MARYLAND HEALTH CARE COMMISSION

School-Based Telehealth

Interim Report

January 2019

Robert E. Moffit, PhD, Chair

Ben Steffen, Executive Director

MARYLAND HEALTH CARE COMMISSION

Table of Contents

Overview

During the 2018 legislative session, the Senate Finance Committee (Committee) expressed concern about the slow pace in the development of school-based telehealth in primary and secondary schools. The Committee requested that the Maryland Health Care Commission (MHCC) convene a workgroup to identify deficiencies in existing policies related to school-based telehealth programs and develop an approach for improving these policies, which may be statutory, regulatory or technical in nature.[1] The Committee asked MHCC to report on the workgroup's findings and provide legislative and regulatory recommendations, including associated budget estimates for programs the State should undertake to improve the delivery of school-based telehealth services. This report details progress of the workgroup; a final report is due to the Committee by November 2019.

School-based telehealth[2, 3] has the potential to create efficiencies in schools. School-based telehealth involves the use of telecommunications, including interactive video conferencing and store-and-forward transmissions, to deliver a variety of health care and other services (i.e., speech therapy) to students.[4] In certain circumstances, schools struggle with obtaining in-person service providers due to workforce shortages, particularly in rural areas of the State. Telehealth can increase access to services, including primary and specialty somatic care, chronic disease management, behavioral and mental health services, and hearing and speech therapy.

[1] See Appendix A for the letter from the Committee.
[2] Telehealth means, as it relates to the delivery of health care services, the use of interactive audio, video, or other telecommunications or electronic technology by a licensed health care provider to deliver a health care service within the scope of practice of the health care provider at a location other than the location of the patient. "Telehealth" does not include: (i) an audio–only telephone conversation between a health care provider and a patient; (ii) an electronic mail message between a health care provider and a patient; or (iii) a facsimile transmission between a health care provider and a patient.
[3] School-based telehealth services include those available to all students and to students with Individualized Education Programs (IEPs), within or outside of a School Based Health Center (SBHC), including but not limited to medical services, non-medical therapeutic services (e.g., mental health counseling, psychoeducational assessments, psychological consultations, etc.) and non-clinical services (e.g., occupational therapy, speech therapy, etc.).
[4] American Telemedicine Association. *State Medicaid Best Practice School-Based Telehealth*. July 2013. Available at: https://www.americantelemed.org/main/policy-page/state-policy-resource-center/state-medicaid-best-practices#.

School-based telehealth can be used to improve health quality and academic performance, and decrease absenteeism of the student population.[5, 6, 7, 8, 9]

Approach

The MHCC convened the School-Based Telehealth Workgroup (workgroup) in May 2017; membership includes 72 representatives from State agencies, local boards of education, local health departments, schools, health plans, and health care providers.[10] Broad outreach to organizational leadership within each category was used to recruit members. A workgroup charter was developed in collaboration with members and defined the workgroup's responsibilities, potential discussion items, timeline and deliverables.[11] Workgroup meetings have occurred about every four weeks and are anticipated to follow a similar meeting frequency through August 2019. All meeting materials are made available to the public through MHCC's website. The MHCC staff facilitates workgroup meetings. Key takeaways from workgroup meetings provide the framework that will be used by the workgroup to develop recommendations.[12]

The workgroup met seven times in 2018. The initial meetings of the workgroup were used to build awareness among members regarding current policies that shape the school-based telehealth landscape in Maryland.[13] Presentations were provided by various State agencies and schools, including the Maryland Department of Health (MDH), Maryland State Department of Education (MSDE), Maryland Community Health Resources Commission (CHRC), and Howard County Health Department.[14] This approach helped to ensure that all workgroup members had a basic understanding of the landscape.

The workgroup used a modified Strengths, Weaknesses, Opportunities, Threats (SWOT) analysis as the framework for identifying issues related to the use of telehealth in primary and secondary

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[5] mHealth Intelligence. *Factors Behind the Adoption of School-based Telehealth*. November 2016. Available at: https://mhealthintelligence.com/features/factors-behind-the-adoption-of-school-based-telehealth.

[6] D. A. Bergman, et al., *The Use of Telemedicine in the Schools to Improve Access to Expert Asthma Care for Underserved Children*. Abstract from Pediatric Academic Societies Meeting, Washington, D.C., Vol. 57: (2005) 224.

[7] K.M. McConnochie, et al. *Telemedicine in Urban and Suburban Childcare and Elementary Schools Lightens Family Burdens*. Telemedicine and e-Health. June 2010.

[8] A. McCullough. *Viability and Effectiveness of Teletherapy for Pre-school Children with Special Needs*. International Journal of Language and Communication Disorders. November 2009.

[9] S.R. Daniels. *School-centered Telemedicine for Type 1 Diabetes Mellitus*. The Journal of Pediatrics. September 2009.

[10] See the Acknowledgements section of the report for the full membership roster.

[11] See Appendix B for the workgroup charter.

[12] A minority report will not be presented; however differences among members will be noted in the final report.

[13] The first hour of the meetings were dedicated to informational presentations.

[14] See Appendices C and D for workgroup meeting agendas, summaries, and presentation materials.

schools. The SWOT analysis focused on benefits[15], barriers/challenges[16], and solutions[17] as related to the key policy area. Eight tables were developed by members based on the following key policy areas identified:

- Implementation of telehealth within schools;
- Building awareness about the value of telehealth;
- Ensuring the continuum of care/service coordination via telehealth;
- Technology used in telehealth encounters;
- Management of people, processes, and procedures to deliver telehealth services;
- Existing telehealth compliance requirements;
- Establishing adequate funding sources to implement and sustain telehealth programs; and
- Existing Medicaid and private payor reimbursement models.[18]

Meetings are structured in a roundtable-like approach where everyone has an equal opportunity to influence the development of potential policies and practices. Emerging themes that will be deliberated in 2019 include:

- Establish a flexible telehealth adoption pathway that fosters alternative approaches to using technology where care delivery is equivalent to an in-person office visit;
- Engage parents or guardians through outreach and education initiatives that facilitate involvement in the student's health care, and the consent to treat via telehealth can be obtained;
- Promote continuity of care in telehealth programs by connecting to local providers or coordinating care with a student's medical home; and
- Ensure telehealth technology is dependable and meets established State and federal privacy and security laws.

[15] Defined as the value derived from producing or consuming a service.
[16] Defined as a circumstance or obstacle (e.g. economic, political, institutional, environment, social, etc.) that hinders or prevents progress, including a difficult task or complex situation that must be overcome in order to implement a solution.
[17] Defined as an idea aimed at solving a problem or managing a difficult or complex situation.
[18] See Appendix E for the information gathering tables.

Limitations

This report does not include recommendations for legislative or regulatory action. Workgroup members were invited to comment on the report. The report merely represents a compilation of workgroup activities. Deliberations in 2019 may impact items included in the report.

Maryland Landscape

School Health Services

School Health Services (SHS), provided by all Maryland schools as required by Maryland law, focus on prevention of disease and promotion of health.[19] Care provided to students is documented within the student's educational record. Services include acute care for injuries and illnesses, care for chronic health conditions,[20] health screenings and counseling, and maintenance of health and immunization records.[21] SHS are provided in a health suite that must include: space for waiting, examination, treatment, storage, and resting; a separate room for private consultation; a restroom with a toilet and a sink; a telephone; and locked file cabinets.[22]

SHS are provided by a SHS professional defined as a physician, certified nurse practitioner, or registered nurse, with experience and/or training in working with children or school health programs.[23] Typically, SHS professionals are registered nurses. Schools must have coverage by a SHS professional, though no specific student-to-SHS professional ratio requirement exists.[24] Some school districts have a registered nurse or licensed practical nurse in each school, while others employ a cluster model[25] where one SHS professional may be responsible for many schools. Telehealth is rarely used as a mechanism for providing SHS, as policies to support its use have not been established. Current Medicaid and private payor policies do not reimburse for school health services, including telehealth, as the originating site. Over the next six months, the workgroup will continue to explore policy consideration that can foster telehealth for SHS.

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[19] Maryland law, Educ. Art. § 7–401(a), Ann. Code of MD, requires each county board of education to provide SHS. Local school systems, with the assistance of local health departments, are responsible for providing SHS to all public schools.

[20] Care must be delivered in coordination with a primary care provider, per Maryland regulations COMAR 13A.05.05.07.

[21] COMAR 13A.05.05.07. More information is available at: http://www.dsd.state.md.us/comar/comarhtml/13a/13a.05.05.07.htm.

[22] COMAR 13A.05.05.10. More information is available at: http://www.dsd.state.md.us/comar/comarhtml/13a/13a.05.05.10.htm.

[23] COMAR 13A.05.05.06. More information is available at http://www.dsd.state.md.us/comar/comarhtml/13a/13a.05.05.06.htm.

[24] Ibid.

[25] The cluster model is where a registered nurse may be responsible for overseeing SHS at many schools and is only available at certain days and times at the school. The nurse defines the time spent at the school based on the health needs of the students. A trained unlicensed health staff is available at each school working under the supervision of the school nurse.

School Based Health Centers

Maryland School Based Health Centers (SBHCs) are health centers, located in a school or on a school campus, that provide onsite comprehensive preventive and primary health services.[26, 27] SBHCs are an optional addition to the services schools provide and serve as an enhancement, not a replacement, of the required SHS. Services may also include mental health, oral health, ancillary, and other supportive services. SBHCs must meet certain standards to receive State recognition through a joint process with MSDE and MDH, as required by Maryland regulations.[28, 29, 30] Developed in 2006 by the Maryland School-Based Health Center Policy Advisory Council,[31] standards related to staffing levels, facilities and equipment, enrollment and consent, and patient confidentiality.[32] SBHCs must meet all required standards to provide in-person services.

In order to provide telehealth services, SBHCs must meet more than 25 criteria related to telehealth.[33, 34] Examples include procedures for communicating required prescriptions and orders for laboratory or imaging studies, administering medications, technical protocols for testing and maintenance of telehealth equipment, identifying clinical goals for the telehealth encounter, and documenting the encounter in the patient's medical record. The workgroup will consider policies over the next six months that could allow SBHCs greater flexibility in achieving State recognition when implementing telehealth.

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[26] There are approximately 84 SBHCs in 12 of Maryland's 24 school districts. The Maryland State Department of Education. School-Based Health Centers. Available at: http://marylandpublicschools.org/Pages/default.aspx.

[27] COMAR 10.09.76.04. More information is available at: http://www.dsd.state.md.us/comar/comarhtml/10/10.09.76.04.htm.

[28] COMAR 13A.05.05.05. More information is available at: http://www.dsd.state.md.us/comar/comarhtml/13a/13a.05.05.05.htm.

[29] Maryland State Department of Education, *Maryland SBHC Application,* 2018. Available at: http://marylandpublicschools.org/about/Pages/DSFSS/SSSP/SBHC/sbhcapp.aspx.

[30] SBHCs must renew their recognition annually.

[31] A 2005 law, Md. Education Code Ann. §7–4A–01 and §7–4A–05, required the MSDE to establish and staff the Maryland School-Based Health Center Policy Advisory Council (Council) charged with establishing standards of practice within SBHCs. The law was amended in 2013, replacing the Council and establishing the Maryland Council on Advancement of School-Based Health Centers (CASBHC). In 2017, the CASBHC staffing responsibilities were transferred to MDH with support from the Community Health Resources Commission. The CASBHC is charged with developing policy recommendations to improve the health and education outcomes of students who receive services from SBHCs. The CASBHC reports findings and recommendations to MSDE, MDH, and CHRC annually. More information is available at: https://health.maryland.gov/mchrc/Pages/Maryland-Council-on-Advancement-of-School%E2%80%93Based-Health-Centers.aspx.

[32] Maryland State Department of Education. *Maryland School-Based Health Center Standards*. April 2006. Available at: http://marylandpublicschools.org/about/Documents/DSFSS/SSSP/SBHC/MarylandStandardsSBHC2018.pdf.

[33] SBHCs must be approved to provide services via telehealth by MSDE under guidance from MDH.

[34] See Appendix F for the Maryland School-Based Health Center Telehealth Checklist.

Special Education Services

All Maryland schools provide special education and related services, as required by law. Special education provides specially designed instruction to meet the unique needs of a student with a disability and may include related services. Related services include occupational therapy, speech therapy, and other services to support students with disabilities. The Individuals with Disabilities Education Act of 2004 (IDEA)[35] aims to ensure students with disabilities are provided with free and appropriate education. IDEA and Maryland regulations,[36] which implement the requirements of IDEA, govern how State agencies and local education agencies provide early intervention, special education, and related services to eligible children and youths with disabilities.[37]

Many school districts with students who have special needs find it difficult to gain access to qualified professionals, especially in rural areas where workforce shortages exist.[38] Incorporating teletherapy[39] into special education programs can assist school districts that may be experiencing shortages of qualified related-service professionals within their geographic area. Students with special needs often face unique logistical and sometimes behavioral barriers in accessing care.[40] For example, special transportation, equipment, or attendants may be needed to enable a provider visit. Traveling long distances to unfamiliar health care facilities may exacerbate anxiety, fear or aggression in students with behavioral challenges. Teletherapy can help to facilitate treatment and the provision of related services for certain students and decrease the stigma that may be associated with being removed from a classroom to receive services. Evidence suggests that use of teletherapy for delivery of special education related services can be equivalent and, in some cases, more effective as in-person.[41, 42] The MSDE and

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[35] 20 U.S. Code Chapter 33 – Education of Individuals with Disabilities.

[36] COMAR 13A.05.01 *Provision of a Free Appropriate Public Education to Students with Disabilities*, and COMAR 13A.08.03 *Discipline of Students with Disabilities.*

[37] IDEA and Maryland regulations require that each child with a disability has an IEP designed to meet their unique and individual needs.

[38] Telemedicine Journal and e-Health. *Telemedicine for Children with Developmental Disabilities: A More Effective Clinical Process than Office-Based Care.* February 2015. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4312787/.

[39] The term *teletherapy* is defined as the application of telecommunications technology to delivery of professional services at a distance and is intended to include both non-medical therapeutic services (e.g., mental health counseling, psychoeducational assessments) and non-clinical services (e.g., occupational therapy, speech therapy, etc.).

[40] See n. 38, *Supra*

[41] American Journal of Speech Language Pathology. *Comparing Traditional Service Delivery and Telepractice for Speech Sound Production Using a Functional Outcome Measure*. February 2018. Available at: https://www.ncbi.nlm.nih.gov/pubmed/29188278.

[42] Archives of Assessment Psychology. *Equivalence of Remote, Online Administration and Traditional, Face-to-Face Administration of Woodcock-Johnson IV Cognitive and Achievement Tests*. 2018. Available at: http://www.assessmentpsychologyboard.org/journal/index.php/AAP/article/view/122.

MDH do not have policies that impact a school's use of teletherapy. The workgroup will consider policies in the first half of 2019 that could lead to greater diffusion of teletherapy in schools.

Privacy and School-Based Telehealth

The Family Educational Rights and Privacy Act (FERPA)[43] and Maryland student records regulation[44] protect the privacy of student education records. Under FERPA, education records generally may not be released to third parties without parental consent.[45] FERPA also gives parents and students the right to inspect and review the student's education records. A student's health records in the SHS are maintained by the school[46] including the school nurse, are considered part of the education record, and are subject to FERPA.[47, 48]

A school is subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)[49] when it provides care through its SBHC or clinic, and maintains health information not in a student's education record. The school is also subject to HIPAA if it engages in a HIPAA-covered transaction (e.g., billing a health plan).[50] Third parties providing medical services directly to students (either on-site or at a distant site) that are not employed by, under contract with, or acting on behalf of the school are subject to HIPAA. HIPAA defines minimum standards for the privacy and security of protected health information.[51] HIPAA gives parents and students certain rights with respect to use and disclosure of their health information. Schools with SBHCs that adopt telehealth may need to comply with FERPA and HIPAA.

