Mavis, B., Bates, L. September 2008. Michigan Evaluation of School-Based Health, Baseline Clinic Service Records: Children's Use of School-Based Health Care Services. Michigan State University.
[xxxvi] Oregon School-Based Health Centers: Status Report, 2018.
[xxxvii] Adams, Kathleen & Johnson, V. (2000). An Elementary School-Based Health Clinic: Can It Reduce Medicaid Costs?. Pediatrics. 105. 780-8. 10.1542/peds.105.4.780.
[xxxviii] Ran et al., 2016.
[xxxix] Tijerino, Antonio & Ginn, Melanie S. June 2012. Hispanic Heritage Foundation.
[xl] https://www.knack.com/
[xli] NCQA HEDIS and Performance Measurement. Available at: https://www.ncqa.org/hedis/.
[xlii] CMS Children's Health Care Quality Measures. Available at: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html.
[xliii] School-Based Health Alliance Performance Measures: Quality Counts Initiative. Available at: https://www.sbh4all.org/current_initiatives/nqi/.
[xliv] California School-Based Health Alliance Key Performance Measures for School-Based Health Centers. Available at: http://cshca-wpengine.netdna-ssl.com/wp-content/uploads/2014/10/CSHA-Key-Performance-Measures-for-SBHCs.pdf.
[xlv] National School-Based Health Alliance. Test Measures Toolkit. Client Experience of Care. Available at: https://tools.sbh4all.org/s/test-measures-toolkit/client-experience-of-care/. Oregon 2018-2019 Student Satisfaction Survey. Available at: https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/YOUTH/HEALTHSCHOOL/SCHOOLBASEDHEALTHCENT

ERS/Documents/SBHC%20Data/SatSurveyCurrent.pdf. Connecticut Student Satisfaction Survey Results 2016 – 2017. Available at: http://files.constantcontact.com/7690759c001/f31047a0-4bc5-40a8-90d0-b15ed917b9b5.pdf.

[xlvi] Michigan Child and Adolescent Health Centers Quarterly Reporting Data Elements Definitions, Effective October 1, 2018. Available at: https://www.michigan.gov/documents/mdhhs/CAHC_Report_Definitions_610330_7.pdf

[xlvii] School-Based Health Alliance. Standardized Performance Measures for SBHCs. Available at: http://www.sbh4all.org/wp-content/uploads/2018/06/Quality-Counts-Standardized-Performance-Measure-Definitions-112717-1.pdf. School-Based Health Alliance Quality Counts Webinars. Available at: https://www.sbh4all.org/current_initiatives/nqi/quality-counts-webinars/. School-Based Health Alliance. Preparing to Participate: General Tips. Available at: https://www.sbh4all.org/current_initiatives/nqi/preparing-to-participate-general-tips/.

[xlviii] In addition to the HEDIS measures in the recommended and modified performance measures set, SBHCs could also support Medicaid MCO efforts to improve on HEDIS measures including: Childhood Immunization Status, Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life, Adolescent Well-Care Visits, and Medication Management for People with Asthma. See Medicaid MCO HEDIS measures at: https://mmcp.health.maryland.gov/healthchoice/Documents/2017-09-27%20-%20HEDIS%20Executive%20Summary%20Report%20-%20Updated%20(3).pdf.

[xlix] 34 CFR 99.3

[l] 34 CFR 99.37

[li] More information about HIPAA and FERPA, including the interplay between the federal laws, is available in a U.S. Department of Health and Human Services and Department of Education's *Joint Guidance on the Application of the Family Educational Rights and Privacy Act (FERPA) And the Health Insurance Portability and Accountability Act of 1996 (HIPAA) To Student Health Records*.

[lii]For example, in New Mexico, student data that is exported can only be in aggregate form in a flat, delimited file with a unique identifier other than the student's name.[lii] HIPAA allows for the use and disclosure of de-identified data (since it is no longer considered personally identifiable information/personal health information), and permits two de-identification approaches. It is important for SBHC partners to be mindful that even properly de-identified data are not completely free from risk, and that other processes may need to be considered (e.g., encryption, data sharing agreements) to help manage and protect de-identified information. HIPAA requirements are available at: https://www.hhs.gov/hipaa/for-professionals/privacy/special-topics/de-identification/index.html#rationale.

[liii] The following SBHA website has policy documents from three other states that require Medicaid MCOs to reimburse SBHCs for covered services: https://www.sbh4all.org/advocacy/medicaid-policies-that-work-for-sbhcs/.

[liv] Oregon School-Based Health Centers Status Update 2018. Oregon Health Authority. Available at: https://apps.state.or.us/Forms/Served/le8926.pdf. Michigan Child and Adolescent Health Center FY27 Report Card. Available at: https://www.michigan.gov/documents/mdhhs/CAHC_FY17_Report_Card_620687_7.pdf.

[lv] California School-Based Health Alliance School-Based Health Center Best Practices Checklist. Available at: https://www.schoolhealthcenters.org/sbhc-best-practices-checklist/.

[lvi] Communication with MSDE on October 31, 2018.

[lvii] National School-Based Health Alliance. Table 4. States with Ten-plus Years Investment in SBHCs, FY2002, 2008, 2014 – Data from 2013-2014 school year. Available at: http://www.sbh4all.org/wp-content/uploads/2016/11/policy-survey-2014-executive-summary-FINAL.pdf. Note that this survey shows state funding of $2.8 million for school year 2013 – 2014, which is slightly higher than the MSDE-produced state funding amount of $2.6 million for school year 2018 - 2019.

[lviii] National School-Based Health Association. Available at: https://www.sbh4all.org/school-health-care/aboutsbhcs/school-based-health-care-state-policy-survey/. Data for Michigan is based on communications with the Michigan Department of Health & Human Services.

[lix] Other states – Connecticut, Illinois, Indiana, New York, and Texas – leverage the federal Health Resources & Services Administration (HRSA) Maternal and Child Health grant funding. Some states provide incentives to Medicaid MCOs to contract with public health providers such as SBHCs (e.g., Minnesota and West Virginia) as a supplement to their monthly capitation payments.

[lxi] Based on Harbage Consulting analysis of MD SBHC contact information for SBHC medical sponsor, available at: http://marylandpublicschools.org/about/Documents/DSFSS/SSSP/SBHC/SBHCContactListFY19.pdf.
[lxii] National School-Based Health Alliance 2013-2014 Census Report - Health System Partnerships. Available at: http://censusreport.sbh4all.org/.
[lxiii] Communication with National School-Based Health Alliance. National School-Based Health Alliance 2013-2014 Census Report. Available at: http://censusreport.sbh4all.org/.
[lxiv] Oregon School-Based Health Centers Status Update, 2018. Available at: https://apps.state.or.us/Forms/Served/le8926.pdf.
[lxv] New York School-Based Health Centers Fact Sheet. Available at: https://www.health.ny.gov/statistics/school/skfacts.htm.
[lxvi] Oregon Standards for Certification-Version 4. Available at: https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/YOUTH/HEALTHSCHOOL/SCHOOLBASEDHEALTHCENTERS/Documents/SBHC%20Certification/SBHCstandardsforcertificationV4.pdf. Louisiana Principles, Standards, and Guidelines for School-Based Health Centers in Louisiana. Available at: http://ldh.la.gov/assets/oph/pcrh/adolescent/2012-13DocumentsAndForms/Principles_tandards_and_Guidelines_7-2012_FINAL.doc. Michigan Minimum Program Requirements. Available at: https://www.michigan.gov/documents/mdch/Minimum_Program_Requirements_1014_FINAL_475622_7.pdf. New Mexico Standards and Benchmarks for School-Based Health Clinics. Available at: http://www.hsd.state.nm.us/uploads/files/Looking%20For%20Information/General%20Information/Rules%20and%20Statutes/Medical%20Assistance%20Division/2015-2016%20NM%20Standards-final.pdf.
[lxvii] In New York, when a student enrolls in the SBHC and the student's PCP is an outside entity, the SBHC must initiate a written communication process. "At a minimum, this should include: Notification that the student has enrolled in the SBHC; The scope of services offered by the SBHC; A request for the student's health records, including the most recent physical exam, history, and current treatment plan, along with the transmittal of the appropriate medical release authorization form." Additionally, SBHCs must have policies and procedures in place to "strengthen the services of the PCP by fostering comprehensive and coordinated health care delivery while avoiding service duplication. Topics to be addressed in these policies and procedures include: Appropriate information and sharing of medical records; Mechanisms to ensure confidentiality; Referral for specialty care; and Coordination of treatment." New York Principles and Guidelines for School Based Health Centers in New York. Available at: https://www.health.ny.gov/facilities/school_based_health_centers/docs/principles_and_guidelines.pdf.
[lxviii] Principles and Guidelines for School Based Health Centers in New York State. Available at: https://www.health.ny.gov/facilities/school_based_health_centers/docs/principles_and_guidelines.pdf.
[lxix] Council 2017 – 2018 Annual Report.
[lxx] Council 2017 – 2018 Annual Report.
[lxxi] Dorchester County FY 2018 Report.
[lxxii] Oregon – Available at: https://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/YOUTH/HEALTHSCHOOL/SCHOOLBASEDHEALTHCENTERS/Documents/SBHC__Pubs/SBHC.GenFactSheet_ENGLISH.pdf. District of Columbia – Available at: https://dchealth.dc.gov/sites/default/files/dc/sites/doh/service_content/attachments/SBHC%20Fact%20Sheet%20ENG.pdf.
[lxxiii] New Mexico SBHC Standards. Available at: http://www.hsd.state.nm.us/uploads/files/Looking%20For%20Information/General%20Information/Rules%20and%20Statutes/Medical%20Assistance%20Division/2015-2016%20NM%20Standards-final.pdf.
[lxxiv] https://www.michigan.gov/documents/mdhhs/FY15CAHC_DashboardFinal_545015_7.pdf.
[lxxv] SBHA Standardized Performance Measures for SBHCs. Available at: http://www.sbh4all.org/wp-content/uploads/2018/06/Quality-Counts-Standardized-Performance-Measure-Definitions-112717-1.pdf.
[lxxvi] CMS Children's Health Care Quality Measures. Available at: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html.

