School Based Health Center (SBHC) Expansion Working Group
Final Report

Issued pursuant to Section 16 of Public Act 21-35, An Act Equalizing Comprehensive Access To Mental, Behavioral And Physical Health Care In Response To The Pandemic

February 2022

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I. Charge of the School Based Health Center Expansion Working Group

The School Based Health Center Expansion Working Group was charged with developing recommendations for the strategic expansion of school based health center services in the state.

The workgroup considered the following items outlined in Section 16 of Public Act 21-35, An Act Equalizing Comprehensive Access To Mental, Behavioral, And Physical Health Care In Response To The Pandemic (the Act's full language can be found in Appendix D):

(a.) Specific geographical regions of the state where additional school based health centers may be needed
(b.) Options to expand or add services at existing school based health centers
(c.) Methods for providing additional support for school based health centers to expand telehealth services
(d.) Options for expanding insurance reimbursement for school based health centers
(e.) Options to expand access to school based health centers or expand school based health center sites, which may include establishing school based mental health clinics

The committee met four times (December 16, 2021, January 6, 2022, January 26, 2022, and January 31, 2022) to discuss the five criteria above. Recommendations and details of the meetings are outlined in this report. All notes and PowerPoint presentations are contained in Appendix C.

II. Membership of the School Based Health Center Expansion Working Group

Ann Gionet (Co-Chair), Health Program Supervisor, Department of Public Health
(designee of Manisha Juthani, Commissioner of Public Health)

Dana Robinson-Rush, Heath Program Assistant 2, Department of Social Services
(designee of Deidre S. Gifford, Commissioner of Social Services)

John Frassinelli, Division Director, State Department of Education
(designee of Charlene M. Russell-Tucker, Commissioner of Education)

Tim Marshall, Director Office of Community Mental Health, Department of Children and Families
(designee of Vannessa Dorantes, Commissioner of Children and Families)

Alice Forrester (Co-Chair), CEO, Clifford Beers
(designee of Vannessa Dorantes, Commissioner of Children and Families)

Jill Holmes Brown, Chief Operating Officer, Integrated Health Services

Melanie Wilde Lane, Director of Branford School Based Health Center

Lena Bahar, Associate Insurance Examiner, State Insurance Department
(designee of Andrew N. Mais, Insurance Department)

Senator Mary Abrams, Chairperson of the Public Health Committee

Representative Jonathan Steinberg, Chairperson of the Public Health Committee

Senator Heather Somers, Ranking Member of the Public Health Committee

Senator Tony Hwang, Ranking Member of the Public Health Committee

Representative Bill Petit, Ranking Member of the Public Health Committee

Senator Cathy Osten, Chairperson of Appropriations

Representative Toni Walker, Chairperson of Appropriations

Senator Craig Miner, Ranking Member of Appropriations

Representative Mike France, Ranking Member of Appropriations

Sara LeMaster, Manager, Community Health Center Association of Connecticut

Susan Halpin, Executive Director, Connecticut Association of Healthcare Plans

Jane Hylan, Director of School Based Health Services, Community Health Center, Inc.

III. Recommendations

The School Based Health Center (SBHC) Expansion Working Group strongly recommends the following:

Geographic regions where additional SBHCs are needed

1. The Working Group combined multiple databases and utilized the Centers for Disease Control and Prevention (CDC) Social Vulnerability Index (SVI) and federally designated Health Professional Shortages Areas (HPSA) to identify priority schools that presently do not have a school based health center. As a result, 157 schools identified in 21 towns are recommended to be considered for potential SBHCs.

Options to expand or add services at existing SBHCs

The Working Group utilized the same methodology as noted above to identify SBHC sites that may be expanded or services to be added; two proposals were identified.

Recommendation #1. Fund 36 sites located in 11 towns identified in this report that provide no mental health services;

OR

Recommendation #2. Fund 124 sites located in 22 towns identified in this report that provide mental health and/or medical services, but where services are not offered full time.

Methods to expand telehealth services

1. Continuation of funding and support for telehealth for mental health services and medical care at Connecticut SBHCs in order to meet student demand related to the COVID-19 pandemic and beyond.

2. Additional support and funding for SBHC workforce expansion, which would promote the hiring of more clinical staff to serve a greater number of Connecticut's children through telehealth, mobile and in person visits to address need due to the mental health crisis.

Options for expanding insurance reimbursement

1. Current blending of funding is inadequate to address the crisis-based needs of children, families, and schools resulting from the pandemic. Continue to explore insurance reimbursement with both commercial and public insurance entities. Focus attention on reimbursement as the present system for behavioral health reimbursement is not equal in funding amounts or documentation requirements.

2. As SBHCs are identified as essential community providers, work to expand availability of SBHCs to more communities to address rising demand for children's mental health services by providing on-going screening, preventative education supports, direct behavioral health services, and linkage to community providers.

Options for expansion of school based mental health services

Refer to above "Geographic regions where additional SBHCs are needed" and **"**Options to expand or add services at existing SBHCs."

IV. School Based Health Centers

a. Definition

The definitions of "school-based health center" and "expanded school health site" were established through Public Act 15-59, An Act Concerning School Based Health Centers.

A SBHC means a health center that (b.1[1]):

1. Is located in, or on the grounds of, a school facility of a school district or school board or of an Indian tribe or tribal organization;
2. is organized through school, community and health provider relationships;
3. is administered by a sponsoring facility; and
4. provides comprehensive on-site medical ***and*** behavioral health services to children and adolescents in accordance with state and local law, including laws relating to licensure and certification.

An expanded school health site means a health center that (b.1):

1. Is located in, or on the grounds of, a school facility of a school district or school board;
2. is organized through school, community, and health provider relationships;
3. is administered by a sponsoring facility; and
4. provides medical ***or*** behavioral services, including, but not limited to, dental services, counseling, health education, health screening and prevention services, to children and adolescents in accordance with state and local laws, including laws relating to licensure and certification.

It should be noted that "school based mental health clinic" is not a term that is presently used in statute. An entity meeting criteria 1.-4. above that solely provides behavioral health services would be considered an expanded school health site.

b. Benefits

SBHCs are intentionally located in schools where students are predominantly members of disadvantaged, minority, or ethnic populations, who have historically experienced health care access disparities and are often publicly insured, underinsured, or uninsured.

Evidence from recent studies reveal the following benefits and impacts of SBHCs (b.2):

- Better access to health services – Healthier families and students
- Healthy students learn better – Gains in student academic success
- Helps build trust - Families connect with the school
- Attendance rates increase – Dropout rates decrease
- Lower Medicaid costs
- Reduced emergency room usage

[1] "b.1" refers to the first source referenced in Appendix B, see page 40. Henceforth, other sources are annotated similarly.

- More time at work – Increase families' financial security

Health outcomes and educational achievement are interrelated. Health issues (e.g., vision and oral health problems, asthma, teen pregnancy, malnutrition, obesity, chronic stress, trauma, and risk-taking behaviors) are associated with high student absenteeism, dropout rates and low scholastic performance. By addressing physical and mental health issues and providing consistent support, SBHCs help students to be mentally and physically healthy, to stay in school and be able to reach their full potential in school and in life.

c. Client stories

The following stories have been graciously shared by individuals attending a Connecticut public school, noting the support they received from school based health center staff.

Celia's Story

Celia is a freshman in high school who loves to dance. However, she began exhibiting signs of depression in the years following her father's unexpected death, which began to impact her school performance and relationships with family members. Concerned for her emotional wellbeing, Celia's school psychologist referred her to the school based health center program for individual and family therapy.

The SBHC clinician arranged to meet Celia and her family in their home, as school buildings were closed due to the pandemic. Through the assessment process, the SBHC team learned that Celia and her five siblings were legally in the care of their 25-year-old sister, Monica, due to their mother's struggles with addiction. Stress at home was high, as Monica worked a full-time job while also attending college and trying to support Celia and her siblings. Celia and Monica argued often and did not communicate well. These recent stressors, coupled with a history of unresolved loss and trauma, overwhelmed Celia's ability to safely cope with her feelings and she began having suicidal thoughts and cutting herself to express her emotional pain.

The SBHC clinician recognized that stabilization services and safety planning were imperative and worked with Monica to arrange brief respite care for Celia. During this time, the SBHC clinician provided Monica with individualized caregiver sessions to provide emotional support. Once Celia was safe and ready to return home, the SBHC clinician arranged for Celia's medication management to continue through a community service provider and collaborated closely with the school to ensure that academic accommodations were put in place for successful distance learning.

Celia and her sister Monica engaged in therapy with the SBHC clinician multiple times per week. During this time, Celia began processing the unresolved grief, loss, and trauma she had experienced while also learning healthy, safe ways to cope with distress. Monica and Celia worked together to understand the ways in which stress and trauma affected their relationship and to develop healthier ways to communicate. Additionally, to lessen the financial burden on Monica, the SBHC program was able to use philanthropic dollars to provide gift cards for groceries and other basic needs.

Within six months, Celia's mood, behavior, and relationship with others improved significantly.

She began participating in school and even made the honor roll two marking periods in a row. Surprised and proud of herself, she stated "I never had good grades like this before!" Her sister Monica reports that their relationship has changed for the better, stating "Celia has proven her maturity...I have no complaints!" Celia's motivation and social engagement have also improved, as she currently works as a summer camp counselor and plans to try out for the volleyball team next school year.

Marcus's Story

Marcus is a bright 10-year-old boy who has always loved school. He is talkative, funny, and likes to make jokes. But a few months into his fifth-grade school year, his mother noticed that Marcus just wasn't himself. His sense of humor and playful demeanor diminished and he became increasingly angry, disrespectful, and defiant at home. He started having difficulty concentrating in school and lacked motivation to complete his work or participate in class. His mother shared her concerns with his teacher, who then made a referral for therapy with the school based mental health clinician.

During the intake process, the SBHC clinician learned that Marcus had been physically abused by an extended family member while visiting his grandmother over summer vacation. After further assessment and screening, it became clear that Marcus's change in mood and behavior directly resulted from the trauma he had experienced months prior.

Marcus began meeting weekly with his SBHC clinician to develop skills to cope with distressing thoughts and feelings, so that he could effectively process the traumatic event, function well at home and in school, and get back to feeling like himself again. His mother also participated in individual parenting support to help repair and strengthen communication and family interactions.

By spring, Marcus's mother saw noticeable improvements at home, stating that "he opens up more," "takes responsibility for his actions," and "'takes space when he needs to." Marcus was equally proud to share that he "doesn't get as mad as much anymore," and that he and his mother now talk through their problems rather than avoiding them, stating, "My mom apologized for [something she said]. Before, we never would even talk about it." Marcus made notable progress at school as well. His teacher reported that his effort and attention to schoolwork had improved so significantly that he was presented with an achievement award. Marcus eagerly ran down the hallway to his Project Strengthening Opportunities from Adversity to Resilience (SOAR) clinician's office to share the good news.

As the school year came to a close, follow-up assessments showed that Marcus was no longer exhibiting clinically significant trauma-related symptoms and successfully completed therapy. Now, a year after the traumatic event occurred, Marcus's mother provided his SBHC clinician with an update, stating that "He is doing really well! There are no issues. He is really looking forward to coming back to school!"

d. DPH funded SBHC data collection and reporting

In school year 2020-2021, DPH funded 90 SBHCs (this included 12 expanded school based health centers). These sites served 28 towns in CT, and have a total student population of approximately

67,200, which is about 13% of Connecticut's overall student population. Enrollment in these clinics was approximately 54% of the total population (or 36,000) and the number of unduplicated students served was approximately 13,000.

Data on medical and mental health visits is collected from all the DPH funded sites. Related to medical visits, collected data includes, but is not limited to, insurance information, number of physicals, BMI status (percent overweight and obese), screenings done to identify children at risk, asthma incidence, and visit outcomes. In the past two years, COVID-19 data has also been collected, including information on the numbers of students tested (576) and with a positive test result (60); and at the end of last year, the number of students vaccinated (62). There were 25,711 medical visits in the 2019-2020 school year. Mental health data is collected on insurance information, number of visits per client (average being 11.3), number achieving treatment goals and outcomes.

Although SBHCs implemented telehealth services for both medical and mental health care following the onset of the COVID-19 pandemic in the 2019-2020 school year, medical services were difficult to perform; this problem persisted into the following school year since most schools were still offering remote learning. Initiation of mental health telehealth services led to multiple technical difficulties being experienced, e.g., students not having access to laptops or internet connections, and difficulties figuring out how telehealth software worked (there was a steep learning curve). By the beginning of 2020-2021 many of these problems were resolved, resulting in a substantial increase in mental health visits, almost back to pre-pandemic levels. In the 2020-2021 school year, over 19,000 of the more than 51,000 mental health visits were done via telehealth.

Approximately 23% of the students seen at DPH funded centers have no health insurance. This is data collect directly from the DPH funded SBHCs and had been consistent for the past several years. As a result, they have limited access to health care providers. SBHCs provide easy access to care in school, resulting in much less missed class time. Students that do have insurance are primarily covered by public insurance (about 60% of the total students seen) with the remainder (17%) having private insurance coverage. These numbers vary from site to site, corresponding closely to the socioeconomic and SVI status of each school's population.

V. Areas of Focus

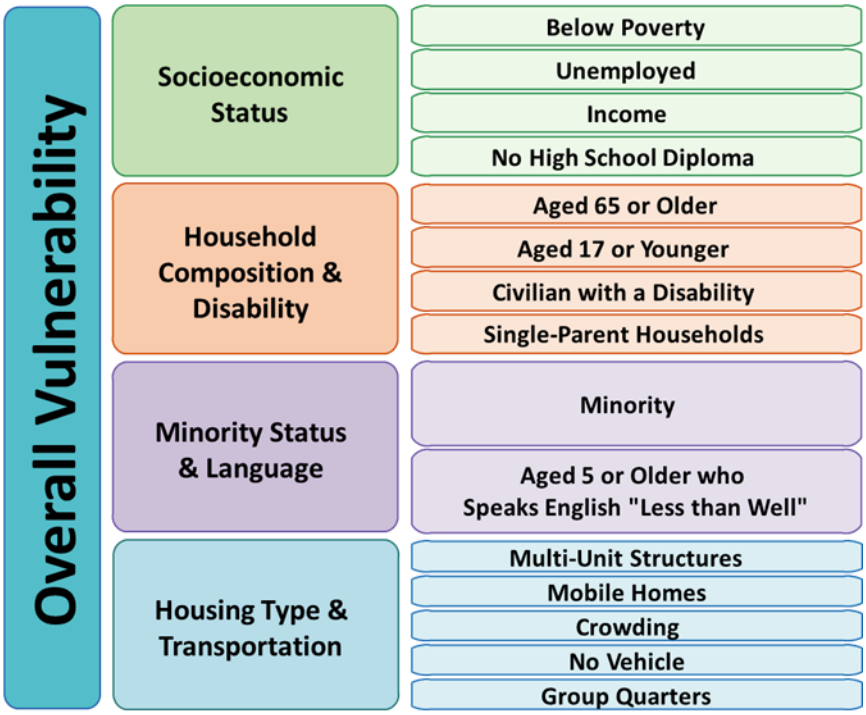
a. Geographic regions where additional SBHCs are needed

This past year, SBHCs experienced slightly lower numbers of visits than during the 2018-2019 school year, which was the last full school year prior to COVID-19. Schools shut down in March 2020 for the remainder of that school year. The SBHCs located within those schools also closed and there were no on-site visits to the SBHC for almost a third of the school year. These sites turned to remote telehealth visits with mixed success.

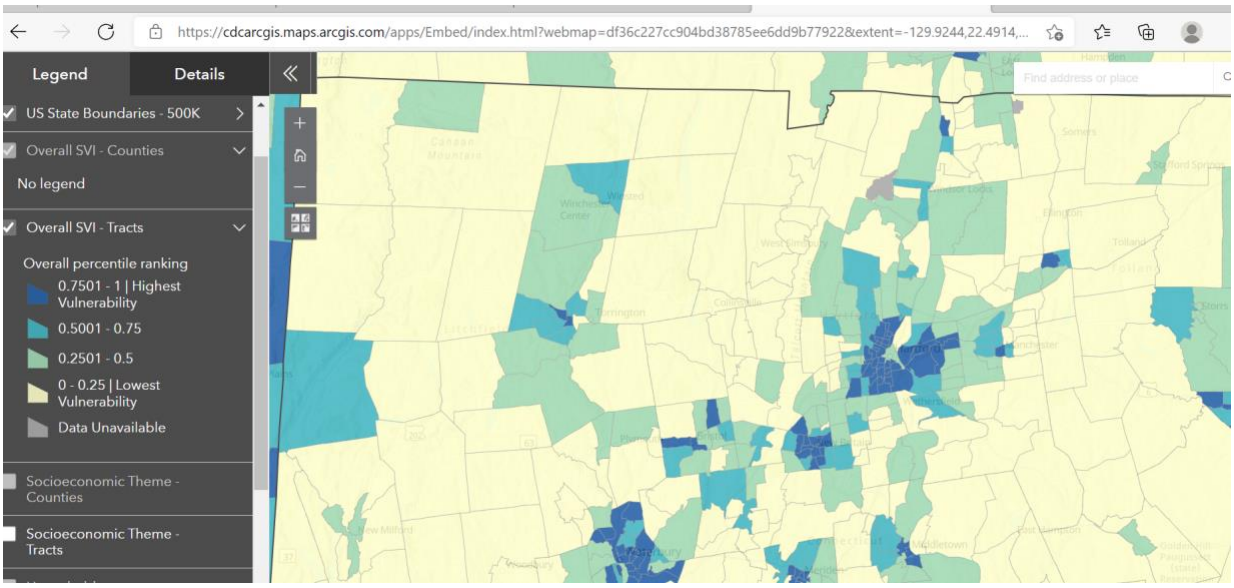
Now that students are back in school, and in light of the mental health epidemic for Connecticut's children, expansion of SBHCs in Connecticut is being evaluated. In looking at Connecticut towns where an expansion of SBHCs could possibly take place, data was collected from DPH funded School Based Health Centers, DPH's Facility Licensing and Investigations Section, the CT State Department of Education, the Department of Children and Families, School-Based Health Alliance, community health centers, the Centers for Disease Control and Prevention, and the Health Resources and Services Administration. Data on all schools in CT was collected. Public, charter, magnet, technical and regional school data was compiled to be considered. Of the 999 schools reviewed, 694 did not have any type of SBHC services. The sites were then further scrutinized to assess their specific level of need based on the characteristics of the towns in which they are located.

First, the schools that were not located in a high SVI area were excluded from the analysis. SVI is a CDC assessment tool used to assess which areas (measuring down to census tract level) are in most need of help after disasters (such as hurricanes, pandemics, and tornadoes). SVI scores were used by DPH during the COVID-19 pandemic to determine where mobile vans were needed to test and vaccinate Connecticut residents around the state. The SVI ranks communities based on fifteen social factors, grouped under four overarching categories (see chart below). The SVI scores range from 1-4, from least to most needy.

Below are the four categories and fifteen subcategories for SVI scoring.



Below is an example of a map showing part of Connecticut and indicating the four different levels of SVI. See Appendix C (c.6) for similar maps of the state and each of the eight counties.