Reimbursement for Telehealth Services in Schools

Maryland Medicaid Telehealth Program regulations, which govern reimbursable synchronous audio/video telehealth visits, define telehealth as the delivery of medically necessary somatic or

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[43] 20 U.S.C. § 1232g, Family Educational and Privacy Rights.
[44] COMAR 13A.08.02, Student Records.
[45] 34 CFR Part 99, Family Educational Rights and Privacy. December 2018. Available at: https://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&sid=11975031b82001bed902b3e73f33e604&rgn=div5&view=text&node=34%3A1.1.1.1.33&idno=34.
[46] Schools subject to FERPA include those educational agencies and institutions that receive funds under any program administered by the U.S. Department of Education.
[47] U.S. Department of Health and Human Services and U.S. Department of Education. *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*. November 2008. Available at: https://www2.ed.gov/policy/gen/guid/fpco/doc/ferpa-hippa-guidance.pdf.
[48] The health records of an eligible student that do not meet the definition of an education record are not subject to FERPA.
[49] 45 CFR Part 160(A); 45 CFR Part 164(E). More information is available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=58542bd6be129f38e90e0979f4b4d909&mc=true&node=sp45.1.160.a&rgn=div6; https://www.ecfr.gov/cgi-bin/text-idx?SID=58542bd6be129f38e90e0979f4b4d909&mc=true&node=sp45.1.164.e&rgn=div6.
[50] See n. 47, *Supra*.
[51] Protected health information generally refers to any information about health status, provision of health care, or payment for health care that is created or collected by certain organizations or individuals that can be linked by specific individual.

behavioral health services to a patient at an originating site by a distant site provider, through technology-assisted communication.[52] Medicaid will not reimburse telehealth providers for services that require in-person evaluation or cannot be reasonably delivered via telehealth.[53] Telehealth providers are required to provide clinically appropriate[54] services that are distinct from those provided by the originating site provider (i.e., where the patient is located).[55] Telehealth policies require that distant care be administered by a clinician; the originating site is reimbursed for the facility fee/telehealth transmission fee. Medicaid can only reimburse an MSDE-approved SBHC enrolled with the Medicaid program as an originating site. A SHS program can act as an originating site under the Medicaid telehealth regulations;[56] however, Medicaid will not reimburse for facility fee/telehealth transmission fee as SHS are not recognized as Medicaid providers.

Federal law requires Medicaid to reimburse for special education related services if they qualify as a Medicaid covered benefit.[57] However, Medicaid does not reimburse special education related services provided via telehealth.[58] This does not prevent schools from providing special education and related services through telehealth; though, the school will not receive Medicaid reimbursement for the services. Private payors provide coverage for habilitative services, and do not cover any special education related services.

Maryland School-Based Telehealth Projects

Anecdotal information suggests that school districts exploring telehealth implementation are often deterred from adoption due to funding, technology cost, space availability, and policy challenges. Some schools believe that telehealth can be of most value to enhance SHS programs. Only three Maryland school districts have implemented telehealth programs – Howard County, Baltimore City, and Charles County. Seven schools located in Howard County currently conduct virtual examinations with physicians at the Howard County General Hospital and two community primary care practices[59] for sick care and follow-up for acute illness and chronic

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[52] COMAR 10.09.49.02. More information is available at: http://www.dsd.state.md.us/comar/comarhtml/10/10.09.49.02.htm.
[53] Md. Medicaid Telehealth Program, Telehealth Provider Manual, updated May 2, 2018, accessed September, 2018. More information is available at: https://mmcp.health.maryland.gov/SiteAssets/SitePages/Telehealth/Telehealth%20Program%20Manual%205.2.18.pdf.
[54] COMAR 10.09.49.05(A)(3). More information is available at: http://www.dsd.state.md.us/comar/comarhtml/10/10.09.49.05.htm.
[55] *Id.* at section (A)(1).
[56] COMAR 10.09.49.02(B)(10). More information is available at: http://www.dsd.state.md.us/comar/comarhtml/10/10.09.49.02.htm.
[57] 20 USC § 1412(a)(12)(A)(i). Individuals with Disabilities Education Act.
[58] COMAR 10.09.50.07(B)(1). More information is available at: http://www.dsd.state.md.us/comar/comarhtml/10/10.09.49.07.htm.
[59] Columbia Medical Practice and Klebanow and Associates.

health problems.[60, 61, 62] The program began conducting telehealth visits in January 2015 with grant funding from the Howard County Government. Initially, nine community practices agreed to participate in the telehealth program by providing virtual visits to their patients. After initial grant funding ended, practices with only a few established patients in the school-based telehealth program could not justify the 125 dollars per month per provider licensing fee for maintaining the technology.[63]

The University of Maryland Center for School Mental Health operates a Telemental Health Program that provides behavioral health services to 25 schools in Baltimore City.[64] Schools are required to provide school psychology services to students, which includes mental health status exams, psychiatric consultation, and medication management, among other things.[65] The program began in 2007 to expand access to child and adolescent psychiatrists in Baltimore City public schools to address the high rates of youth mental health disorders.[66] The program is able to be offered more widely in the school district as telemental health services are not restricted to SBHCs,[67] unlike somatic care services provided via telehealth. Charles County Public Schools (CCPS) began using telehealth in 2016 to increase access to speech-language pathologists to serve special need students. CCPS experienced difficultly in recruiting in-person speech-language pathologists due to professional shortages in the area. One school in Charles County has implemented telehealth and three more plan to implement the technology in the near future.[68]

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[60] For more information, see Maryland Assembly on School-Based Health Care. (October 7, 2014). *Howard County Public Schools Introduces Telemedicine Initiative*. Available at: http://masbhc.org/howard-county-public-schools-introduces-telemedicine-initiative/.

[61] Howard County. *School based Health Centers*. Retrieved from: https://www.howardcountymd.gov/Departments/Health/Child-Health/School-Based-Health-Centers.

[62] In the 2016-2017 school year, the program connected 217 students to physicians. More information is available at: https://www.fiercehealthcare.com/mobile/pediatric-practices-feel-ripple-effect-school-telemedicine-programs.

[63] Fierce Health. Maryland pediatric practices feel the ripple effect of school telemedicine programs. July 2017. Available at: https://www.fiercehealthcare.com/mobile/pediatric-practices-feel-ripple-effect-school-telemedicine-programs.

[64] Cox, J., Willis, K., Lever, N.m Mayworm, A., & Stephan. S. n.d. *A Telemental Health Pilot in an Urban Setting*. Available at: http://csmh.umaryland.edu/media/SOM/Microsites/CSMH/docs/Conferences/21st-Annual-Conference-/Wave-2-Presentations/5.4-A-Telemental-Health-Pilot-in-an-Urban-Setting-(TH).pdf.

[65] COMAR 13A.05.05.01. More information is available at: http://www.dsd.state.md.us/comar/comarhtml/13a/13a.05.05.01.htm.

[66] 187 telepsychiatry sessions and 355 on-site sessions were provided during the evaluation period.

[67] Schools are still required to meet any local school district requirements, as well as any licensing board requirements of the practitioners providing the service.

[68] Presentation by Kelly Bryant, Charles County Public Schools. June 2018.

National Landscape

Roughly 2,315 SBHCs exist nationwide that meet the needs of students with a wide-range of services.[69] Estimates on the number of SBHCs that offer services provided via telehealth for their students are not readily available. About 94 percent of SBHCs are located on school property, three percent are mobile health centers, three percent are school-linked, and about 0.2 percent of schools offer telehealth-only.[70]

Approximately 23 states and the District of Columbia provide telehealth reimbursement for somatic care to schools under Medicaid.[71] Over 25 states have models of Medicaid reimbursement of telehealth for special education and related services. Medicaid reimbursement is available for speech therapy only in roughly six states, while 17 states reimburse for speech therapy, occupational therapy, and behavioral and mental health services provided via telehealth. Limitations of Medicaid reimbursement to only students in rural areas exists in some states.[72]

Texas, Kansas, North Carolina, and South Dakota have school-based telehealth initiatives that parallel those underway in Maryland. Texas and Kansas have developed telehealth programs focused on enhancing behavioral health services, like the Baltimore City Telemental Health Program.[73] Texas launched the Telemedicine Wellness, Intervention, Triage and Referral program, offering psychiatric screenings and limited psychiatric services.[74] Similarly, based in southern Kansas, Telehealth ROCKS Schools provides behavioral strategies for autism; psychological strategies for behavioral concerns, trauma, and chronic conditions; and other services.[75]

Two states have telehealth programs that are equivalent to the Howard County model. North Carolina implemented Health-e-Schools to provide acute care services, chronic disease management, medication management, and wellness check-ups.[76] The Sioux Falls school district in South Dakota implemented eCARE School Health. The program provides students with acute

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[69] School-Based Health Alliance, 2013-2014 Digital Census Report available at: https://censusreport.sbh4all.org/ (2017 census is currently underway).
[70] Ibid.
[71] See Appendix H for Medicaid Reimbursement for Schools as the Originating Site.
[72] PresenceLearning. *Equity in Reimbursement = Equity in Access*. Available at: https://www.presencelearning.com/resources/medicaid-reimbursement-for-online-services/?.
[73] See above section on *Maryland School-Based Telehealth Projects* for more details.
[74] Eric Wicklund. (2018, May 30). Texas Governor Lobbies for Statewide School Telehealth Program. *mHealth Intelligence*. Available at: https://mhealthintelligence.com/news/texas-governor-lobbies-for-statewide-school-telehealth-program.
[75] KU Medical Center, The University of Kansas, *Telehealth ROCKS Schools*, August 2018. Available at: http://www.kumc.edu/community-engagement/ku-center-for-telemedicine-and-telehealth/telehealth-rocks/telehealth-rocks-schools.html.
[76] Center for Rural Health Innovation, Health-e-Schools. Available at: http://www.crhi.org/MY-Health-e-Schools/index.html.

care, chronic disease management, medical advice, case management, and medication management.[77, 78]

School-Based Telehealth Grant

The MHCC released two school-based telehealth funding announcements on July 11, 2018. The *School-Based Teletherapy for Special Education Services* is aimed at increasing access to special education services within schools, and *Enhancing School-Based Health Care Services via Telehealth* focused on providing health care services within schools via telehealth. Funding was up to $200,000 for each grant over an 18-month period. The MHCC elected to withdraw the *Enhancing School-Based Health Care Services via Telehealth* grant.[79] The *School-Based Teletherapy for Special Education Services* grant was awarded to Charles County Public Schools. The grantee will report to the workgroup to inform policy discussions.

The MSDE, MDH, school districts, and technology vendors provided input into the design of the grants. The funding announcements were released via email to over 700 individuals from hospitals, schools, local health departments, technology vendors, and providers; and through MHCC's social media outlets. An external review panel with diverse expertise informed the award decision. Applicants were evaluated for technical and administrative qualifications (e.g., established telehealth protocols, staffing models, training processes, telehealth technology, etc.) and demonstrated capacity and need to implement the project. The MHCC staff conducted a site visit with the top applicant.

Next Steps

Workgroup deliberations are expected to continue over the next six months. The workgroup anticipates that some recommendations will require legislation while others may be implemented through regulation or a coordinated programmatic effort by State agencies, school districts, and community providers. During the first quarter of 2019, the workgroup plans to finalize key themes that will frame the proposed recommendations. The workgroup anticipates finalizing the proposed recommendations during the second quarter. Draft recommendations will be vetted with stakeholders; their feedback will be considered by the workgroup in finalizing recommendations. Presentation of the recommendations to the MHCC Commission is targeted for the November 2019 meeting.

[77] Avera eCARE, Avera eCARE School Health Available at: https://www.averaecare.org/ecare/what-we-do/school-health/.
[78] See Appendix G for additional details regarding school-based telehealth programs in other states.
[79] Development of supporting policy for use of telehealth in SHS is underway between MDH and MSDE. Finalizing of the policies is anticipated by mid-2019.

Acknowledgments

The MHCC recognizes the contribution made to this report by the wide range of stakeholders that participated on the workgroup. More than 77 representatives participated in the work effort. The high level of enthusiasm among the participants regarding the potential benefits in care delivery using school-based telehealth is laudable. The MHCC thanks The Hilltop Institute's for assistance in completing the work associated with the workgroup.

Appendix A. Senate Finance Committee Request

THOMAS MAC MIDDLETON
Legislative District 28
Charles County

Chair
Finance Committee

Executive Nominations Committee
Rules Committee
Legislative Policy Committee
Spending Affordability Committee

THE SENATE OF MARYLAND
ANNAPOLIS, MARYLAND 21401

Annapolis Office
Miller Senate Office Building
11 Bladen Sreet, Suite 3 East
Annapolis, Maryland 21401
410-841-3616 · 301-858-3616
800-492-7122 *Ext.* 3616
Fax 410-841-3682 · 301-858-3682
Thomas.McLain.Middleton@senate.state.md.us

District Office
P. O. Box 1735
Waldorf, Maryland 20604
301-932-0909
Fax 301-934-3049

March 15, 2018

Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Steffen:

The Senate Finance Committee has learned about the slow pace in the development of school-based telehealth care programs at Maryland primary and secondary schools. We believe that the educational and medical policies that provide the foundation for telehealth programs may be outdated and in need of a review given growing needs of children for physical and behavioral health care, the rapid development of technology and growing interest among practitioners in delivering this care. Further, the school-based setting may be an ideal site to deliver telehealth services because children spend more time in school than in any other place except their homes during their formative years. As our school systems throughout the state struggle with finding direct related service providers, it is imperative that we identify a way to allow medical assistance (MA) reimbursement for counties utilizing the tele-therapy platform. Our school systems are using MA money to help fund their special education programs.

The Senate Finance Committee requests that the Maryland Health Care Commission (MHCC) convene a workgroup on school-based telehealth to identify deficiencies in the existing policies and develop an approach for correcting these problems be they statutory, regulatory, or technical. If a consensus exists among the workgroup on changes that can be tested, the Committee encourages MHCC to launch one or more pilot programs to test the feasibility of establishing new telehealth programs at Maryland schools. Should a pilot go forward, it is important that a pilot include rural, suburban, and urban educational facilities as situations and preferences differ among Maryland communities.

The Committee hopes that the workgroup's recommendations and findings will lead the MHCC to provide legislative and regulatory recommendations along with associated budget estimates for programs that the State should undertake to improve the delivery of school-based telehealth services in Maryland. The Committee requests that MHCC submit a final Workgroup report by November 2019 and make an interim presentation to the Committee early in the 2019 Legislative Session.

Sincerely,

Mac Middleton

Thomas McLain Middleton
Chairman

Appendix B. Workgroup Charter

School-Based Telehealth Workgroup

CHARTER

Purpose

During the 2018 legislative session, the Senate Finance Committee (Committee) expressed concern about the slow pace in the development of school-based telehealth in primary and secondary schools. The Committee requested that the Maryland Health Care Commission (MHCC) convene a workgroup to identify deficiencies in existing policies related to school-based telehealth programs and develop an approach for improving these policies, which may be statutory, regulatory or technical in nature. The Committee asked MHCC to report on the workgroup's findings and provide legislative and regulatory recommendations, including associated budget estimates for programs the State should undertake to improve the delivery of school-based telehealth services. An interim presentation to the Committee was requested in January 2019 and a final report is due November 2019.

Background

School-based telehealth involves the use of telecommunications, including interactive video conferencing and store-and-forward transmissions, to deliver a variety of health care and other services (i.e., speech therapy) to children.[80] In certain circumstances, schools struggle with obtaining direct service providers due to workforce shortages, particularly in rural areas of the State. Telehealth has the potential to create efficiencies in schools by increasing access to services, including primary and specialty somatic care, chronic disease management, behavioral and mental health services, hearing and speech therapy, among others. School-based telehealth can be used to improve health quality and academic performance, and decrease absenteeism of the student

[80] State Medicaid Best Practice School-Based Telehealth. American Telemedicine Association. July 2013. Available at: https://www.americantelemed.org/main/policy-page/state-policy-resource-center/state-medicaid-best-practices#.

population.[81, 82, 83, 84, 85] Telehealth can complement and expand the capacity of schools to meet student's health care needs by using technology to connect to remote providers.

