Meeting Minutes
CT Kids Report Card Leadership Committee Meeting:
Tuesday, September 16th, 2014 Quarterly Meeting
9:30AM in Room 2B of the LOB

1. Welcome and Co-Chairs Remarks
   a. The meeting was convened at 9:47AM.
   b. Co-Chair David Nee provided opening remarks regarding today's agenda.
2. School-Based Health Centers (SBHCs): A State Strategy for making Connecticut Kids Better Off
   a. Presentation by Connecticut Association of School Based Health Centers (CASBHC)
      i. Jesse White-Fresè provided a brief history of the establishment of SBHCs as a response to reports of declining health in children nationwide. Over time SBHCs having physical and mental health services was prioritized. Jesse White-Fresè stated that SBHCs have proven to improve attendance, grades, test scores, and the handling of chronic health issues. She noted in addition to physical health, everything going on physically and mentally at home is carried into the school and can be expressed in a school environment, making it critical for schools to be aware of these issues and have the capacity to respond. Jesse White-Fresè then presented a comparative chart of the traditional school nurse role and SBHCs to illustrate how these two models share various responsibilities throughout a school system and/or the school district. She delved deeper into the mental health services and community references SBHCs provide to children. She also discussed how school social worker duties differ from SBHC mental health services provided. Her report briefly highlighted some of the mental health issues SBHCs receive/treat and that some sites provide dental services. Jesse White-Fresè then presented information on the impact that SBHCs play in schools and communities, notably the impact poor health has on school performance. Jesse White-Fresè went on to discuss ongoing challenges regarding SBHCs. Funding continues to be a challenge, as it is often either time limited at a private level or unstable at the governmental level. Jesse White-Fresè discussed the need to maintain the integrity of the model to heighten the privacy and trust they can have in the SBHCs. A clear definition of SBHCs is needed, as well as implementation of an electronic health records in order to have accurate and disaggregated data for consistent analysis.
   b. Questions
      i. Rep. Urban asked if Jesse White-Fresè believes there is a positive relationship between SBHCs and absenteeism. Jesse White-Fresè responded that there is because SBHCs can treat conditions that would otherwise cause the student to leave school. She noted this relationship is acknowledged partially through data and partially through anecdotes from students and parents in focus groups. She indicated that anecdotes have shown children felt trust, safety, and privacy at the centers, but also learned new behaviors to assist in their emotional/mental health issues.
      ii. Rep. Whit Betts asked whether the visits at SBHCs are shared with the primary care doctor, is the SBHC physician considered their primary care doctor, or do they often not have a primary care doctor at all. Jesse White-Fresè noted that some students that use SBHCs do not have primary care doctors, but students can only use a SBHC if their parents sign a legal form and provide the child's medical history to the SBHC. This history would include information for the SBHC to contact the child's primary care doctor if applicable. Rep. Betts stated his concern that the SBHC may be making decisions for the child such as tests that would otherwise be decided by their primary care doctor and the risk of miscommunication. Jesse White-Fresè responded that SBHCs are required to have a collaborative relationship with the primary care doctor, as they are co-managing the child's care. Rep. Betts asked if SBHC physicians are allowed to make referrals to specialists. Jesse White-Fresè responded they can, but would be required to notify the primary care doctor immediately. Rep. Betts asked what kind of funding is required and what it would take to sustain. Jesse White-Fresè indicated current funding for SBHC sites in the state is 11 million dollars. SBHCs that serve students with HUSKY are reimbursed by the state for their services and legislation years ago allowed SBHCs to work with private insurers to bill them as well. Additional funds SBHCs seek are often through local non-governmental organizations like United Way. Rep. Betts stated he is concerned that a successful model would overextend itself or that the state is overextended when funding long-term programs that need consistent operational support.
      iii. Sen. Bartolomeo asked whether the SBHCs could become a resource for DCF and DPH to increase family and youth engagement in medical homes in accordance with Public Act 13-178. Jesse White-Fresè responded that there are a number of SBHCs that are considered medical homes because their sponsoring organization is an Federally Qualified Health Center (FQHC), which is has achieved a status of medical home. However, some of the requirements to be given that status (ex: open for longer hours and year-round) are difficult to achieve in the SBHC.
      iv. Morna Murray asked how the SBHCs can drill down on the data they are collecting for children that use their mental health services and whether they have data on referrals to community providers for mental health services. Jesse White-Fresè responded any data collected by the SBHC, which would include the use of mental health services and referrals to community providers would be transmitted to DPH.
   c. Status of CT SBHCs: how much are they doing, how well are they doing it and is anyone better off?
      i. Mark Keenan indicated state assistance for SBHCs is largely within highly concentrated populations with high levels of poverty. The SBHCs supported include both mental and physical health for children with a variety of health insurance statuses. In fiscal year 2011 83 sites were given funding by DPH, and in fiscal year 2015 96 sites will be partially funded by DPH. A total of 24 contractors will receive this funding in 29 towns. An additional 39 SBHCs are licensed,