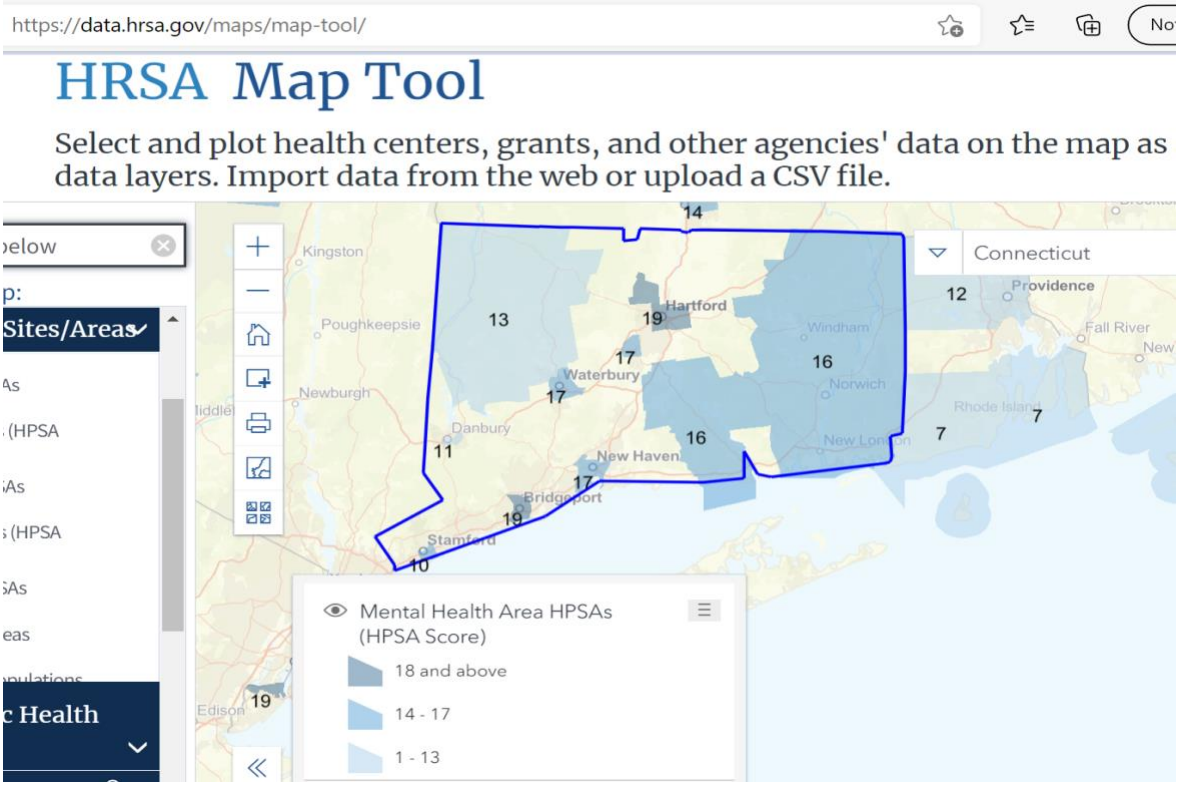


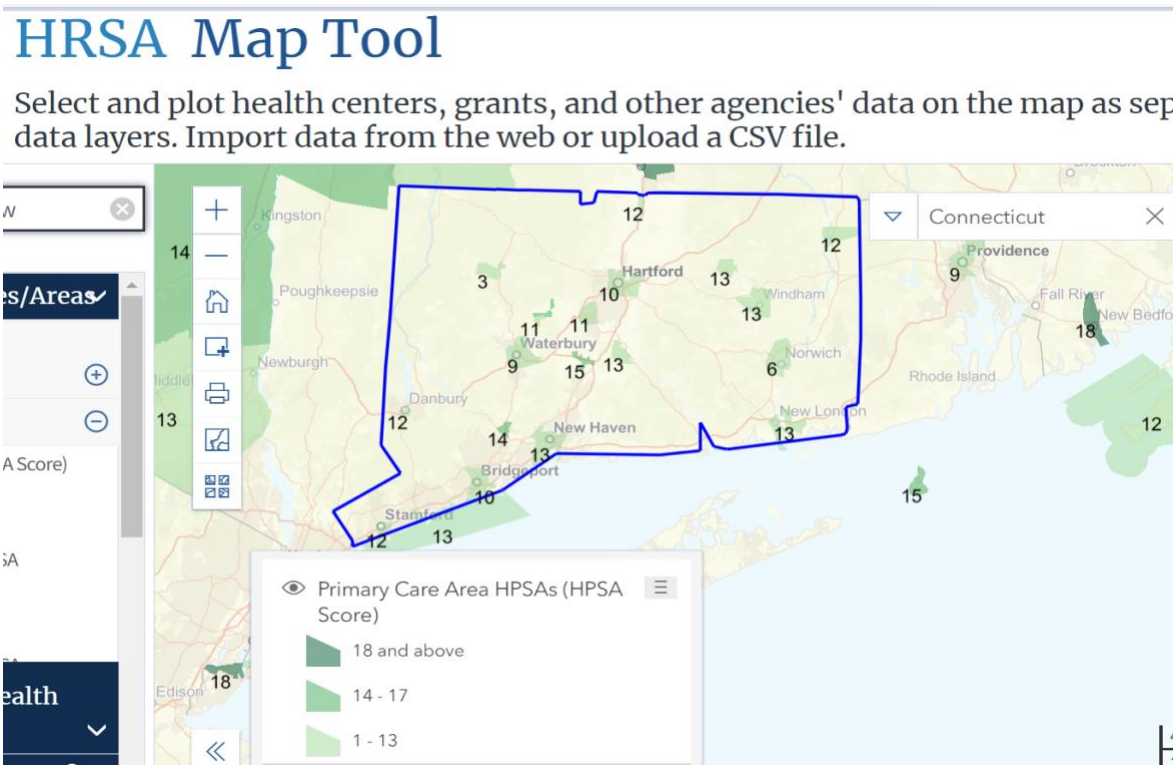
After excluding the schools that were in the highest SVI group (rank of 4), there were 229 potential schools left. These were then scored based on how many census tracts within the town were high SVI, with the number of high SVI census tracts ranging from 1 to 29. The results were then evenly

distributed into six categories, ranking from 1 being the lowest number of high SVI census tracts to 6 being the highest. Grouping the data in this manner allows for a more even weighting of the different variables that contributed to the needs assessment. Without this categorization, SVI would become the predominant factor in the analysis; the towns with the most SVI census tracts would be determined to have the sites with the highest scores, regardless of other indicators of need.

Next, each school's town was reviewed to see if the school was located in a designated medical and/or mental health Health Professional Shortage Area. HPSAs are designated by the U.S. Health Resources and Services Administration (HRSA) to identify areas which are determined to experience a shortage of health care professionals. There are both medical and mental health designations. Each school was then assigned a value of 1 if in a designated area, 0 if not in a designated area, and 0.5 if in a partially designated area. Geographic HPSAs can be determined by census tracts, towns, counties, or regions. Much of Connecticut is designated as a mental health HPSA. As shown in the map below, the entire eastern part of the state, and Middlesex and Litchfield counties fall within designated areas. So do the larger cities including Hartford, New Haven, Bridgeport, Waterbury, East Hartford, Danbury and New Britain. There are far fewer areas designated as medical HPSAs, and they are mostly located in the larger cities and towns in the state.

Below are maps of the HPSAs in Connecticut, both mental health and medical.





Another factor utilized in the ranking of these sites was school population. Each school's population data was assigned to one of six categories, 1 being the least populated to 6 being the most populated. Populations at these schools ranged from 107 to 1,492.

Utilizing the SVI, HPSA designation and school population datapoints, the sites were scored and subsequent rankings were made based on the sum of these three variables. 157 schools were determined to have a score of 4 or more. These are the recommended school sites to be considered for potential SBHCs.

Below is the ranking and scoring template.

City	School Name	Population	One or More High SVI tract	Number of high SVI	SVI rank *	Pop rank **	MH HPSA ***	Medical HPSA ***	score
Town in CT	*General HS*	*number of students in school*	*1*	*range from 1-29*	*1-6*	*0-6*	*0 -1*	*0-1*	*= #SVI rank + Pop rank + MH HPSA + Medical HPSA*

Listed below are the 21 towns that had schools selected.

City	School Count
Bridgeport	24
Danbury	3
East Hartford	11
Griswold	3
Groton	3
Hartford	18
Killingly	4
Manchester	1
Montville	1
New Britain	2
New Haven	24
New London	3
Norwich	4
Stamford	8
Torrington	2
Waterbury	29
Waterford	2
West Hartford	4
West Haven	7
Winchester	1
Windham	3
TOTAL	157

Most of the 157 sites recommended for SBHCs are in the poorest cities and towns in the state, which are also the areas where DPH funded sites are predominantly located. The table on the following page presents the data for each of the 157 schools.

157 Schools Recommended for New SBHCs

Rank Scoring for 157 Sites

Rank	population
1	250
2	500
3	750
4	1,000
5	1,250
6	1,500

Rank	# High SVI
1	1-5
2	6-10
3	11-15
4	16-20
5	21-25
6	26-30

Rank	HPSA Mental Health	HPSA Medical Health
0	Not Designated	Not Designated
.5	Partially Designed	Partially Designed
1	Designated	Designated

City/Town	School Name	Population	Number of high SVI	SVI Rank *	Pop Rank **	MH HPSA ***	Medical HPSA ***	Score
Hartford	Achievement First Hartford Academy	1,164	27	6	5	1	1	13
Bridgeport	Achievement First Bridgeport Academy	1,127	29	6	5	1	1	13
New Haven	Amistad Academy	1,134	21	5	5	1	1	12
Bridgeport	Capital Preparatory Harbor School	785	29	6	4	1	1	12
New Haven	DiLoreto Elementary and Middle School	806	21	5	4	1	1	11
New Haven	Elm City College Preparatory School	774	21	5	4	1	1	11
Bridgeport	Geraldine Johnson School	750	29	6	3	1	1	11
Hartford	Jumoke Academy	686	27	6	3	1	1	11
Bridgeport	Great Oaks Charter School	670	29	6	3	1	1	11
Hartford	Capital Preparatory Magnet School	660	27	6	3	1	1	11
Hartford	Sport and Medical Sciences Academy	606	27	6	3	1	1	11
Bridgeport	New Beginnings Inc. Family Academy	502	29	6	3	1	1	11
Waterbury	John F. Kennedy High School	1,216	19	4	5		1	10
New Haven	Conte/West Hills Magnet School	662	21	5	3	1	1	10
New Haven	Ross/Woodward School	639	21	5	3	1	1	10
New Haven	Cooperative High School - Inter-District Magnet	630	21	5	3	1	1	10
Hartford	Environmental Sciences Magnet at Hooker School	573	27	6	3		1	10
New Haven	John C. Daniels	515	21	5	3	1	1	10
New Haven	Beecher School	511	21	5	3	1	1	10
New Haven	Benjamin Jepson Magnet School	501	21	5	3	1	1	10
Bridgeport	Park City Magnet School	498	29	6	2	1	1	10
Bridgeport	Inter-District. Discovery Magnet School	486	29	6	2	1	1	10
Bridgeport	Black Rock School	474	29	6	2	1	1	10
Bridgeport	Biotechnology, Research & Zoological Studies Magnet High School	467	29	6	2	1	1	10
Hartford	Classical Magnet School	452	27	6	2	1	1	10
Bridgeport	Six-Six Magnet School	449	29	6	2	1	1	10
Bridgeport	Multicultural Magnet School	439	29	6	2	1	1	10

Hartford	Greater Hartford Academy of the Arts Human Services	439	27	6	2	1	1	10
Hartford	Global Communications Academy	438	27	6	2	1	1	10
Hartford	University High School of Science and Engineering	431	27	6	2	1	1	10
Bridgeport	Classical Studies Academy	425	29	6	2	1	1	10
Bridgeport	Madison School	413	29	6	2	1	1	10
Bridgeport	Geraldine Claytor Magnet Academy	403	29	6	2	1	1	10
Hartford	Naylor/CCSU Leadership Academy	388	27	6	2	1	1	10
Bridgeport	Information Tech and Software Engineering Magnet High School	374	29	6	2	1	1	10
Hartford	Montessori Magnet at Batchelder School	373	27	6	2	1	1	10
Bridgeport	Park City Prep Charter School	360	29	6	2	1	1	10
Hartford	Montessori Magnet at Fisher School	360	27	6	2	1	1	10
Hartford	Breakthrough Magnet School	358	27	6	2	1	1	10
Hartford	Montessori Magnet School	358	27	6	2	1	1	10
Hartford	Greater Hartford Academy of the Arts Magnet Middle School	349	27	6	2	1	1	10
Hartford	STEM Magnet at Annie Fisher School	342	27	6	2	1	1	10
Bridgeport	Bridgeport Military Academy	340	29	6	2	1	1	10
Bridgeport	Bryant School	310	29	6	2	1	1	10
Bridgeport	Beardsley School	292	29	6	2	1	1	10
Bridgeport	Hallen School	284	29	6	2	1	1	10
Bridgeport	The Bridge Academy	281	29	6	2	1	1	10
Waterbury	West Side Middle School	935	19	4	4		1	9
Waterbury	North End Middle School	896	19	4	4		1	9
Waterbury	Waterbury Career Academy	807	19	4	4		1	9
New Haven	Booker T. Washington Academy	480	21	5	2	1	1	9
New Haven	Highville Charter School	447	21	5	2	1	1	9
New Haven	East Rock Community Magnet School	435	21	5	2	1	1	9
New Haven	Betsy Ross Arts Magnet School	405	21	5	2	1	1	9
New Haven	Worthington Hooker School	400	21	5	2	1	1	9
New Haven	Celentano BioTech, Health and Medical Magnet School	359	21	5	2	1	1	9
New Haven	Wexler/Grant Community School	338	21	5	2	1	1	9
New Haven	Sound School	328	21	5	2	1	1	9
New Haven	New Haven Academy	297	21	5	2	1	1	9
New Haven	Barack H. Obama Magnet University School	284	21	5	2	1	1	9
New Haven	Edgewood School	264	21	5	2	1	1	9
New Haven	Elm City Montessori School	259	21	5	2	1	1	9
New Haven	Quinnipiac Real World Math STEM School	253	21	5	2	1	1	9
Hartford	Betances STEM Magnet School	229	27	6	1	1	1	9
Bridgeport	A.B. Skane Center	205	29	6	1	1	1	9
Bridgeport	Edison School	196	29	6	1	1	1	9
Hartford	Hartford PreKindergarten Magnet School	180	27	6	1	1	1	9
Bridgeport	Hall School	175	29	6	1	1	1	9
Waterbury	ACES at Chase	720	19	4	3		1	8
Waterbury	Rotella InterD. Magnet School	613	19	4	3		1	8
Waterbury	Maloney InterD. Magnet School	590	19	4	3		1	8

Waterbury	B. W. Tinker School	524	19	4	3		1	8
Waterbury	Margaret M. Generali Elementary School	518	19	4	3		1	8
New Haven	Common Ground High School	236	21	5	1	1	1	8
New Haven	West Rock Authors Academy	157	21	5	1	1	1	8
West Hartford	Hall High School	1,492	3	1	6			7
West Hartford	Conard High School	1,453	3	1	6			7
West Haven	Harry M. Bailey Middle School	927	8	2	4		1	7
East Hartford	Connecticut River Academy at Goodwin University	533	8	2	3	1	1	7
East Hartford	Dr. Thomas S. O'Connell School	530	8	2	3	1	1	7
Waterbury	Duggan School	473	19	4	2		1	7
Waterbury	Carrington School	469	19	4	2		1	7
Waterbury	Waterbury Arts Magnet School	455	19	4	2		1	7
Waterbury	Reed School	454	19	4	2		1	7
Waterbury	F. J. Kingsbury School	453	19	4	2		1	7
Waterbury	Bunker Hill School	450	19	4	2		1	7
Waterbury	Gilmartin School	447	19	4	2		1	7
Waterbury	Woodrow Wilson School	414	19	4	2		1	7
Waterbury	Waterbury Arts Magnet School (Middle)	373	19	4	2		1	7
Waterbury	Walsh School	355	19	4	2		1	7
Waterbury	Hopeville School	325	19	4	2		1	7
Waterbury	Wendell L. Cross School	321	19	4	2		1	7
Waterbury	Bucks Hill School	312	19	4	2		1	7
Waterbury	Washington School	286	19	4	2		1	7
Stamford	Rogers International School	811	5	1	4	1	0.5	6.5
Waterford	Waterford High School	778	1	1	4	1		6
Groton	Ella T. Grasso Technical High School	578	2	1	3	1	1	6
East Hartford	Riverside Magnet Schat Goodwin University	478	8	2	2	1	1	6
New London	Science and Tech Magnet Pathway for High School	470	7	2	2	1	1	6
East Hartford	Pathways Academy of Technology and Design	426	8	2	2	1	1	6
East Hartford	Robert J. O'Brien School	368	8	2	2	1	1	6
East Hartford	Joseph O. Goodwin School	350	8	2	2	1	1	6
East Hartford	Sunset Ridge Middle School	346	8	2	2	1	1	6
East Hartford	Governor William Pitkin School	301	8	2	2	1	1	6
East Hartford	Anna E. Norris School	271	8	2	2	1	1	6
New London	Harbor Elementary School	260	7	2	2	1	1	6
Waterbury	Regan School	207	19	4	1		1	6
Waterbury	Special Education Preschool	165	19	4	1		1	6
New Britain	House of Arts Letters and Science (HALS) Academy	163	15	3	1	1	1	6

Waterbury	Hopeville Bilingual	163	19	4	1		1	6
Waterbury	Chase Bilingual	152	19	4	1		1	6
New Britain	New Britain HS Satellite Careers Academy	131	15	3	1	1	1	6
Waterbury	Enlightenment School	126	19	4	1		1	6
Waterbury	State Street School	112	19	4	1		1	6
Stamford	The Academy of Information, Tech and Engineering	652	5	1	3	1	0.5	5.5
Stamford	Scofield Middle School	643	5	1	3	1	0.5	5.5
Stamford	Davenport Ridge School	609	5	1	3	1	0.5	5.5
Stamford	Northeast School	571	5	1	3	1	0.5	5.5
Stamford	Westover School	569	5	1	3	1	0.5	5.5
Stamford	Hart School	564	5	1	3	1	0.5	5.5
Stamford	Newfield School	513	5	1	3	1	0.5	5.5
Manchester	Elisabeth M. Bennet Academy	889	2	1	4			5
West Hartford	King Philip Middle School	871	3	1	4			5
West Hartford	Sedgwick Middle School	867	3	1	4			5
Killingly	Killingly High School	746	1	1	3	1		5
Danbury	Westside Middle School Academy	744	5	1	3	0.5	0.5	5
Killingly	H. H. Ellis Technical High School	717	1	1	3	1		5
Killingly	Killingly Intermediate School	636	1	1	3	1		5
Winchester	Northwestern Regional High School	624	1	1	3	1		5
Griswold	Griswold Elementary School	619	1	1	3	1		5
Danbury	Park Avenue School	597	5	1	3	0.5	0.5	5
Waterford	Clark Lane Middle School	581	1	1	3	1		5
Griswold	Griswold Middle School	525	1	1	3	1		5
Danbury	Shelter Rock School	518	5	1	3	0.5	0.5	5
Killingly	Killingly Memorial School	513	1	1	3	1		5
Montville	Leonard J. Tyl Middle School	509	2	1	3	1		5
Griswold	Griswold High School	503	1	1	3	1		5
Windham	Windham Technical High School	478	5	1	2	1	1	5
West Haven	Savin Rock Community School	444	8	2	2		1	5
Windham	North Windham School	431	5	1	2	1	1	5
Norwich	Moriarty Magnet School	425	5	1	2	1	1	5
Groton	Northeast Academy Elementary School	406	2	1	2	1	1	5
West Haven	Washington School	403	8	2	2		1	5
West Haven	Forest School	398	8	2	2		1	5
West Haven	Seth G. Haley School	382	8	2	2		1	5
West Haven	Alma E. Pagels School	362	8	2	2		1	5
Norwich	Integrated Day Charter School	353	5	1	2	1	1	5
Groton	Charles Barnum School	351	2	1	2	1	1	5
Torrington	Forbes School	308	4	1	2	1	1	5
Norwich	Samuel Huntington School	297	5	1	2	1	1	5
West Haven	Edith E. Mackrille School	293	8	2	2		1	5
Windham	Natchaug School	288	5	1	2	1	1	5
Torrington	Southwest School	286	4	1	2	1	1	5
Norwich	Uncas Elementary School	251	5	1	2	1	1	5

New London	New London Visual & Performing Arts Magnet School	235	7	2	1	1	1	5
East Hartford	Woodland School	195	8	2	1	1	1	5
East Hartford	Connecticut IB Academy	182	8	2	1	1	1	5
	* See ranking score tab							
	** See ranking score tab							
	*** HPSA ranking score tab							

Disclaimer - Schools may or may not meet the physical plant requirements to establish a SBHC.

b. Options to expand or add services at existing SBHCs

The committee was also asked for a list of sites that could be recommended for expansion of their hours of service. This would pertain to schools that do not currently offer full time services. There are 305 part time SBHCs in Connecticut. This was derived from databases that contain SDE school number, school name, address, grade levels, DPH licensure information, DCF licensure information, and hours of operation for both medical and mental health services. To determine which sites are in the highest need areas and have the least amount of service hours, SVI, school population, mental health and medical HPSA designations were once again considered, along with the actual hours of service listed on licensure documents for both medical and mental health care. This data was collected from multiple sources: DPH funded SBHCs, HRSA, School Based Health Alliance (SBHA), SDE, DCF, and school websites. After eliminating the sites that were not in a high SVI town, 124 sites remained.