[lxxvii] SBHA Standardized Performance Measures for SBHCs. Available at: http://www.sbh4all.org/wp-content/uploads/2018/06/Quality-Counts-Standardized-Performance-Measure-Definitions-112717-1.pdf.
[lxxviii] CMS Children's Health Care Quality Measures. Available at: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html.
[lxxix] Classroom Seat Time Saved. Available at: https://tools.sbh4all.org/s/test-measures-toolkit/classroom-seat-time-saved/.
[lxxx] California School-Based Health Alliance. Key Performance Measures for School-Based Health Centers. Available at: http://cshca-wpengine.netdna-ssl.com/wp-content/uploads/2014/10/CSHA-Key-Performance-Measures-for-SBHCs.pdf.
[lxxxi] SBHA Standardized Performance Measures for SBHCs. Available at: http://www.sbh4all.org/wp-content/uploads/2018/06/Quality-Counts-Standardized-Performance-Measure-Definitions-112717-1.pdf.
[lxxxii] SBHA Standardized Performance Measures for SBHCs. Available at: http://www.sbh4all.org/wp-content/uploads/2018/06/Quality-Counts-Standardized-Performance-Measure-Definitions-112717-1.pdf.
[lxxxiii] SBHA Standardized Performance Measures for SBHCs. Available at: http://www.sbh4all.org/wp-content/uploads/2018/06/Quality-Counts-Standardized-Performance-Measure-Definitions-112717-1.pdf.
[lxxxiv] CMS Children's Health Care Quality Measures. Available at: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html.
[lxxxv] CMS Instructions for Completing Form CMS-416: Annual Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Participation Report. Available at: https://www.medicaid.gov/medicaid/benefits/downloads/cms-416-instructions.pdf.

STATE OF MARYLAND
Community Health Resources Commission
45 Calvert Street, Room 336 • Annapolis, Maryland 21401

Larry Hogan, Governor - Boyd Rutherford, Lt. Governor
Allan Anderson, M.D., Chair – Mark Luckner, Executive Director

September 20, 2019

Re: *Senate Bill 1030 (Chapter 0771) Blueprint for Maryland's Future*

Dear Maryland Department of Health and Maryland State Department of Education Colleagues:

During the 2019 Legislative Session, the Kirwan Commission's instrumental leadership for educational reform produced, amongst many formative transformations, a critical deliverable for the advancement of school health, "The Blueprint for Maryland's Future". Section 18 of the law states that the Maryland Department of Health and Maryland State Department of Education shall consult with the Council on Advancement of School-Based Health Centers and other interested stakeholders on a plan to build a sustainable sponsorship model by expanding the type of organizations that can sponsor school-based health centers. The findings and recommendations are required to be delivered to the Governor and General Assembly on or before November 1, 2019. In response to this legislative assignment, the Council convened an ad hoc Workgroup. The following letter describes the Council's ad hoc workgroup response to questions posed by the Agencies.

The Council believes it is critical to both support the long-term sustainability of existing school-based health centers (SBHCs) and to expand the number of SBHCs in the State. Funding should be commensurate with both goals. Long-term financial sustainability of these Centers must be thoughtfully considered and the central Agency oversight of SBHCs should be expanded to facilitate sustainability. It is with these goals in mind, the Council offers the following letter.

The Council's response was largely driven by considerations of the legislation to expand the number of SBHCs across Maryland and make them more accessible. Currently, due to state Medicaid regulations, Sponsoring Entities for SBHCs in Maryland are limited to Local Health Departments, Federally Qualified Health Centers, and General Clinics. The School Based Health Alliance, the national organization for SBHCs, in its most recent publication indicates that across the nation many additional organizational types, beyond the types in Maryland, serve as Sponsoring Entities. These include FQHC look-a-likes, Public and Private School Systems, Nonprofits, and Hospitals/Health Systems. In fact, the current Maryland State Department of Education SBHC Standards also allow for these sponsor types, though they are not practically able to be implemented due to the Maryland Medicaid regulations. The Council endorses these organizations as additional SBHC Sponsoring Entities. Moreover, the Council endorses Accountable Care Organizations, under Centers for Medicare and Medicaid Services, and Care Transformation Organizations, under the Maryland Primary Care Program, to also serve as Sponsoring Entities. Given the evolving transformation of healthcare delivery, the Council recommends that Sponsoring Entities should not only be limited to the above recommendations; the language should allow for innovative models that do not currently exist.

Maryland is uniquely positioned to adopt innovative models of healthcare delivery. Maryland's Total Cost of Care Waiver, regulated by the Maryland Department of Health's Health Service Cost Review Commission (HSCRC), promotes the quadruple aim of population health, with demonstrated achievements in improved patient health, improved access, improved patient experience, and reduced

healthcare expenditures within hospital systems of care delivery. These transformative objectives are increasingly reliant upon successful partnerships with community-based care. The Council believes that SBHCs are community-based models of care that align to the Total Cost of Care Waiver. The Council believes the innovative landscape of Maryland is a foundation for the recommendation of Hospitals and Health Systems as Sponsoring Entities. Further considerations to promote hospital sponsorship include such activities as a community benefit. Such benefits include improving access to health services, enhancing the public's health, and reducing the burden of the government to improve health in the education environment. Additional considerations may include decoupling HSCRC rates.

The Council believes that any agency, including Hospitals / Health Systems, serving as Sponsoring Entities should have demonstrated experience in serving the pediatric population. The Council believes it is of utmost importance that a primary care provider relationship is retained for children served by SBHCs. To that end, if pediatric care was provided in the practice setting, the Council would ideally like to see the practice have a relationship with the Sponsoring Hospital. Finally, in consideration of the recommendation of hospitals as Sponsoring Entities, the Council highlights that most hospitals are not currently able to meet the definition of General Clinic. While the General Clinic definition is codified in federal regulation, the Council recommends considerations for modifying Maryland State Medicaid regulations to include hospitals, and additional Sponsoring Entities beyond LHD, FQHC, and general clinic, endorsed by the Council, as outlined above.

The Council believes it is of utmost importance that SBHCs continue to serve as safety net providers and uphold the Institute of Medicine's safety net provider definition. The current MSDE Standards enumerate the requirements of SBHCs to serve as safety net providers, including the requirements to enable sliding fee scales for payment. The Council believes the safety net provider Standards should be upheld and continue to be reflected in future versions of the Standards. With that context in mind, the Council recommends caution in the consideration of for-profit entities, including Health Plans, Managed Care, and provider practices to serve as Sponsoring Entities. Voluntary enrollment into SBHCs is a critical Standard that should be adhered to for preservation of safety net services. The Council recognizes potential conflicts of interest in the operation of SBHCs by Health Plans, Managed Care, and practices, and therefore recommends clear Standards be put in place to ensure SBHC service delivery is not influenced or limited to Plan / Practice members. Moreover, successful community-based care is rooted in practice and experience. Entities that have not successfully delivered services in the community may enter an unsustainable position. This creates further vulnerability because for-profit entities may be more likely to not sustain services if key performance indicators are not met. This scenario leads the Council to recommend that SBHC Standards be adapted to include transition plans for Sponsors that terminate their relationships with SBHCs.

The existing SBHC Standards enumerate the potential for bifurcated sponsorship models, whereby there is an Administrative Sponsor and Medical Sponsor. The Council believes the bifurcated model may protect the safety net components of school-based health care through the robust infrastructure of an Administrative Sponsor and clinical expertise of a Medical Sponsor. The Council believes that it is of utmost importance that medical sponsors have pediatric care experience. The Council emphasizes the bifurcated sponsorship model because it may promote a solution to recruitment of Sponsoring Entities through diversification.

While expanding the types of sponsors is a good solution, this effort alone will not adequately ensure the sustainability and expansion of SBHCs as a model of care within Maryland. Consideration should be given to funding sources beyond traditional fee for services billing, potentially including but not limited to: investment of public dollars, grants and contracts, philanthropy, and hospital community benefit. Funds are needed, not just for SBHC operations, but also to support the SBHC infrastructure at the Agency level.