Since 2014, MHCC has awarded approximately $700,000 in grants to 14 provider organizations to demonstrate the impact of telehealth and mHealth. These grants have helped inform: 1) better practices; 2) industry implementation and expansion efforts; 3) policies to support advancement of telehealth; and 4) the design of telehealth programs across the State. The grants have also complemented efforts to advance a strong, flexible health information technology (health IT) ecosystem in Maryland, the foundation of advanced care delivery and payment models.

To help inform the workgroup's recommendations, MHCC plans to fund two school-based telehealth pilot projects—the first, is aimed at increasing access to special education services within schools; and the other is focused on providing health care services[86] within schools via telehealth. Staff from each project will report on their implementation progress, including key findings, challenges, and solutions on a quarterly basis as a grant requirement.

Workgroup Responsibilities

The School-Based Telehealth Workgroup (workgroup) may be divided into subgroups. Potential subgroups consist of technology, operations, and financing. Potential discussion topics include, but are not limited to, the following:

1) **Technology**
    - Existing technology available for school-based telehealth and technology development opportunities
    - Federated or centralized telehealth technology
    - Privacy and security considerations and policies
    - Resource requirements for staff training on the technology
    - Electronic health records interoperability considerations
2) **Operational**

[81] Factors Behind the Adoption of School-based Telehealth. mHealth Intelligence. Available at: https://mhealthintelligence.com/features/factors-behind-the-adoption-of-school-based-telehealth.
[82] D. A. Bergman, et al., "The Use of Telemedicine in the Schools to Improve Access to Expert Asthma Care for Underserved Children," Abstract from Pediatric Academic Societies Meeting, Washington, D.C., Vol. 57: (2005) 224.
[83] K.M. McConnochie, et al. Telemedicine in urban and suburban childcare and elementary schools lightens family burdens. Telemedicine and e-Health. June 2010.
McConnochie KM1, Wood NE, Herendeen NE, ten Hoopen CB, Roghmann KJ.
[84] A. McCullough. Viability and Effectiveness of Teletherapy for Pre-school Children with Special Needs. International Journal of Language and Communication Disorders. November 2009.
[85] S.R. Daniels. School-centered Telemedicine for Type 1 Diabetes Mellitus. The Journal of Pediatrics. September 2009.
[86] These include preventive and primary health services and mental health, oral health, ancillary, and other supportive services.

- Workforce shortages in school districts as they relate to special education and/or health services that could be provided via telehealth/teletherapy
- Administrative challenges with meeting current SBHC certification requirements related to providing telehealth services (*see related bullet in Financial Subgroup*)
- Communication requirements for staff, guardians, and students – health services provided using telehealth
- Coordination of information sessions for teachers and school-based administration and information sessions for parents/guardians
- Resource and policy requirements for school nurse involvement
- Opportunities to revise telehealth service requirements in schools
- Patient privacy considerations, HIPAA and FERPA

3) **Financial**

- Current challenges in funding technology
- Resources required of school systems to meet current SBHC certification requirements as it relates to providing telehealth services
- Current challenges with providing special education and somatic services due to limited budgets
- Medicaid policy related to SBHC reimbursement and telehealth service reimbursement alignment
- Medicaid and private payor reimbursement opportunities and challenges, such as in network/out of network providers
- Sustainability of telehealth programs in schools

Workgroup Meetings

A simple majority of the members shall constitute a quorum at any meeting for the conducting of the business of the workgroup and potential subgroups. All meetings of the workgroup/subgroups are open to the public.[87] The workgroup/subgroup meetings are anticipated to convene about every four to six weeks at a date and time scheduled by MHCC beginning in June 2018 to August 2019. The majority of workgroup/subgroup meetings will be held via teleconference. In-person meetings will be held at MHCC located at 4160 Patterson Avenue, Baltimore, MD 21215. Reasonable notice of all meetings, stating the time, place (if applicable) and teleconference information, shall be given to each member by email. Reasonable notice of all meetings shall be provided to the public by posting on MHCC's website here: mhcc.maryland.gov/mhcc/pages/home/meeting_schedule/meeting_schedule.aspx.

[87] As a State agency, MHCC follows the Open Meeting Act.

Membership and Chairs' Responsibilities

Members are strongly encouraged to attend meetings in-person when held in-person; teleconference will be made available. Members participating via teleconference shall count for quorum purposes, and their position (i.e., support, oppose, abstain) on recommendations shall be noted so long as their participation is included in the attendance.

Members are encouraged to offer their input on all topics presented to the workgroup/subgroup. Members' position for each policy recommendation will be included in the meeting notes at the member level.

It is likely that a Chair will be identified for the workgroup and each subgroup, if subgroups are formed. Should MHCC decide to identify subgroup Chairs', terms shall last for the duration of the subgroup in which they serve. In addition to presiding at meetings, subgroup Chairs shall take an active role in developing policy recommendations and work with MHCC to determine action items requiring MHCC support resources.

Timeline and Deliverables

The workgroup/subgroups will be convened in the summer of 2018 and meet through August 2019; meetings may take place after August 2019 if a discussion topic warrants additional time to deliberate on a proposed recommendation. The output from these workgroup/subgroup meetings will be compiled into a report that forms the basis for any findings and recommendations presented in a final report by MHCC. The final report will include the names of all workgroup participants and proposed recommendations to inform future legislation.

Appendix C. Workgroup Meeting Agendas and Presentations

School-Based Telehealth Workgroup

Meeting Agenda

DRAFT

June 20, 2018
2:00pm-4:00pm
4160 Patterson Ave., Baltimore MD 21215
Remote (registration required):
https://register.gotowebinar.com/register/5407621777686538754

I. INTRODUCTIONS

II. OPENING REMARKS

Ben Steffen, *Executive Director, MHCC*

III. CURRENT STATE OF SCHOOL-BASED TELEHEALTH – POLICY AND PRACTICE

1. Special education

   Kelly Bryant*, Related Services Agency Liaison, Charles County Board of Education*

   - The need for teletherapy services in Charles County
   - How teletherapy is being used to improve care delivery

2. School health services and health centers

   Cheryl DePinto*, Medical Director, Maryland Department of Health, Office of Population Health Improvement*

   Sharon Hobson, *School-Based Wellness Centers Program Administrator, Howard County Health Department*

   - MDH and MSDE's role in school-based telehealth policies and programs
   - How telehealth is being used in Howard County schools to improve care delivery

3. Maryland Council on Advancement of School-Based Health Centers

   Moira Lawson, *Program Administrator, Maryland Community Health Resources Commission*

- CHRC's role in school-based telehealth policies and programs

IV. DISCUSSION

1. Workgroup activities
2. Discussion items
    - Review of discussion items
    - Identification of additional questions
    - Prioritization of questions

V. UPDATE ON POTENTIAL GRANT OPPORTUNITIES, ACTIVITIES AND TIMELINE

VI. NEXT STEPS

1. MHCC staff and participant action items
2. Next workgroup meeting: July 18th; 2pm-4pm

School-Based Telehealth Workgroup

Meeting Agenda

July 18, 2018
1:45pm-4:00pm
4160 Patterson Ave., Baltimore MD 21215

I. MEMBER ENGAGEMENT

II. INTRODUCTIONS

III. OVERVIEW OF LAST MEETING

IV. CURRENT STATE OF SCHOOL-BASED TELEHEALTH – POLICY AND PRACTICE

Maryland Council on Advancement of School-Based Health Centers

Mark Luckner, *Executive Director, Maryland Community Health Resources Commission* (MCHRC)

- MCHRC's role in school-based telehealth policies and programs

V. DISCUSSION

1. Review proposed discussion items and questions
2. Identification of additional questions
3. Prioritization of questions

VI. GRANT OPPORTUNITIES

1. Overview
2. Activities
3. Timeline

VII. NEXT STEPS

1. MHCC staff and participant action items
2. Next workgroup meeting: August 22nd; 2:45pm-4:30pm

School-Based Telehealth Workgroup

Meeting Agenda

August 22, 2018
2:15pm-4:00pm
4160 Patterson Ave., Baltimore MD 21215

I. MEMBER ENGAGEMENT

II. INTRODUCTIONS

III. OVERVIEW OF LAST MEETING

IV. SCHOOL-BASED TELEHEALTH/TELETHERAPY – AN OVERVIEW OF ADMINISTRATIVE AND REIMBURSEMENT POLICIES

1. Overview/distinction of school health services and school-based health centers
2. Overview of individualized education program (IEP) services and supports
3. Administrative requirements for telehealth and teletherapy services in schools
4. Reimbursement requirements and mechanisms for telehealth and teletherapy services in schools

V. DISCUSSION

Considerations as it relates to implementing telehealth and teletherapy in schools – identifying the benefits, barriers, challenges, and solutions

VI. NEXT STEPS

1. MHCC staff and participant action items
2. Next workgroup meeting (note schedule change): October 2nd; 2:15pm-4:00pm

School-Based Telehealth Workgroup

Meeting Agenda

October 2, 2018
2:00pm-4:00pm
4160 Patterson Ave., Baltimore MD 21215

I. INTRODUCTIONS

II. OVERVIEW OF LAST MEETING

III. SCHOOL HEALTH SERVICES (SHS) STANDARDS – A SUMMARY OF COMAR 13A.05.05.05-.15

Laura Spicer, Hilltop

IV. DISCUSSION

1. Objective and approach to information gathering grids
2. Review discussion items/grids

V. NEXT STEPS

1. MHCC staff and participant action items
2. Next workgroup meeting: October 29, 2018; 2:00pm-4:00pm

School-Based Telehealth Workgroup

Meeting Agenda

October 29, 2018
2:00pm-4:00pm
4160 Patterson Ave., Baltimore MD 21215

I. INTRODUCTIONS

II. OVERVIEW OF LAST MEETING

III. DISCUSSION ITEMS/GRIDS

1. Objective and approach to information gathering grids
2. Overview of changes made since last version
3. Continue deliberations (Version 3)

IV. NEXT STEPS

1. MHCC staff and participant action items
2. Next workgroup meeting: November 28, 2018; 2:00pm-4:00pm

School-Based Telehealth Workgroup

Meeting Agenda

November 28, 2018
2:00pm-4:00pm
4160 Patterson Ave., Baltimore MD 21215

I. INTRODUCTIONS

II. OVERVIEW OF LAST MEETING

III. DISCUSSION ITEMS/GRIDS: SUMMARY OBSERVATIONS & CONCEPTUAL IDEAS

Objective and approach (Version 4.1)

IV. NEXT STEPS

1. MHCC staff and participant action items
2. Next workgroup meeting: January 10, 2019; 2:00pm-3:30pm (Virtual)

Community Health Resources Commission

July 18, 2018

Mark Luckner
Executive Director, Maryland
Community Health Resources Commission

mark.luckner@maryland.gov
410.260.6290

BACKGROUND ON THE CHRC

- The Community Health Resources Commission (CHRC) was created by the Maryland General Assembly in 2005 to expand access for low-income Marylanders and underserved communities.
- **Statutory responsibilities include:**
  - Increase access to primary and specialty care through community health resources
  - Promote emergency department diversion programs to prevent avoidable hospital utilization and generate cost savings
  - Facilitate the adoption of health information technology
  - Support long-term sustainability of safety net providers
- **The Maryland General Assembly approved legislation (Chapter 328) in 2014 to re-authorize the CHRC until 2025.**

2

BACKGROUND ON THE CHRC

- **Eleven Commissioners of the CHRC are appointed by the Governor**

Allan Anderson, M.D., Chairman

Elizabeth Chung, Vice Chair, Executive Director, Asian American Center of Frederick

Scott T. Gibson, Vice President for Human Resources, Melwood Horticultural Training Center, Inc.

J. Wayne Howard, Former President and CEO, Choptank Community Health System, Inc.

Celeste James, Executive Director of Community Health and Benefit, Kaiser Permanente of the Mid-Atlantic States

Surina Jordan, PhD, Zima Health, LLC, President and Senior Health Advisor

Barry Ronan, President and CEO, Western Maryland Health System

Erica I. Shelton, M.D., Physician and Assistant Professor, Johns Hopkins University School of Medicine, Department of Emergency Medicine

Ivy Simmons, PhD, Clinical Director, International Association of Fire Fighters Center of Excellence

Julie Wagner, Vice President of Community Affairs, CareFirst BlueCross BlueShield

Anthony C. Wisniewski, Esq., Chairman of the Board and Chief of External and Governmental Affairs, Livanta LLC

3

IMPACT OF CHRC GRANTS

- Since 2007, CHRC has awarded 210 grants totaling $64.1 million. Most grants are for multiple years. (Currently 55 open grants)
- CHRC has supported programs in all 24 jurisdictions.
- These programs have collectively served over 455,000 Marylanders. Most individuals have complex health and social service needs.
- Grants awarded by the CHRC have enabled grantees to leverage $22.9 million in **additional** federal and private/ nonprofit resources.
- **Of this $22.9 million, more than $19M has been from private and local resources.**

4

CHRC FY 2018 CALL FOR PROPOSALS

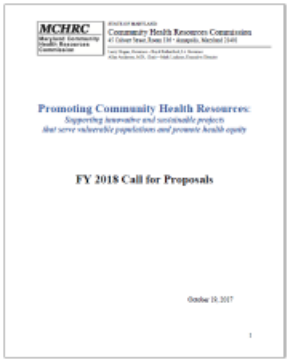
MCHRC
MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION

Strategic Priorities:

(1) Preserving state's ability to serve vulnerable populations, regardless of insurance status;

(2) Promoting health equity by addressing the social determinants of health; and

(3) Supporting community-based projects that are **innovative**, **sustainable**, and **replicable**.


MCHRC
Community Health Resources Commission

Promoting Community Health Resources:
Supporting innovative and sustainable projects that serve vulnerable populations and promote health equity

FY 2018 Call for Proposals

October 19, 2017

Three Types of Projects:
Essential health services
Behavioral health/Substance Use
Obesity and food security

This year's RFP generated 46 proposals requesting a total of $18.9 million. The Commission awarded 20 grants totaling $3.7 million.

5

TYPES OF COMMUNITY HEALTH RESOURCES

MCHRC
MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION

1. **Designated Community Health Resources**
   - Federally Qualified Health Centers
   - School-based Health Centers
   - Local Health Departments
   - Free Clinics
   - Outpatient Mental Health Clinics
   - Substance Use Treatment Providers
   - Teaching Clinics
   - Wellmobiles
2. **Provide Clinical Health Care Services with a Sliding Fee Scale/Nominal Charge**
3. **Provide Referrals to Clinical Health Care Services with a Sliding Fee Scale/Nominal Charge**

6

CHRC SUPPORT OF SCHOOL-BASED HEALTH CENTERS

- The Commission has awarded 15 grants totaling $3.35 million to support SBHCs in 11 jurisdictions.
- CHRC SBHC grants have supported programs in rural, urban, and suburban neighborhoods.
- These programs have collectively served more than 14,000 individuals.
- The CHRC is currently supporting a new School-based Wellness Center, the second one in Wicomico County, with a three-year $425,000 grant. The center provides both somatic and behavioral health services.
- Metrics collected include number of individuals served; number of services provided (including vaccinations); number of ED visits for asthma, acute illness, and behavioral health issues.

7

COUNCIL ON ADVANCEMENT OF SCHOOL-BASED HEALTH CENTERS

- The Council is charged with developing policy recommendations to improve the health and educational outcomes of students who receive services from School-based Health Centers (SBHCs).
- The CHRC provides day-to-day staffing support for the Council under legislation approved by the Maryland General Assembly.
- The Council is comprised of 15 appointed and 6 *ex officio* members appointed by the Governor (see next slide).