One option would be to fund all of the 36 sites that currently provide no mental health services to add these services. This would be a relatively easier and lower cost option since expenses would only need to be incurred to support additional staff and use of a room (space for counseling). Since these sites already have a health care facility license, they could add mental health services easily.

Below is the list of towns and number of sites per town that make up the 36. A detailed listing is found on the following page.

City	Number of Sites
East Haven	3
Enfield	5
Meriden	5
Middletown	6
Montville	1
New Britain	7
New London	1
Norwich	2
Stamford	4
Waterbury	1
Winchester	1
Total	36

Recommended 36 sites for Expanded Mental Health Services

Ranking for Expanded SBHCs

Rank	Population
1	350
2	700
3	1050
4	1400
5	1750

Rank	# High SVI
1	1-4
2	5-8
3	9-12
4	13-16
5	17-20

Rank	HPSA Mental Health	HPSA Medical Health
0	Not Designated	Not Designated
0.5	Partially Designed	Partially Designed
1	Designated	Designated

Rank	Hours of service
0	Full time Services (31+)
1	4 Days a week
2	3 Days a week
3	2 Days a week
4	1 Day a week
5	No hours

Rank	Licensed
0	Not Licensed
1	licensed

School Name	City	Population	Number of high SVI	Pop rank	SVI rank	Medical HPSA	MH HPSA	Med hours rank	MH hours rank	DCF Licensed	Total Score
Slade Middle School	New Britain	842	15	3	4	1	1	5	0	1	15
ACES Chase	Waterbury	656	19	2	5	1	1	5	0	0	14
Diloreto Magnet school	New Britain	806	15	3	4	1	1	5	0	0	14
Smith Elementary School	New Britain	484	15	2	4	1	1	5	0	1	14
Vance Elementary School	New Britain	478	15	2	4	1	1	5	0	1	14
Jefferson Elementary School	New Britain	445	15	2	4	1	1	5	0	1	14
Chamberlain Elementary School	New Britain	412	15	2	4	1	1	5	0	1	14
Holmes Elementary School	New Britain	479	15	2	4	1	1	5	0	0	13
Kelly STEAM Magnet Middle School	Norwich	656	5	2	2	1	1	5	0	1	12
Julia A. Stark School	Stamford	574	5	2	2	0.5	1	5	0	1	11.5
Roxbury School	Stamford	570	5	2	2	0.5	1	5	0	1	11.5
Springdale School	Stamford	541	5	2	2	0.5	1	5	0	1	11.5
Enfield High School	Enfield	1,521	2	4	1	0.5	0	5	0	1	11.5

John B. Stanton School	Norwich	316	5	1	2	1	1	5	0	1	11
Israel Putnam School	Meriden	517	8	2	2	0.5	0	5	0	1	10.5
Nathan Hale School	Meriden	515	8	2	2	0.5	0	5	0	1	10.5
John Barry School	Meriden	482	8	2	2	0.5	0	5	0	1	10.5
Roger Sherman School	Meriden	479	8	2	2	0.5	0	5	0	1	10.5
Turn of River School	Stamford	663	5	2	2	0.5	1	5	0	0	10.5
John F. Kennedy Middle School	Enfield	1,112	2	3	1	0.5	0	5	0	1	10.5
Snow School	Middletown	332	3	1	1	0.5	1	5	0	1	9.5
Lawrence School Elementary School	Middletown	304	3	1	1	0.5	1	5	0	1	9.5
Bielefield School	Middletown	255	3	1	1	0.5	1	5	0	1	9.5
Moody School	Middletown	210	3	1	1	0.5	1	5	0	1	9.5
Batcheller Early Education Center	Winchester	249	1	1	1	0	1	5	0	1	9
Edison Middle School	Meriden	400	8	1	2	0.5	0	5	0	0	8.5
Farm Hill School	Middletown	305	3	1	1	0.5	1	5	0	0	8.5
Prudence Crandall School	Enfield	373	2	1	1	0.5	0	5	0	1	8.5
Eli Whitney School	Enfield	352	2	1	1	0.5	0	5	0	1	8.5
Enfield Street School	Enfield	258	2	1	1	0.5	0	5	0	1	8.5
Montville High School	Montville	496	2	2	1	0	1	3	0	1	8
Dominick H. Ferrara School	East Haven	165	1	1	1	0	0	5	0	1	8
Overbrook Early Learning Center	East Haven	107	1	1	1	0	0	5	0	1	8
MacDonough School	Middletown	209	3	1	1	0.5	1	3	0	1	7.5
Inter D. School for Arts & Communication	New London	281	7	1	2	1	1	2	0	0	7
Momauguin School	East Haven	280	1	1	1	0	0	3	0	1	6

* See SVI - ranking score tab
** See Population - ranking score tab
*** See HPSA - ranking score tab
**** See Medical and Mental Health Hours ranking score tab
***** See DCF - ranking score tab

Disclaimer - Schools may or may not meet the physical plant requirements to establish a SBHC.

The second option would be to fund an expansion of hours at all or some of the 124 sites. Utilizing a methodology similar to that applied to determine geographic need (as described above), these sites were ranked according to their SVIs counts, populations, HPSA medical and mental health designations, DCF licensure status (0 for not licensed or 1 for licensed), hours of service ranging from 0 to 5 (0 for having full time (31+) hours of services, to 5 for sites with no service hours). Many of the sites have full time services for one type of care (medical or mental health) but not the other.

Scores for the 124 sites range from 5.5 to 21. Although there is a wide range in total scores, this is mostly attributable to variability in populations and SVI rankings. By including hours of service in the ranking methodology, the variability in scores was mitigated. However, hours of service may be subject to frequent change and thus this data point can be the hardest to verify. Additionally, different sources listed different hours of operation for the same site. If funding were to be given based on rankings formulated with data on hours of service, the number of hours should be directly verified for each site.

Below is the ranking and scoring template.

City	School Name	Population	Number of high SVI	SVI rank	Pop rank	Medical HPSA	Mental Health HPSA	Med hours rank	MH hours rank	DCF Licensed	total Score
Town in CT	*General HS*	*Number of students in school*	*1-27*	*1-5*	*1-5*	*0-1*	*0-1*	*0-5*	*0-5*	*0 or 1*	*= SVI rank + Pop rank + Medical HPSA + MH HPSA + Medical hours rank + Mental hours rank + DCF licensing*

Below is the list of towns and number of sites by town included in the 124.

City	Number of Sites
Ansonia	1
Bristol	11
East Hartford	4
East Haven	5
Enfield	9
Hartford	16
Manchester	8
Meriden	9
Middletown	8
Montville	1
New Britain	9
New Haven	4
New London	1
Norwalk	14
Norwich	4
Plainfield	2
Stamford	6
Torrington	4
Waterbury	2
West Haven	1
Winchester	2
Windsor Locks	3
TOTAL	124

Recommended 124 Schools for Expanded SBHC Medical and Mental Health Services

Ranking for Expanded SBHCs

Rank	Population
1	350
2	700
3	1050
4	1400
5	1750

Rank	# High SVI
1	1-4
2	5-8
3	9-12
4	13-16
5	17-20

Rank	HPSA Mental Health	HPSA Medical Health
0	Not Designated	Not Designated
0.5	Partially Designed	Partially Designed
1	Designated	Designated

Rank	Hours of service
0	Full time Services (31+)
1	4 Days a week
2	3 Days a week
3	2 Days a week
4	1 Day a week
5	No hours

Rank	Licensed
0	Not Licensed
1	licensed

School Name	City	Pop-ulation	number of high SVI	SVI rank	Pop rank	Medical HPSA	MH HPSA	Med hours rank	MH hours rank	DCF Licensed	Total Score
Hartford Magnet Trinity College Academy	Hartford	1,026	27	5	3	1	1	5	5	1	21
Webster Micro Society Magnet School	Hartford	642	27	5	2	1	1	5	5	1	20
Bishop Woods Architecture and Design Magnet School	New Haven	444	21	4	2	1	1	5	5	1	19
SAND School	Hartford	286	27	5	1	1	1	5	5	1	19
Wish Museum School	Hartford	285	27	5	1	1	1	5	5	1	19
West Middle School	Hartford	262	27	5	1	1	1	5	5	1	19
Burns Latino Studies Academy	Hartford	241	27	5	1	1	1	5	5	1	19
Kennelly School	Hartford	605	27	5	2	1	1	3.5	5	1	18.5
Carrigan 5/6 Intermediate School	West Haven	823	8	2	3	1	1	5	5	1	18
Academy of Science and Innovation	New Britain	778	15	3	2	1	1	5	5	1	18
Metropolitan Business Academy	New Haven	398	21	4	1	1	1	5	5	1	18

Sprague School ES	Waterbury	388	19	4	1	1	1	5	5	1	18
Brennan Rogers School	New Haven	356	21	4	1	1	1	5	5	1	18
High School In The Community	New Haven	278	21	4	1	1	1	5	5	1	18
Parkville Community School	Hartford	385	27	5	1	1	1	3.5	5	1	17.5
McDonough Middle School	Hartford	345	27	5	1	1	1	3.5	5	1	17.5
Milner Middle School	Hartford	328	27	5	1	1	1	3.5	5	1	17.5
Burr Middle School	Hartford	324	27	5	1	1	1	3.5	5	1	17.5
Renzulli Gifted and Talented Academy	Hartford	122	27	5	1	1	1	3.5	5	1	17.5
Manchester High School	Manchester	1,640	2	1	5	0	0	5	5	1	17
Bristol Eastern High School	Bristol	1,108	3	1	3	1	1	5	5	1	17
Torrington Middle School	Torrington	988	4	1	3	1	1	5	5	1	17
Greene-Hills School	Bristol	898	3	1	3	1	1	5	5	1	17
Torrington High School	Torrington	888	4	1	3	1	1	5	5	1	17
West Bristol School	Bristol	843	3	1	3	1	1	5	5	1	17
Two Rivers Magnet Middle School	East Hartford	676	8	2	2	1	1	5	5	1	17
A. I. Prince Technical High School	Hartford	781	27	5	2	1	1	2	4	1	16
Chippens Hill Middle School	Bristol	694	3	1	2	1	1	5	5	1	16
Norwich Technical High School	Norwich	681	5	1	2	1	1	5	5	1	16
Torringford Elementary School	Torrington	591	4	1	2	1	1	5	5	1	16
Vogel-Wetmore School	Torrington	514	4	1	2	1	1	5	5	1	16
South Side School	Bristol	467	3	1	2	1	1	5	5	1	16
Edgewood School	Bristol	428	3	1	2	1	1	5	5	1	16
Northeast Middle School	Bristol	421	3	1	2	1	1	5	5	1	16
Illing Middle School	Manchester	852	2	1	3	0	0	5	5	1	15
Bulkeley High School	Hartford	592	27	5	2	1	1	0	5	1	15
Plainfield High School	Plainfield	553	1	1	2	0	1	5	5	1	15
Plainfield Central School	Plainfield	479	1	1	2	0	1	5	5	1	15
Ellen P. Hubbell School	Bristol	374	3	1	1	1	1	5	5	1	15
Ivy Drive School	Bristol	358	3	1	1	1	1	5	5	1	15
Stafford School	Bristol	327	3	1	1	1	1	5	5	1	15
Mountain View School	Bristol	316	3	1	1	1	1	5	5	1	15
Silvermine Dual Language Magnet School	Norwalk	466	6	1	2	0.5	0	5	5	1	14.5

Tracey Magnet School	Norwalk	453	6	1	2	0.5	0	5	5	1	14.5
Hanover School	Meriden	440	8	2	2	0.5	0	5	4	1	14.5
Civic Leadership High School	Enfield	410	2	1	2	0.5	0	5	5	1	14.5
Stamford Charter School for Excellence	Stamford	391	5	1	1	0.5	1	5	5	1	14.5
Benjamin Franklin School	Meriden	343	8	2	1	0.5	0	5	5	1	14.5
Thomas Hooker ES	Meriden	319	8	2	1	0.5	0	5	5	1	14.5
New Britain HS Satellite Careers Academy	New Britain	131	15	3	1	1	1	5	3.5	0	14.5
Slade Middle School	New Britain	842	15	3	3	1	1	5	0	1	14
Verplanck School	Manchester	434	2	1	2	0	0	5	5	1	14
Waddell School	Manchester	405	2	1	2	0	0	5	5	1	14
M. L. King, Jr. Middle School	Hartford	274	27	5	1	1	1	0	5	1	14
Rawson School	Hartford	255	27	5	1	1	1	0	5	1	14
Ansonia Middle School	Ansonia	365	1	1	1	0.5	0	5	5	1	13.5
Wolfpit School	Norwalk	303	6	1	1	0.5	0	5	5	1	13.5
Diloreto Magnet school	New Britain	806	15	3	3	1	1	5	0	0	13
ACES Chase	Waterbury	656	19	4	2	1	1	5	0	0	13
Smith Elementary School	New Britain	484	15	3	2	1	1	5	0	1	13
Vance Elementary School	New Britain	478	15	3	2	1	1	5	0	1	13
Jefferson Elementary School	New Britain	445	15	3	2	1	1	5	0	1	13
Chamberlain Elementary School	New Britain	412	15	3	2	1	1	5	0	1	13
Teachers' Mem. Global Studies Magnet MS	Norwich	407	5	1	2	1	1	5	2	1	13
South Elementary School	Windsor Locks	330	1	1	1	0	0	5	5	1	13
Keeney School	Manchester	303	2	1	1	0	0	5	5	1	13
Highland Park School	Manchester	288	2	1	1	0	0	5	5	1	13
Grove J. Tuttle School	East Haven	259	1	1	1	0	0	5	5	1	13
Martin School	Manchester	233	2	1	1	0	0	5	5	1	13
Stillmeadow School	Stamford	610	5	1	2	0.5	1	5	3	0	12.5
Thomas Hooker School	Meriden	305	8	2	1	0.5	0	5	3	1	12.5
Holmes ES	New Britain	479	15	3	2	1	1	5	0	0	12
Enfield High School	Enfield	1,521	2	1	4	0.5	0	5	0	1	11.5
Spencer School	Middletown	252	3	1	1	0.5	1	5	3	0	11.5
East Hartford High School	East Hartford	1,675	8	2	5	1	1	0	2	0	11
Kelly STEAM Magnet Middle School	Norwich	656	5	1	2	1	1	5	0	1	11

John F. Kennedy Middle School	Enfield	1,112	2	1	3	0.5	0	5	0	1	10.5
Julia A. Stark School	Stamford	574	5	1	2	0.5	1	5	0	1	10.5
Roxbury School	Stamford	570	5	1	2	0.5	1	5	0	1	10.5
Springdale School	Stamford	541	5	1	2	0.5	1	5	0	1	10.5
Israel Putnam School	Meriden	517	8	2	2	0.5	0	5	0	1	10.5
Nathan Hale School	Meriden	515	8	2	2	0.5	0	5	0	1	10.5
John Barry School	Meriden	482	8	2	2	0.5	0	5	0	1	10.5
Roger Sherman School	Meriden	479	8	2	2	0.5	0	5	0	1	10.5
Henry Barnard School	Enfield	336	2	1	1	0.5	0	5	2	1	10.5
Edgar H. Parkman School	Enfield	318	2	1	1	0.5	0	5	2	1	10.5
Carbone School/East Haven Academy	East Haven	303	1	1	1	0	0	5	3.5	0	10.5
The Gilbert School	Winchester	452	1	1	2	0	1	0	5	1	10
John B. Stanton School	Norwich	316	5	1	1	1	1	5	0	1	10
Turn of River School	Stamford	663	5	1	2	0.5	1	5	0	0	9.5
Ponus Ridge Middle School	Norwalk	656	6	1	2	0.5	0	0	5	1	9.5
Roton Middle School	Norwalk	592	6	1	2	0.5	0	0	5	1	9.5
Kendall Elementary School	Norwalk	472	6	1	2	0.5	0	0	5	1	9.5
Cranbury Elementary School	Norwalk	433	6	1	2	0.5	0	0	5	1	9.5
Brookside Elementary School	Norwalk	425	6	1	2	0.5	0	0	5	1	9.5
Snow School	Middletown	332	3	1	1	0.5	1	5	0	1	9.5
Hazardville Memorial School	Enfield	330	2	1	1	0.5	0	5	1	1	9.5
Lawrence School ES	Middletown	304	3	1	1	0.5	1	5	0	1	9.5
Bielefield School	Middletown	255	3	1	1	0.5	1	5	0	1	9.5
Side By Side Charter School	Norwalk	235	6	2	1	0.5	0	0	5	1	9.5
Moody School	Middletown	210	3	1	1	0.5	1	5	0	1	9.5
Dr. Franklin H. Mayberry School	East Hartford	312	8	2	1	1	1	2	2	0	9
Batcheller Early Education Center	Winchester	249	1	1	1	0	1	5	0	1	9
Brien McMahon High School	Norwalk	1,710	6	1	5	0.5	0	1	1	0	8.5
Edison MS	Meriden	400	8	2	1	0.5	0	5	0	0	8.5
Marvin Elementary School	Norwalk	399	6	1	1	0.5	0	0	5	1	8.5
Prudence Crandall School	Enfield	373	2	1	1	0.5	0	5	0	1	8.5
Fox Run Elementary School	Norwalk	369	6	1	1	0.5	0	0	5	1	8.5
Naramake Elementary School	Norwalk	356	6	1	1	0.5	0	0	5	1	8.5
Eli Whitney School	Enfield	352	2	1	1	0.5	0	5	0	1	8.5