Sustainability and expansion may also be through policies and regulations that support the integration of SBHCs into the public health and healthcare infrastructure. For example, the promotion of data sharing (with appropriate parent/guardian consent) that allows for optimal care coordination and communication between SBHCs, medical homes, and Health Plan/Managed Care Plans. Innovative care models, such as telehealth, can also expand SBHC capacity enhancing both impact and sustainability. Financial sustainability of Sponsoring Entities is also a critical consideration. For example, if a Sponsoring Entity, such as a nonprofit can no longer sustain the sponsorship of a SBHC, there should be strong consideration for Standards around effective transition of operations, as noted above. These approaches will require both revision of the current MSDE SBHC Standards and additional coordination between Agencies and invested stakeholders. Taken together, these efforts will require substantial Agency resources. *The Council believes that in order to pursue sustainable expansion of SBHCs, there must be further consideration of increased Agency staffing resources and infrastructure.*

The Council is confident the outlined recommendations will support the Agencies in responding to this deliverable. The Council looks forward to supplementing the great work of this legislative deliverable through key recommendations that further support sustainability, including robust recommendations for improved data systems, systems integration, diversified funding, and quality and best practices through the adoption of Standards that support innovation and improved care delivery to students. As our partners in school-based health care, we truly value the great work you are leading and commend you on the thoughtful and comprehensive process to engage stakeholders. Please send any questions or comments to Jennifer Newman Barnhart, Staff Consultant to the Council at: jennifer.barnhart1@maryland.gov or 443-995-0479.

Sincerely,

Dr. Katherine Connor
Chair, CASBHC

Mr. Mark Luckner
Executive Director, CHRC

Cc: Jennifer Newman Barnhart, Council Staff Consultant

STATE OF MARYLAND
Community Health Resources Commission
45 Calvert Street, Room 336 • Annapolis, Maryland 21401

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Council on Advancement of School-Based Health Centers
House Office Building, 6 Bladen St, Room 170, Annapolis, MD 21401
MINUTES

Monday, March 4, 2019 | 9:30AM – 12:30PM

Attendees / Roll-Call

In- Person Appointee Membership

1. Dr. Katherine Connor, CASBHC Chair | Medical Director Johns Hopkins Rales SBHC | KIPP Baltimore
2. Barb Masiulis, CASBHC Vice Chair | Health Services Supervisor, Baltimore County Public Schools
3. Dr. Patryce Toye, Maryland Assembly on School-Based Health Care | Medical Director, MedStar Family Choice
4. Mark Luckner, CASBHC Community Health Resource Commission (CHRC) Ex Officio Member | Executive Director CHRC
5. Dr. Arethusa Kirk, CASBHC Managed Care Organization Member | Chief Medical Officer United HealthCare Community Plan
6. Cathy Allen, Maryland Association of Boards of Education | Vice Chair, St. Mary's County Board of Education
7. Kelly Kesler, Parent Member | Director, Howard County Local Health Improvement Coalition
8. Dr. Maura Rossman, Maryland Association of County Health Officers Member | Local Health Officer, Howard County
9. Jennifer Dahl, Commercial Health Insurance Member | Credentialing Coordinator, CareFirst

In-Person Ex Officio

10. Delegate Cullison, Ex Officio Member | House of Delegates, District 19 (Montgomery County)
11. Mark Luckner, CASBHC Community Health Resource Commission (CHRC) Ex Officio Member | Executive Director CHRC
12. Jennifer Barnhart, CASBHC Staff Consultant | President LUMA Health Consulting
13. Dr. Cheryl De Pinto, CASBHC Maryland Department of Health (MDH) Ex Officio Member | Director, MDH Population Health

In-Person Public

14. Sharon Hobson, Public Member | Howard County Health Department
15. Joanie Glick, Public Member | Montgomery County Health and Human Services
16. Lynne Muller, Public Member | Maryland State Department of Education
17. William (Mike) Shaw, Public Member | St. Mary's County Health Department
18. Caroline Dushel, Graduate nursing student for MASBHC | University of Maryland
19. Dr. Nithin Paul, Preventative Medicine | Family Practice Resident, Johns Hopkins School of Public Health & MedStar Franklin Square

20. Dr. Alana Koeler, Pediatric Resident | Johns Hopkins All Children's Hospital
21. Robyn Elliot, Public Member | Partner at Public Policy Partners
22. Rachael Faulkner, Public Member | Director at Public Policy Partners

On the Phone Appointee Membership (Note: Phone quality was poor and made it difficult for the following members to actively participate)

23. Karen Williams, Federally Qualified Health Center Member | Chief Executive Officer, Mid-Atlantic Assoc. of Community Health Centers
24. Sharon Morgan, Maryland Association of Elementary School Principals Member | Maryland State Department of Education
25. Dr. Jonathan Brice, Public Schools Superintendents Association of Maryland Member | Associate Superintendent Montgomery County Public Schools
26. Jean-Marie Kelly, Maryland Hospital Association Member | Community Benefits, Union Hospital
27. Kristi Peters, Public Member | Maryland State Department of Education
28. Dr. Diana Fertsch, Maryland Chapter of American Academy of Pediatrics Member | Pediatrician, Dundalk Pediatric Associates

On the Phone Ex Officio

29. Senator Lam, Ex Officio Member | Maryland State Senate, District 12 (Howard & Baltimore City)
30. Andrew (Andy) Ratner, Ex Officio Maryland Health Benefit Exchange Member | Chief of Staff, Maryland Health Benefit Exchange

On the Phone Public

31. Alicia Mezu, Public Member | Maryland State Department of Education
32. Kristi Peters, Public Member | Maryland State Department of Education

Members unable to participate

1. Angel Lewis, Public Member | Maryland State Department of Education
2. Dr. Uma Ahluwalia, Public Member | Principal, Health Management Associates
3. Mary Gable, Public Member | Assistant State Superintendent, Maryland State Department of Education

Note: Action Items are Italicized below in the following Minutes

9:30AM Welcome (Chair: Dr. Katherine Connor)

Dr. Connor welcomed members and thanked everyone for convening.

9:35AM: Introduction of new Council Members:

Senate Member: Senator Clarence Lam, M.D., M.P.H.

Dr. Connor introduced Senator Lam and thanked him very much for participating. Senator Lam is Director of the Johns Hopkins Preventative Medicine Residency Program and State Senator for District 12 (Baltimore City and Howard County). Senator Lam will be participating in the Systems Integration and Funding Workgroup. Dr. Connor thanked Delegate Cullison for the invitation to Senator Lam.

Staff Consultant: Jennifer Newman Barnhart, M.P.H.

Jen is part-time staff consultant for the CASBHC, hired by the CHRC. Jen started her public health management and consulting firm in November 2018, LUMA Health Consulting. Prior to LUMA Health, Jen was the Director of the Hopkins-led Health Services Cost Review Commission Regional Partnership. Prior to directing the Community Health Partnership Baltimore | HSCRC Transformation Grant, Jen had progressive leadership roles at MDH, including Population Health Director, Public Health Services Chief of Staff for Dr. Howard Haft, and

Deputy Director at Maryland Public Health Laboratory. Jen is honored to support the great work of the CASBHC.

Parent Member: Kelly Kesler, M.S., C.H.E.S.

Dr. Rossman made the introduction of Kelly. Kelly is the Local Health Improvement Coalition Director for Howard County. Kelly is a former middle and high school teacher. Her children attend a Title I school with a telehealth SBHC in Howard County. Kelly and her children have received SBHC services. Dr. Connor expressed her gratitude for having this important membership position filled. Kelly is undergoing the official CASBHC appointment process with the Governors Appointment Office.

Housekeeping: Dr. Connor reminded members to please submit their financial disclosures by April 30th.

Vice Chair Barb Masiulis echoed Dr. Connor's welcome and thanked everyone for convening and participating today.

Delegate Cullison thanked everyone and expressed her excitement about the commitment and future of the CASBHC.

9:40AM Minutes from November 2018 CASBHC Meeting (Page 36 of meeting packet)

Dr. Connor asked for comments on the minutes. CASBHC did not have comments or concerns. Cathy Allen moved for approval of the minutes. Dr. Toye seconded the approval. The minutes were approved unanimously by the full Council.

9:45AM 2019 CASBHC Priorities

Dr. Connor expressed gratitude for the immense amount of work the CASBHC accomplished in 2018. She considered 2018 as an information-gathering phase for CASBHC to further define priorities in 2019. A summary of the progress made in 2018 includes: Survey changes, standards updates, and engagement with Maryland Medicaid on data sharing and billing. As a result of the CASBHC's expressed need for a comprehensive overview of SBHCs in Maryland, Harbage Consulting was hired to prepare a White Paper on the Value Proposition of SBHCs and make recommendations to further the objectives of SBHCs. Dr. Connor described the Harbage Report as one of the organizing structures for 2019 goals, but not the only source. Over the next several months, CASBHC will work to identify the recommendations they wish to adopt and develop priorities for each Workgroup.

10:00AM Harbage Report

Harbage Consulting was hired to create a White Paper to show the value proposition of SBHCs. The two key recommendations of the Report were the (1) Creation of a SBHC Program Office and, (2) Improved Data collection, Reporting, and Analysis. Dr. Connor noted that the Report is not automatically adopted by CASBHC.

The process of adoption of recommendations defines the need for creation of CASBHC By-Laws and a Vision Statement. Dr. Connor envisions that this work will be done in parallel with the development of the 2019 priorities. *Jen will draft a Vision Statement and By-Laws. The By-Laws will define a process by which recommendations are put forward by Workgroups and voted for approval by full CASBHC at the Spring 2019 meeting.*

Harbage Report Table: Dr. Connor described the key and table (color, proposed assignments, timeline, and notes based on CASBHC prior work). The color coding is a guiding framework:

Green: Near-term actionable, feasible, and impactful

Yellow: Longer term actionable, feasible, and impactful

Red: Longer term, resource intensive, difficult implementation

Dr. Connor requested that each Workgroup review their proposed assignments during Break-Out. Workgroup Chairs should then offer feedback on the proposed assignments, priority (i.e., color), and timeline during Report Out.