8

COUNCIL ON ADVANCEMENT OF SCHOOL-BASED HEALTH CENTERS

MCHRC MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION

Chair - Kate Connor, M.D., MSPH
Vice Chair – Barbara Masiulis, MS, CRNP

Patryce Toye, M.D. - Maryland Assembly on School-based Health Care

Barbara Masiulis, MS, CRNP - school-based health center

Kate Connor M.D., MSPH - school-based health care center

Uma S. Ahluwalia - school-based health care center

John B. Gaddis - Public School Superintendents Association of Maryland

Cathy Mary C. Allen - Maryland Association of Boards of Education

Sharon Lynn Morgan - elementary school principals of schools with a school-based health center

Angel L. Lewis - secondary school principals of schools with a school-based health center

Jean-Marie Kelly - Maryland Hospital Association

Maura J. Rossman, M.D. - Maryland Association of County Health Officers

Judy Lichty-Hess - federally qualified health center

Arethusa S. Kirk - managed care organization

Jennifer Dahl - commercial health insurance carrier

Diana Fertsch, M.D. – pediatrician

Ex Officio Members

Senator Richard Madaleno – Member of the Senate

Delegate Bonnie Cullison – Member of the House of Delegates

Cheryl DePinto, M.D. – Maryland Department of Health

Mary L. Gable – State Superintendent of Schools

Michele Eberle – Maryland Health Benefit Exchange

Mark Luckner – Maryland Community Health Resources Commission

9

CHRC TELE-HEALTH GRANTS

MCHRC MARYLAND COMMUNITY HEALTH RESOURCES COMMISSION

- **Garrett County Health Department** – support Medication Assisted Treatment program in underserved and remote area of state. Collaboration with University of Maryland School of Medicine Department of Psychiatry.
- **Mid-Shore Mental Health System** – supported a program to use videoconferencing to link Mid-Shore youth referred to the Jackson Unit in Allegany County for a 60 day residential stay to: (1) families; and (2) community-based providers who will provide somatic and mental health treatment after release from the unit.
- **Somerset County Health Department** – supported a telepsychiatry program for the uninsured in Somerset County, an underserved area of the state. Collaboration with University of Maryland School of Medicine Department of Psychiatry.

10

The Hilltop Institute
analysis to advance the health of vulnerable populations

DRAFT

School-Based Telehealth Workgroup

August 22, 2018

Laura Spicer

UMBC

Agenda

- Overview of school health services (SHS) and School-Based Health Centers (SBHCs)
- Telehealth in schools
- Payer reimbursement of telehealth
- Overview of Individualized Education Program (IEP) services
- Funding for IEP services and teletherapy
- Privacy and security requirements

SHS AND SBHCs

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Overview of SHS

- SHS are mandated for all Maryland public schools
  - Intended for preventive services and screening of minor illnesses and injuries
  - Typically staffed by a registered nurse
  - School nurses do not diagnose or treat illness; they refer a child to appropriate care (i.e., SBHC practitioner, mental health provider, or the child's primary care provider)
  - Standards jointly defined by Maryland Department of Education (MSDE) and Maryland Department of Health (MDH)
- School health suite includes
  - Space for waiting, examination and treatment, storage, and resting
  - A separate room for private consultation and for use as a designated school health services professional's office
  - Toilets, a lavatory, a telephone, and locked file cabinets available for storing health records and for medications
  - Quiet, separate screening facilities

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Overview of SBHCs

- SBHCs provide comprehensive preventive and primary health services delivered by a licensed medical practitioner to children at school; some provide behavioral health, dental, and other health care services
- Unlike SHS, SBHCs are optional and work with the school nurse to screen, diagnose, treat, and refer children for medical conditions
- SBHCs do not:
  - Serve as a child's "primary medical home"
  - Compete with other providers of care


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-5-

SBHC Standards

- MSDE develops standards for SBHCs at three different levels based on hours, staffing, and services offered:
  - Level I, or Core - provide acute, urgent, and primary care services at least eight hours per week
  - Level II, or Expanded - offer additional services, including mental health care and comprehensive preventive care at least 12 hours per week
  - Level III, or Comprehensive - provide comprehensive acute, urgent, preventive, and primary care services, as well as mental health care at least 20 hours per week
- SBHCs are approved annually through an application process carried out jointly by MSDE and MDH


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-6-

SBHC Standards cont.

- SBHCs must be a permanent space located on a school campus that is used only for the purpose of providing school health services
- All SBHCs must have a sponsoring agency that is responsible for: designation of a SBHC Medical Director, ongoing involvement in operations of the SBHC, liability coverage, ownership of the medical record, and obtaining a Medicaid SBHC Medical Assistance provider number
- All students are eligible to enroll in the SBHC and minor children must have written parental/guardian consent to enroll
- SBHCs are required to collect and report data annually to MSDE and MDH

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-7-

SBHC Landscape (2016-2017)

- 83 SBHCs
  - 52 – Level 1
  - 14 – Level 2
  - 17 – Level 3
- 41,348 students enrolled
- 14,897 unique students served
- 65,144 visits
  - 42,513 – somatic care
  - 19,328 – behavioral health
  - 2,156 – dental
  - 1,147 – case management or other

Source: Council on Advancement of School-Based Health Centers Annual Report (December 2017). Available at: https://health.maryland.gov/mchrc/Documents/SBHC%20PAGE/Microsoft%20Word%20-%20CASBHC%20Annual%20Report%20for%20CY%202017,%20FINAL%20FOR%20EXTERNAL%20SUBMISSION,%20Dec%2015,%202017.pdf.

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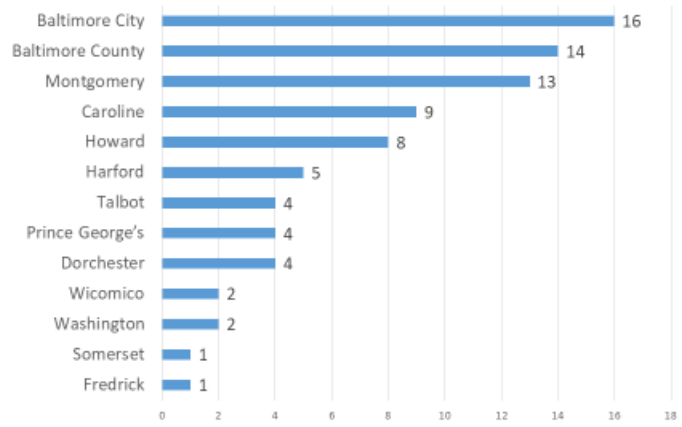
-8-

SBHC Programs by Jurisdiction



Source: Council on Advancement of School-Based Health Centers Annual Report (December 2017). Maryland State Department of Education, 2016-2017 SBHC Survey (Preliminary Data)

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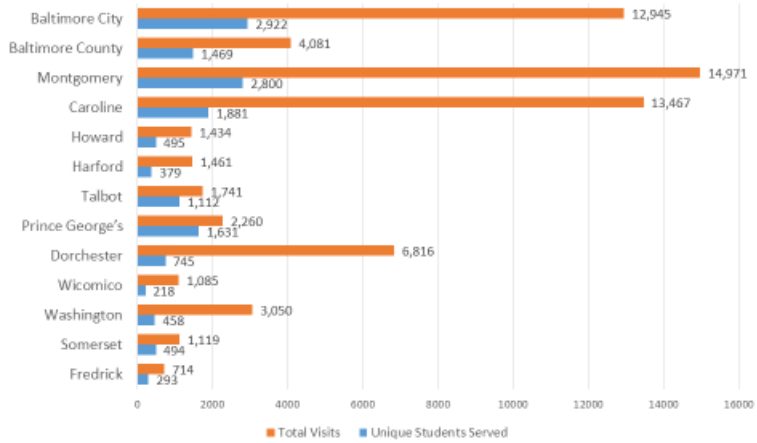
-9-

SBHC Visits and Students Served



Source: Council on Advancement of School-Based Health Centers Annual Report (December 2017). Maryland State Department of Education, 2016-2017 SBHC Survey (Preliminary Data)

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-10-

Funding for SBHC

- SBHC can be funded through MSDE funds, local (county) funds, grant funds, billing, and private donations
  - No new funding available through MSDE
  - MSDE is only providing ongoing funding to SBHCs that are currently funded by MSDE
  - New SBHCs primarily rely on grant funding for initial start-up costs and billing for ongoing sustainability

Telehealth in Schools

- SBHC must meet an additional set of standards in order to render care via telehealth
  - Established workflow and communication policies to ensure coordination of telehealth with other health care providers (e.g., SHS, primary care providers, labs, referrals, etc.)
  - Establish protocols for HIPAA compliance and testing and maintenance of technology
  - Establish education and training for students and providers
  - Establish protocols for follow-up activities, including appointments, referrals, and documentation of the encounter
- Telehealth has been used for other services, such as screening and management of a specific disease condition (i.e., asthma) and mental health outside of the SBHC

Private Payer Telehealth Coverage

- Maryland Insurance Code §15-139 requires private payers to cover health care services provided appropriately through telehealth
  - Applies only to services that are covered by the patient's plan
- May not exclude a service solely because it is provided through telehealth instead of in-person, e.g., a covered service offered in-person in a SBHC would also be covered by telehealth
- SHS are not covered

Medicaid Reimbursement of Telehealth Services

- Medicaid does not cover services that require in-person evaluation
- Eligible originating and distant site telehealth providers must register before providing telehealth services
- An originating site in a school must be a qualified SBHC with a federally qualified health center (FQHC), general clinic, or a local health department sponsoring entity in order to bill Medicaid
- Originating site only receives the originating site fee

Medicaid Reimbursement of Telehealth – Distant Site

- Distant site must be one of the following; some of these would not be the typical distant site for a school:
  - Community-based substance use disorder provider
  - Opioid treatment program
  - Outpatient mental health center
  - FQHC
- Distant site providers permitted places of services:
  - School
  - Office
  - Inpatient hospital
  - Outpatient hospital
  - Emergency room
  - Nursing facility
  - Independent clinic
  - Community mental health center
  - Public health clinic

Medicaid Reimbursement of Telehealth – Distant Site cont.

- Distant site providers may include:
  - Nurse midwife or practitioner
  - Psychiatric nurse practitioner
  - Physician
  - Physician assistant
  - Provider fluent in ASL for telehealth services for the deaf or hard of hearing

Summary SHS vs SBHC

Characteristic	SHS	SBHC
Mandatory in Schools	Yes	No
Clinical Staff	Typically an RN	Licensed medical practitioner
Services	Emphasis on health promotion and disease prevention	Full health clinic services
Third Party Billing	No	Yes
Meet Free-Standing Clinic Requirement	No	Yes

IEP SERVICES AND TELETHERAPY

Introduction

- Teletherapy is the application of telecommunications technology to delivery of professional services at a distance and is intended to include both non-medical therapeutic services and non-clinical services
- An IEP is a written statement for each child with a disability that describes the child's current academic and functional levels, and the measureable annual goals, including the special education and related services that will help the child to attain those goals.

IEP Services

- Federal requirement from the Individuals with Disabilities Education Act (IDEA) for schools to create plans for students with disabilities
- Must identify services needed to meet academic and functional goals, e.g.,
  - Speech, PT, OT
  - Audiology
  - Psychological services
  - Transportation
  - Counseling

IEP Process

- Maryland law defines "student with a disability" as children aged 3-21 identified through the IEP process as having one of a list of disabilities (e.g., autism, learning disability, hearing impairment, etc.)
- The IEP evaluation is conducted annually by a team of individuals, including the child's parents and qualified school staff, that identifies the services needed for a student to meet their annual academic and functional goals
- These services include developmental, corrective, and other supportive services as may be required to assist a student with a disability to benefit from special education

Funding for IEP Services

- Medicaid and school system funds covers IEP services for those who qualify
  - Federal law requires that Medicaid be the first payer for IEP services if the services qualify as a covered benefit
- Federal government provides formula grants to states for the excess costs of providing special education
  - Funds are allocated among states based on a variety of factors
  - Most of these funds must be passed to local education agencies

IEP Reimbursement

- Medicaid will reimburse for IEP services that are a covered benefit delivered in-person
  - Does not cover teletherapy for IEP services
- Private payers are not required to reimburse for services delivered through early intervention or school services

PRIVACY AND SECURITY

Privacy and Security Requirements

- All providers and schools have to comply with both the Family Educational Rights and Privacy Act (FERPA) and the Health Protection and Privacy Act (HIPAA)
  - FERPA protects student education records
  - HIPAA protects health information
- Telehealth providers and schools must use HIPAA compliant audio-video transmissions

Contact Information

Laura Spicer

Director of Health Reform Studies

The Hilltop Institute

University of Maryland, Baltimore County (UMBC)

410.455.6536

lspicer@hilltop.umbc.edu

www.hilltopinstitute.org

The Hilltop Institute

analysis to advance the health of vulnerable populations

Brief Overview: School Health Services Standards:

COMAR 13A.05.05.05-.15

October 2, 2018

Laura Spicer

UMBC

Presentation Goal

- To provide brief, high-level background on school health services (SHS) regulations as context for today's Workgroup discussion
- Corresponding guidance and policy are not included in this presentation

Overview of SHS Standards

- Background
- Standards for all students
- Standards for students with special health needs
- Implementation

Background

- Education Article §7-401 requires the Maryland Department of Education (MSDE) and the Department of Health (MDH) to jointly develop public standards and guidelines for school health programs
  - MSDE initially enacted COMAR 13A.05.05 in 1985, several amendments through 2010
  - MDSE and MDH must offer assistance to the local boards of education and health departments in the implementation of these standards

COMAR 13A.05.05.05

Key Definitions

- A "designated SHS professional" is defined as a physician, certified nurse practitioner, or registered nurse, or all of these, with experience or special training in working with children and families in community or school health programs
- A "SHS aide" is defined as an unlicensed person who functions under the supervision of a designated SHS professional
  - The aide, at a minimum, should be certified in cardiopulmonary resuscitation annually and a basic first aid course every 3 years

COMAR 13A.05.05.06

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-5-

SHS Standards for All Students

- Physical exam
  - A physical exam is required for each child entering the Maryland public school system for the first time
- Review of students' health records
  - Identifies students with health problems or concerns who are then referred for a health appraisal

COMAR 13A.05.05.07

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-6-

SHS Standards for All Students (cont.)

- Health appraisal
  - Process by which a designated SHS professional identifies health problems that may interfere with learning
  - When a health problem is identified, the designated SHS professional must notify and assist students or parents/guardians in selecting recommended services

COMAR 13A.05.05.07

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-7-

SHS Standards for All Students (cont.)

- Health counseling
  - A service that provides opportunities for students and parents/guardians to explore options, make decisions, and receive support for understanding and adjusting to or coping with their health problems

COMAR 13A.05.05.07

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-8-

SHS Standards for All Students (cont.)

- Emergency services
  - At least one adult in each school, other than the designated SHS professional and the SHS aide, should be first aid and CPR certified
  - An emergency card should be maintained for each student
  - An emergency evacuation plan should be developed
  - Local school districts should have a guide for emergency care management
    - The state developed a guide for emergency care to aid the school systems

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-9- COMAR 13A.05.05.09

SHS Standards for Students with Special Health Needs

- A student with special health needs that may require particular attention during the school day must have a statement of those health needs and a nursing care plan
- School staff should be made aware of students who have special health needs that may require intervention during the day

COMAR 13A.05.05.08

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-10-

SHS Standards for Students with Special Health Needs (cont.)