Columbus Magnet School	Norwalk	312	6	1	1	0.5	0	0	5	1	8.5
Farm Hill School	Middletown	305	3	1	1	0.5	1	5	0	0	8.5
Enfield Street School	Enfield	258	2	1	1	0.5	0	5	0	1	8.5
Montville High School	Montville	496	2	1	2	0	1	3	0	1	8
Windsor Locks High School	Windsor Locks	399	1	1	1	0	0	0	5	1	8
Windsor Locks Middle School	Windsor Locks	322	1	1	1	0	0	0	5	1	8
Dominick H. Ferrara School	East Haven	165	1	1	1	0	0	5	0	1	8
Overbrook Early Learning Center	East Haven	107	1	1	1	0	0	5	0	1	8
MacDonough School	Middletown	209	3	1	1	0.5	1	3	0	1	7.5
Buckley School	Manchester	326	2	1	1	0	0	0	5	0	7
Inter D. School For Arts & Communication	New London	281	7	2	1	1	1	2	0	0	7
Momauguin School	East Haven	280	1	1	1	0	0	3	0	1	6
Silver Lane School	East Hartford	270	8	2	1	1	1	0	1	0	6
Wesley School	Middletown	213	3	1	1	0.5	1	0	2	0	5.5

* See SVI - ranking score tab
** See Population - ranking score tab
*** See HPSA - ranking score tab
**** See Medical and Mental Health Hours ranking score tab
***** See DCF - ranking score tab

Disclaimer - Schools may or may not meet the physical plant requirements to establish a SBHC.

c. Methods to expand telehealth services

Telehealth

Telehealth, sometimes called telemedicine, lets your doctor provide care for you without an in-person office visit. Telehealth is done primarily online with internet access on your computer, tablet, or smartphone. There are several options for telehealth care: Talking to your doctor live over the phone or on computer; sending and receiving messages from your doctor using secure messaging, email, and secure file exchange; and using remote monitoring so your doctor can check on you at home. (b.3)

Changes in the way that health care is delivered during this pandemic are needed to reduce staff exposure to ill persons, preserve personal protective equipment (PPE), and minimize the impact of patient surges on facilities. Healthcare systems have had to adjust the way they triage, evaluate, and care for patients using methods that do not rely on in-person services. Telehealth services help provide necessary care to patients while minimizing the transmission risk of COVID-19. (b.4)

While telehealth technology and its use are not new, widespread adoption among health care providers and patients beyond simple telephone communication has been relatively slow. Before the COVID-19 pandemic, trends show some increased interest in use of telehealth services by both health care providers and patients. However, recent policy changes during the pandemic have reduced barriers to telehealth access and have promoted its use to deliver acute, chronic, primary and specialty care. Many professional medical societies endorse telehealth services and provide guidance for medical practice in this evolving landscape. Telehealth can also improve patient health outcomes. (b.4)

In March 2020, all of Connecticut schools were closed due to COVID-19. This had an immense immediate impact on SBHCs, which also had to close their doors and shut down services temporarily. For many school based health centers, ongoing COVID-19 related precautions restricted who was allowed in school buildings, leading to many school based health centers continuing to temporarily pause in-person services and a surge in the use of telehealth visits.

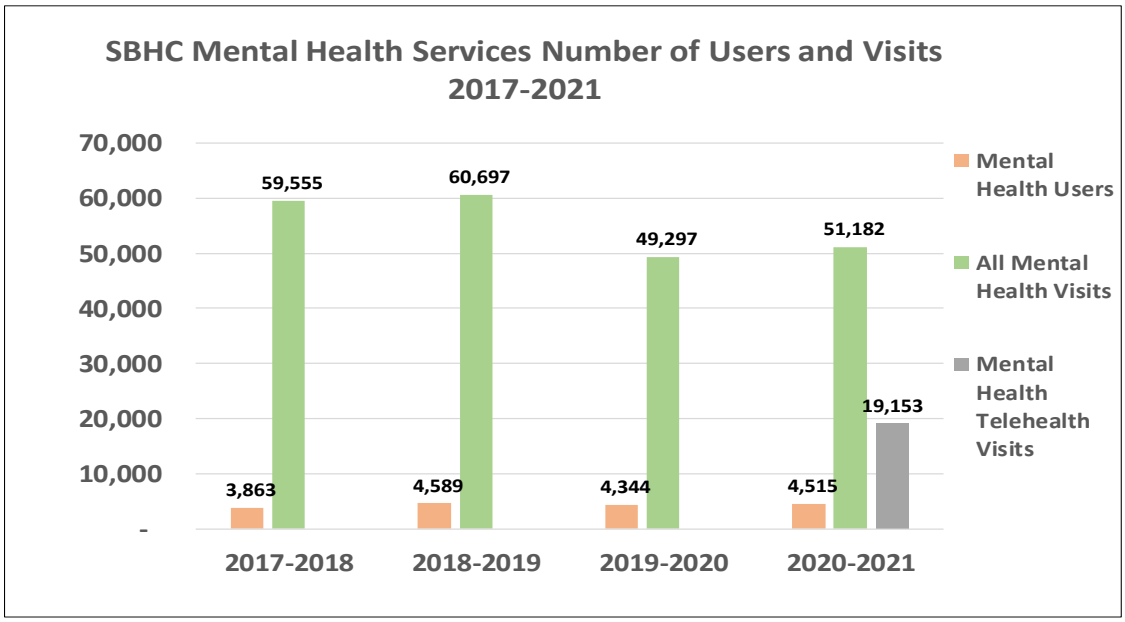
Traditionally, SBHC staff can reach children while they are in school. During the past two years, as schools transitioned from in-person learning to hybrid and remote models, and back to in-person, a disconnect was created that made it challenging to stay in regular contact with students. The use of telehealth for medical and mental health services bridged the gap in many cases, however the use of technology as the sole means to connect created new challenges for both the children and staff. Those challenges included a lack of bandwidth and unreliable internet connections for both staff and children, difficulty finding private space for conversations with providers, and learning to use new technology and digital applications. In addition, many Connecticut children did not have digital technology to participate in video conversations and needed to rely on audio only means for services. Providers were tasked with purchasing and distributing technology to children and families for them to be able to engage in their services. Other challenges included security issues using digital technology and a lack of experience using digital platforms that required both staff and patient education. Administratively, the restrictions

and limitations to reimbursement for telehealth services under Medicaid created challenges to provide seamless services for children. (b.5)

As social distancing guidelines went into place, many, if not all SBHCs reported that their sites and providers quickly initiated telemedicine services for their patients for sick visits, medication management, mental health services and other reasons such as consultations with other providers, follow-up check-ins after a health service encounter, or to provide service to students when no clinician was available. Staff training and education was necessary to ensure that all clinicians had the technical capability to use hardware and software to ensure their ability to provide services while meeting confidentiality and HIPAA privacy requirements. (b.5)

After initial set up, many telehealth visits were held successfully with no breaks in coverage for the students. Telehealth is a critical strategy for delivering continued care to students. On a national survey conducted by the School Based Health Alliance, over 80% of SBHC survey respondents reported they delivered some services via telehealth since the start of the pandemic, a significant increase compared to prior years. Over 60% of survey respondents began offering primary care and/or mental health services via telehealth in the 2020-2021 school year, and half improved technology to expand pre-pandemic telehealth services. (b.6)

In Connecticut, all 20 DPH funded SBHCs contractors transitioned their sites to the telehealth model during the 2020-2021 school year. Due to the telehealth option, Connecticut SBHC sites were able to serve a comparable number of students during the 2020-2021 school year, when most students were home or attending school on a hybrid basis, as in a previous non-pandemic year. In 2020-2021 DPH funded SBHCs provided 51,182 mental health visits for 4,515 users, about 11.3 visits per user. Out of the 51,182 mental health visits, 19,153 visits were conducted through telehealth. In 2019-2020 there were 49,297 mental health visits for 4,344 users (11.3 visits per user) and in 2018-2019 there were 60,697 mental health visits for 4,589 users (13.2 visits per user).



The U.S. Surgeon General, Dr. Vivek Murthy, issued a new Surgeon General's Advisory to highlight the urgent need to address the nation's youth mental health crisis. In the advisory he stated "Mental health challenges in children, adolescents, and young adults are real and widespread. Even before the pandemic, an alarming number of young people struggled with feelings of helplessness, depression, and thoughts of suicide — and rates have increased over the past decade. The COVID-19 pandemic further altered their experiences at home, school, and in the community, and the effect on their mental health has been devastating. The future wellbeing of our country depends on how we support and invest in the next generation." (b.7) The American Academy of Pediatrics (AAP), the American Academy of Child and Adolescent Psychiatry (AACAP) and the Children's Hospital Association (CHA) joined together to declare a National State of Emergency in Children's Mental Health. (b.8)

Connecticut's students are suffering from increasing feelings of isolation, anxiety and depression, loneliness, and uncertainty, and the associated effects of mental health stressors and conditions. Many students in Connecticut are returning to in-person learning following long periods of remote learning, which creates a new level of anxiety and care needs while others continue to attend school remotely leaving them vulnerable. Other Connecticut students have not engaged in any learning at all during parts of the pandemic, creating an enormous risk to their mental and physical health as well as their safety. The uncertainty of the new variants puts additional stress on our children. Our school based health centers will require increased levels of funding and service points, such as telehealth, to provide adequate mental health counseling and medical care. We fear that without mental health supports in place, student outcomes will suffer dramatically.

Current research shows increased mental health concerns and needs in the pediatric population, especially ages 12-18, which have resulted in an increase in ED visits for mental health during the COVID-19 pandemic. There is additional concern for this age group's access to mental health services, and concern for adolescents' access in lower socioeconomic groups, certain races and ethnic groups. These needs and access issues encompass physical health needs which have been affected by the pandemic and in turn effect mental health status. SBHCs play a critical role in reaching these populations. (b.5)

Many of the DPH funded SBHC sites currently have a wait list for mental health services, which has not been seen in past years. Providers are struggling to keep up with already full caseloads and are seeing students with more complex mental health needs. Telehealth has helped SBHC providers in many ways to stay connected with their students, connect with parents and families, have more flexible hours for students and families, and provide services to students during this mental health crisis. In order to provide comprehensive telehealth services to our students now and in the future an investment must be made to recruit and expand the workforce capacity. The workforce as it is cannot support the need that is being seen in our schools today.

Workforce Expansion

The committee endorses the following as means to address workforce shortages that impact SBHCs and the broader health and mental health care arenas:

1. Provide financial incentive programs or funding to providers that support recruitment and retention efforts. Top priorities should include recognizing non-wage compensation

(sign-on/retention bonuses, tuition reimbursement, loan repayment assistance, etc.), developing a State loan forgiveness and repayment program for behavioral health, increased paid internship opportunities, and review of funding levels/rates across service types/levels of care to assure adequate support for providers to sustain competitive salaries. (b.9)

2. Optimize access to the available behavioral health workforce. Top priorities should include expediting processing of licensing exams and determination notifications, to review licensing examination data and conduct disparity analyses, developing recommendations to increase equity, providing licensing examinations in Spanish and other high-need languages for applicants whose first language is not English, allowing reimbursement for clinicians eligible and working toward licensure, such as through provisional licenses for those who have completed at least 2/3 of required supervised clinical work, and provide payment to leverage non-traditional (paraprofessional) and peer support specialists in behavioral health. (b.9)

Governor's Executive Orders

On March 19, 2020, Connecticut Governor Ned Lamont issued Executive Order No. 7G, which is intended to expand access to telehealth services for Connecticut residents amidst the COVID-19 pandemic. (b.10)

On May 10, 2021, Connecticut Governor Ned Lamont signed into law "An Act Concerning Telehealth" (the "Act"). The Act extends, until June 30, 2023, many of the COVID-19 related telehealth expansions issued by Governor Lamont through executive orders. The Act's purpose is to extend the duration of the expansion of telehealth services permitted by Executive Order 7G Among other things, the Act: Expands the types of providers that can provide telehealth services to include: physicians, physicians assistants, physical therapists, chiropractors, clinical social workers, registered and advanced practice nurses, and others; until June 30, 2023, permits telehealth to be provided through audio-only technology and through store-and-forward technology; permits out of state licensed providers to provide telehealth services in Connecticut as long as they are providing such services pursuant to a relevant order issued by the Connecticut Commissioner of Public Health and maintain proper professional malpractice insurance; outlines the scope of permitted telehealth prescribing practices to permit prescribing schedule II and III non-opioid controlled substances for the treatment of a person with a psychiatric disability or substance use disorder; prohibits facility fees associated with telehealth services; allows providers to provide telehealth services from any location; and requires providers to accept as payment in full for telehealth services: (a) An amount equal to the Medicare reimbursement for such services if the provider determines the patient does not have health coverage for such services; or (b) the amount the patient's health coverage reimburses, and any coinsurance, copayment, deductible or other out-of-pocket expense imposed by the patient's health coverage, for such services if the provider determines the patient has health coverage for such services. (b.11)

In summary, the committee strongly recommends the following:

1. Continuation of funding and support for telehealth for mental health services and medical care at Connecticut SBHCs in order to meet student demand related to the COVID-19 pandemic and beyond.

2. Additional support and funding for SBHC workforce expansion, which would promote the hiring of more clinical staff to serve a greater number of Connecticut's children through telehealth, mobile and in person visits to address need due to the mental health crisis.

d. Options for expanding insurance reimbursement

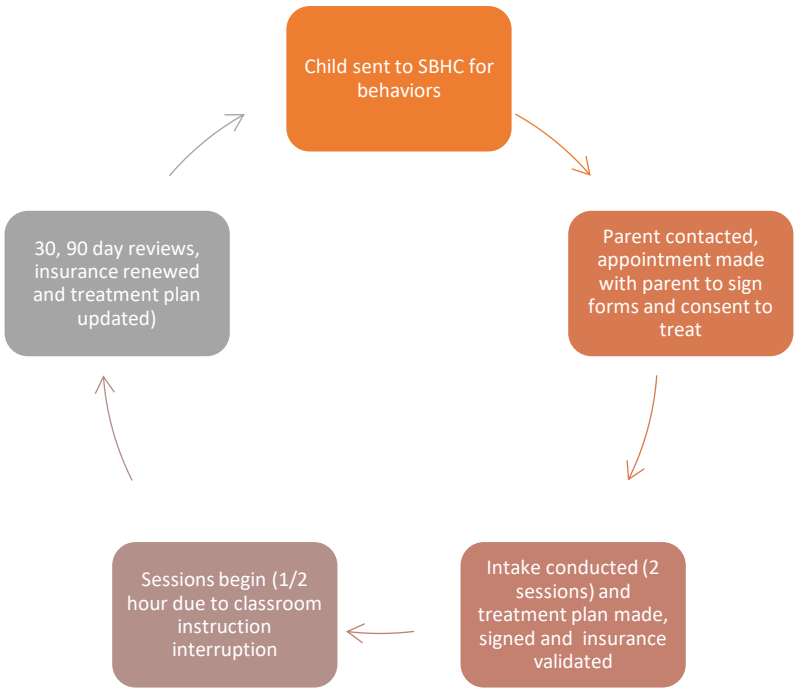
Healthcare insurance reimbursement describes the payment that a hospital, healthcare provider, diagnostic facility, or other healthcare providers receive for a medical service. Often, a health insurer or a government payer covers the cost of all or part of a person's healthcare.

Healthcare providers are paid by insurance or government payers through a system of reimbursement. After a person receives a medical service, the provider sends a bill to whomever is responsible for covering medical costs. The amount that is billed is based on the service and the agreed-upon amount that the public or private health insurer has contracted to pay for that service. Private insurance companies negotiate their own reimbursement rates with providers and hospitals. (b.13)

All DPH funded School Based Health Centers report on their annual aggregate billing status. As noted above, billing amounts can differ from reimbursement amounts.

A presentation shared during the School Based Expansion Working Group meeting on January 6, 2022, outlined the efforts required to document and bill for behavioral health services. This process requires a significant amount of time and attention to detail. (c.7). DCF and DSS guidelines help to ensure quality behavioral health services are provided. To illustrate the process (see chart below) a scenario is presented that begins when a student is sent to the SBHC for behavioral issues. SBHC staff contact the child's parent or guardian, an intake process is conducted, and a treatment plan made. The plan is signed by the parent or guardian; if insurance is available, it is validated; the sessions begin; and at 30 and 90 days the case is reviewed, insurance is renewed, and the treatment plan is updated as needed.

Documentation Burden Related to Billing Fee for Service



The Department of Children and Families licenses psychiatric outpatient clinics for children. The licensing requirements are spelled out in twenty-six pages of regulations related to guidelines for treatment. Section 17a-20-41 (re: Assessment) requires a detailed written psychosocial assessment of the individual and the family. Treatment plan requirements are listed in section 17a-20-42 and state that by the second appointment a written, signed, and dated plan must be in place with measurable and time-bound goals and objectives.

Treatment plan review is covered under section 17a-20-43 and is required every 90 days; the plan is to be signed by the parent or guardian and clinician. Discharge and aftercare procedures are listed under section 17a-20-44 and must happen within 30 days of discharge. Treatments that remain, follow-up services and other recommendations are to be listed.

The Department of Social Services' Medicaid billing requirements for behavioral health clinics for children encompass seventeen pages, beginning with section 17b-262-824 of CT State Regulations which relates to need for service and evaluation. Services must be under the direction of a physician; evaluation must be performed by a qualified physician or allied health professional, and include seven elements of evaluation; and treatment must follow the plan of care elements as required by DCF. Section 17b-262-828 states that the plan of care must be reviewed and signed by the second appointment and initial evaluation; and each update within 30 days of period review must be signed. Also within this section are details about supervision and progress notes.[2]

[2] Rates for services through the CT Department of Social Services Medical Assistance Program can be viewed at the following website: https://www.ctdssmap.com/CTPortal. The site provides important information for healthcare providers about the CT Medical Assistance Program and contains a variety of documents including billing manuals, program regulations and more.