After assignments are finalized, Workgroups will prioritize recommendations on their respective teleconference meetings later this month. The full Council will review and adopt recommendations as proposed by Workgroups.

Harbage Report Feedback & Factual Errors

Joanie Glick is the only Council member to submit comments in advance of Council meeting. Joanie identified factual errors contained in the report. Examples include: Number of SBHCs who receive MSDE funding.

Mark Luckner noted that the Harbage Report is a completed deliverable. The full contract amount has been paid.

Dr. Rossman asked if we can ask amend the Harbage Report based on the errors CASBHC identifies.
Dr. De Pinto sees the Harbage report edits as CASBHC work and not Harbage's responsibility.
Dr. Connor noted that factual corrections have already started to be captured. *Dr. Connor asked the CASBHC to provide Jen with specific items that are factually incorrect, including the cite of the source for factual changes. Also send Jen additional comments.* After comprehensive edits are received by Jen, *a track changes version will be generated.* It is important to have a correct report because this report will be made publicly available. Harbage Report edits are due in late March.

Cathy Allen asked how comprehensively will this report be shared. The Council discussed the fact that the Report should be made publicly available since State funds (provide by the CHRC) were used to create the report.
Dr. De Pinto reinforced Cathy's comment stating that we want to ensure there are no perception issues.
Dr. Connor stated that the Report has currently been shared with MDH, MSDE, MASBHC, and CASBHC, and CHRC staff commented that the Report has not been posted on the CHRC's or Council's website, yet.

10:20AM Maryland Assembly on School-Based Health Care Letter

The CASBHC received a letter from MASBHC expressing concerns about the lack of acknowledgement of MASBHC in the Harbage Report. Dr. Toye, MASBHC representative on the Council, stated that MASBHC found it disappointing they were not included in the Report in a more significant manner. MASBHC has a robust history of advocacy for SBHC and understands the tremendous amount of work that requires funding. Further, MASBHC has a strong relationship with the School-Based Health Alliance. MASBHC requested that its role and long history with SBHCs in Maryland be included and acknowledged in the Report. They very much want to be a strong part of this effort.
Dr. Connor agrees that it was very disappointing there was a lack of MASBHC inclusion. Dr. Connor suggested that CASBHC contact Harbage to better understand their methodology for stakeholder engagement and the interview process with MASBHC. *The Council staff will write a letter responding to MASBHC's letter, and this letter will be prepared after the Council has received all of the corrections on the Harbage report. Council staff will inquire with Harbage about the non-inclusion of MASBHC in the Report and also discuss factual errors that will be corrected in the final Report before it is released externally.*

Cathy Allen noted there are a lot of Harbage recommendations that inferred CASBHC undertake. Cathy additionally noted that CASBHC is not structured to be an implementer and executor. Dr. De Pinto asked who the recommendations are being made to- MDH, MSDE, others? Dr. De Pinto agreed with Cathy that the

recommendations are not appropriate for CASBHC to implement and execute. There would need to be a close examination of the authorizing statute of the CASBHC to determine appropriate obligations as they relate to the Harbage recommendations. Moreover, there are resource challenges related to the roles of MSDE and MDH in the implementation and execution of recommendations. Dr. Connor noted the most significant recommendation is the SBHC Program Office creation.

Delegate Cullison noted that the Report identified a need for expanded infrastructure. This is Delegate Cullison's intent in her sponsorship of House Bill 681 (MSDE & MDH School-Based Health Center Ombudsmen Bill).

Kelly Kesler asked how student and parent groups can be actively engaged in the recommendation process (e.g., PTA, community members). Dr. Connor confirmed that Workgroups are encouraged to engage appropriate public members in an effort to better inform the CASBHC.

Dr. Toye asked what CASBHC's role should be with regard to resource advocacy, including both capital resources and continuing resources. Dr. Connor noted that there will be a more robust discussion about CASBHC's policy role after the Workgroups meet and report out.

Data related discussion about Harbage:
Jen asked if there is opportunity to identify SBHC(s) with more advanced infrastructure to pilot a smaller evaluation / value demonstration. Dr. Connor noted this was discussed in the past during discussions about how to highlight existing data capacity.

Dr. Connor noted one of the largest challenges is denominator information cannot be accessed and MCOs are not able to accurately extract their SBHC enrollment data. What is the definition for enrollment? How do we identify SBHC eligible enrollees?

Kelly and Dr. Toye noted that productivity measures for parents is a very important data feature to be considered.

Dr. Connor and Dr. Rossman noted that as we think through data capacity, we should not let 'perfect be the enemy of good'.

10:35AM Break

10:45AM Quality, Systems, and Data Workgroups: Break-Out
Workgroups broke out to discuss proposed assignments and agree on final assignments. The Workgroups are not being asked to consider implementer ownership and priority recommendations.

11:20AM Quality, Systems, and Data Workgroups: Report-Out
Data Workgroup Report Out (Chair: Barb Masiulis)
The Data workgroup discussed Survey revisions, Survey cross-walk against Harbage data recommendations, and need for data definitions with the Survey. The Survey revisions included more outcomes-based data questions. Barb said that some SBHCs will pilot the Survey before it is fully launched in June. The Survey will be reviewed on March 19 at the SBHC Administrators meeting.

The Data assignments were all adopted with some edits to priority and timeline. Barb will send to Jen.

Systems Integration and Funding (SIF) (Chair: Dr. Rossman)

Dr. Rossman said many of the discussions SIF had were around policy's relationship to data capture. SIF has agreed with all the recommended assignments. #23 was changed to red and #37 was changed to green. Dr. Rossman highlighted the importance of data sharing and the need to identify MOUs and BAAs. There is a common theme as it relates to FERPA's legal interpretation and student health privacy. Dr. Rossman asked if perhaps the consent forms need to be changed to mitigate the FERPA barriers.

There is a technical assistance opportunity for SBHCs to better understand the capabilities of CRISP. Jean-Marie noted that the identified PCP in the CRISP record does not need to be a physician. For example, HSCRC Transformation grants allow Nurse / Care Managers to be the provider of record in CRISP. Jen confirmed that this was the case for the Hopkins-led HSCRC Transformation Grant as well.

Quality and Best Practices (QBP) Report Out (Vice Chair: Dr. Toye)
Dr. Toye noted there was discussion about color / priority changes. Moreover, Dr. Toye noted the Workgroup identified places where the QBP could be helpful. Kelly asked if there is a way to engage an ad hoc group like parents (i.e., Question # 38). QBP discussed color changes.

Deliverable: Jen will send a revised version of the table incorporating all the Workgroup edits. Each Workgroup should finalize the CASBHC recommendation assignments by late March.

11:30AM Legislative Updates from Delegate Cullison and Senator Lam

Delegate Cullison Updates
House Bill 47 | Sponsor: Delegate Cullison et. al. "State Department of Education and Maryland Health Department – Maryland School-Based Health Centers Standards" enabling Nurse Practitioners to be primary SBHC provider. HB47 passed the House and was cross-file in the Senate by Senator Lam (Senate Bill 404).

House Bill 681| Sponsor: Delegate Cullison "State Department of Education and Maryland Health Department – School-Based Health Centers – Ombudsmen" requiring MSDE and MDH to designate an ombudsman for SBHCs; altering membership of CASBHC to include each ombudsman; manage SBHCs and their expansion in alignment with Total Cost of Care objectives. The ombudsmen will understand regulations and roles as they relate to SBHC and be the primary contact with other Agencies. First reading is on March 7, 2019 in House Health and Government Operations and Ways and Means Committees.

12:00PM Kirwan Commission Update (Rachel Faulkner, Director of Research and Policy Development, Public Policy Partners Maryland)

School-based health services is a clear priority of the Kirwan Commission, specifically mental health service delivery.

The Kirwan Commission is recommending that $325M be allocated in FY20 to begin implementing the recommendations. In FY2020, Kirwan is recommending that approximately $120K be provided to each school in Maryland which has at least 80% of students eligible for free and reduced meals. This is expected to total over $33M in new spending. Schools which receive this funding would be required to have a health care practitioner within a school health services program, SBHC, or school-partnered behavioral health program.

In FY2021, Kirwan recommends schools receive these grant dollars if at least 55% of students are eligible for free and reduced meals. In addition, there is a recommendation to include an additional $6.5M to MSDE for grants to SBHC. Grants have been flat-funded at $2.5M since the late 90s.

The flow of money is expected to be from State to District to School. Conversations have been focused on General Fund allocations and not local dollars.

12:20PM Policy Discussion

One year ago, CASBHC agreed they will give general recommendations and MASBHC and other organizations would lead the advocacy role, take positions on pending legislation, etc. Dr. Connor would like CASBHC to re-visit what their role is in the legislative process. Should the CASBHC be providing input into SBHC legislation and make recommendations about SBHC legislative initiatives? Should CASBHC be taking positions on the Bills?

CASBHC staff will prepare a By-Laws document that would outline how voting and policy decisions would be considered and this document will be considered by the full CASBHC at a future meeting.