but not funded. He noted Alliance Districts received a lot of focus in the Education Reform Act passed in 2012 with a focus on providing SBHC funding to those districts with need, roughly 11 sites, of which 6 were given funding to expand. Mark Kennan did note that eight Alliance districts do not have a SBHC yet and provided the number of SBHCs per-town. He then highlighted how many individuals are enrolled in SBHCs, those youths served and those youths who used mental health vs. medical health services, and the total number of visits. Mark Kennan highlighted that the majority of youths enrolled in SBHCs are enrolled in public insurance (Medicaid) and most SBHCs funded by DPH do receive reimbursements from Medicaid. He then discussed SBHCs have analyzed the key measures that were identified by the Program Review and Investigation (PRI): Enrollment & utilization, immunizations, psychological functioning, asthma, obesity, STDs, oral health (if applicable), cultural competency, and annual satisfaction surveys. These measures as well as others are subsequently produced into RBA inspired report cards by site and provided an example for the members to view. Mark Keenan highlighted discussions DPH is having with SBHCs regarding a longitudinal study, challenges, technical assistance, and training on RBA to SBHCs.

ii. Joanna Davis presented the level of accountability and data required by DPH from SBHCs. She stated the transition has been gradual for those entities required to transmit data to DPH switch to filing health records through an electronic system. The primary issue with these systems is that there is not a universal system. Her presentation lists 13 different electronic health record systems used throughout the state. Reports for the data are developed to go along with the data spreadsheets and provided a brief summary of the various disaggregations like insurance status, demographics, etc. The hope is that these reports will be easier and more quickly produced in conjunction with the data once all the organizations they collaborate with transition to electronic data reporting systems.

d. Questions
   i. Rep Urban asked if the overall enrollment rate staying flat because of limited funding. Mark Keenan responded that in a number of SBHCs inadequate staffing creates a limiting factor that keeps enrollment flat. Rep. Urban provided comment on the savings that would be produced using the SBHCs versus the emergency department. Mark Keenan added that 90% of students receiving mental health services through the SBHC were reported as having improved their behavioral health and classroom behavior.
   ii. Sen. Bartolomeo asked why the sharing of academic information is not done or allowed in the majority of cases. Mark Keenan responded that the barrier is primarily local policies through the boards of education. Bennett Pudlin added both federal and local can be implicated here, but if presented on a pilot basis, he could attempt to work through the challenges of personally identifiable data by presenting it at an aggregate, state-wide level to understand if students have overall higher levels of academic achievement and performance because of SBHCs. Charlene Russell-Tucker added that she agreed, and SDE can begin to have these conversations with DPH regarding SBHCs.
   iii. David Nee recommended Bennett Pudlin, Charlene Russell-Tucker, and Mark Keenan convene and discuss how to effectively collect this data and advise this group on the best approach. David Nee asked Joanna Davis when she thinks those not on an electronic reporting system will have adapted to that system. Joanna Davis responded that starting this school year, all but two contractors will be using an electronic health records. Despite the fact that most are providing electronic records, many are still going through ACCESS because not all of the required information is being collected on their electronic record systems. Joanna Davis stated it would likely be at least another year before even the sites doing electronic collection starting this year can move on to just doing electronic health records for all their data.

e. How Healthy are Connecticut Adolescents? Presentation by Celeste Jorge of DPH
   i. Celeste Jorge started by discussing the trend in teenage fatalities from 2002-2011, indicating a drop by roughly 20 fatalities per 100,000 during that time, though disparities between white and black teens remain high. She then presented overweight children of high-school age, noting that all categories except Hispanic students were below the national average and a gap between white and Black/African American as well as Hispanic exists. Celeste Jorge then presented students who felt sad or hopeless and those who had seriously considered suicide. She noted the various gender and racial gaps that existed in both sets of data. Binge drinking in Connecticut saw a gradual decline that dipped below the national level for the first time in 2013. Drug use by high school students also dipped below the national average in 2009 and 2011 but aligned with national levels in 2013. Celeste Jorge then presented data on teen births. Celeste Jorge presented data on the rate of uninsured children in Connecticut, which has consistently been half of the national rate, but has changed very little in the past six years.

f. Discussion of strategies to ensure access to high quality, efficient and effective school-based health centers. (This section was not covered)

3. Electronic Report Card/Website Update (This section was not covered)
4. Children's Behavioral Health Developments (This section was not covered)
5. Next Steps for the Leadership Committee (This section was not covered)
6. Other Business
   a. David Nee indicated that future meeting agendas would have time-limits.
   b. Charlene Russell-Tucker provided a brief update regarding the Chronic Absenteeism Strategic Action Group.
7. Adjourn
   a. The meeting was adjourned at 11:37AM