Many school based health centers in CT are operated by federally qualified health Centers (FQHCs). Medicare pays FQHCs based on the FQHC Prospective Payment System (PPS) for medically necessary primary health services and qualified preventive health services from an FQHC practitioner. FQHCs must include an FQHC payment code on their claim. Medicare pays claims at 80% of the lesser of the FQHC charges based on their payment codes or the FQHC PPS rate (a national encounter-based rate with geographic and other adjustments). The Centers for Medicare & Medicaid Services (CMS) annually updates the FQHC PPS base payment rate using the FQHC market basket. (b.16). The payment schedule for Connecticut FQHC's can be found in Appendix c.10.

The National Council for Mental Wellness suggests potential solutions to waive burdensome documentation and administrative activities (b.9). Top priorities include:

- Pare required elements of the comprehensive psychosocial assessment and streamline collection across funders and regulators to reduce duplication
    - Create a core set of psychosocial elements
- Extend timelines for completion of assessment and treatment plans
- Consider eliminating the requirement that the treatment plan be a separate document
    - Standard medical care integrates the treatment plan into the body of the visit note allowing the plan to be reviewed and updated at each visit
- Identify and implement other "paperwork" reductions so that behavioral health is more aligned with routine documentation standards for other health care disciplines, and Medicaid is more aligned with private insurance

Three Connecticut Children's Behavioral Health Plan Implementation Workgroups submitted their summary reports to the Children's Behavioral Health Advisory Board on January 24, 2022. The Alternative Payment Methods and Measurement-Based Care Workgroup reported six recommendations. This report will highlight two relevant to the SBHC Expansion Working Group activities. (b.14) The first specifically addressed the concern to raise reimbursement rates to meet costs more adequately with opportunities to further enhance payments to providers through an alternate payment method. The second is to tie the alternative payment methods to improvement of child, family, and provider-level outcomes as well as critical system-level outcomes including but not limited to the following: improvements in child and family clinical outcomes, improvements in health equity, reduction in emergency department volume, reduction in total inpatient days, improved connect-to-care rates, increased use of mobile crisis, implementation of evidence-based treatments, and behavioral health/primary care integration.

Alternative payment models (APMs) change the way Medicaid providers are paid, moving away from fee-for-service (which rewards volume) to methods that incentivize value. Value-based care (VBC) seeks to deliver high quality care efficiently, reduce disparities in the healthcare system and improve beneficiary health and align provider incentives across payers. VBC can also help the healthcare system handle unexpected challenges and disruptions, such as the COVID-19 pandemic. (b.15)

Connecticut law regarding insurance coverage of school based health services was discussed by the Working Group members. Sec. 38a-472e of the general statutes states that "each health insurer

licensed to do business in this state shall, at the request of any school based health center or group of school based health centers, offer to contract with such center or centers to provide reimbursement for covered health care services to persons who are insured by such licensed insurer. Such offer shall be made on terms and conditions similar to contracts offered to other providers of health care services."

The comment below was received from a community provider participant in the SBHC Working Group regarding insurance reimbursement.

"We would encourage a continued focus on insurance parity and achieving a more equitable and sustainable fee structure. For years, rates for independent non-profit school based health centers have been stagnant and have not covered the cost of providing the services. In fact, the rates for this group of school based health centers are lower than the rates for the same services provided in an outpatient physician's office. This disparity contributes to the overall inequities in rates, where independent non-profit SBHCs are significantly underpaid compared to similar services performed by outpatient physician offices, federally qualified health centers and hospital-based services." Statement received 2.1.22

The committee strongly recommends the following:

1. The current blending of funding is inadequate to address the crisis-based needs of children, families, and schools resulting from the pandemic. Continue to explore insurance reimbursement with both commercial and public insurance entities. Focus attention on reimbursement as the present system for behavioral health reimbursement is not equal in funding amounts or documentation requirements.

2. As School Based Health Centers are identified as an essential community provider, work to expand availability of SBHCs to more communities to address rising demand for children's mental health services by providing on-going screening, preventative education supports, direct behavioral health services, and linkage to community providers.

e. Options to expand access

This report makes recommendations on page 3 detailing specific schools where additional SBHC's are needed and options to expand or add services at existing SBHCs.

Geographic regions where additional SBHCs are needed

The Working Group combined multiple databases and utilized the CDC Social Vulnerability Index (SVI) and Health Professional Shortages Areas (HPSA) to identify priority schools that presently do not have a school based health center. As a result, 157 schools identified in 21 towns are recommended to be considered for potential SBHCs.

Options to expand or add services at existing SBHCs

The Working Group utilized the same methodology as noted above to identify SBHC sites that may be expanded or services to be added; two-choices were identified.

Recommendation #1. Fund 36 sites located in 11 towns identified in this report that have no mental health services.

OR

Recommendation #2. Fund 124 sites located in 22 towns identified in this report that have mental health and/or medical services but are not offered full time.

Other important efforts to support children's behavioral health in Connecticut

Ensuring access to children's behavioral health services, like any type of health care service, does not have a one size fits all solution. School based health centers can offer a full range of primary and behavioral health services from in-house staff who are familiar with their students, can reduce the use of emergency departments, reduce absenteeism, and more. Connecticut also has many Advisory Groups and Task Forces working hard to address the behavioral health needs of children. Throughout the report the work of several advisory groups was highlighted.

The children's behavioral health system in Connecticut will be strengthened by the blending and braiding of funding streams to create a variety of programs that offer preventative, educational, and direct mental health services and supports. Current blending of funding is inadequate to address the crisis-based needs of children, families, and schools resulting from the pandemic. In particular mental health services are specifically underfunded, and alternative mechanisms should be explored.

Below is a list of presentations shared; and organizations', advisory group and task force materials discussed during the SBHC Expansion Working Group's meetings that provide support for the critical infrastructure for children's behavioral health in Connecticut.

State Department of Education PowerPoint/CSDE's Commitment to Addressing Schools Social-Emotional and Behavioral Health Needs. (Appendix c.3)

Department of Children and Families, Children Behavioral Health Implementation Advisory Council https://www.plan4children.org/connecticuts-plan/#plan-implementation-advisory-board

Child Health and Development Institute (CHDI) improves access to quality children's mental health services and systems by identifying, implementing, and evaluating effective models of treatment. With a focus on prevention, early intervention, and connection to high-quality treatment and the development and integration of effective mental health systems for children and families. https://www.chdi.org/our-work/mental-health/

Trauma-Informed School Mental Health Task Force. To promote equitable access and outcomes for students and families within a statewide trauma-informed infrastructure that integrates behavioral health services, school, pediatric primary care and community supports. https://www.plan4children.org/connecting-to-care/trauma-informed-school-based-mental-health/

VI. Appendices

Appendix A. Membership

School Based Health Center Expansion Working Group

Established Public Act 21-35, Section 16

Appointing Authority	Membership Role	Designee	E-mail
Commissioner/designee	DPH	Ann Gionet, Co-Chair	Ann.Gionet@ct.gov
Commissioner/designee	DSS	Dana Robinson-Rush	dana.robinson-rush@ct.gov
Commissioner/designee	SDE	John Frassinelli	john.frassinelli@ct.gov
Commissioner/designee	DCF	Tim Marshall	tim.marshall@ct.gov
DCF	Children's mental health service provider	Alice Forrester, Co-Chair designee of Vannessa Dorantes	AForrester@cliffordbears.org
CASBHC		Jill Holmes Brown	jbrown@ihssbhc.org
CASBHC		Melanie Wilde Lane	mwilde@branfordschools.org
Commissioner/designee	Insurance	Lena Bahar	Lena.Bahar@ct.gov
Chairpersons of the joint standing committee of the General Assembly/designee – Public Health	Senator Mary Abrams Rep. Jonathan Steinberg	Senator Mary Abrams Rep. Jonathan Steinberg	Mary.Abrams@cga.ct.gov Jonathan.Steinberg@cga.ct.gov
Ranking members of the joint standing committee of the General Assembly/ designee – Public Health	Senator Heather Somers Senator Tony Hwang Rep. Bill Petit	Senator Heather Somers Senator Tony Hwang Rep. Bill Petit	Heather.Somers@cga.ct.gov Tony.Hwang@cga.ct.gov William.Petit@cga.ct.gov
Chairpersons of the joint standing committee of the General Assembly/ designee - Appropriations	Senator Cathy Osten Rep. Toni Walker	Senator Cathy Osten Rep. Toni Walker	Catherine.Osten@cga.ct.gov Toni.Walker@cga.ct.gov
Ranking members of the joint standing committee of the General Assembly/ designee – Appropriations	Senator Craig Miner Rep. Mike France	Senator Craig Miner Rep. Mike France	Craig.Miner@cga.ct.gov Mike.France@cga.ct.gov
Community Health Center Association of CT (CHC ACT)		Sara LeMaster	SLeMaster@chcact.org
CT Association of Healthcare Plans		Susan Halpin	shalpin@RC.com
Community Health Center Inc.		Jane Hylan	HylanJ@chc1.com

Appendix B. References

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b.5. "Interim Report to the Public Health and Education Committees on School Based Health Centers, Pursuant to Section 19a-6i of the General Statutes, School based Health Center Advisory Committee", April 15, 2021

b.6. " School Based Health Alliance 2020-21 National Survey of School based Health Centers: The Impact of the COVID-19 Pandemic", https://www.sbh4all.org/wp-content/uploads/2022/01/National-Survey-2021-Summary-Report-Final.pdf

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Appendix C. Meetings – Minutes and PowerPoint Presentations

c.1

School-Based Health Center Expansion Working Group

December 16, 2021
Microsoft Teams Meeting
10:00am – 11:30pm

Meeting Summary

Membership Attendees: Ann Gionet (Co-Chair), Dana Robinson-Rush, John Frassinelli, Tim Marshall, Alice Forrester (Co-Chair), Jill Holms Brown, Melanie Wilde Lane, Lena Bahar, Rep. Jonathan Steinberg, Rep. Bill Petit, Sen. Cathy Osten, Rep. Toni Walker, Susan Halpin, Jane Hylan.
Other Attendees: Christine Velasquez, Selma Alves, Johanna Davis, Amy Soto, Melanie Flaherty, Meghan Friedmann, Jared Picco, Jason Lang, Jay Aronson, Joe Walkovich, Miriam Miller, Amanda Pickett, Kari Sassu, Eric Scoville, Tricia Orozco, Mary Katherine Wildeman, Melanie Bonjour

Item	Action	Follow Up
1. Introductions	• Ann Gionet (Co-Chair) started the meeting and welcomed everyone. Dr. Juthani is very focused on this working group and the mental health of children. • Senator Steinberg said that they are focused on children's mental health and SBHCs this legislative session. • Ann Gionet email questions or materials to Christine Velasquez Christine.Velasquez@ct.gov or Ann Gionet Ann.Gionet@ct.gov.	
2. Welcome / Public Comment	Ann Gionet • Opened meeting for public comment. No comments. • Presented a PowerPoint (attached) on what is a SBHC, benefits of SBHC, SBHCs and COVID and National State of Emergency in Children's Mental Health – October 2021.	DPH to send out: • DPH PPT presentation.
3. Overview PA 21-35 Section 16	Ann Gionet a. Geographic regions where additional SBHC may be needed, b. Options to expand or add services at existing SBHCs, c. Methods to expand telehealth services, d. Options for expanding insurance reimbursement, e. Options to expand access. f. Submit a report on findings and any recommendations for the strategic expansion of school-based health center services, no later than 2.1.2022 • The language in the PA describes a SBHC site. DPH operates mental health only sites (Expanded School Health Sites) or primary care and mental health sites (SBHC Site). DPH has definitions already established. • Senator Osten: Does SBHC # include FQHC in number?	

	Ann Gionet: Johanna Davis will show how many are funded directly through DPH and sites that are not. The 90 are the ones that have a contract with DPH and get state funds. Alice Forester: There are School Based mental health services that are funded through DCF, private, and districts…but they're not full SBHCs. Dana Robinson-Rush: Does this include dental? Ann Gionet: Yes, we have 24 dental sites within the 90 sites. • Ann Gionet identified members of the SBHC Expansion Working Group.	
4. Elect Co-Chair	• Alice Forrester volunteered to co-chair. John Frassinelli nominated Alice Forrester. Vote taken and Alice voted in.	
5. Discussion of a. b. and c. Above	Ann Gionet: • PowerPoint presentation • DPH SBHC visits and users: 51,182 mental health visits by 4,515 users (11.3 average visits per user). Mental health data is the inverse of medical and dental data. Last school year, when schools were closed, DPH funded SBHCs served more people than the year before. Utilizing telehealth was a big factor. • Showed DPH funded SBHC map by town. In 27 communities. SBHC Sites by Grade Served and by age group. • Tim Marshall: Questions on "enrolled" vs "served" definitions in the data. Johanna Davis responded that enrolled are the number of students that have had parents signed permission to go to the clinic. Served are the actual number of students seen. We will provide % and total number data. Johanna Davis (DPH SBHC Epidemiologist) gave PowerPoint presentation on SBHC data. • Social Vulnerability Index (SVI) by CDC (based on census tracks) are areas of high need There is only 1 town in top 20 towns in the SVI list that does not have a DPH funded SBHC. There are 90 DPH funded SBHCs (76 are both medical and dental, 11 mental health only, 3, medical only). We are looking to expand hours of service since some are not full time, # staff, and who operates the clinics. • HRSA data: 202 FQHC SBHC. 60 of these are DPH funded. 30 are not. • Requested information from SDE and School Based Health Alliance. • SDE: 1,373 schools listed with address and school population. • School Based Health Alliance (SBHA): lists all schools, lists all SBHC in CT (160). • DPH Licensing of outpatient clinics – 252 SBHCs licensed. • We are looking at who has the least amount of support to see where we need to focus SBHC funding. • Dana Robinson-Rush: Can CHC ACT help?	DPH to send out: • List of data links • CSDE PPT presentation.

	Johanna Davis: We can get more information from HRSA. Need to get more info from CHC ACT. Susan Halpin: Is the data available to the public? Can they query the system the same way? Are mental health services available by region? What does 211 use to find SBHC services? Do that have access to these maps? Johanna Davis: Yes, from SBHA. DPH is going to try to update the system to make sure everything is covered. Lists have not been compared and updated. FQHCs are available to public from HRSA. • Rep Walker: Mental health services – the term is so broad. Are we making sure the definitions are equal across the board? Who is paying for this? Medicaid reimbursement? Where do we go from here funding-wise? Relationship SBHCs have with the schools? • Jill Holmes Brown: How do you tease out data to show students in highest need are getting services? Where are gaps? Inconsistency with definitions of SBHCs. Hours aren't consistent. What about data for those who do not report to DPH (magnet schools)? • Alice Forrester: Defining served. Our SBHC clinicians have people waiting in line to be served. Some are sent by the principal to talk to therapist. Some are on treatment plan to be seen. Currently a medical model. What else can happen instead of just individual therapy? • John Frassinelli: Map, overlay where other external health behavioral services are. Districts need imbedded supports, and external supports to get a feedback loop that continues care. We need to see everything that is out there. • Tim Marshall: DCF under system of care federal grant has embarked on care connections. Staff time of 6 people (regions). Directly invite school representatives to link with local mental health provider and local pediatric practices. Data shows a complete disconnect among schools, medical, mental health. Green referral form developed. • Senator Osten: Urban/rural. Just because numbers aren't there doesn't mean mental health component is not there. We've known for a while there is a problem in the farming community with lack of mental health treatment. • Alice Forrester: Northeast quadrant has highest sexual abuse in state…adults on children. SDE PowerPoint Presentation (attached) • Amanda Pickett/John Frassinelli – Snapshot of CT schools: 205 districts; 1,505 schools/programs	

	(includes private and outpaced schools). Over 52k FTE staff. 513,079 students. • CSDE's Guide to priorities. • 80 million invested in social/emotional learning. • 6% increase in FTE of counselors, school psychologists, and school social workers. • CSDE Current Initiatives and Investments – Project AWARE, Learner engagement and Attendance Program (LEAP); Tiered Supports for School Discipline; Webinars; DESSA System, Components of Social Emotional and Intellectual Habits; Statewide SEL Landscape Scan, Designed SEL Hub; Behavioral health pilot (make sure very school has access to behavioral health resources); Healthy and Balanced Living Curriculum Framework; Support for Youth in the Criminal Justice System. • Tim Marshall: How many school buildings are there? John Frassinelli: I can get that data. Probably similar to the 1,300 schools. • John Frassinelli: School nursing services are provided to nonpublic schools as well. SDE doesn't have jurisdiction over nonpublic. • Alice Forrester: Getting deep into what works in a school/outcomes is where we will have the greatest impact. It would be good to look at other states/districts.	
6. Meetings	Ann Gionet • We will begin the next meeting with section b. and info about c. telehealth. We will forward slides and other materials to the group. Others can forward helpful resources/info to Christine Velasquez or Ann Gionet to send out to the group. • Next Meeting Dates: **January 6, 2022 10:00 am -11:30 am** Microsoft Teams meeting (1/6/22) Join on your computer or mobile app Click here to join the meeting Or call in (audio only) +1 860-840-2075,,958554147# United States, Hartford Phone Conference ID: 958 554 147# **January 20, 2022 10:00 am -11:30 am** **January 26, 2022 10:00 am -11:30 am** • Ann Gionet closed out the meeting.	DPH to send out: • Teams meeting invites, • Meeting notes, • 1/6/22 meeting agenda.

c.2

Public Act No. 21-35

AN ACT EQUALIZING COMPREHENSIVE ACCESS TO MENTAL, BEHAVIORAL AND PHYSICAL HEALTH CARE IN RESPONSE TO THE PANDEMIC.

CT Department of Public Health
School Based Health Center Program
Ann Gionet, Co-Chair SBHC Expansion
Johanna Davis
Christine Velasquez
Angela Jimenez

Welcome

School-Based Health Center Expansion Working Group Members

Please type your name & organization in the chat

Use the raise your hand feature

Information to share with the working group, email:
Ann.Gionet@ct.gov or Christine.Velasquez@ct.gov

What is a School-Based Health Center?

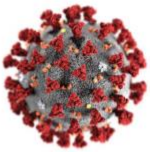
- Free standing medical clinics located within or on the grounds of schools.
- Licensed as outpatient clinics or as hospital satellites.
- Open to all enrolled in the school regardless of ability to pay/insurance status.
- Work collaboratively with schools, parents, and the community.
- Ensure that students are healthy and ready to learn.

What are the Benefits of SBHCs?

- Tend to unmet health care needs by placing health care where the kids are.
- A safe place to talk about sensitive issues.
- Supports the school environment by helping children stay in school.
- Supports families by allowing parents to stay at work
- Saves money by keeping children out of hospitals and emergency rooms.

SBHCs and COVID

- Telehealth visits.
- Pop up clinics for vaccines, testing, exams.
- Assisting with Covid activities.
- Helping with anxiety.
- Covid information distribution.