In the event that CASBHC is contacted to take a position on pending legislation or other policy matters, the By-Laws document will address this? Dr. Connor and Mark noted that Counsel for Community Health Resource Commission opined that it is within CASBHC's legislative authority to take a position on legislation that relates to the policy mission of the CASBHC, ie that involves advancing SBHCs.

CASBHC members noted that there are often conflicts with their primary employment role which would exclude them from voting.

Cathy is supportive of providing information (absent a position). Cathy feels a voting member's position should reflect their employment role within the CASBHC.

Dr. Kirk asked if it is possible to review each piece of legislation and offer a position.

Dr. Toye asked what the down-side of taking a position is. Would individuals come to CASBHC to lobby?

Dr. Rossman noted that she represents MACHO so her position would always be on behalf of MACHO, and not as the Howard County Local Health Officer.

Dr. De Pinto noted that MDH & MSDE are non-voting members so this obviates the State Agency conflict.

Robyn Elliott provided a definition of lobbying (i.e., CASBHC could not be a lobbying entity).

Dr. Connor asked if CASBHC gets a request to respond to legislation should then CASBHC consider a response?

Barb noted MASBHC will be presenting on May 16, 2019: Dr. Jess "Risky teen behaviors" / NYU

The next full Council meeting will be scheduled in the late Spring: mid – May / early – June 2019 at Howard County Health Department.

Cathy Allen motioned to adjourn, Barb Masiulis seconded the motion. Dr. Connor closed the meeting.

MEETING MATERIALS (5)

Harbage Report, Harbage Recommendations
Membership Roster, 2018 Final Report, MASBHC Letter

STATE OF MARYLAND
Community Health Resources Commission
45 Calvert Street, Room 336 • Annapolis, Maryland 21401

Larry Hogan, Governor - Boyd Rutherford, Lt. Governor
Allan Anderson, M.D., Chair – Mark Luckner, Executive Director

Council on Advancement of School-Based Health Centers
Howard County Health Department
MINUTES

Monday, June 3, 2019
9:30A-12:30P

Attendees / Roll-Call

In- Person Appointee Membership

1. Dr. Katherine Connor, CASBHC Chair | Medical Director Johns Hopkins Rales SBHC | KIPP Baltimore
2. Barb Masiulis, CASBHC Vice Chair | Health Services Supervisor, Baltimore County Public Schools
3. Dr. Patryce Toye, Maryland Assembly on School-Based Health Care | Medical Director, MedStar Family Choice
4. Dr. Arethusa Kirk, CASBHC Managed Care Organization Member | Chief Medical Officer United HealthCare Community Plan
5. Kelly Kesler, Parent Member | Director, Howard County Local Health Improvement Coalition
6. Dr. Maura Rossman, Maryland Association of County Health Officers Member | Local Health Officer, Howard County
7. Jennifer Dahl, Commercial Health Insurance Member | Credentialing Coordinator, CareFirst
8. Jean-Marie Kelly, Maryland Hospital Association Member | Community Benefits, Union Hospital

In-Person Ex Officio

9. Delegate Cullison, Ex Officio Member | House of Delegates, District 19 (Montgomery County)
10. Senator Lam, Ex Officio Member | Maryland State Senate, District 12 (Howard & Baltimore City)
11. Mark Luckner, CASBHC Community Health Resource Commission (CHRC) Ex Officio Member | Executive Director CHRC
12. Jennifer Barnhart, CASBHC Staff Consultant | President LUMA Health Consulting
13. Dr. Cheryl De Pinto, CASBHC Maryland Department of Health (MDH) Ex Officio Member | Director, MDH Population Health
14. Mary Gable, CASBHC Maryland State Department of Education (MSDE) Ex Officio Member | Assistant State Superintendent, Maryland State Department of Education

In-Person Public

15. Sharon Hobson, Public Member | Howard County Health Department
16. Joanie Glick, Public Member | Montgomery County Health and Human Services
17. Lynne Muller, Public Member | Maryland State Department of Education
18. William (Mike) Shaw, Public Member | St. Mary's County Health Department
19. Caroline Dushel, Graduate nursing student for MASBHC | University of Maryland
20. Ken Miller, Landsdowne Secondary School Principal, Baltimore County

On the Phone Appointee Membership

21. Karen Williams, Federally Qualified Health Center Member | Chief Executive Officer, Mid-Atlantic Assoc. of Community Health Centers
22. Uma Ahluwalia, Public Member | Principal, Health Management Associates

On the Phone Ex Officio

23. Andrew (Andy) Ratner, Ex Officio Maryland Health Benefit Exchange Member | Chief of Staff, Maryland Health Benefit Exchange

On the Phone Public

24. Tanya Schwartz, Director, Medicaid Policy, Harbage Consulting

Members unable to participate

1. Cathy Allen, Maryland Association of Boards of Education | Vice Chair, St. Mary's County Board of Education
2. Kristi Peters, Public Member | Maryland State Department of Education
3. Dr. Diana Fertsch, Maryland Chapter of American Academy of Pediatrics Member | Pediatrician, Dundalk Pediatric Associates

Note: Action Items are Italicized below in the following Minutes

9:30AM Welcome (Chair: Dr. Katherine Connor)

Dr. Connor welcomed members and thanked everyone for convening. The largest objective of today's meeting is to consider recommendations outlined in the Harbage report that each Workgroup has adopted. As a Council, we must then decide if we want to move the recommendations on for approval and full adoption. The main focus of this meeting will be for each Workgroup to present their recommendations. Recommendations do not imply that CASBHC is the implementer.

Delegate Cullison noted that there is opportune momentum to make recommendations because of the work of Kirwan Commission. Delegate Cullison noted that this is our moment to make significant improvements for SBHCs to be integrated into public health. Dr. Connor encouraged the Council to be bold in their recommendations and then we can take more detailed and stepwise approaches to accomplishing the recommendations.

9:40AM Minutes from March meeting

Dr. Connor asked for changes / comments to the minutes. Kelly Kesler should be one S (change from Kessler to Kesler). Cheryl De Pinto should have a space in her last name (DePinto to De Pinto). Patryce noted that on page 6 the Kirwan funding noted is inconsistent with the amounts that were ultimately funded, specifically in FY20, Kirwan recommended that approximately $120K be provided to each school in Maryland which has at least 80% of students eligible for free and reduced meals; $285K was funded in the final passing of this legislation. Barb motioned to approve and Jean-Marie seconded the motion. The minutes were adopted.

9:45AM Membership Positions

Superintendent: Jonathon Brice is no longer serving on the Council. We have sent an ask to PSSAM for a replacement.

Secondary School Principal: Angel Lewis is no longer serving on the Council. Ken Miller, Principal, Lansdowne Highschool in Baltimore County is currently undergoing the appointment process.

Parent whose child attends a school with a SBHC: Kelly Kesler's appointment is confirmed by the Governor's Office.
Elementary School Principal: Sharon Morgan is no longer serving on the Council. We are working with MAESP to identify a replacement.

Welcome to Senator Lam's first in-person meeting. Senator Lam expressed that it was a pleasure to be a part of the great work of this Council.

Dr. Connor announced her deep regret for Barb Masiulis's upcoming retirement. This will be Barb's last meeting on the Council. Dr. Connor expressed her gratefulness for Barb's service to the Council. Barb has massively overhauled the Data Workgroup and accomplished a revised Survey. Barb will continue to serve on the Data Workgroup for a period of continuing time.

Delegate Cullison awarded Barb a Resolution from House Speaker Adrienne Ellis for her commitment to the advancement of school-based health care.

At the next meeting the Council will think through the process for appointing a Vice Chair.

10AM Legislative update from Delegate Cullison & Senator Lam
HB47 (Del. Cullison): HB47's passage repeals the requirement of physicians to serve as Medical Directors and replaces with the enablement of both Nurse Practitioners and Physicians ability to serve as a Clinical Director / Consultant for a SBHC.

Ombudsmen Bill (Del. Cullison): Del. Cullison expressed her gratitude to Harbage about highlighting the lack of school health resources. The goal of the Ombudsmen Bill that Del. Cullison sponsored is to create a dedicated infrastructure for school health for MSDE and MDH. The cost of the positions including benefits and survey support is $300,000. There was a lot of support for this legislation but lack of support for the fiscal requirements (i.e., Fiscal Note was too big). The one thing from the legislation that can be near-term salvaged is to examine sustainable sponsorship models. This resulted in the MDH/MSDE deliverable on sustainable sponsorship models in the Blueprint.

Senator Lam said that school health legislation this past session allows for a stepwise approach to continue school health improvement and allowing us to make important changes. Kirwan raised the awareness of school health and mental health access. It is very important for legislators to understand the identified needs and take advantage of these opportunities.

10:10 SB1030: Blueprint deliverable: "The MDH and the MSDE shall consult with the CASBHC and other interested stakeholders on a plan to build a sustainable sponsorship model by expanding the type of organizations that can sponsor school-based health centers." CASBHC is being called upon to consult on this deliverable. CASBHC should be prepared to coordinate an ad hoc committee. *If you are interested in participating, please let Jen know and we can start organizing an ad hoc committee.* Cheryl is MDH lead and Lynne is MSDE lead. Internal discussion between MDH Medicaid, MDH Public / Population Health, and MSDE is starting around federal regulations, i.e., definition of clinic. MDH is coordinating a meeting with Medicaid because Medicaid currently does not allow for a Hospital to be a Sponsoring Agency of a SBHC to receive reimbursement. The Sponsoring Agency is defined as the entity who bills.