- A designated SHS professional may serve on all levels of the pupil services team and the admissions, review, and dismissal committees and participate, when appropriate, in the health services component of the Individualized Education Plan (IEP)
  - The pupil services team is responsible for developing and implementing school-wide and individual strategies to assist students with achieving academic, health, career, personal, and interpersonal competencies

COMAR 13A.05.05.08

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-11-

Dissemination of SHS Information

- At the beginning of each school year, all parents/guardians and students must be informed of the SHS program
- The information must include (but is not be limited to) staffing, emergency care, medications, and communicable diseases, and be specific to that school's health services program

COMAR 13A.05.05.12

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-12-

Implementation and Coordination of SHS

- The local school superintendent and the local health officer are jointly responsible for implementing the SHS requirements
- When medical direction is necessary, the designated SHS professional should work in collaboration with the local health officer

COMAR 13A.05.05.13

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-13-

Implementation and Coordination of SHS

- The designated SHS professional, other than a physician, and the SHS aide should receive nursing direction from a registered nurse or the health officer's designee employed by either the local health department or the local board of education
- Health services provided in school should be coordinated with other health services in the community

COMAR 13A.05.05.13

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-14-

SHS Monitoring and Evaluation

- MSDE and MDH must jointly develop, in collaboration with local boards of education and health departments, a monitoring and evaluation component for school health programs that may include on-site reviews
- MSDE and MDH have quarterly meetings with the SHS coordinators, collect annual certification statements, and have a tool for site visits that mirror these standards

COMAR 13A.05.05.14

Contact Information

Laura Spicer

Director of Health Reform Studies

The Hilltop Institute

University of Maryland, Baltimore County (UMBC)

410.455.6536

lspicer@hilltop.umbc.edu

www.hilltopinstitute.org

Appendix D. Workgroup Meeting Summaries

School-Based Telehealth Workgroup

June 20, 2018

Meeting Summary

Key discussion items include:

- The Maryland Health Care Commission (MHCC) framed the discussion by providing an overview of the role of the School-Based Telehealth Workgroup (workgroup) in identifying deficiencies in existing policies related to school-based telehealth programs and development of recommendations, including reporting timeframes and deliverables.
- Stakeholders attending the meeting introduced the current landscape of school-based telehealth as it relates to the provision of Individualized Education Plan (IEP) services and somatic care services in Maryland public schools. Charles County overviewed IEP services provided, the federal mandate in providing these services, the need for teletherapy, and how they are currently using teletherapy to address services needs in their schools. Program logistics, therapist shortage, and reimbursement were discussed. Howard County presented on their telehealth model offered through school based health centers (SBHCs), including technology costs, community partnerships, licensing, reimbursement, outcomes, and staffing models.
- Representatives from the Maryland Department of Health (MDH) and the Maryland State Department of Education (MSDE) provided an overview of the process to establish SBHCs in State public schools. The application process is carried jointly by both departments; MSDE is the authority on providing State recognition of SBHCs. Requirements to receive State recognition were discussed, including staffing models, standards, and renewal. MDH has established requirements for telehealth as a method of service delivery within a SBHC, these include administrative procedures, technology, staffing credentials, among other things. Regulations related to the differences in the provision of somatic services and school health services were discussed.
- Representatives from Maryland Medicaid and commercial payors in the State provided information in response to workgroup members' inquiries on current policies as it relates to reimbursement of school-based services, including IEP and somatic care services when provided via telehealth or in-person.
- Benefits and barriers of public schools partnering with local hospitals and local health departments were discussed, including emerging initiatives with Johns Hopkins Hospital and University of Maryland Medical Center.
- *The MHCC intends to create educational resource guides highlighting the differences between IEP, SBHC, and school health services and Maryland Medicaid reimbursement for school-based services; these will be presented at the next workgroup meeting. The MHCC will also prioritize discussion items based on initial discussions to guide the next meeting.*
- *The workgroup is scheduled to meet on July 18th from 1:45pm-4:00pm at MHCC and further discuss an approach for improving school-based telehealth programs in the State.*

School-Based Telehealth Workgroup

July 18, 2018

Meeting Summary

Key discussion items include:

- The Maryland Health Care Commission (MHCC) began the meeting by recapping the highlights of the previous meeting and announcing the participation of The Hilltop Institute as support for the School-Based Telehealth Workgroup's (workgroup's) efforts.
- Mark Luckner, Executive Director of the Maryland Community Health Resources Commission (CHRC), gave an overview of the CHRC's work, including background on the organization's structure, grant-making process, and policy priorities. He described several CHRC activities of particular interest to the workgroup, including (1) the CHRC's role as a funder of new school-based health centers (SBHCs) in Maryland, particularly in underserved schools; (2) the CHRC's role in staffing the Council on the Advancement of SBHCs (Council), which develops standards for SBHCs, among other responsibilities; and (3) that the CHRC has also funded telehealth projects outside of SBHCs.
- Representatives from the Maryland State Department of Education (MSDE) described their work with the CHRC and the Council on the Advancement of SBHCs on the revisions to the annual survey of SBHCs collected by MSDE. The surveys include information on enrollment by grade, race, insurance status, and gender, as well as data regarding diagnoses, treatments, and providers in the SBHC. Members expressed interest in additional information about this survey and findings.
- Based on feedback during the kick-off meeting, MHCC developed a list of proposed questions to guide future discussions and the development of recommendations. The workgroup collaborated to review and edit this list. Members recommended the discussion topics be identified as those that pertain to either: school health services; special education or individualized education plan (IEP) services; or both school health services and special education services. Members provided feedback on the terms included in the document, the prioritization of items, and suggested new topics. Discussions generated requests for more information about billing, coverage, and scope of practice requirements for offering SBHC and special education telehealth services.
- The MHCC provided an overview of the announcements for two school-based telehealth grant opportunities that were released on July 11, 2018. Grant applications are due to MHCC by August 15, 2018.
- *The MHCC intends to distribute an updated list of discussion topics based on feedback during this meeting.*
- *The workgroup is scheduled to meet on Wednesday, August 22, 2018 from 2:15pm to 4:00pm at MHCC to further discuss an approach for improving school-based telehealth programs in the State.*

School-Based Telehealth Workgroup

August 22, 2018

Meeting Summary

Key discussion items included:

- The Hilltop Institute presented an overview of school-based telehealth/teletherapy administrative and reimbursement policies. The presentation highlighted the distinction between school health services and school-based health centers (SBHCs) in Maryland as it relates to staffing models, services provided, requirements for individualized education program (IEP) services, and third party reimbursement requirements and funding mechanisms for telehealth and teletherapy services in schools.
- Workgroup members discussed the different models of school health services and SBHCs, funding challenges for SBHCs, and the current use of telehealth services in schools. Workgroup members also discussed some of the challenges under the current regulatory environment, including the absence of standards or a model for billing for telehealth through school health services, scope of practice requirements for originating site billing, and the lack of third party reimbursement for teletherapy for IEP services.
- The MHCC outlined the approach for guiding future workgroup deliberations. The MHCC developed a set of information-gathering tables on three key discussion categories: engagement, finance and sustainability, and care delivery and coordination. The tables are designed to gather benefits, barriers, challenges, and solutions for each discussion item. The tables are organized by school setting: school health services, SBHCs, and IEP/special education services, as each setting has its own policy considerations. The goal is to develop recommendations by summer 2019.
- *The MHCC intends to distribute the information-gathering document to workgroup members, as well as guidance for providing feedback.*
- *The MHCC intends to host a webinar for a more in-depth discussion around Medicaid reimbursement for telehealth services in schools, including originating and distant site provider requirements and managed care organization policies in response to workgroup inquiries.*
- *The workgroup is scheduled to meet on Tuesday, October 2, 2018 from 2:00 pm to 4:00 pm at MHCC. Meeting materials will be posted to the workgroup webpage prior to the meeting.*

School-Based Telehealth Workgroup

October 2, 2018

Meeting Summary

Key discussion items include:

- The Hilltop Institute presented an overview of the school health services (SHS) regulations, specifically COMAR 13A.05.05.05-.15. The presentation highlighted key definitions, standards for all students, standards for students with special health needs, and implementation of the regulations. Maryland State Department of Education (MSDE) and Maryland Department of Health (MDH) staff provided clarifying comments on the information presented. After the presentation, workgroup members discussed the role of school nurses, annual certification of SHS programs, and additional guidelines for SHS.
- The workgroup reviewed and discussed on the process for completing version 2 of the information gathering tables designed to collect information about benefits, barriers/challenges, and solutions on topic areas relevant to school-based telehealth. There was discussion regarding whether the term "telehealth" should be utilized throughout the document as an all-encompassing term for the delivery of somatic, behavioral health, and IEP services virtually.
- Discussion of Table 1 aimed to identify the benefits, barriers & challenges, and solutions to building awareness on the value of using telehealth to provide special education services. The conversation brought to light benefits around improved compliance with federal individualized education plan (IEP) requirements and greater access to services. Barriers and challenges around parental and provider education of telehealth, parental linguistic and cultural barriers, and the scope of provider practice were discussed. Regarding solutions, workgroup members discussed implementing live/hands-on demonstrations of telehealth services to improve awareness and acceptance.
- *The workgroup is scheduled to meet on Monday, October 29, 2018 from 2:00 pm to 4:00 pm at MHCC. Topics will include an update on the school telehealth grants that are scheduled to be awarded in November. Meeting materials will be posted to the workgroup webpage prior to the meeting.*

School-Based Telehealth Workgroup

October 29, 2018

Meeting Summary

Key discussion items include:

- The workgroup reviewed version 3 of the information gathering tables (tables) designed to collect information about benefits, barriers/challenges, and solutions on topic areas relevant to school-based telehealth. The MHCC plans to use these tables as the foundation for drafting recommendations.
- The workgroup reviewed tables 1 through 5. These tables focused on implementation, building awareness, ensuring the continuum of care and care coordination, technology, and the administrative components of telehealth in schools.
- The workgroup identified the benefits, barriers/challenges, and solutions for tables 6 to 8. Table 6 discussion focused on expanding telehealth in schools within existing telehealth compliance requirements, including the school-based health center (SBHC) application process, standards, and reporting. Some benefits identified were consistency for monitoring, reporting, and evaluating telehealth programs, as well as child and provider protection. Barriers/challenges included lack of statute/regulations for SBHCs, school's technical infrastructure, and using telehealth as a completely separate service offering from the services currently being delivered in schools through a SBHC. Possible solutions identified included creating policy for the use of telehealth in schools including school health services and determining the core competencies needed for the team establishing the telehealth program.
- Discussions of tables 7 and 8 focused on funding and reimbursement models. Benefits included cost savings to the school/school districts by augmenting/expanding services with telehealth versus hiring additional staff. Barriers/challenges include services to support students with Individualized Education Programs are not reimbursable by Medicaid through telehealth, as they are in person, resulting in a school district losing funding if services are delivered via telehealth. Additional barriers regarding Medicaid provider types and commercial payor reimbursement for out of network providers were also discussed. Solutions discussed were developing a cost-sharing model for telehealth encounters, increasing services and provider types reimbursable through Medicaid, and commercial carriers adding more SBHCs as in-network providers.
- *The workgroup is scheduled to meet on Wednesday, November 28, 2018 from 2:00 pm to 4:00 pm EST at MHCC. The workgroup will continue to discuss the informational gathering tables and initial recommendations. Meeting materials will be posted to the workgroup webpage prior to the meeting.*

School-Based Telehealth Workgroup

November 28, 2018

Meeting Summary

Key discussion items include:

- The workgroup reviewed version 4.1 of the information gathering tables, which included a key themes for each of the eight categories. The key themes aimed to summarize the solutions, previously identified by the workgroup, and form the foundation for drafting recommendations. The members were asked to provide both feedback on the sample draft themes, as well as to identify new themes to be added. The workgroup reviewed tables 1 through 5 during the meeting.
- Among the items discussed were; 1) establishment and expansion of telehealth in schools, including preventive services; 2) expanding awareness-building efforts to include government and community agencies, school staff, providers, and payers; and 3) ensuring the continuum of care/care coordination via telehealth.
- The workgroup also discussed issues pertaining to technology particularly around user literacy of technology and sufficient broadband access needed for the telehealth implementation, especially in rural areas.
- Members also discussed the notion of allowing school districts the flexibility to implement and identify telehealth use cases that meet the needs of their community. Members discuss the potential for a third-party organization to certify school districts in compliance with relevant State laws, regulations, and policies.
- *The workgroup is scheduled to meet virtually on January 10, 2019 from 2:00 pm to 4:00 pm EST. The workgroup will continue to discuss key themes of the remaining tables. Meeting materials will be posted to the workgroup webpage prior to the meeting.*

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Appendix E. Information Gathering Tables

School-Based Telehealth Workgroup

INFORMATION GATHERING TABLES

Draft Version 4.1

The Maryland Health Care Commission (MHCC) appreciates the contribution made by members of the School-Based Telehealth Workgroup (workgroup). The MHCC is in the *information gathering stage* and seeks workgroup member input to complete the tables on the topic categories below. This information will be used to guide future deliberations by the workgroup. We anticipate completing the tables over multiple meetings with the diverse perspectives of workgroup members.

The items are organized by key categories based on discussions with the workgroup. This document is for information gathering purposes only and should not be considered a comprehensive list of all topic categories of discussion. Certain bullet points identified in the grids are supported by literature while others are aspirational or anecdotal. Those that are literature-based are marked with an asterisk; references used for these items are included at the end of this document.

Instructions

The top row of each table identifies a topic/concept of discussion. Each table includes three quadrants: benefits, barriers/challenges, and solutions. Each quadrant is subdivided to include persons or entities (e.g., students, MSDE, schools or school districts, grant funds, private payors) that have a role in or may be impacted by the topic/concept of discussion. Other persons and entities may be added by the workgroup during discussions. We ask that workgroup participants list possible benefits, barriers/challenges, and solutions related to the topic/concept. Workgroup participants are not required to complete each quadrant for each table; we ask that participants identify benefits, barriers/challenges and solutions that are most relevant for them and are supported by literature, if possible. If the item is literature-based, please include an end note. After benefits, barriers/challenges, and solutions are identified, workgroup participants are asked to identify key themes that summarizes solutions identified for each table. Identify key themes will be considered in developing informal draft recommendations.

Definitions

Benefit: The value derived from producing or consuming a service.

Barrier/Challenge: A circumstance or obstacle (e.g., economic, political, institutional, environment, social, etc.) that hinders or prevents progress, including a difficult task or complex situation that must be overcome in order to implement a solution.

Key Themes: A key takeaway statement that summarizes table quadrants that can be used to formulate potential recommendations.

Solution: An idea aimed at solving a problem or managing a difficult or complex situation.

Key Categories

- Service Delivery/Operations: Providing school-based telehealth[88] services[89] including implementation, compliance, management and maintenance

Table 1

Implementation of telehealth within schools	
BENEFITS *Students* • Increased access to services, particularly in areas with provider shortages • Decreased absenteeism* • Enhanced health literacy • Improved academic and health outcomes *Parents/guardians* • Expanded access to health and Individualized Education Plan (IEP)[90] services for children • Ability for child to be treated at school, reducing time off of work • Reduced travel costs to school/provider • Health equity for caregivers who are unable to provide these services for their children *Schools or school districts* • Addresses provider shortages • Ability to better provide support to students with specialized needs (e.g., IEPs, behavioral health, chronic disease management, etc.) • Increased access to compensatory services or home/hospital services • Minimizes student absenteeism	**BARRIERS & CHALLENGES** *Students* • Concerns with potential disruption to the medical home • Confidentiality concerns* • Potential discomfort with seeing a new provider, especially in cases where parent is unable to join visit *Parents/guardians* • Parent desire for child to see their own primary/specialty care provider • Confidentiality concerns* • Addressing concerns around the treatment relationship with unknown telehealth providers • Lack of support or enthusiasm for the program* *Schools or school districts* • Beliefs that telehealth is not able to adequately support students* • Cost • Need for private, physical space to offer telehealth services • Lack of staff support/buy-in • Ownership of the child's medical record (FERPA/HIPAA) • A telehealth-only model presents challenges when a service is not appropriate to be delivered via telehealth (i.e., reproductive health for secondary school, children)

[88] Telehealth, means as it relates to the delivery of health care services, the use of interactive audio, video, or other telecommunications or electronic technology by a licensed health care provider to deliver a health care service within the scope of practice of the health care provider at a location other than the location of the patient. "Telehealth" does not include: (i) an audio–only telephone conversation between a health care provider and a patient; (ii) an electronic mail message between a health care provider and a patient; or (iii) a facsimile transmission between a health care provider and a patient.

[89] School-based telehealth services include those available to all students, students with IEP, within or outside of a SBHC, including but not limited to non-medical therapeutic services (e.g., mental health counseling, psychoeducational assessments, psychological consultations, etc.) and non-clinical services (e.g., occupational therapy, speech therapy, etc.).