DPH Connecticut Department of Public Health

American Academy of Pediatrics — Dedicated to the Health of All Children

American Academy of Child & Adolescent Psychiatry

CHA Children's Hospital Association

Declare a National State of Emergency in Children's Mental Health

* Call on policymakers and advocates at all levels

- School-based mental health care
- Evidence-based mental health screening, diagnosis, and treatment
- Improve access to technology & telemedicine
- Reduce risk of suicide
- Enhance services to reduce ED bed shortage
- Fund comprehensive, community-based systems of care that connect families to behavioral health services
- Address longstanding workforce challenges in child mental health

PA 21-35 Access to health care in response to COVID
Section 16

A working group to develop recommendations for the strategic expansion of school-based health center (SBHC) services in the state.

a. Specific **geographic regions** where additional SBHC may be needed,

b. Options to **expand or add services** at existing SBHCs,

c. Methods for providing additional supports to expand **telehealth services**,

d. Options for expanding insurance reimbursement,

e. Options to expand access to School-based health centers or expanded school-based health center sites, specifically mental health.

f. Submit a report on findings and any recommendations for the strategic expansion of school-based health center services to Public Health and Appropriations Committees, no later than 2.1.2022

SBHC Expansion Working Group Members

- State agencies DPH, DSS, SDE, DCF, Dept of Insurance
- CT Association of School Based Health Centers
- Chairpersons and Ranking Members of Public Health & Appropriations
- Community Health Center Association of CT (CHC ACT)
- CT Association of Healthcare Plans
- CHC, Inc.

Elect a co-chair

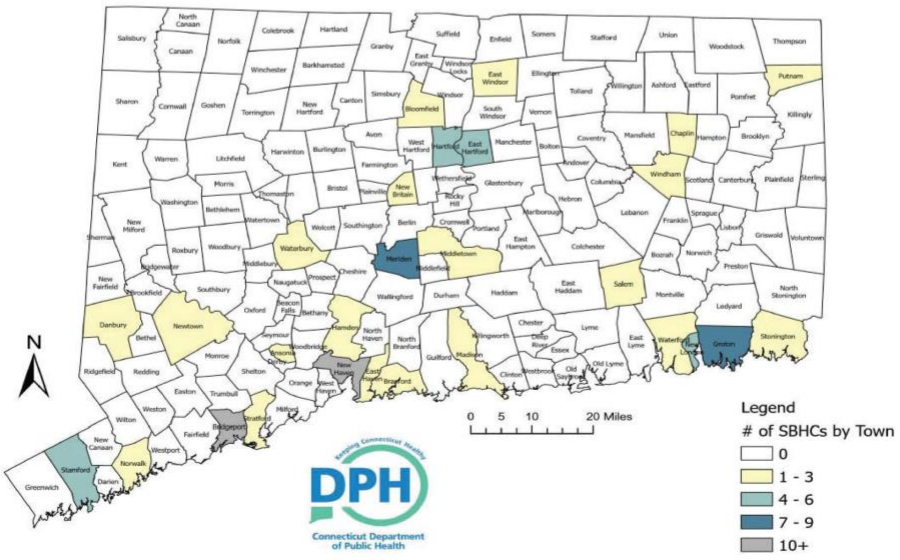
- a. Specific geographic regions where additional SBHC's may be needed
- &
- b. Options to expand or add services at existing SBHC's

Mental Health Enrollment and Visits Data

	2018-2019	2019-2020	2020-2021
Mental Health Visits	60,697	49,297	51,182
Mental Health Users	4,589	4,344	4,515
Average # of Mental Health Visits	13.2	11.3	11.3

Source: DPH SBHC Year-end Reports.

DPH Funded School Based Health Centers

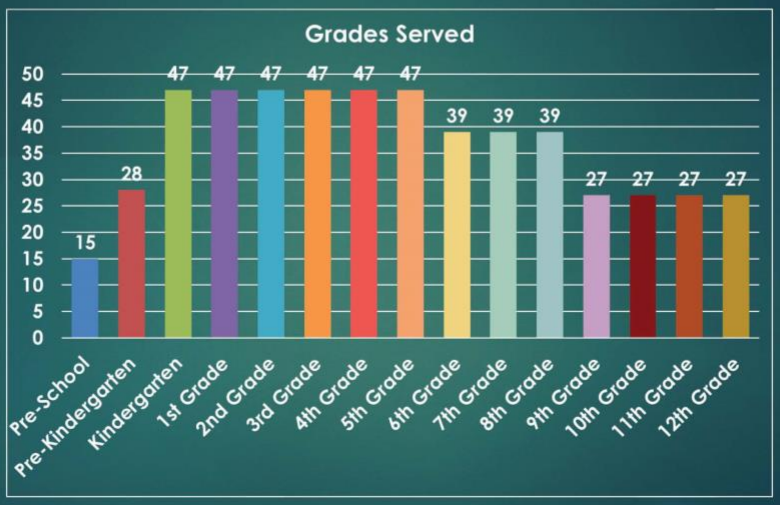


CT Communities with DPH Funded SBHCs

- Ansonia
- Bloomfield
- Branford
- Bridgeport
- Chaplin
- Danbury
- East Hartford
- East Haven
- East Windsor
- Groton
- Hamden
- Hartford
- Madison
- Meriden
- Middletown
- Mystic
- New Britain
- New Haven
- New London
- Newtown
- Norwalk
- Putnam
- Stratford
- Stamford
- Waterbury
- Waterford
- Windham

TOTAL: 27 Communities

SBHC Sites by Grade Served



Source: 2020-2021 SBHC Period 1 Report (Q9) What is your school's population?

SBHC Age Groups Served

Source: 2020-2021 SBHC Year End Report (Q10) Number Unduplicated SBHC Students by Age-group that had at least one Medical, Mental Health or Dental Visit.

Data from 6 sources – to be combined into one comprehensive database

1. Social Vulnerability Index (SVI) by CDC - Areas of high need, using 15 different indicators of high need
   - Top 20 towns with high SVI – DPH has SBHCs in all but 5 towns, 4 of which are covered by FQHCs, only 1 town in top 20 SVI has no SBHC

2. DPH SBHC – 90 DPH funded SBHCs (services at sites 76 Full –both Medical and Mental Health, 11 Mental Health only, 3 Medical only)
   - Type of service (medical, mental health)
   - Hours of service
   - Number of Staff
   - Who operates clinics

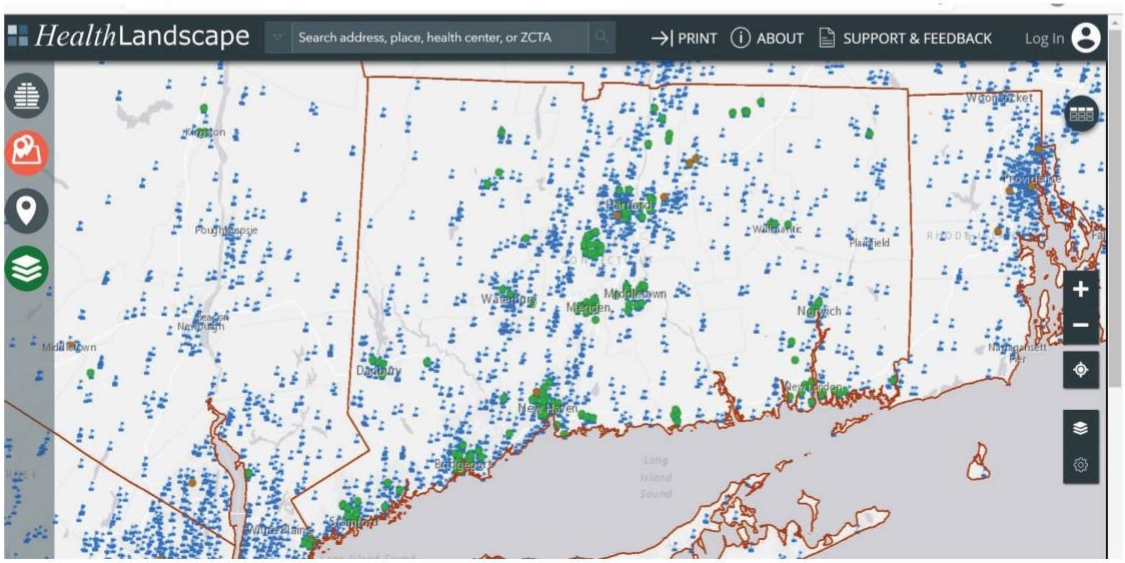
3. Health Resources and Services Administration (HRSA) -202 Federally Qualified Health Centers (FQHC) SBHCs
   - Addresses, Towns, Contact Person, Email, Phone Number
   - 60 of these are DPHs -30 are not
   - 14 different FQHCs
   - 42 different towns
   - Who is served – Students (one school or multiple), Family, Community

4. State Department of Education – List of all schools 1,373
    - ID number
    - Addresses
    - School populations

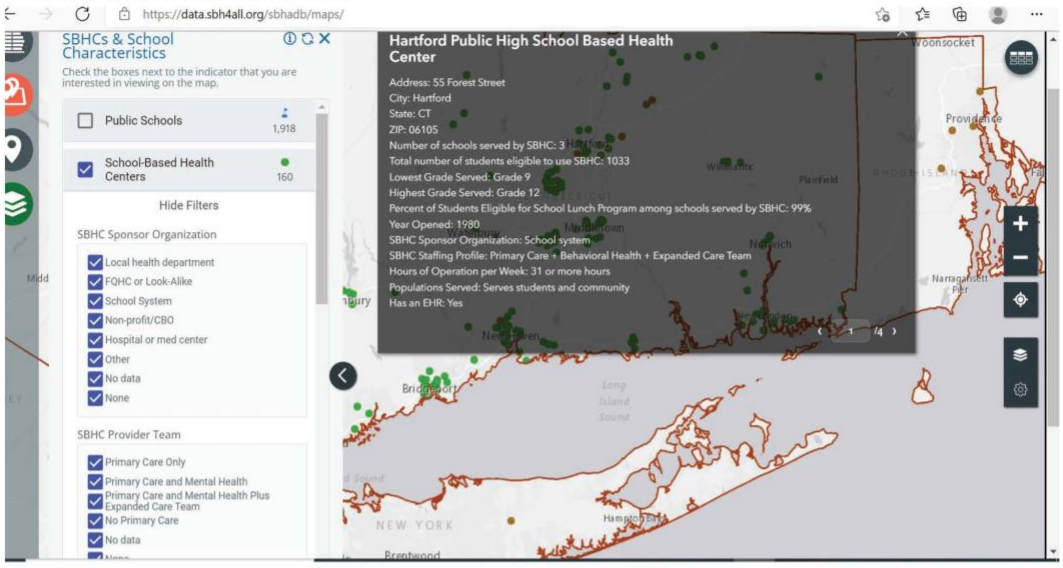
5. School Based Health Alliance
    - List of all CT Schools (already mapped)
    - List of SBHCs in CT 160 (already mapped)
    - Type of service and hours
    - HPSA – Health Professional Shortage Area
    - MUA – Medically Underserved Areas
    - Mapping tool can be used as base and add in data from other databases

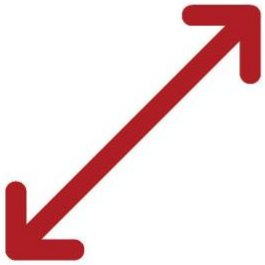
6. DPH Licensing – Outpatient Clinics
    - SBHCs licensed (252) – some have license but not all are open

SBHA – all public schools and SBHCs



SBHA – filters and site-specific data





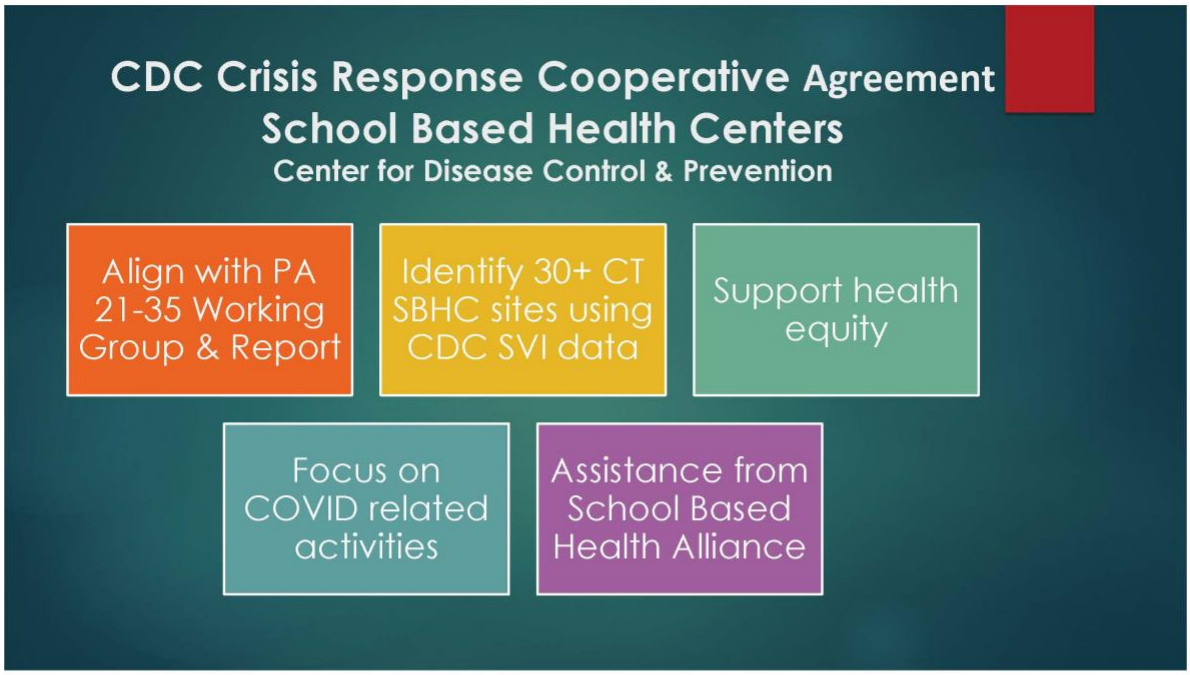
b. Options to expand or add services at existing SBHCs

SBHC Funding Sources

- State Funding
- HRSA Maternal and Child Health Block Grant (MCHBG)
- Third Party Billing/Reimbursement (State and Private Insurance)
- Local Boards of Education, municipal and local funds, private funds, and in-kind services.

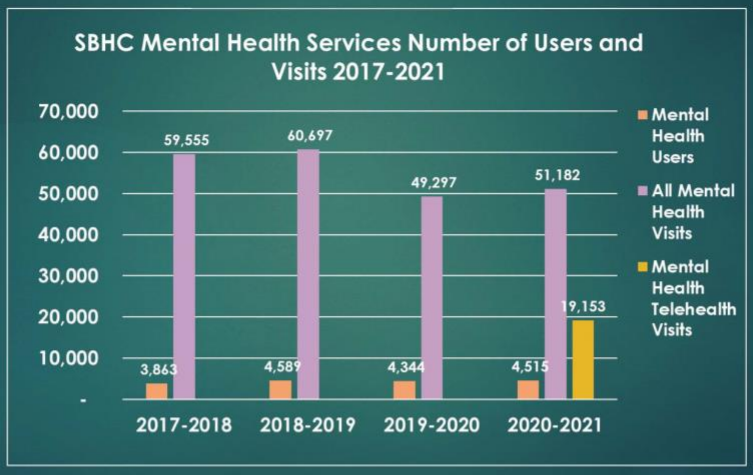
SBHC Types

School Based Health Center Sites	Expanded School Health Sites
A health clinic that provides comprehensive on-site medical **and** behavioral health services to children and adolescents.	A health clinic that provides medical **or** behavioral services, which may include but not limited to dental services, counseling, health education, health screening and prevention services to children and adolescents.


CDC Crisis Response Cooperative Agreement
School Based Health Centers
Center for Disease Control & Prevention
Align with PA 21-35 Working Group & Report
Identify 30+ CT SBHC sites using CDC SVI data
Support health equity
Focus on COVID related activities
Assistance from School Based Health Alliance


c. Methods for providing additional supports to expand telehealth services

Utilization of Mental Health Services



Source: DPH SBHC Year End Report Data. All mental health visits include telehealth visits.

School-Based Health Center Expansion Working Group

Established PA 21-35, Section 16

Thursday January 6th
10:00 am to 11:30 am

Microsoft Teams meeting
Join on your computer or mobile app
Click here to join the meeting
Or call in (audio only)
+1 860-840-2075,,958554147# United States, Hartford
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School-Based Health Center Expansion Working Group

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Phone Conference ID: 553 658 173#
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Ann.Gionet@ct.gov

Christine.Velasquez@ct.gov

c.3

CSDE

CONNECTICUT STATE DEPARTMENT OF EDUCATION

CSDE's Commitment to Addressing Schools' Social-Emotional and Behavioral Health Needs

School-Based Health Center Expansion Working Group Meeting

December 2021

Snapshot of Connecticut

205 School Districts
1,505 Schools/Programs
52,135.8 Certified Staff FTE

Source: http://edsight.ct.gov

513, 079 Students
- 50% Nonwhite
- 42.7% Eligible for Free/ Reduced-Price Meals
- 16.2% with Disabilities
- 8.2% English Learners

Snapshot of CT District Staffing

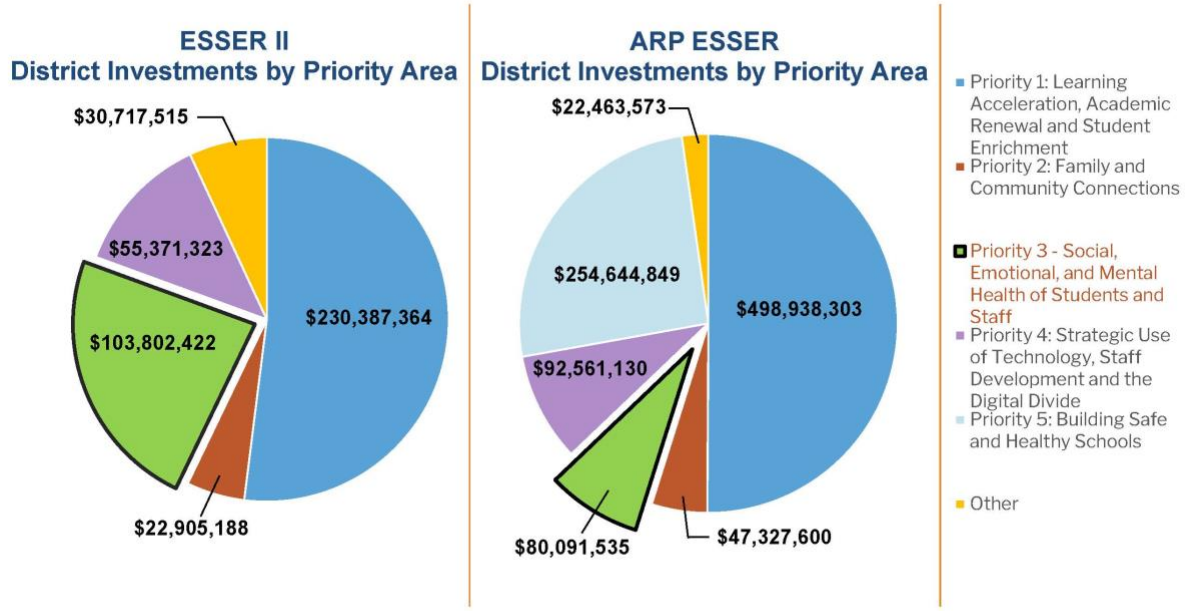
	2018-19	2019-20	2020-21
Schools Counselors	1434	1450	1466
School Psychologists	1024	1029	1041
School Social Workers	1020	1094	1126

CSDE's Priorities to Guide Investment Decisions

Five State-Level Priorities

guiding the investment of more than $1.7 billion in Federal Elementary and Secondary School Emergency Relief (ESSER) funds since the start of the pandemic

- Learning Acceleration, Academic Renewal, and Student Enrichment
- Social, Emotional, & Mental Health of the Students & School Staff
- Strategic use of Technology, Staff Development, & the Digital Divide
- Family & Community Connections
- Building Safe & Healthy Schools



Highlighted District Investments in Social, Emotional, & Mental Health

Investments have been made to support students and school staff to re-engage with their school communities as schools returned to in-person learning.