10:20 Harbage Report public release
The objective of the Harbage Report was to demonstrate a value proposition for SBHCs. It is a report of an independent consultant, Harbage Consulting, and not a report of the Council. At the last meeting the Report was

commended about meeting it's intended goals. There were two issues raised with regard to the Report: factual edits and MASBHC's lack of inclusion. Tanya Schwartz, Medicaid Director for Harbage Consulting has reconciled these edits. There was a new version of the Report distributed to MASBHC and MASBHC provided further edits to Tanya which she is finalizing.

Dr. Connor discussed the public release process for the Report. The reconciled Report will go through the following release steps, being shared with the following entities: 1. Council, 2. Harbage, 3. Legislature, 4. Agency (MSDE / MDH), 5. MASBHC, 6. Health Officers, 7. Medicaid Advisory Committee, 8. Maryland Rural Health Association. In addition, the Report should be shared with the leaders of organizations we represent, including MD PTA, MASBHC, Elementary/Secondary Principals and Superintendents. After all these stakeholders have received the Report, it will be prominently posted on the CHRC website for public access.

Jen will develop key talking points and a cover letter that lays out summaries for legislature to clarify objectives of the Report and relationship to Council's responsibilities. The letter should include a timeline for release and how to offer public comments on the Report.

The Council will see final report before it's disseminated. The goal of today is for each Workgroup to report out their adopted recommendations. The Council has the opportunity to provide feedback on each workgroup's recommendations. The next step will be prioritizing recommendations and then begin discussions about the nuances of recommendation implementation. We need to be very clear about the message of the Report in that the Report was not automatically adopted and the Council. The Report was commissioned by the Council and the Council is now considering the adoption of recommendations. Tanya clarified if we release in September 2019 the Report may be one year old.

Each Workgroup will meet in June to reconcile today's recommendation edits. Jen will then consolidate each Workgroup's recommendations into one document. That document will be distributed to the full Council, including the revised Report. Recommendations will be discussed on a phone call in mid-July. This teleconference will be the forum for final recommendation adoption.

Tanya expressed her gratitude for continuing in her role to advise on the contents on the Report. Harbage is honored to have the Report publicly released.

The September meeting will include Workgroup report-outs on priorities. Implementation will be discussed at the September meeting.

10:50A Break

11A SIF Recommendations (Dr. Rossman): Sixteen of the recommendations support the overall objectives of achieving sustainability and systems integration for SBHCs. SIF adopted 3 recommendations without amendments, 9 recommendations with amendments, 1 new recommendation, and 1 would be considered at a later date. Two recommendations were collapsed under one recommendation. The following is a summary of the feedback provided to SIF from the Council:

<u>SIF Recommendations with Amendments</u>:

"Promote and create systems to support care and data sharing between SBHC, PCP, and payers to improve care coordination."

Feedback: Data sharing is dependent on data availability. Relevant parties should be defined (i.e., with whom data is being shared and by whom shares data). Provide specificity about the type of data that

should be shared. Include quality, process, and outcome measures, including educational outcomes, in addition to health outcomes. Information should be shared multi-directionally since more than two partners are involved. Consent forms should include language about the minimum set of information to be collected on the consent form.

"Create site-specific SBHC unique identifiers (it does not have to be NPI)."
Feedback: NPIs are not provided for telemedicine sites.

"Explore CRISP Encounter Notification System (ENS) to improve care coordination goals of SBHCs."
Feedback: Do not limit to ENS and include all relevant CRISP tools, services, and reporting capabilities to improve care coordination goals of SBHCs.

Council provided feedback to develop a new SIF recommendation:
How can MSDE disseminate funds to schools most in-need? SBHC applicants can coordinate with needs assessment processes like Hospital Community Benefits, Community Health Needs Assessment, and Local Health Improvement Coalition(s) priorities.

11:30A Quality and Best Practices Recommendations (Jean-Marie Kelly): Eleven of the 42 recommendations support the overall objectives of achieving quality and best practices for SBHCs. QBP adopted 4 recommendations without amendments, 5 recommendations with amendments, and 1 would be considered at a later date. Two recommendations were collapsed under one recommendation. The following is a summary of the feedback provided to QBP:

Key recommendations that QBP adopted:
"Assess current baseline for each SBHC on recommended SBHA measures and compare to statewide SBHC averages."
Feedback: Organize this recommendation into two: (1a) Create matrix of measures, (1b) Assess current baseline for readiness of each SBHC on existing measures. SBHA measures should be used as a starting point. We however should not limit ourselves on recommended measures.

"Use data to drive TA, QI, and Decision-Making through (a) ad hoc TA webinars/calls, (b) Issue-specific affinity groups, (c) Statewide training, (d) Individualized TA.
Feedback: Who is the accountability owner for this recommendation?

QBP recommendations adopted with amendments:
"Collect more outcomes-based data, including educational outcomes:
Feedback: Include process and outcomes-based data for collection.

"Establish performance goals and consider performance measurement incentives for SBHCs"
Feedback: Who provides the incentive?

12P Data Recommendations (Barb Masiulis): Fourteen of the 42 recommendations support the overall objectives of improved data collection and reporting for SBHCs. The Data Workgroup adopted 5 recommendations without amendments, 5 recommendations with amendments, and 4 would be considered at a later date. The following is a summary of the feedback provided to Data:

Feedback: We need to define what data we need and who needs it.

Data recommendations adopted with amendments:
"Add client experience measures to the Survey"

Feedback: What SBHCs are currently reporting on experience? SBHC Administrators should be surveyed.

Educational outcomes are population health measures. Ideally each SBHC would have a dashboard for reporting.

Dr. Connor expressed her gratitude for everyone's work on the recommendations. Once we have voted on the broad set of recommendations, then workgroups will prioritize and create steps on how to implement these recommendations. Implementation planning will include ownership.

12:20P: Vision Statement & By-Laws

Vision Statement: Dr. Connor stated that the goal is to create a draft one-page vision statement based on the legislative order of the Council, activities to date, and current recommendations. We want the recommendations to be linked to Vision.

By-Laws: The By-Laws should be created with a similar process however the CHRC Counsel will need to be included. The Council will have the opportunity to review the By-Laws

12:25P School-Health Conferences

MASBHC Annual Conference: Dr. Toye and Barb updated everyone on the annual MASBHC conference. The keynote speaker did a great job on presenting on adolescent behavior, risk, and development. The population health session was very well received. Thank you to Kate and Cheryl. The MASBHC conference received very good overall feedback.

Maryland Rural Health Association Conference (October 20-22): There will be a school health plenary within the population health track.

State Health Interdisciplinary Program: August 6-8, 2019 in Columbia, Maryland

The meeting was adjourned.

STATE OF MARYLAND

Community Health Resources Commission

45 Calvert Street, Room 336 • Annapolis, Maryland 21401

Larry Hogan, Governor - Boyd Rutherford, Lt. Governor
Allan Anderson, M.D., Chair – Mark Luckner, Executive Director

Council on Advancement of School-Based Health Centers
MINUTES

Tuesday, July 23, 2019 | 2:30PM-4:00PM

TELECONFERENCE: 605-475-4000, 142685#

Attendees / Roll-Call

Appointee Membership

1. Dr. Katherine Connor, Chair, Council on Advancement of School-Based Health Centers (CASBHC) & Maryland Assembly School-Based Health Care (MASBHC) Representative | Medical Director Johns Hopkins Rales SBHC, KIPP Baltimore
2. Barb Masiulis, CASBHC Vice Chair & Maryland Assembly School-Based Health Care Representative | Health Services Supervisor, Baltimore County Public Schools
3. Dr. Patryce Toye, Maryland Assembly on School-Based Health Care Representative | Medical Director, MedStar Family Choice
4. Uma Ahluwalia, Maryland Assembly School-Based Health Care | Principal, Health Management Associates
5. Dr. Arethusa Kirk, Managed Care Organization Representative | Chief Medical Officer, United HealthCare Community Plan
6. Kelly Kesler, Parent Representative | Director, Howard County Local Health Improvement Coalition
7. Dr. Maura Rossman, Maryland Association of County Health Officers (MACHO) Representative | Local Health Officer, Howard County Health Department
8. Cathy Allen, Maryland Association of Boards of Education Representative| Vice Chair, St. Mary's County Board of Education

Ex Officio

9. Delegate Cullison, Ex Officio House Member | House of Delegates, District 19 (Montgomery County)
10. Senator Lam, Ex Officio Senate Member | Maryland State Senate, District 12 (Howard & Baltimore City)
11. Mark Luckner, Community Health Resource Commission (CHRC) Ex Officio Member | Executive Director CHRC

12. Jennifer Barnhart, CASBHC Staff Consultant, Community Health Resource Commission (CHRC) | President, LUMA Health Consulting
13. Dr. Cheryl De Pinto, CASBHC Maryland Department of Health (MDH) Ex Officio Member | Director, MDH Population Health
14. Andrew (Andy) Ratner, Ex Officio Maryland Health Benefit Exchange Member | Chief of Staff, Maryland Health Benefit Exchange

Public

15. Joanie Glick, Administrator, School Health Services, Montgomery County Health and Human Services
16. Lynne Muller, Section Chief, Student Services and School Counseling, Maryland State Department of Education
17. Alicia Mezu, Health Services Specialist, Maryland State Department of Education
18. Sean Bulson, Superintendent, Harford County
19. Kristi Peters, Coordinator, Research and Evaluation, Maryland State Department of Education
20. Rachael Faulkner, Director of Research and Policy Development, Public Policy Partners
21. Pam Kasemeyer, Managing Partner ,Schwartz, Metz, and Wise, PA
22. Kamilla Decomb, Graduate Student | Maryland State Department of Education
23. Joy Twesigye, Director of School Health Program Planning and Evaluation, Baltimore City Health Department

2:30PM Welcome (Chair: Dr. Katherine Connor)

Dr. Connor thanked everyone for convening over the Summer to continue momentum before the October 2019 meeting. The primary objective of this meeting was to consider recommendations being put forward by each Workgroup. A 2/3 quorum of voting members was confirmed.