[90] The IEP is a written plan that describes the special education and related service support needed for a child with a disability. The IEP defines the type and amount of services needed and where the services will be delivered. School staff is responsible for the implementation of the IEP.

SOLUTIONS

Students

- Provide relevant clinical information to the child's primary/specialty care provider regarding the telehealth encounter/intervention
- Engage community-based primary/specialty care provider to deliver care via telehealth

Parents/guardians

- Build awareness around the potential value in using telehealth services
- Connect the child to their primary/specialty care provider for a telehealth encounter

Schools or school districts

- Demonstrate the instances for which outcomes of telehealth services can be the same as an in-person service
- Provide an education ROI model that focuses on student impact of telehealth services
- Create a learning community of providers, hospitals, FQHCs, local health departments, etc. to share best practices and best communication strategies
- Seek grant funds to cover implementation costs, such as training, equipment purchases, upgrades to technical infrastructure, etc.

KEY THEMES

- Expand the use of telehealth in primary and secondary schools
- Encourage school districts to be innovative in developing telehealth models
- Explore opportunities to foster medical home participation in telehealth
- Build awareness among students, parents, and school administrators in the value of telehealth

PARKING LOT

- Online therapies can also include evaluations, re-evaluations, and participation in IEP meetings
- Impact on the larger community
- Industry supports that are available (i.e., ASHA)
- Transfer of service delivery from a person in the school to someone located remotely
- Medical neighborhood (stakeholder)
- Issues of educating the distant site service providers regarding using technology
- Scope of provider practice

Table 2

Building awareness about the value of telehealth services	
BENEFITS *Students* • Opportunity to learn about alternative methods to receive services using technology *Parents/guardians* • Awareness that the services are available to start a conversation about their child receiving these services *Schools or school districts* • Opportunity to gain buy-in from school leadership to offer telehealth • Opportunity to obtain information to advocate for bringing services into the school	**BARRIERS & CHALLENGES** *Students* • Caution from immigrant parents around talking to someone they do not know • Appropriately targeting awareness building for self-directive services • Potential stigma if technology is only used for IEP/mental health services • Messaging about which students are suitable for telehealth and what services are offered for these students *Parents/guardians* • Messaging about which students are suitable for telehealth and what services are offered for these students • Parent preconceived notions about telehealth services being inferior to in-person • Parent linguistic/cultural barriers *Schools or school districts* • Competing priorities of leadership and availability to learn about telehealth services • Identifying who/where/when/how the awareness building should be targeted • Appropriately developing awareness building strategies for all parents/guardians including language, culture, etc. • Remaining cognizant of different equity issues across all students including translation issues • Access to parents and the ability to educate them about telehealth • Messaging about costs
SOLUTIONS *Students* • Educate students about the process and benefits of telehealth services, including live demonstrations of the technology • Reassure students that telehealth is similar to seeing a provider in-person • Provide opportunities to try and test use of new technology • Target awareness building to students that are good candidates for telehealth *Parents/guardians* • Provide parents information about the benefits of using telehealth to connect their children to the services they need, including live demonstrations of the technology • Implement an awareness building strategy that considers parents and guardians across all students of the population *Schools or school districts* • Offer hands-on demonstration of the telehealth technology • Providing clear facts to leadership on current challenges and how telehealth services can address these challenges • Demonstrate the instances for which outcomes for telehealth services can be the same as an in-person service, including success stories from schools that have implemented telehealth services	

KEY THEMES

- Build awareness among students, parents, and school administrators on the value of telehealth
- Use culturally sensitive messages

PARKING LOT

- Methods to increase awareness to students could include:
  - Demonstrations and videos of exams to increase comfort level of students
  - Peer promotion from telehealth users
  - Presentations to student groups
  - Focus groups for older students on how to best promote a telehealth program to parents and other students
- Methods to increase awareness for parents could include:
  - Promoting the benefits of telehealth through the schools' email blasts
  - School principals promoting the program in a letter to parents, as well as speaking about the program at Back to School Nights, PTA meetings, and other parent events.
  - Including telehealth information in enrollment packets of school mailings, as well as incorporating it in new student registrations
- Cost savings of not having a translator by accessing a service provider that is linguistically appropriate

Table 3

Ensuring the continuum of care/care coordination via telehealth	
BENEFITS *Students* • Increase in coordination between students' primary/specialty providers and school healthcare professionals • Potential for an increase in medication adherence, monitoring, and education* *Parents/guardians* • Decrease in time away from work while maintaining continuum of care • Increase in communication between schools and service providers with parents to discuss care management and coordination* • Potential for fewer visits/less duplicity *Primary care and specialty care providers* • Improved ability to successfully treat patients due to an increase in access to patients* *Schools or school districts* • Decreased absenteeism and enhanced overall health of students* • Enhanced continuity of care and communication with school nurse*	**BARRIERS & CHALLENGES** *Students* • Consent and HIPAA/FERPA concerns* • Inability to be seen by their own provider via telehealth • Lapses in communication between school/remote providers and the child's primary/specialty care provider due to technology or other gaps (i.e., lack of EHR) *Parents/guardians* • Child's primary/specialty care provider is not engaging in telehealth services • Concerns around sharing a child's information *Primary care and specialty care* • Lack of buy-in or support from providers* • Technical limitations of some community providers (e.g., insufficient internet access, lack of an EHR, etc.). • Concern that telehealth could lead to the "doc-in-a-box" model and reduce continuity of care over time *Schools or school districts* • Lack of buy-in or support from school staff and leadership* • HIPAA/FERPA requirements and obtaining consent to share information*
SOLUTIONS *Students* • Strive to coordinate with local providers • Obtain parental consent to contact the child's primary/specialty provider • Ensure streamlined workflow for information sharing, particularly for providers who lack certain technical capabilities (e.g., EHR) • Provide a combination of in-person and telehealth services *Parents/guardians* • Inform parents of the benefits to sharing the child's information with the appropriate providers • Inform parents of the confidentiality requirements around the child's information and the methods used to protect child information *Primary care and specialty care* • Engage the community and secure community support using community wide-meetings and personal visits to crucial stakeholders* • Ensure that the telehealth program is filling a health care gap and not duplicating services* *Schools or school districts* • Ensure that the telehealth program is filling a health care gap and not duplicating services* • Use the beginning of the year/enrollment as a time to obtain consent* • Engage community providers to deliver telehealth services • Develop a process to engage and/or communicate relevant information to the child's primary/specialty provider • Provide a combination of in-person and telehealth services • Develop partnerships with FQHCs to align on similar goals/continuity of care	

KEY THEMES • Develop telehealth policies that foster its use and minimizes disruption to existing care delivery initiatives • Engage parents/guardians in telehealth encounters
Parking Lot •

Table 4

Technology (i.e., hardware and software) used in a telehealth encounter	
BENEFITS *Schools and Providers* • Increased access to providers to deliver necessary services, while providing quality care* *Students* • Technology could be viewed as "cool" thereby potentially reducing stigma of IEP services *Parents/guardians* • Opportunity for increased involvement of parents/guardians in services provided at school through virtual participation (e.g., 3-way conferencing)	**BARRIERS & CHALLENGES** *Schools and Providers* • Access to broadband connectivity, particularly in rural areas* • Access to technicians to address problems with equipment * • Training of providers and staff* • Level of comfort with the technology* • Limited space for telehealth equipment that is both private and secure • Ownership over the technology processes *Students* • Ability to use technology and the potential need for significant oversight/supervision and/or modifications to the technology *Parents/guardians* • Level of comfort with the technology*
SOLUTIONS *Schools and providers* • Provide hands-on training and demonstrations, including tutorials and practice drills* • Provide continual technical support* • Research partnerships with local universities, hospitals, health care systems, or telehealth vendors for implementing and maintaining technology* • Use mobile hotspots to increase connectivity • Establish interoperability to help with continuity of care *Students* • Utilize user experience design when developing a solution to support telemedicine* *Parents/guardians* • Provide demonstrations of the technology	
KEY THEMES • Encourage innovative technical solutions and models for implementing telehealth	
PARKING LOT	

Table 5

Management and administration of people, processes, and procedures to deliver telehealth services	
BENEFITS *State regulation* • Develop program standards for staffing qualifications, training, etc. • Develop standards for telehealth technologies and treatment protocols • Ability to provide oversight of telehealth services to ensure that quality and confidentiality standards are met *Schools or school district* • Control resource allocation and distribution across the school district according to measured or perceived needs for telehealth • Oversight of individuals delivering telehealth services with standardized protocols *Third Party Payers/Medicaid* • Ability to require certain standards to be met in order for schools to be reimbursed for telehealth services	**BARRIERS & CHALLENGES** *State regulation* • "One-size fits all" regulations may not be appropriate solutions for diverse schools and districts • Limitations imposed by licensing boards on telehealth service providers *Schools or school districts* • Schools with limited resources may have staffing challenges to be able to manage telehealth services • Difficulty hiring providers • Contract management • Authority over telehealth service providers who may not be employed by the school *Third Party Payers/Medicaid* • Time to develop and implement new processes for reimbursement of telehealth services
SOLUTIONS *State regulation* • Include flexibility in development and periodic reevaluations of regulations • Incorporate stakeholders in rules development • Provide flexibility to schools/school districts to manage the delivery of telehealth services *Schools or school districts* • Dedicate funds for telehealth at the district-level to facilitate staff hiring • Ensure contracts have clear language around authority governing telehealth services providers (i.e., school vs. telehealth service company/health care organization) • Establish innovative care delivery models incorporating telehealth with hands-on care *Third Party Payers/Medicaid* • Modify Medicaid regulations/policies • Expand reimbursement from non-government payers for telehealth services	
KEY THEMES • Allow school districts greater autonomy in developing telehealth programs that meet the unique needs of their populations/community	
PARKING LOT • Legislative involvement – Specify authority to regulate • Cost and quality of care among the various staffing solutions to determine the most efficient resource allocation	

Table 6

Existing telehealth compliance requirements, including SBHC application process, standards, and reporting

BENEFITS

MSDE/MDH

- Consistent process for monitoring, reporting, and evaluating quality standards
- Ability to model the established process to other areas of the school (i.e., SHS)
- Authority to provide professional development and technical assistance to schools seeking to implement telehealth

Schools or school districts

- Establishes a framework for financing
- Protection for the provider and child
- Benefits the students who have special needs (both medical and special ed)
- Expansion of services to areas experiencing shortages of qualified providers

BARRIERS & CHALLENGES

MSDE/MDH

- There are no laws that govern SBHCs, only policies
- No policies around using telehealth in the SHS setting
- Policies around mental health services are not clear
- Separating telehealth as a care delivery modality from the care delivery within a SBHC

Schools or school districts

- Technical infrastructure to support telehealth
- Time required to go through the process to set up a SBHC, regardless of telehealth
- Cost to set up a full SBHC is significant
- SBHC requirement to have a provider on site
- Availability of school nurses to use telehealth
- Lack of policies for emergencies that may arise when a school nurse is utilizing telehealth, etc.
- Staffing resources and consideration of the burden on providers and school nurses

SOLUTIONS

MSDE/MDH

- Develop policy for having telehealth in SHS that allows for some innovation while protecting students and quality of care
- Look to other states for existing models for using telehealth in schools
- Identify core competencies that are needed for setting up telehealth programs

Schools or school districts

- Adding to/streamlining existing/developing new policies for telehealth programs
-

KEY THEMES

- Explore third party certification opportunities for schools that use telehealth for SHS or in a SBHC

PARKING LOT

- Schools that are using telehealth could serve as a model for other school districts to develop policies
- Schools may not be seeking the originating site fee from Medicaid
- Lack of definition for what constitutes adequate health services, which schools are required to provide by statute
- Meeting to discuss telehealth policies MDH and MSDE to support new solutions is in the works

Table 7

Establishing adequate funding sources to implement telehealth and establishing a sustainable telehealth program	
BENEFITS • Cost savings for having only an RN vs. MD, NP etc. • Use with certain sub-specialties where a funding model exists • Expanding capacity for certain specialties for consultations only to augment services on site	**BARRIERS & CHALLENGES** • Potentially not a good ROI for all services in the SHS setting • Must have a high volume of visits to off-set the upfront costs • Anti-kick back laws that limit providers/practices from reimbursing school for delivering care via telehealth • Using telehealth for IEP services does not result in a cost saving benefit for using remote providers
SOLUTIONS • Use existing models, (e.g., Howard County has a partnership with hospitals and is not paying the providers) • Develop mechanism(s) for a provider to reimburse the schools • Develop a telehealth cost sharing model (ACO-like) • Develop a funding mechanism for telehealth for IEP services	
KEY THEMES • Explore the expansion of Medicaid and private payor reimbursement for telehealth, including SHS and special education and related services	
PARKING LOT • Project ECHO – dealt with issues regarding linking to the community and funding which occurred through grants • University of Rochester model – mobile tele-presenter model funded through agreement with MCOs • Continuity of care from a SHS to the child's medical home doesn't exist currently absent telehealth • SHS using telehealth does not have a huge cost to the school (originating site) and the provider could still bill for the distant site	

Table 8

Existing Medicaid and private payor telehealth reimbursement models

BENEFITS

Commercial

- Private payors reimburse for any service that is rendered that would be covered in person (SBHCs would be included)

Medicaid

- Medicaid will reimburse for services within a SBHC
- Medicaid reimburses both the telehealth originating and distant sites; distant sites reimbursed at the full Medicaid rate

1

BARRIERS & CHALLENGES

Commercial

- In-network vs. out-of-network providers
- Getting the in-network status for some private payors can be prohibitive
- Do not reimburse telehealth originating sites
- Do not cover IEP services

Medicaid

- Originating site vs. distant site (i.e., SBHCs are only approved school originating site and both must have a Medicaid ID to bill)
- No policies and potential scope of practice concerns for school nurses to bill for Q-codes (i.e., originating site fees) for services via telehealth
- Only SBHCs can register as originating sites to be eligible for reimbursement
- Providers must register and be approved as telehealth providers to bill
- IEP telehealth services are not reimbursed
- Reimbursement issues regarding the place of the student (e.g., students at home)

2

SOLUTIONS

Commercial

- Work to get more schools as in-network providers

Medicaid

- Allow for IEP services to be reimbursed when rendered through telehealth
- Allow for other types of sites (i.e., SHS) to be reimbursed
- Allow for other provider types (i.e., RNs) to be eligible for reimbursement

3

KEY THEMES

- Explore the expansion of Medicaid and private payor reimbursement for telehealth, including SHS and special education and related services

PARKING LOT

- Carriers, including CareFirst, are enrolling SBHCs in-network regardless of telehealth
- Medical home models
- Change of policies for Medicaid to add schools/RNs etc. would be a heavy lift
- Data to articulate the cost savings

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Appendix F. School-Based Health Center Telehealth Checklist

FY19 Chart B2: Initial Checklist for the Delivery of Telehealth Services in School-Based Health Centers
NOT REQUIRED FOR CONTINUING SBHCS UNLESS THERE HAVE BEEN PROGRAMMATIC CHANGES

Administrative Procedures

- ☐ Provide workflow procedures to manage telehealth alongside school health suite and other school-based health center services, including:
    - Staffing allocation including credentials and training relevant to each staff person's role in the telehealth program.
    - Role of each staff including the role of the school nurse or health aid present in the school health suite.
    - Proposed range of telehealth services based on needs assessment.
    - Process used to for determine appropriateness of student's health concern for the telehealth program.
    - Demonstrate familiarity with and adherence to relevant confidentiality protections (i.e. HIPAA and FERPA, as applicable).
        - Description of the plan to records keeping for telehealth services separate from health suite records.
        - Policy on sharing records between school nurse and telehealth program staff when needed.
- ☐ Policy and procedures regarding communication with parents to advertise the center services and during visits when a parent is not present.
- ☐ Policy and procedures regarding communication with the student's primary care providers in compliance with COMAR 10.09.68.03(C)(5).
- ☐ Process for communicating any required prescriptions and orders for laboratory or imaging studies.
- ☐ Policy and procedures regarding immediate referral to acute care, as needed.
- ☐ Policy and process regarding administering medications in the telehealth center according to the center implementation plan (SBHC level of service).