District Highlights
• Contracting with local health providers to expand mental, physical, and behavioral 1-to-1 services both during and after the school day
• Continuing and expanding district Social-Emotional Learning (SEL) teams to monitor staff training and implementation
• Professional development on trauma-informed practices; culturally relevant pedagogy; SEL; Diversity, Equity, and Inclusion (DEI); and non-discriminatory policies and practices
• Establishing districtwide common language, plus procedures in conflict resolution
• Hiring Behavioral Tutors to address learning loss and implement SEL practices
• Creating a district 'train-the-trainer' model for therapeutic crisis intervention

Across CT, **there has been a 6% increase in full-time equivalent counselors, social workers, and school psychologists** to provide necessary academic and social-emotional/mental health supports to students.

CSDE Current Initiatives & Investments

Project AWARE: 5-yr, SAMHSA-funded initiative using trauma-informed, multi-tiered system of supports for addressing mental health and preventing violence among school-age youth

Statewide Behavioral Health Landscape Scan & Focus Group: Snapshot of emerging trends, concerns, and work taking place in schools regarding mental health services

Learner Engagement and Attendance Program (LEAP): $10.7M program providing targeted support to 15 districts through home visits in order to improve attendance and engagement, as well as address chronic absenteeism

Webinars & Digital Resources: Free, online resources to assist students, parents, caregivers, educators, and student support personnel, as well as virtual events to engage in social, emotional, and mental health discussions

Tiered Supports for School Discipline: Advised by the CT School Discipline Collaborative, developed tiered system of supports aimed at reducing school discipline and disproportionality

CSDE Current Initiatives & Investments

Statewide SEL Landscape Scan: Systematic collection of data, offering insight into great work already taking place in districts, plus emerging concerns and trends related to SEL for K-12 across CT

Designed SEL Hub: Providing on-demand resources to inform, educate, and develop compassionate learning spaces, as well as accelerate learning and advance equity

Components of Social, Emotional, and Intellectual Habits: Framework for districts to integrate SEL content into lessons so that K-3 students can learn, practice, and model essential personal life habits that will contribute to academic and personal success

Student & Teacher Engagement: Boosting student participation (e.g., Voice4Change) & educator recruitment & retention efforts (e.g., TEACH CT)

Devereux Student Strengths Assessment (DESSA) System: Free tool to measure 8 SEL competencies and quickly assess students for SEL attributes, available to all districts

Connecticut State Department of Education

CSDE Planned Initiatives & Investments

Behavioral Health Pilot: 'Big Audacious Goal' to create a scalable/ sustainable system of coordinated care for all K-12 schools to provide comprehensive behavioral and mental health supports and services to students and staff

Healthy and Balanced Living Curriculum Framework: Research-based, theory-driven framework providing districts with a best practice approach to implement a planned, ongoing, and sequential pre-K-12 curriculum that addresses the physical, mental, social, and emotional dimensions of health

Support for Youth in the Criminal Justice System: In partnership with programs serving students involved with the juvenile justice system, providing high-quality instructional resources, devices, and access to digital curricula to align with public school settings

Continued Support Addressing School Discipline: Using 2018-19 district tiers to identify LEAs needing additional support in their efforts to reduce and eliminate disparities in school discipline

Comprehensive School Counseling Framework: Providing a proactive, preventative, and early intervention model for school counselors to support all students in reaching their full potential and acquire critical skills in the areas of academic, career, and SEL

c.4

School-Based Health Center Expansion Working Group

January 6, 2022
Microsoft Teams Meeting
10:00am – 11:30pm

Meeting Summary

Membership Attendees: Ann Gionet (Co-Chair), Dana Robinson-Rush, John Frassinelli, Tim Marshall, Alice Forrester (Co-Chair), Jill Holmes Brown, Melanie Wilde Lane, Lena Bahar, Rep. Jonathan Steinberg, Rep. Bill Petit, Sen. Tony Hwang, Lisa LeMasler, Susan Halpin, Jane Hylan.
Other Attendees: Christine Velasquez, Selma Alves, Johanna Davis, Amy Soto, Jason Lang, Jay Aronson, Joe Walkovich, Miriam Miller, Amanda Pickett, Tricia Orozco, Mary Katherine Wildeman, Melanie Bonjour, Lisa Baxter, Denise Tafuto, Jamie LoCurto, Chlo-Anne Boborowski, Cayla Bamberger, Connor Favre, Alison Blake, Evan Dantos, Scott Newgass, Brian Sullivan, Rebekah Behan, Sherry Linton Massiah, LeeAnn Wayne, Suzanne Krach, Ali Mulvihil, Nicole, Saryenid Guzman

Item	Action	Follow Up
1. Introductions	• Ann Gionet (Co-Chair) started the meeting and welcomed everyone. Ann asked all committee members to add their names and organizations in the chat.	
2. Welcome / Public Comment	Ann Gionet • Opened meeting for public comment. There were no comments. • Ann let everyone know this meeting will be recorded. • Ann asked if anyone wanted any changes made to the minutes. • Melanie Wilde Lane made a motion to approve the minutes as written. Jane Hyland seconded. • Minutes were approved as written by the committee.	DPH to send out: • DPH PPT presentation and SBHA Report.

3. Review PA 21-35 Section 16	Ann Gionet presented
	a. Geographic regions where additional SBHC may be needed,
	b. Options to expand or add services at existing SBHCs,
	c. Methods to expand telehealth services,
	d. Options for expanding insurance reimbursement,
	e. Options to expand access.
	f. Submit a report on findings and any recommendations for the strategic expansion of school-based health center services, no later than 2.1.2022
	
	• 2-1-1 United Way Infoline – School Based Health Center (SBHC) services are listed on the website to find the DPH funded school centers in the community
	• SBHC Licensing & Staffing – DPH and DCF both license based on type.
	  • Staffed by interdisciplinary team of professionals with expertise in child and adolescent health
	  • Care is provided under clinical direction of medical director/designated physician	

	• SBHCs provide mental health services and screening; crisis intervention; Individual, family, and group counseling • SBHC vs Expanded site defined • Enrollment and Served Data for DPH funded sites for medical and mental health Tim Marshall asked how to get more parents to enroll their children. What is the difference in schools with fewer enrolled? Johanna Davis: some schools have almost 100% whereas others have a much smaller percentage. You'll find in the poor cities and towns there's a higher percentage of enrollment. Everybody has a different procedure for how they go about enrolling students. • SBHC Funding Sources – State, HRSA, Third party billing reimbursement, • CDC Crisis Response Cooperative Agreement funding • SBH Alliance – works to improve the health of children and youth by advancing and advocating for SBH care; national; developed NQI goals which CT adopted; provides field with resources and training; WEBSITE • DPH funds 78 full SBHC sites and 12 expanded sites • Screening, testing, vaccinating of COVID 19 funding is trying to get out into community • Sen Tony Hwang - Are we capable of expanding testing capacity RIGHT NOW in SBHC? Trish O. – East Hartford is doing some testing for staff/kids. Need more rapid tests. Jane H. – testing…need more test kits. • Johanna Davis – provided data links for Social Vulnerability Index (SVI) by Census Track; SVI Interactive Map; Children's Health and Educational Mapping tool and showed how to use. • CDC does statistics by county and by census track, not towns. • We are collecting several variables from different sources including by insurance status • Ann Gionet – telehealth 19,153 visits in 2020-2021. Also had more mental health visits in 2020-2021 than in the 2019-2020 • 2020-21 National survey of SBHC: The impact of COVID-19 Pandemic report to be sent • Expanding insurance reimbursement – 75% of client's have public/private ins and the SBHC can bill and may be reimbursed	
4. Discussion of b. c. and d.	Alice Forrester • There is a large documentation burden related to billing fee for services • DCF Regulations related to treatment of client – more documentation. Must have treatment plan signed, dated, measurable time bound goals, reviewed by DCF and parent every 90 days; significant revisions require new written plan/signatures • DSS requirements – more paperwork and signatures • Funding sketch for SBHC 2 clinicians in 2 different schools – expenses higher than revenue (even including billing)	

	• Susan Halpin: In Connecticut only 30% of the commercial market is subject to state regulation. The other 70% of the market is self-insured, and it's the employers that make the decisions in those situations.	
5. Meeting dates ***Edited post meeting***	• Next Meeting Dates: January 20th meeting cancelled and replaced by January 31st meeting. **January 26, 2022 10:00 am -11:30 am** Microsoft Teams meeting Join on your computer or mobile app Click here to join the meeting Or call in (audio only) +1 860-840-2075,,420845941# United States, Hartford Phone Conference ID: 420 845 941# ***New date*** **January 31, 2022 10:00 am -11:30 am** Microsoft Teams meeting Join on your computer or mobile app Click here to join the meeting **Or call in (audio only)** +1 860-840-2075,,553658173# United States, Hartford Phone Conference ID: 553 658 173#	

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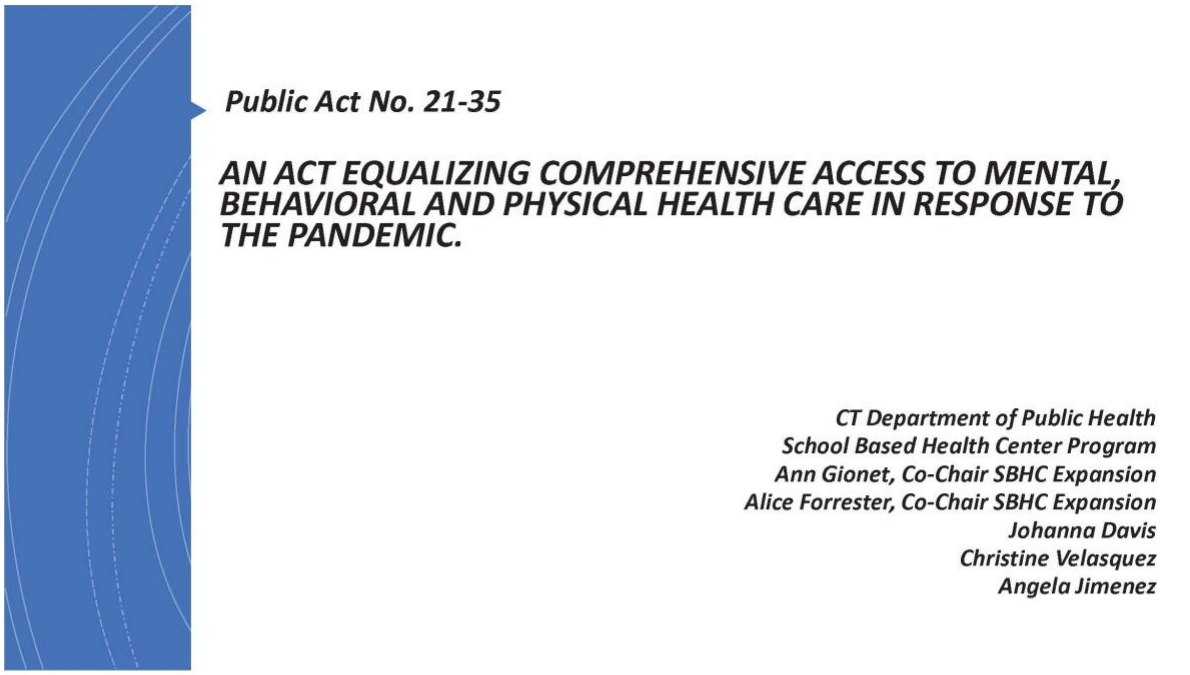

School-Based Health Center Expansion Working Group Members

Please type your name & organization in the chat

Use the raise your hand feature

Information to share with the working group, email:
Ann.Gionet@ct.gov or Christine.Velasquez@ct.gov

PA 21-35 Access to health care in response to COVID
Section 16

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2-1-1 United Way Infoline

United Way of Connecticut - 211 and eLibrary
Resource Center
https://uwc.211ct.org

School Based Health Centers

Categories : Health Issues

What are School-Based Health Centers?
Connecticut's school-based health centers (SBHCs) are comprehensive primary health care facilities located within schools or on school grounds. SBHCs are licensed by the Department of Public Health. Multidisciplinary teams of professionals provide a wide range of services including routine checkups/physical exams, immunizations, mental health services, crisis intervention, prescription and dispensing of medications, dental care (selected sites only) and more.

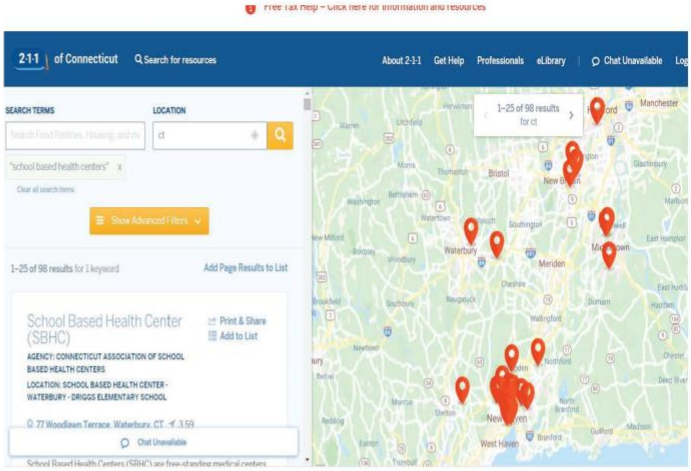
All children enrolled at the site school may use the SBHC regardless of income or health care coverage. SBHC services are aimed at, but not limited to, students who do not have access to a family doctor, or whose families have little or no health insurance. Type and extent of services provided vary.

Since services can't be provided unless there is a signed Parent Permission Form on file, it is recommended that parents complete the form at the start of the school year.

For more information go to: Connecticut Association of School Based Health Centers: http://ctschoolhealth.org/

To Find Providers in Connecticut's Community Resources Database:
Search by service name: School Health Programs

SOURCE: Connecticut Association of School Based Health Centers
PREPARED BY: 211.inmn
CONTENT LAST REVIEWED: February2021



SBHC Licensing & Staffing

- Licensed by the Connecticut Department of Public Health (DPH) as hospital satellite clinics or outpatient clinics.
- Licensed by the Department of Children and Families, Department of Public Health or both to provide mental/behavioral health services.
- SBHCs are staffed by an interdisciplinary team of professionals with expertise in child and adolescent health.
- Care is provided under the clinical direction of a medical director/designated physician.
- Minimum staffing includes a licensed Advanced Practice Registered Nurse (APRN)/ Physician's Assistant and a licensed Mental Health Clinician (MHC).

SBHC Mental Health Services

- Mental health services and screenings
- Individual, family, and group counseling
- Crisis intervention

SBHC Types

School Based Health Center Sites	Expanded School Health Sites
A health clinic that provides comprehensive on-site medical **and** behavioral health services to children and adolescents.	A health clinic that provides medical **or** behavioral services, which may include but not limited to dental services, counseling, health education, health screening and prevention services to children and adolescents.

Enrollment and Served Data

	2018-2019	2019-2020	2020-2021
Student Population	69,926	69,804	67,206
Enrolled	39,776	38,869	35,958
Served	23,109	20,148	12,953
% of Population Served	33%	29%	19%

Source: DPH SBHC Year-end Reports.

DPH SBHC User and Visit Data

Medical Users and Visits Data

	2018-2019	2019-2020	2020-2021
Medical Visits	62,159	44,955	25,711
Medical Users	20,216	17,254	9,831
Average # of Medical Visits	3.1	2.6	2.6

Source: DPH SBHC Year-end Reports.

Mental Health Users and Visits Data

	2018-2019	2019-2020	2020-2021
Mental Health Visits	60,697	49,297	51,182
Mental Health Users	4,589	4,344	4,515
Average # of Mental Health Visits	13.2	11.3	11.3

Source: DPH SBHC Year-end Reports.

b. Options to expand or add services at existing SBHCs

SBHC Funding Sources

- State Funding
- HRSA Maternal and Child Health Block Grant (MCHBG)
- Third Party Billing/Reimbursement (State and Private Insurance)
- Local Boards of Education, municipal and local funds, private funds, and in-kind services.

DPH Funded SBHC Administrators

- Hospitals
- Community Health Centers
- Federally Qualified Health Centers
- Boards of Educations
- Health Departments
- Private Non – Profits
- Mental Health / Social Services Agencies

CDC Crisis Response Cooperative Agreement School Based Health Centers

Center for Disease Control & Prevention

Align with PA 21-35 Working Group & Report

Identify 30+ CT SBHC sites using CDC SVI data

Support health equity

Focus on COVID related activities

Assistance from School Based Health Alliance

School Based Health Alliance

- Works to improve the health of children and youth by advancing and advocating for school-based health care.
- National voice for school-based health care.
- Provides the field with high-quality resources, training, and motivation and inspiration to excel in their work.
- Developed NQI goals, which CT adopted.
- Website: https://www.sbh4all.org/

SCHOOL-BASED HEALTH ALLIANCE
Redefining Health for Kids and Teens

School Based Health Center Expansion Working Group

Established PA 21-35, Section 16

Data Links

Updated 1.6.2022

CT link for Social Vulnerability Index (SVIs) by Census Track.

Provided by CDC
Click on layers that you want to see in the legend.
https://maps.ct.gov/portal/apps/webappviewer/index.html?id=80690e067bb04ed6a8c60dd43952
1382

Social Vulnerability Index (SVIs) Interactive Map.

Provided by CDC
Map of the United States
https://svi.cdc.gov/map.html

The Children's Health and Education Mapping Tool

Provided by the School-Based Health Alliance in partnership with *Health*Landscape
This tool leverages the School-Based Health Alliance Census data and Geographic Information System (GIS) technology to give you an interactive look at the intersection of school-based health centers (SBHCs) and high-need areas.
Mapping Tool - School-Based Health Alliance (sbh4all.org)

HPSA Find

Provided by Health Resources & Services Administration (HRSA)

The Health Professional Shortage Area (HPSA) Find tool displays data on the geographic, population, and facility HPSA designations throughout the U.S.