2:35PM Minutes from June 3, 2019 for review / approval

Dr. Toye made a motion to approve and Ms. Masiulis seconded her motion for approval of minutes. The minutes were approved with no abstentions and no oppositions.

2:40PM Harbage Report Public Release

Ms. Barnhart provided an overview of the SBHC Value Proposition Report delivered by Harbage Consulting. The independently commissioned Report was delivered in December 2018. During March, April, and May 2019, the CASBHC reviewed the Report; factual edits and modifications were reconciled in accordance with CASBHC feedback and the Report was finalized in June 2019. In preparation for the public release of the Report in September, the CASBHC plans to release an advanced copy of the Report to key stakeholders in mid-August.

A draft cover letter was disseminated to CASBHC for consideration. The cover letter is to the stakeholders outlined in the Report and asks for feedback on the Report. Edits will not be considered by CASBHC. In an effort to clarify the cover letter's intent, Delegate Cullison

recommended that the solicitation of feedback should be changed to a solicitation of questions of comments. These questions or comments should be sent to Ms. Barnhart by August 30, 2019. Ms. Barnhart will organize the questions and comments received at the end of August 2019. The Report will then be publicly released in early September 2019 and posted on the CHRC website.

Key stakeholders to receive the advanced copy of the Report include: 1. Harbage Consulting, 2. Legislature, 3. State Agency Leadership (MSDE / MDH), 4. MASBHC, 5. Health Officers / MACHO, 6. Medicaid Advisory Committee, and 7. Maryland Rural Health Association. In addition, the Report will be shared with the leaders of organizations the CASBHC represents and/or has affiliations with, including Maryland Parent Teachers Association, Elementary/Secondary School Principals, Public Schools Superintendents Association of Maryland (PSSAM), Maryland Hospital Association, and Maryland Nurses Association. Ms. Barnhart will work with CASBHC members to ensure the most appropriate routes of Report dissemination (i.e., Dr. De Pinto will distribute the Report amongst MDH Leadership, including Public Health Services & Medicaid). An additional key stakeholder is the Kirwan Commission. Delegate Cullison is the House representative on the Kirwan Commission. Ms. Faulkner will send Ms. Barnhart the generic e-mail address for the Commission. In addition, Mr. Luckner will send Ms. Barnhart the e-mail for the Department of Legislative Services Staff Member for the Commission.

In addition to the public release of the Report, CASBHC has comprehensively and critically considered each of the original and independent 41 recommendations. The 41 recommendations were assigned to the most appropriate Workgroups in March 2019. Since that time, each Workgroup made recommendations using the original recommendations as the framework; these recommendations were revised according to each Workgroup's review. Each Workgroup's recommendations were consolidated into a summary document with a total of 15 recommendations. These consolidated recommendations are being put forward for full CASBHC consideration and adoption today, July 23rd.

3:00PM 2019 Council Recommendations

Dr. Connor proposed the CASBHC move through each of the recommendations and address concerns and edits. The CASBHC will then go back to the top and vote through each of the 15 recommendations, including revised recommendations. *See attached recommendation summary document.*

The CASBHC did not get through all the recommendations. Delegate Cullison recommended the CASBHC should use further time as an opportunity to finalize the recommendations. Dr. Connor, Mr. Luckner, and Ms. Barnhart will revise the existing recommendations #1-4 per the feedback received and recirculate for additional feedback. Feedback for recommendations #5-15 should be sent electronically to Dr. Connor, Mr. Luckner, and Ms. Barnhart. Based on feedback, the recommendations will be re-worked by CASBHC Leadership and redistributed to Workgroups for further consideration and discussion.

3:55PM Blueprint for Maryland's Future: Discussion of Deliverable

Time did not allow for the Blueprint deliverable discussion.

3:58PM By-Laws and Vice Chair nomination

This was Ms. Masiulis's last meeting as Vice Chair of the CASBHC. Dr. Connor thanked Ms. Masiulis very much for her tenure on the CASBHC. To facilitate nominations of Ms. Masiulis's Vice Chair replacement, a draft of the By-Laws will be distributed for CASBHC reaction the end of August.

4:00PM Adjourn

STATE OF MARYLAND
Community Health Resources Commission
45 Calvert Street, Room 336 • Annapolis, Maryland 21401

Larry Hogan, Governor - Boyd Rutherford, Lt. Governor
Allan Anderson, M.D., Chair – Mark Luckner, Executive Director

Council on Advancement of School-Based Health Centers
2019 Harbage Recommendations *for full Council Consideration and Adoption*

In calendar year 2018, CHRC contracted with Harbage Consulting, on behalf of the CASBHC, to develop a White Paper summarizing the value proposition of SBHCs and recommending activities for SBHC advancement. Harbage made 41 recommendations in their Report.

Key recommendations put forward by Harbage Consulting include enhanced data collection, data reporting and measurement, and care coordination data sharing practices. Additional recommendations include increased funding for Maryland State Department of Education, Maryland Department of Health, and School-Based Health Centers to support complex technical assistance needs and resource requirements of individual SBHCs. Recommendations on quality and best practices were offered to support SBHC Standards, communications, and improved enrollment of clients into SBHCs.

The Council sought an independent external body to ensure objective representation of recommendations. The Council believes the Harbage Report is a comprehensive and highly instructive deliverable. With that, the recommendations put forward in the White Paper do not necessarily represent the recommendations of the Council. Over the past 6 months, the Council has thoughtfully and critically considered each of the recommendations provided in the White Paper. This document provides a consolidated summary of recommendations adopted by each Council Workgroup that reflect priorities of urgency, feasibility, and impact for the value of SBHCs in Maryland. Many of the Workgroup recommendations have overlapping intent and have therefore been consolidated to 14 total recommendations *for Council consideration and adoption.*

The following is a summary of key recommendations to be considered for adoption:

(1) Promote and create systems to support reciprocal **data sharing**, including but not limited to, SBHC, PCPs, Health Plans, and schools to improve student care coordination.
   a. Methods to be considered, include but are not limited to, consent form modification, CRISP, BAAs / MOUs, and contracts with Medicaid and Health Plans.
   b. Define the minimum set of necessary data for collection on consent forms and modify the consent forms to include permissions to enable bi-directional information sharing. Other State consent forms should be evaluated to provide a model for consideration. Recommendation is to change the form in the beginning of a school year.
   c. Develop a MOU between Council and MSDE to support data sharing.
   d. Extract key data elements from SBHC Annual Report Form to enable data sharing on consistently collected data.

(2) Explore **additional funding** opportunities, including grants, philanthropy, organizations, nonprofits, and hospitals.

(3) **SBHC Annual Survey Data Collection**: Recommend collection of SBHA annual risk assessment, SBHA depression screen and follow-up, SBHA Return to Class, operating income and revenue of each SBHC, educational outcome measures, and client experience / satisfaction measures. Continually examine SBHA quality measures and engage SBHA on quality measure outcomes. Facilitate on-going

considerations of additional appropriate measures, how they would be gathered, feasibly collected, and prioritized. Continually adapt the survey to include technical specifications, question definitions, and instructions for completing the Annual Survey. Implement a biennial process to review the Survey.

(4) SBHC **Data Reporting**: Extract key data elements for SBHC Annual Report Forms (note: only MSDE grant funded SBHCs are required to complete these) and report on identified measures. Develop a process to streamline data requests to MSDE from SBHC Administrators, CASBHC, and SBHC community stakeholders. Develop public facing data portals for key SBHC measures. Model reporting off of State Health Improvement Process and MHBE Data Reporting.

(5) Analyze **Agency resource requirements** for oversight and SBHC operation to support advocacy for additional State General Fund resource requests for SBHCs. Collect and summarize financial information in 2019 to support policy initiatives to advance SBHCs. Each Workgroup should analyze the resources to successfully carry out recommended activities. Enumerate resources for the following activities:

   a. Infrastructure and staffing resources to support improved data sharing, including MOU construction, software requirements, and policies and procedures.
   b. Technical assistance needs of SBHC Administrators for data collection.
   c. Develop data reporting capabilities and public facing dashboards.
   d. Continually update the Standards and write the document.

(6) **Data Evaluation**: Assess current baseline for each SBHC on recommended SBHA measures and other key measures, and compare to statewide SBHC averages. Additional key benchmark measures to be considered outside of SBHA measures including HEDIS and other outcome measures to support the development of a matrix of measures with EMR readiness, existing reporting capabilities, and resource considerations. Include process, educational, and outcomes-based data for collection.