Technology

- ☐ Demonstrate HIPAA-compliant written protocols for ensuring the authentication and authorization of users of the telehealth equipment, prevention of unauthorized access to the telehealth equipment, and notification procedures for any data breaches.
- ☐ Demonstrate written protocols and schedules for testing and maintenance of telehealth equipment (according to manufacturer's instructions) and including a log of all technical problems or issues and their respective resolutions.
- ☐ Provide a contingency plan to be implemented if there is a loss of connectivity to the distant site provider. Provide a contingency plan to be implemented if there is a problem providing adequate service due to other factors such as child cooperation or difficulty of the exam.

Preparation for Telehealth Visit

- ☐ Provide a copy of preparation work-flow plans, including:
    - Confirming equipment is in working order and accessible.
    - Identifying clinical goals for the encounter

- Providing the distant site provider with relevant health information prior to the telehealth encounter, where possible.

Patient Education and Support

- ☐ Demonstrate plans to educate patients on what to expect during telehealth encounter including identifying camera and microphone locations to the patient.

Knowledge and Skills

- ☐ Provide proof of training of the staff for the knowledge and skills necessary to operate the equipment and any peripheral devices.
- ☐ Demonstrate plans to evaluate telepresenter(s) competency with the equipment.
- ☐ Verify credentials of distant provider and their competency in providing telehealth services.
- ☐ Description of who will staff the telehealth center, their training and competencies.

Follow-Up

- ☐ Provide work-flow plan for:
  - Scheduling follow-up appointments, where necessary,
  - Provide a plan to the patient and his/her parent or guardian, as appropriate, for follow-up with the SBHC when the student does not have a primary care provider. Having a licensed clinician or other individual with appropriate training and skills review instructions with the patient and his/her parent or guardian.
  - Ensuring care coordination with the patient's primary care provider and/or specialty providers, where applicable.
- ☐ Demonstrate work-flow plan to document encounter in the patient's medical record. Medical records must include copies of all patient-related electronic communication, prescriptions, laboratory and test results, evaluations and consultations, and records of past care and instructions.

09/2014

Appendix G. School-Based Telehealth Programs in other States

State	Program Name	Implementation Date	Program Size	Services Provided
Texas[91]	Telemedicine Wellness, Intervention, Triage and Referral (TWITR)	2012	10 school districts	Psychiatric screenings and services
Kansas[92]	Telehealth ROCKS Schools	September 2016	19 school settings in 11 counties	Behavioral strategies for autism; psychological strategies for behavioral concerns, trauma, and chronic conditions; modified parent-child interaction therapy, and other services
North Carolina[93]	Health-e-Schools	2011	22 schools in 3 counties	Acute issues, chronic disease management, medication management, well-child check-ups, sports physicals, adolescent medicine consultations, and telepsychology/telebehavioral health
South Dakota[94]	eCARE School Health	February 2017	31 schools	Acute care, chronic disease management, medical advice for 504 and IEP plans, case management, and medication management

[91] Eric Wicklund. (2018, May 30). Texas Governor Lobbies for Statewide School Telehealth Program. mHealth Intelligence. Retrieved from https://mhealthintelligence.com/news/texas-governor-lobbies-for-statewide-school-telehealth-program. .

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[93] Center for Rural Health Innovation. *Health-e-Schools*. http://www.crhi.org/MY-Health-e-Schools/index.html.

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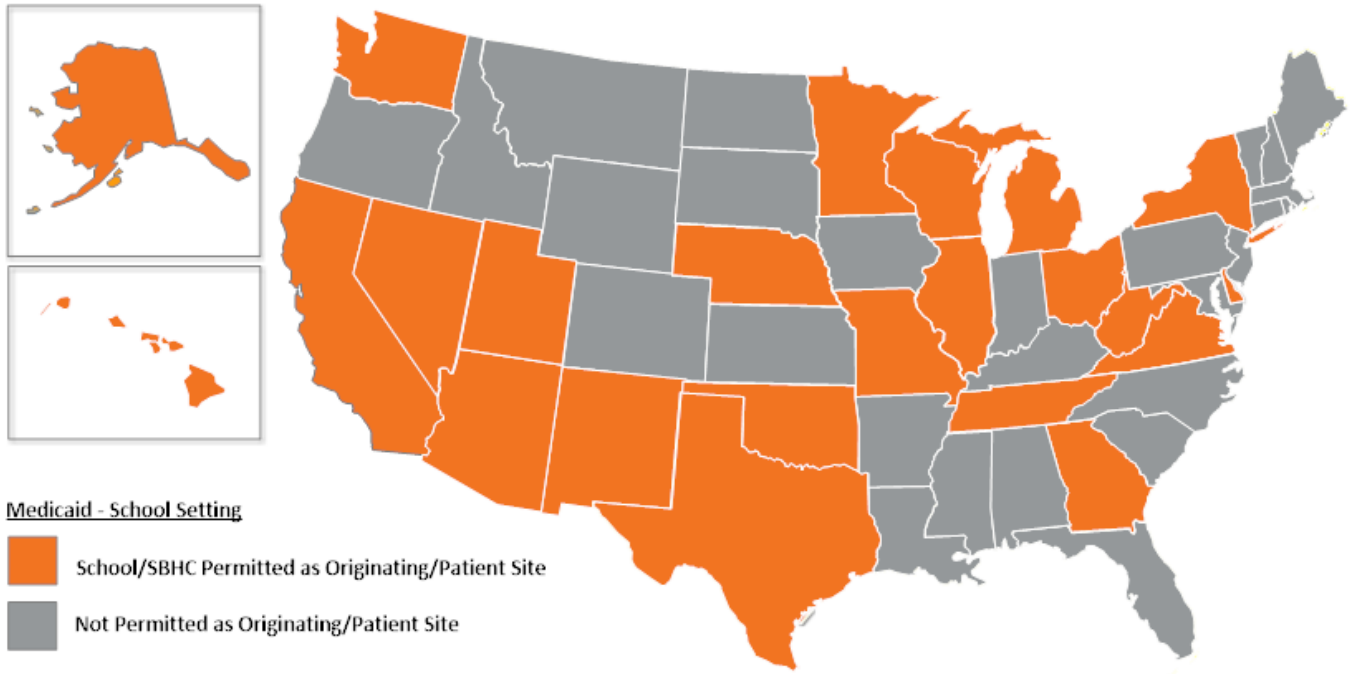
Appendix H. Medicaid Reimbursement for Schools as the Originating Site



Source: American Telemedicine Association. (February 2017). *State Telemedicine Gaps Analysis: Coverage & Reimbursement.* Retrieved from https://simplevisit.com/wp-content/uploads/2018/01/2017-NEW_50-State-Telehealth-Gaps-Analysis-Reimbursement_FINAL.pdf.

Appendix I. Workgroup Feedback Interim Report

MARYLAND

Justine Springer -MDH- <justine.springer@maryland.gov>

Re: Response Requested: Workgroup Draft Interim Report Review

1 message

Lynne Muller -MSDE- <lynne.muller@maryland.gov> Wed, Dec 26, 2018 at 2:02 PM
To: Justine Springer -MDH- <justine.springer@maryland.gov>
Cc: Alicia Mezu <Alicia.mezu@maryland.gov>

Hi! Nice job!! I have a few thoughts and am sending this to our school health specialist, but here goes:

- Page 4 School Based Health Centers section. It would be good to add to the first sentence (or second one) that SBHCs are enhancements to the required school health services program.
- Also in your footnotes #39 you need to add that the Advisory was assigned by legislation to the Maryland Department of Health in 2016.(Alicia can you verify that I have the correct year?)
- I am sure that school health services are also subject to HIPPA (and FERPA) and I did not see that in the section on privacy on page 6.
- There is a strange transition between sentences on page 8 in the paragraph starting "The University of Maryland..., right after the the first sentence. You switch from what U of M is providing and for one sentence mention that counseling and psychological services fall under SHS-which is not correct . School counseling, school social work, and school psychology are provided in all public schools in Maryland) (COMAR) 13A.05.05.01 along with school health services, and pupil personnel services through a program of coordinated student services. Then the rest of the sentences go on to share information about the U of Md program. Not sure why this sentence is even in there...

Hope this helps!

CHANGING Maryland for the Better

Lynne E. Muller, Ph.D., NCC, LCPC
Section Chief, Student Services and School Counseling

Division of Student Support, Academic Enrichment, and Educational Policy
Maryland State Department of Education
200 W. Baltimore Street
Baltimore, MD 21201-2595
410-767-3364(office)
410-333-0880 (fax)
lynne.muller@maryland.gov

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On Fri, Dec 21, 2018 at 2:24 PM Justine Springer -MDH- <justine.springer@maryland.gov> wrote:

Hello all,

We hope this email finds you well. The Maryland Health Care Commission (MHCC) has completed a draft of the School-Based Telehealth Workgroup interim report, as requested by the Senate Finance Committee (Committee). The draft report provides the Committee with an update on the progress of the workgroup. Proposed recommendations are not included, as we intend to continue discussions with the workgroup to finalize potential recommendations in the summer. Attached you will find a copy of the draft report for your review.

We ask that workgroup members send us your comments and feedback either in an email or a separate Word document by **Wednesday, January 9th**. In the spirit of transparency, all comments will be compiled and included in the appendix of the draft report prior to sharing with the Committee. We apologize for the quick turnaround time and any inconvenience this may cause.

We greatly appreciate your contribution to the workgroup effort and taking the time out of your busy schedule to review the draft report. We look forward to working with you in the New Year and continuing our progress. Please do not hesitate to contact me if you have any questions.

Happy Holidays!

Regards,
Justine

Justine Springer, MPH
Program Manager
Maryland Health Care Commission
Center for Health Information Technology and Innovative Care Delivery
4160 Patterson Avenue
Baltimore, MD 21215
Office: (410) 764-3777
Fax: (410) 358-1236
Website: mhcc.maryland.gov/
Facebook: www.facebook.com/mhcc.md
Twitter: www.twitter.com/mhccmd
Health Care Quality Reports: healthcarequality.mhcc.maryland.gov

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Justine Springer -MDH- <justine.springer@maryland.gov>

Re: Response Requested: Workgroup Draft Interim Report Review

1 message

Benjamin Wolff -DHMH- <benjamin.wolff@maryland.gov> Fri, Dec 28, 2018 at 6:12 PM
To: Justine Springer -MDH- <justine.springer@maryland.gov>
Cc: Eva Lenoir -MDH- <eva.lenoir@maryland.gov>, Angela Evatt -MDH- <angela.evatt@maryland.gov>, David Sharp -MDH- <dsharp@maryland.gov>, "Nina W. McHugh -DHMH-" <nina.mchugh@maryland.gov>, Molly Marra <molly.marra@maryland.gov>

Hi Justine,

Thank you for sharing the draft interim report. I do have a few comments about specific language, which I've outlined below. If possible, I'd also like to set up a time to discuss the scope of what's being included in this version. I have some concerns about including the information gathering tables. Could we find some time to discuss after we're back from New Year's?

Comments:
- **page 4: "Current Medicaid and private payor policies do not reimburse for telehealth in schools as the originating site."** - This sentence isn't correct. Medicaid policies include no prohibition on reimbursement for services where schools are an originating site. Therefore, a distant site provider could still receive reimbursement for a visit if the SHS were the originating site. You correctly describe this policy on p. 7. I think what you are trying to say here is that Medicaid would not reimburse the school/SHS itself for being the originating site, which is true. However, that is not due to telehealth policies; it is due to the fact that Medicaid does not reimburse SHS at all for ANY type of service, regardless of the service delivery model. The way this is written conflates telehealth policy with broader school reimbursement policy. Please use this language instead: **"Maryland Medicaid does not enroll or reimburse SHS providers."**

- **page 7: "Medicaid defines telehealth as the delivery of medically necessary somatic or behavioral health services to a patient at an originating site by a distant site provider, through technology-assisted communication."** - This is a regulatory definition that really only pertains to the use of the term "telehealth" within this chapter of COMAR. I don't want to give the impression that this is the only type of telecommunication based delivery model within the program. We also reimburse for remote patient monitoring (separate regs chapter). I would change as follows to clarify: **"Maryland Medicaid Telehealth Program regulations, which govern reimbursable synchronous audio/video telehealth visits, define telehealth as the delivery of medically necessary somatic or behavioral health services to a patient at an originating site by a distant site provider, through technology-assisted communication."**

- **page 7: "Telehealth policies require that distant care be coordinated by a clinician."** I'm not sure what this is trying to say. "Distant care" isn't a term we use. Also, the use of the word "coordinated" suggests that the distant site provider has some kind of specific care coordination requirement, and while that may be desirable it isn't necessarily the case. The SBHC Medicaid regs do require SBHCs to coordinate care with a student's PCP and MCO, but there isn't a care coordination provision in the telehealth regs that I'm aware of.

Thanks, and have a Happy New Year!

Ben

Benjamin Wolff
Medicaid Office of Health Services | Policy & Compliance
Maryland Department of Health
201 West Preston Street, Suite 127 | Baltimore, MD 21201
(410) 767-5294 | (410) 333-5154 (fax)
benjamin.wolff@maryland.gov

MDH is committed to customer service. Click here to take the Customer Satisfaction Survey.

On Fri, Dec 21, 2018 at 2:24 PM Justine Springer -MDH- <justine.springer@maryland.gov> wrote:
> Hello all,

We hope this email finds you well. The Maryland Health Care Commission (MHCC) has completed a draft of the School-Based Telehealth Workgroup interim report, as requested by the Senate Finance Committee (Committee). The draft report provides the Committee with an update on the progress of the workgroup. Proposed recommendations are not included, as we intend to continue discussions with the workgroup to finalize potential recommendations in the summer. Attached you will find a copy of the draft report for your review.

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We greatly appreciate your contribution to the workgroup effort and taking the time out of your busy schedule to review the draft report. We look forward to working with you in the New Year and continuing our progress. Please do not hesitate to contact me if you have any questions.

Happy Holidays!

Regards,
Justine

Justine Springer, MPH
Program Manager
Maryland Health Care Commission
Center for Health Information Technology and Innovative Care Delivery
4160 Patterson Avenue
Baltimore, MD 21215
Office: (410) 764-3777
Fax: (410) 358-1236
Website: mhcc.maryland.gov/
Facebook: www.facebook.com/mhcc.md
Twitter: www.twitter.com/mhccmd
Health Care Quality Reports: healthcarequality.mhcc.maryland.gov

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Justine Springer -MDH- <justine.springer@maryland.gov>

RE: Response Requested: Workgroup Draft Interim Report Review

1 message

Hobson, Sharon <shobson@howardcountymd.gov> Mon, Dec 31, 2018 at 9:33 AM
To: Justine Springer -MDH- <justine.springer@maryland.gov>
Cc: "Dr. David Monroe" <davidmonroemd@gmail.com>, "klebanowkenmd@yahoo.com" <klebanowkenmd@yahoo.com>, "sstrahlman@cmpractice.com" <sstrahlman@cmpractice.com>, "david.sharp@maryland.gov" <david.sharp@maryland.gov>

Ms. Springer:

Good morning and happy almost 2019! Thank you for sharing the interim report. I have the following edits:

- Page 2 and 6/20/18 Meeting Agenda- I am an employee of the Howard County Health Department, not the Howard County School System. The presentation on page 2 should read Howard County Health Department.
- Page 8- The Howard County Health Departments operates 7 school-based telemedicine centers.
- Page 8- The monthly licensing fee for community providers was $125 not $250.
- Howard County Health Department's program began patient enrollment in 12/14 and had its first school-based telemedicine visit in 1/2105.

I only reviewed key themes and solutions and noticed some typos on: Page 64 Key Themes- developing is spelled wrong and page 66- university is spelled incorrectly.

I am requesting the opportunity on our January conference call to discuss the burden of adding any additional regulatory and certifying bodies for school-based wellness telemedicine centers. I was cut off during our last phone call and since Howard County has been through this current certification procedure seven times, I think our experience would be of value to the group and its future recommendations.