(7) Continuously update **SBHC Standards** every two years. Considerations for resources should be analyzed and considered to rewrite the Standards. Performance goals and performance measurement incentives should be considered for the Standards re-write to drive accountability and value payment.

(8) **Increase SBHC enrollment** through coordinated parent and student outreach via MCO outreach to member parents. Increase enrollment through strategies to be considered at state and local level. Outreach at school-level for activities, such as competition to drive return of enrollment forms. These activities should be planned for 2020.

(9) FQHCs have robust infrastructure. This **sponsoring agency** relationship should be leveraged for improved SBHC billing capacity, data sharing, and enrollment of members.

(10) Create site-specific **SBHC unique identifiers** for both on-site and telemedicine, including but not limited to NPIs.

(11) Advocate for **Explanation of Benefits suppression** to ensure confidentiality of services for all relevant Health Plans.

(12) Ensure SBHCs are included in the strategic approaches to achieving **Maryland's population health goals**, such as Total Cost of Care and Maryland Primary Care Program.

(13) Continue expansion of school-based health care models through **telehealth**.

(14) Analyze **FERPA and HIPAA** issues as they relate to data sharing barriers.

Last Updated: July 19, 2019

STATE OF MARYLAND

Community Health Resources Commission

45 Calvert Street, Room 336 • Annapolis, Maryland 21401

Larry Hogan, Governor - Boyd Rutherford, Lt. Governor
Allan Anderson, M.D., Chair – Mark Luckner, Executive Director

Council on Advancement of School-Based Health Centers
Howard County Health Department
MINUTES

Monday, October 7, 2019
9:30AM-12:30PM

Attendees / Roll-Call

In- Person Appointee Membership

1. Dr. Katherine Connor, CASBHC Chair | Medical Director Johns Hopkins Rales SBHC | KIPP Baltimore
2. Cathy Allen, Maryland Association of Boards of Education | Vice Chair, St. Mary's County Board of Education
3. Dr. Patryce Toye, Maryland Assembly on School-Based Health Care | Medical Director, MedStar Family Choice
4. Dr. Arethusa Kirk, CASBHC Managed Care Organization Member | Chief Medical Officer United HealthCare Community Plan
5. Dr. Maura Rossman, Maryland Association of County Health Officers Member | Local Health Officer, Howard County
6. Jennifer Dahl, Commercial Health Insurance Member | Credentialing Coordinator, CareFirst
7. Jean-Marie Kelly, Maryland Hospital Association Member | Community Benefits, Union Hospital
8. Meredith McNerney, Maryland Association of Elementary School Principals | Gaithersburg Elementary School
9. Dr. Sean Bulson, Public Schools Superintendents Association of Maryland | Harford County Public Schools
10. Dr. Diana Fertsch, Maryland Chapter of American Academy of Pediatrics Member | Pediatrician, Dundalk Pediatric Associates

In-Person Ex Officio

11. Delegate Cullison, Ex Officio Member | House of Delegates, District 19 (Montgomery County)
12. Senator Lam, Ex Officio Member | Maryland State Senate, District 12 (Howard & Baltimore City)
13. Mark Luckner, CASBHC Community Health Resource Commission (CHRC) Ex Officio Member | Executive Director CHRC
14. Jennifer Barnhart, CASBHC Staff Consultant | President LUMA Health Consulting
15. Dr. Cheryl De Pinto, CASBHC Maryland Department of Health (MDH) Ex Officio Member | Director, MDH Population Health
16. Mary Gable, CASBHC Maryland State Department of Education (MSDE) Ex Officio Member | Assistant State Superintendent, Maryland State Department of Education

17. Andrew (Andy) Ratner, Ex Officio Maryland Health Benefit Exchange Member | Chief of Staff, Maryland Health Benefit Exchange

In-Person Public

18. Joy Twesigye, Public Member | Baltimore City Health Department
19. Sharon Hobson, Public Member | Howard County Health Department
20. Joanie Glick, Public Member | Montgomery County Health and Human Services
21. Lynne Muller, Public Member | Maryland State Department of Education
22. Pam Kasemeyer, Public Member | Schwartz, Metz, and Wise, PA
23. William (Mike) Shaw, Public Member | St. Mary's County Health Department
24. Teresa McDowell, United Health Care
25. Courtney Pate, Maryland Assembly on School-Based Health Care

9:30AM Welcome (Chair: Dr. Kate Connor)

Dr. Connor welcomed Council members and the public, and thanked everyone for convening. The largest objective of today's meeting is to consider By-Laws and 2019 Council Recommendations.

9:35AM Minutes from June 3, 2019 and July 23rd, 2019 CASBHC Meeting

July 23rd Meeting Minutes were requested to be updated to include recommendation summary document.

June 3rd Meeting Minutes were requested to be updated to ensure the proper spelling of House Speaker Adrienne Jones.

The Council moved to approve the minutes from June 3rd and July 23rd. The minutes were approved with no abstentions and no oppositions, with the changes incorporated above.

9:40AM Council Representative Positions

Dr. Connor welcomed Maryland Assembly on School-Based Health Care nominee Joy Twesigye. Joy is coming from the National Alliance before running the School Health Programs at Baltimore City Health Department. Joy's nomination is currently pending gubernatorial appointment.

Dr. Connor welcomed Meredith McNerney who has been appointed into the elementary school principal representative position on the Council. Meredith is the Principal at Gaithersburg Elementary School, with a 900 student body and strong efforts to enroll their students into their SBHC.

Dr. Connor welcomed Superintendent Sean Bulson. Dr. Bulson is starting his second year with Harford County Public Schools, with 16 years at Montgomery County prior.

After introductions of new members, Dr. Connor allowed all members to introduce themselves.

9:50AM By-Laws

The Council reviewed the By-Laws. Edits were made to the Purpose; Composition; Member Terms; Termination of Membership; Meetings; including how a quorum is defined; and Special Duties.

Dr. Connor told the Council that after By-Law changes were made, they will be released for final approval. Voting will be done via on-line poll.

10:05AM Election Process

Dr. Connor introduced the upcoming Chair and Vice Chair election process. Council Chair and Vice Chair terms are for two years. Chair and Vice Chairs can be nominated for re-election and there is not a limit on the number of terms. The Council is due for another election process. Dr. Connor asked the Council to send their nominations to Jen Barnhart and include a blurb with the nomination. Dr. Connor and Jen will ensure the nominated individual knows they have been nominated by their member organizations.

Voting and ex officio Council members may nominate Chair and Vice Chair. Only voting Council members may be nominated for Chair and Vice Chair. Nominated members should be active participants in the workgroups and be able to speak on behalf of the Council. Nominations are due within two weeks.

10:10AM Blueprint for Maryland's Future

An ad hoc workgroup was convened in June 2019 to respond to the Council related legislative deliverable of the Blueprint for Maryland's Future legislation. Dr. De Pinto thanked the Council for their very valuable input. Dr. De Pinto said that the Agencies received feedback from over 15 organizations. The Report is currently being reviewed by Agency Leadership and will become public on November 1st. The Report was developed with the best interest of Maryland's students and communities.

10:20AM Harbage White Paper: Public Release

The Harbage White Paper is publicly available and can be shared with stakeholders as the Council sees fit. The White Paper will be published to the CHRC website in the next 1-2 weeks.

10:30AM Break

10:45AM 2019 Council Recommendations

Dr. Connor introduced the recommendations. Recommendations are being voted on as a full block. The Council's role with these recommendations is not for implementation or facilitation, *however implementation planning should be included in the Annual Report, including considerations for resources, accountability, and ownership.* Del. Cullison noted that some of these recommendations will require legislation. Before commencing with a vote, Dr. Connor asked if there are recommendations that should be removed for discussion.

The following recommendations were discussed and edits were made: Recommendation # 1 Care Coordination; Recommendation # 2 Explore Additional Funding; Recommendation; # 3 Analyze Agency Resource Requirements; Recommendation #4, 5, 6 Data Planning and Collection, Analysis and Reporting, and Evaluation including consolidation of all data-related recommendations into one recommendation; Recommendation; # 5 Ensure Continuous Quality Improvement for Standards and Best Practices of SBHCs; Recommendation # 12 Analyze FERPA and HIPAA issues.

Del. Cullison plans to reintroduce the Ombudsmen Bill and therefore it's critical to think about resource requirements needed to accomplish the recommendations the Council has developed. Dr. Connor asked the workgroups to develop resource requirements for adopted recommendations during workgroup meetings scheduled for the week of October 28th . Implementation considerations should be included in the 2019 CASBHC Annual Report.

12:00PM 2019 Council Annual Report deliverables

Jen outlined the following deliverables that are proposed to be included in the 2019 Annual Report. The Council agreed with the proposed deliverables. A full Council meeting will be convened for mid-November to review the Annual Report.

a. Harbage Report and Recommendations Process
b. SBHC Annual Survey
c. Standards and Best Practices Matrix

d. Council legislative response to Blueprint Deliverable
e. Wicomico County SBHC enrollment
f. CASBHC School Health presentations at MASBHC conference and MRHA conference

12:30PM Adjourn

Dr. Connor adjourned the meeting at 12:30PM.

Meeting materials:

1. Membership Roster (October 2019)
2. Council Recommendations/ DRAFT
3. By-Laws/DRAFT
4. Council legislative response to Blueprint Deliverable
5. Minutes from June 3, 2019 meeting
6. Minutes from July 23, 2019 meeting