Thank you.

Sharon

Sharon Hobson, MSN, CPNP-PC

School Health Programs Administrator

Howard County Health Department

8930 Stanford Boulevard

Office: (410) 313-7238

Fax: (410) 313-6108

From: Justine Springer -MDH- [mailto:justine.springer@maryland.gov]
Sent: Friday, December 21, 2018 2:24 PM
To: Alicia Mezu -MSDE-; Alyssa L. Brown -DHMH-; Angela Mezzomo; arlene.tyler@bmsi.org; Masiulis, Barbara A.; bzektick@alexander-cleaver.com; Benjamin A. Wolff -MDH-; benjamin.harper@maryland.gov; bbenassa@dictumhealth.com; Carmen Brown -MSDE-; Cheryl DePinto -DHMH-; Danna Kauffman; Flax, David; David Monroe; Daniel.mosebach@carefirst.com; davinathurt@yahoo.com; dpercy@alexander-cleaver.com; Rivkin, Deborah; dsomerville@bcps.org; Young, Diane J.; Donna; Elizabeth Vaidya -MDH-; etocknell@alexander-cleaver.com; Dorrien, Erin; Carter, Ernest L.; ggerlacher@pmpediatrics.com; gransom@medchi.org; gteshome@peds.umaryland.edu; H. Neal Reynolds; Helen Hughes; ihuoma.emenuga@baltimorecity.gov; Ingrid Zimmer Galler; Jenene Washington; jennifer_r_morris@yahoo.com; Witten, Jennifer; Joan.Glick@montgomerycountymd.gov; John Kornak; Joy.Twesigye@baltimorecity.gov; Julie.wagner@carefirst.com; KATHY FRISCH; Bryant, Kelly M. (CCPS); ken klebanow; Gorman, Kristy M; larawilson@mdruralhealth.org; Larry Epp; Laura.J.Howard@kp.org; Kelley, Laura; Laurie G Kuiper; Lesley.Wallace@medstar.net; Lynne Muller -MSDE-; Marcella Franczkowski -MSDE-; Mark Luckner -DHMH-; Mary Stein; mcelentano@fblaw.com; Meredith.Borden@carefirst.com; Palmer, Michelle L; mick connors; mking54@jhmi.edu; miriam struck; Mordechai Raskas; Namisa K. Kramer -MDH-; Nancy C. Brown -DHMH-; Lever, Nancy; NMSMITH@salisbury.edu; Nina W. McHugh -DHMH-; Pam Metz; Paul.Andrews@patientfirst.com; Pooja A. Regmi -DHMH-; Rachael Faulkner; rgattu@peds.umaryland.edu; Rebecca Canino; Sabah Iqbal; spfeifer@mdmassp.org; Scott Strahlman, MD; Hobson, Sharon; Sindy Benavides; Lawson, Sonia; Stephanie.Zawada@heritage.org; tlball@maesp.org; Vijay.Ramasamy@baltimorecity.gov; Walter Sallee -MSDE-; wprice@phiers.org; xue.dai@carefirst.com; ytoribio@pmpediatrics.com; Loughran, Kathleen G.; catherinecarr@hsph.harvard.edu; Claire Seibert -MDH-; Earl Tucker -MDH-; Jill Spector -MDH-; Margaret Berman -MDH-; Molly Marra; Monasha Holloway -MDH-; Monchel D. Pridget -MDH-; Rosemary Murphey -MDH-; Moira A. Lawson -MDH-
Cc: David Sharp -DHMH-; Angela Evatt -DHMH-; Eva Lenoir -MDH-; Bridget Zombro -DHMH-; Megan Renfrew -MDH-; Laura Spicer; Brenna Tan; Charles Betley
Subject: Response Requested: Workgroup Draft Interim Report Review

[Note: This email originated from outside of the organization. Please only click on links or attachments if you know the sender.]

Hello all,

We hope this email finds you well. The Maryland Health Care Commission (MHCC) has completed a draft of the School-Based Telehealth Workgroup interim report, as requested by the Senate Finance Committee (Committee). The draft report provides the Committee with an update on the progress of the workgroup. Proposed recommendations are not included, as we intend to continue discussions with the workgroup to finalize potential recommendations in the summer. Attached you will find a copy of the draft report for your review.

We ask that workgroup members send us your comments and feedback either in an email or a separate Word document by **Wednesday, January 9th**. In the spirit of transparency, all comments will be compiled and included in the

appendix of the draft report prior to sharing with the Committee. We apologize for the quick turnaround time and any inconvenience this may cause.

We greatly appreciate your contribution to the workgroup effort and taking the time out of your busy schedule to review the draft report. We look forward to working with you in the New Year and continuing our progress. Please do not hesitate to contact me if you have any questions.

Happy Holidays!

Regards,

Justine

Justine Springer, MPH
Program Manager
Maryland Health Care Commission
Center for Health Information Technology and Innovative Care Delivery
4160 Patterson Avenue
Baltimore, MD 21215
Office: (410) 764-3777
Fax: (410) 358-1236

Website: mhcc.maryland.gov/

Facebook: www.facebook.com/mhcc.md
Twitter: www.twitter.com/mhccmd

Health Care Quality Reports: healthcarequality.mhcc.maryland.gov

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Justine Springer -MDH- <justine.springer@maryland.gov>

Additional Suggested Revisions

1 message

Hobson, Sharon <shobson@howardcountymd.gov> Mon, Dec 31, 2018 at 10:04 AM
To: "Justine Springer -MDH- (justine.springer@maryland.gov)" <justine.springer@maryland.gov>
Cc: "dsharp@maryland.gov" <dsharp@maryland.gov>

Hello again.

I shared the interim report with our Health Officer and she had the following recommendations:

- Page 3: Please clarify that SHS is referring to school health services that are traditionally provided in health suites and that these records are included in the educational record and covered under FERPA. School-based health centers operated by agencies other than school systems maintain separate records covered under HIPAA.

- Baltimore City and Charles – please provide dates when these services started since they report when HCHD services started.

Thank you.

Sharon

Sharon Hobson, MSN, CPNP-PC

School Health Programs Administrator

Howard County Health Department

8930 Stanford Boulevard

Office: (410) 313-7238

Fax: (410) 313-6108

Justine Springer -MDH- <justine.springer@maryland.gov>

Re: Response Requested: Workgroup Draft Interim Report Review

1 message

Epp, Larry <larry.epp@fs-inc.org> Fri, Jan 4, 2019 at 10:02 AM
To: Justine Springer -MDH- <justine.springer@maryland.gov>

Dear Justine,

I wanted to add a comment. We recently had our IT department do an estimate to start up a high quality Video Teleconferencing System to enable Telepsychiatry between our Outpatient Mental Health Clinic in Montgomery County and a high school in Prince Georges County. Prince Georges County faces a serious shortage of child psychiatrists. We discovered the start up and maintenance costs exceeded our expectations. To purchase high quality equipment at both the distant and originating sites would cost $5117.61. The annual cost for the internet service to support this system would be $1020.00. I cite this example because it illustrates that grant support would be necessary to initiate school based telehealth projects. We developed this estimate only because a governmental agency could potentially underwrite the start up costs. My recommendation would be state or governmental funding would be essential to start up telehealth projects. Their start up cost are presently too costly to rely on future reimbursement from Medicaid billing. Without initial grant support, I fear the dissemination of this promising technology will be too gradual to make the impact we wish to see.

On Fri, Dec 21, 2018 at 2:24 PM Justine Springer -MDH- <justine.springer@maryland.gov> **wrote:**

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Health Care Quality Reports: healthcarequality.mhcc.maryland.gov

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Larry Epp, Ed.D.
Director of School Mental Health Services
Linkages to Learning Program (Montgomery County) &
Transforming Neighborhoods Initiative at School
(Prince George's Community Schools Network)
Clinical Consultant to Care & Connections to Families
(Child Crisis Stabilization Program)
Family Services, Inc.
Part of the Sheppard Pratt Health System
620 East Diamond Avenue, Suite H
Gaithersburg, Maryland 20877
240-683-6580 Extension 205
240-683-6586 (Fax)
301-351-6139 (Cell)
240-708-2167 (Text)
larry.epp@fs-inc.org
Website: www.fs-inc.org
Facebook.com/FamilyServicesInc
Twitter.com/FamilyServInc

MARYLAND

Justine Springer -MDH- <justine.springer@maryland.gov>

Re: Response Requested: Workgroup Draft Interim Report Review

1 message

Carmen Brown -MSDE- <carmen.brown1@maryland.gov> Wed, Jan 9, 2019 at 1:37 PM
To: Justine Springer -MDH- <justine.springer@maryland.gov>
Cc: Marcella Franczkowski -MSDE- <marcella.franczkowski@maryland.gov>

Justine,

Marcella and I have reviewed the document and would like to offer comments specific to: the Special Education Services portion of the draft report on pages 5 & 6.

I have attached a document with the bulk of our comments, but would like to also add the following:

In paragraph one, sentence two on page 5: please amend to read: Special Education **provides** specially designed instruction..... with a disability **and may include related services.**

In that same paragraph, please substitute (Local School System) **LSS** for LEA

At the top on page 6, please change: Teletherapy can help to facilitate treatment for certain students and decrease stigma..... **to:** Teletherapy can help to facilitate **the provision of related services** for certain students and decrease stigma **that may be associated.....**

I am not in the office today which is the reason the comments are not presented in one format. If you prefer, I can update the document tomorrow and submit all comments in one document.

Thank you for your time and consideration.

Carmen

CHANGING Maryland for the Better

Carmen A. Brown, LCSW-C
Branch Chief, Interagency Collaboration
MD State Department of Education
Division of Early Intervention/
Special Education Services
200 West Baltimore Street
Baltimore, Maryland 21201
410-767-7197 (office)
410-333-1571 (fax)
carmen.brown1@maryland.gov

On Fri, Dec 21, 2018 at 2:24 PM Justine Springer -MDH- <justine.springer@maryland.gov> wrote:

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>
> We hope this email finds you well. The Maryland Health Care Commission (MHCC) has completed a draft of the School-Based Telehealth Workgroup interim report, as requested by the Senate Finance Committee (Committee). The

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facilities and equipment, enrollment and consent, and patient confidentiality.[32] SBHCs must meet all required standards to provide in-person services.

In order to provide telehealth services, SBHCs must meet more than 25 criteria related to telehealth.[33, 34] Examples include procedures for communicating required prescriptions and orders for laboratory or imaging studies, administering medications, technical protocols for testing and maintenance of telehealth equipment, identifying clinical goals for the telehealth encounter, and documenting the encounter in the patient's medical record. The workgroup will consider policies over the next six months that could allow SBHCs greater flexibility in achieving State recognition when implementing telehealth.

Special Education Services

All Maryland schools provide special education and related services, as required by law. Special education includes specially designed instruction to meet the unique needs of a student with a disability. Related services include occupational therapy, speech therapy, and other services to support students with disabilities. The Individuals with Disabilities Education Act of 2004 (IDEA)[35] aims to ensure students with disabilities are provided with free and appropriate education. IDEA and Maryland regulations,[36] which implement the requirements of IDEA, govern how State agencies and local school systems' education agencies (LEAs) provide early intervention, special education, and related services to eligible children and youths with disabilities.[37]

Many families and school districts with students with special needs find it difficult to gain access to qualified professionals, especially in rural areas where workforce shortages exist.[38] Incorporating teletherapy[39] into special education programs can assist school districts that may be struggling to find qualified specialist-related service professionals. Students with special

experiencing shortages of qualified related service professionals within their geographic area.

(This statement is not related to the provision of IEP services

with developing policy recommendations to improve the health and education outcomes of students who receive services from SBHCs.

[32] Maryland State Department of Education. *Maryland School-Based Health Center Standards*. April 2006. Available at: http://marylandpublicschools.org/about/Documents/DSFSS/SSSP/SBHC/MarylandStandardsSBHC2018.pdf.

[33] SBHCs must be approved to provide services via telehealth by MSDE under guidance from MDH.

[34] See Appendix F for the Maryland School-Based Health Center Telehealth Checklist.

[35] 20 U.S. Code Chapter 33 – Education of Individuals with Disabilities.

[36] COMAR 13A.05.01 *Provision of a Free Appropriate Public Education to Students with Disabilities*, and COMAR 13A.08.03 *Discipline of Students with Disabilities*.

[37] IDEA and Maryland regulations require that each child with a disability has an IEP designed to meet their unique and individual needs.

[38] Telemedicine Journal and e-Health. *Telemedicine for Children with Developmental Disabilities: A More Effective Clinical Process Than Office-Based Care*. February 2015. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4312787/.

[39] The term *teletherapy* is defined as the application of telecommunications technology to delivery of professional services at a distance and is intended to include both non-medical therapeutic services (e.g., mental health counseling, psychoeducational assessments) and non-clinical services (e.g. occupational therapy, speech therapy, etc.).

needs often face unique logistical and sometimes behavioral barriers in accessing care.[40] For example, special transportation, equipment, or attendants may be needed to enable a provider visit. Traveling long distances to unfamiliar health care facilities may exacerbate anxiety, fear or aggression in students with behavioral challenges. Teletherapy can help to facilitate treatment for certain students and decrease the stigma associated with being removed from a classroom to receive services. Evidence suggests that use of teletherapy for delivery of special education related services can be equivalent and, in some cases, more effective as in-person.[41, 42] The MSDE and MDH do not have policies that impact a school's use of teletherapy. The workgroup will consider policies in the first half of 2019 that could lead to greater diffusion of teletherapy in schools.

Privacy and School-Based Telehealth

The Family Educational Rights and Privacy Act (FERPA)[43] and Maryland student records regulation[44] protect the privacy of student education records. Under FERPA, education records generally may not be released to third parties without parental consent.[45] FERPA also gives parents and students the right to inspect and review the student's education records. A student's health records, maintained by the school[46] including the school nurse, are considered part of the education record and are subject to FERPA.[47, 48]

A school is subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)[49] when it provides care through its SBHC or clinic, and maintains health information not in a student's education record. The school is also subject to HIPAA if it engages in a HIPAA-covered

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[40] See n. 38, *Supra*

[41] American Journal of Speech Language Pathology. *Comparing Traditional Service Delivery and Telepractice for Speech Sound Production Using a Functional Outcome Measure*. February 2018. Available at: https://www.ncbi.nlm.nih.gov/pubmed/29180278.

[42] Archives of Assessment Psychology. *Equivalence of Remote, Online Administration and Traditional, Face-to-Face Administration of Woodcock-Johnson IV Cognitive and Achievement Tests*. 2018. Available at: http://www.assessmentpsychologyboard.org/journal/index.php/AAP/article/view/122.

[43] 20 U.S.C. § 1232g, Family Educational and Privacy Rights.

[44] COMAR 13A.08.02, Student Records.

[45] 34 CFR Part 99, Family Educational Rights and Privacy. December 2018. Available at: https://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&sid=11975031b82001bed902b3e73f33e604&rgn=div5&view=text&node=34%3A1.1.1.1.33&idno=34.

[46] Schools subject to FERPA include those educational agencies and institutions that receive funds under any program administered by the U.S. Department of Education.

[47] U.S. Department of Health and Human Services and U.S. Department of Education. *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*. November 2008. Available at: https://www2.ed.gov/policy/gen/guid/fpco/doc/ferpa-hippa-guidance.pdf.

[48] The health records of an eligible student that do not meet the definition of an education record are not subject to FERPA.

[49] 45 CFR Part 160(A); 45 CFR Part 164(E). More information is available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=58542bd6be129f38e90e0979f4b4d909&mc=true&node=sp45.1.160.a&rgn=div6; https://www.ecfr.gov/cgi-bin/text-idx?SID=58542bd6be129f38e90e0979f4b4d909&mc=true&node=sp45.1.164.e&rgn=div6.

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David Sharp, PhD, Director

Center for Health Information Technology and

Innovative Care Delivery

4160 Patterson Avenue

Baltimore, MD 21215

410-764-3460

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