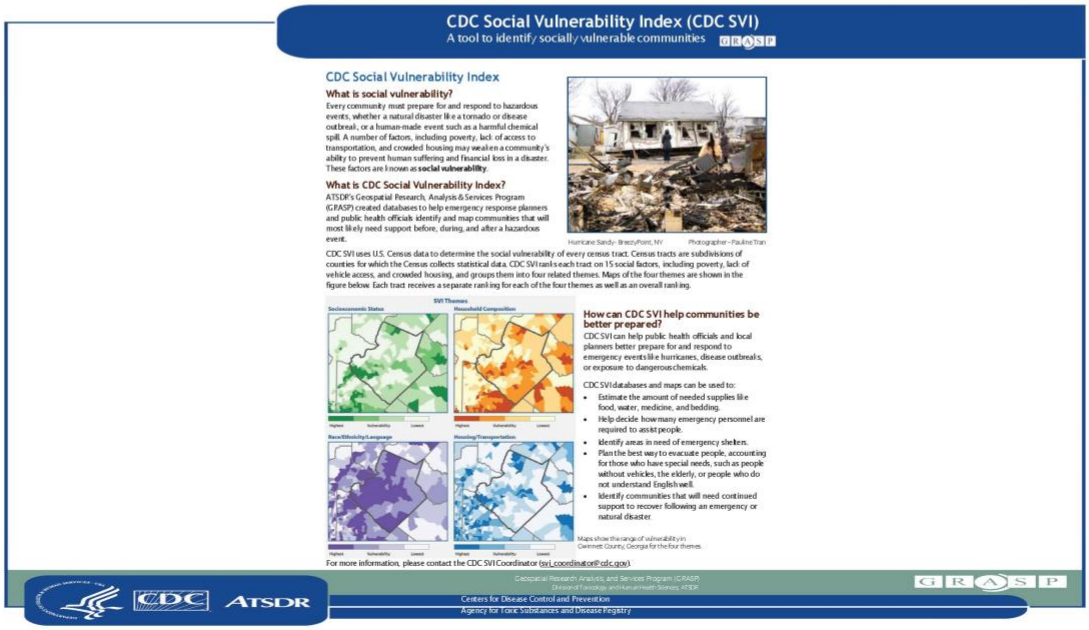
HPSA Find (hrsa.gov)

CT Department of Education link to School data.

EdSight - Connecticut State Department of Education

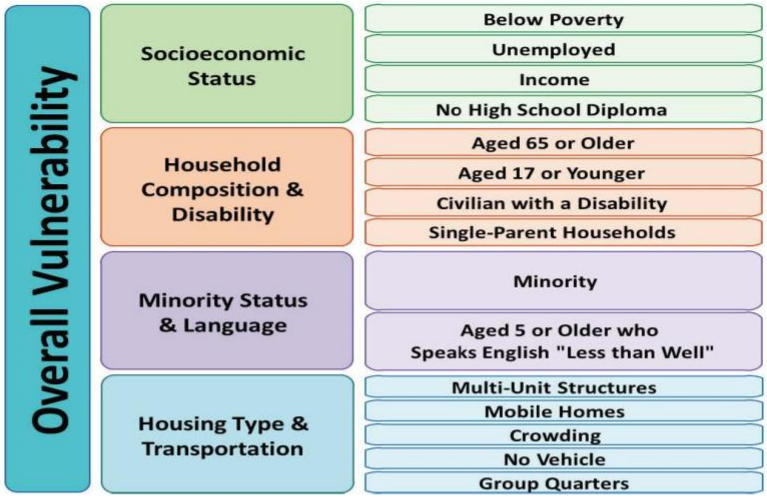
CT DPH link to look up any DPH licenses

eLicense Online (ct.gov)

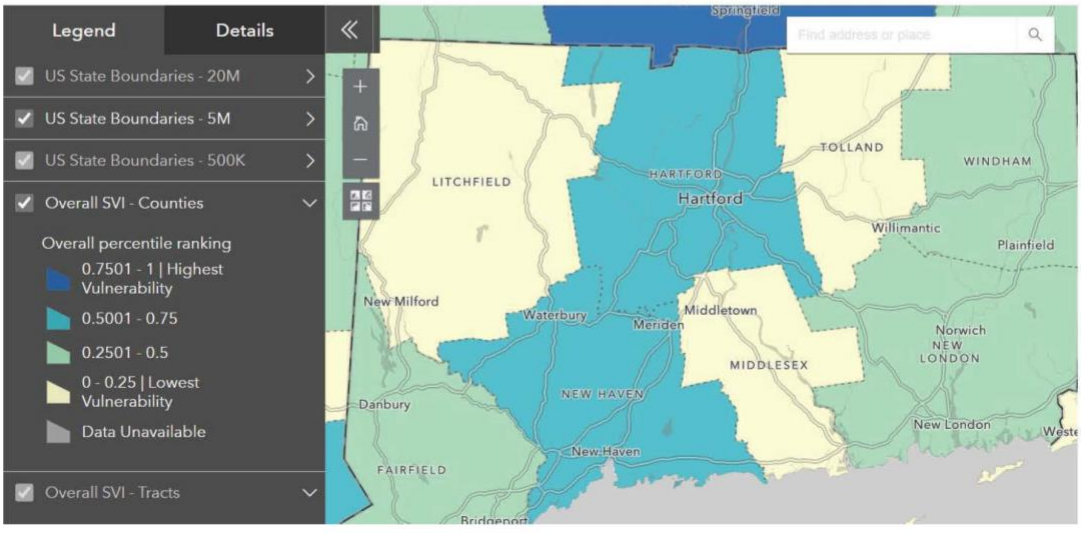


Methods

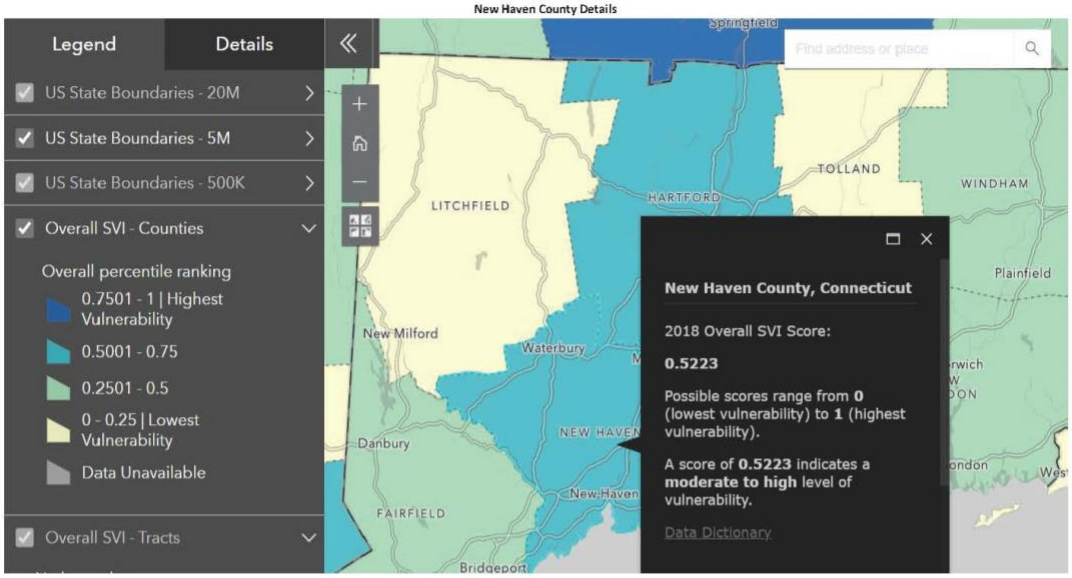
Variables Used



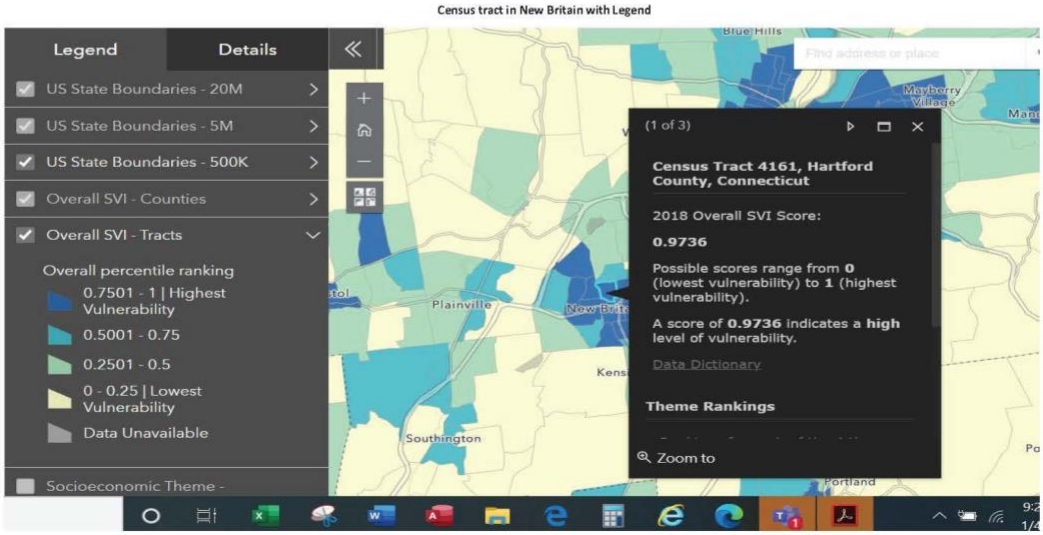
https://svi.cdc.gov/map.html

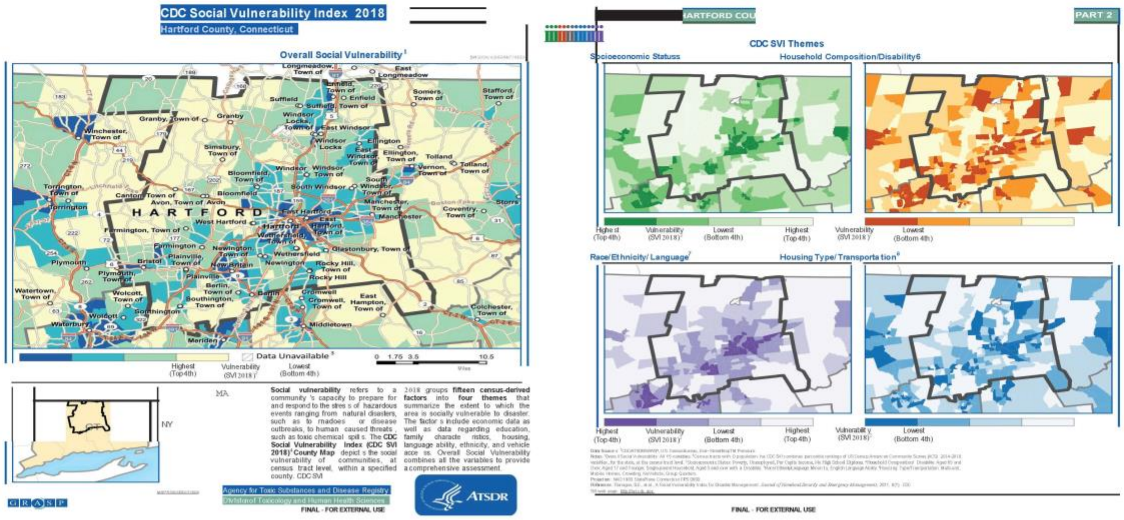


New Haven County Details



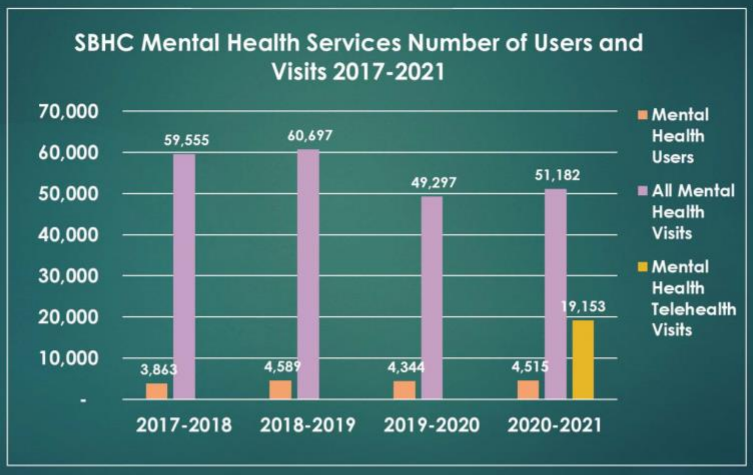
Census tract in New Britain with Legend





c. Methods for providing additional supports to expand telehealth services

Utilization of Mental Health Services

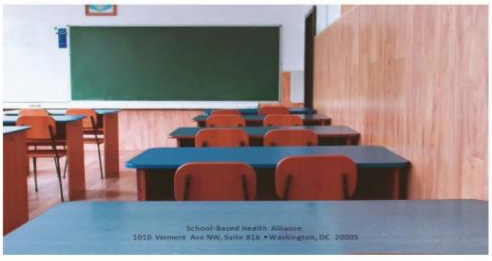


Source: DPH SBHC Year End Report Data. All mental health visits include telehealth visits.

SCHOOL-BASED HEALTH ALLIANCE
The National Voice for School-Based Health Care

2020-21 National Survey of School-Based Health Centers:

The Impact of the COVID-19 Pandemic



School-Based Health Center Delivery Models, Sponsorship, and Funding

SCHOOL-BASED HEALTH CENTER DELIVERY MODELS

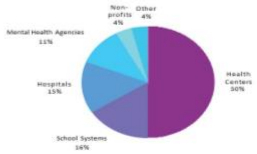
Most National Survey respondents described their health centers as school-based (75%, n=835), meaning their patients access care in a fixed facility on a school campus. Fifteen percent (n=166) reported operating as telehealth exclusive, with patients accessing care in a designated space at the school exclusively via telehealth. Seven percent of respondents (n=80) identified as school-linked, with patients accessing care in a fixed facility near the school campus, and 3% (n=37) operated as mobile models, with patients accessing care in a specially equipped van or bus parked on or near a school campus.

Most school-based health centers in the survey sample were open ten years or more (40%, n=430) or five to nine years (40%, n=427). Fourteen percent (n=155) had been open for two to four years and 6% (n=67) for less than two years.

SPONSORSHIP AND FUNDING

School-based health center lead sponsors are local healthcare, education, or community-based organizations that generally oversee clinical and fiscal operations. They provide staffing and other support necessary for school-based health centers. The most commonly reported sponsor type in the National Survey was Health Centers (50%, n=544). Other[2] sponsor types included school systems (16%, n=177), hospitals/medical centers (15%, n=167), mental health agencies (11%, n=120), non-profit/community-based organizations (4%, n=44), and other sponsor types (e.g., local health departments, universities, tribal governments; 4%, n=43).

Survey School-Based Health Center Sponsor Types (n=1,095)



2 Health Centers, previously known as federally-qualified health centers or FQHCs.
3 https://bphc.hrsa.gov/about/what-we-do/health-center-models.html
4 https://www.nachc.org/about/about-our-health-centers/

Services

SERVICES CHANGES DURING THE 2020-21 SCHOOL YEAR

For many school-based health centers, COVID-19 related precautions restricted who was in school buildings, leading to many school-based health centers temporarily pausing in-person services and a surge in the use of telehealth.

Of the 1,026 school-based health centers that reported changes to their primary care services, many began offering telehealth services (62%, n=631) or improved technology to expand pre-pandemic telehealth services (52%, n=534). In direct response to the pandemic, 45% (n=466) offered COVID testing or follow-up, and 25% (n=252) administered COVID vaccines or follow-up. One out of five survey respondents (21%, n=219) reduced physical services hours or staffing.

Of the 1,016 school-based health centers that reported changes to mental health services, 64% (n=648) began offering telemental health services, and 49% (n=493) improved technology to expand pre-pandemic telemental health services. One-quarter (27%, n=277) delivered professional development or consulting to school staff and/or teachers to support student mental health, and (22%, n=223) expanded their mental health referral networks.

SERVICES AVAILABLE

Of the school-based health centers that reported the services they provided (n=869), most provided primary care (81%, n=705) and behavioral health (80%, n=693) either on-site, via telehealth, or both. Over half (55%, n=475) reported that their school-based health centers provided primary care, behavioral health, and other services (such as oral health, health education or youth development programming) on-site or via telehealth.

As noted, many school-based health centers shifted to providing telehealth services in the 2020-21 school year, with 82% (n=709) of survey respondents reporting they provided some services via telehealth. Though the survey samples vary, this is a large increase compared to the 2016-17 Census of School-Based Health Centers, when only 19% of school-based health centers nationwide reported using telehealth.

* During the 2020-21 school year, COVID-19 immunizations were only available for those over 12 years of age after Spring 2021.

Main Takeaways

As demonstrated by the National Survey findings, school-based health centers pivoted to continue serving their school communities despite the challenges they faced due to the COVID-19 pandemic.

- School-based health centers in the survey faced significant challenges, including reaching or engaging students (59%), having to close when the school facility closed (39%), and having staff redeployed to other roles, furloughed, or laid off (38%). Yet, nearly all respondents to the survey (92%) remained fully or partially open by Spring 2021, though it is likely that school-based health centers that closed did not respond to the survey.
- Telehealth was a critical strategy for delivering continued care, with over 80% of survey respondents reporting they delivered some services via telehealth—a significant increase compared to prior years. Over 60% of survey respondents began offering primary care and/or mental health services via telehealth in the 2020-21 school year, and half improved technology to expand pre-pandemic telehealth services.
- School-based health centers transitioned quickly to providing direct services to combat the COVID-19 pandemic. Half of the survey respondents offered COVID-19 testing or follow-up, and one-quarter administered COVID-19 vaccines or follow-up. These numbers have likely increased as vaccine availability was expanded to children five years and older in Fall 2021.

What's Next

THE SCHOOL-BASED HEALTH ALLIANCE'S NEXT STEPS

As we advocate for national policy and legislative action, we will use the findings from the 2021 National Survey to tell the story of how COVID-19 impacted school-based health centers across the country and how they responded to meet the needs of their communities. The details on implementing telehealth, vaccinating and testing students and their families, and the challenges related to operating services during the COVID-19 pandemic illustrate the true strength of our field.

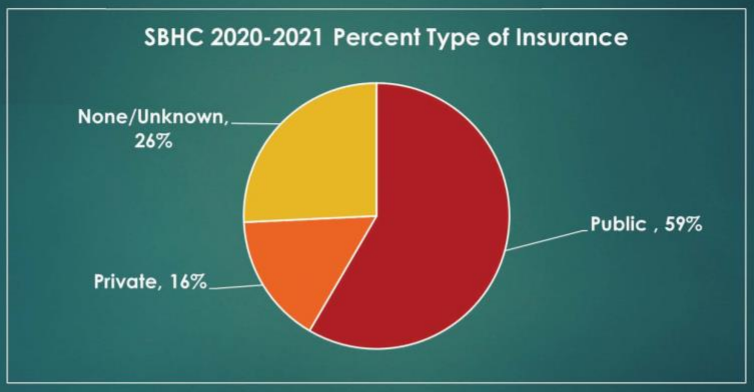
The National Survey was designed to obtain timely information from the field and does not capture all school-based health centers nationally. We hope that every school-based health center will participate in the 2021-22 National Census launching this upcoming spring. We aim to capture an accurate landscape of the impact that school-based health centers are making across the country with full participation from all school-based health center sites.

HOW YOU CAN HELP

1. Share this report with your colleagues to launch dialogue and inform decision-making.
2. Connect with [redacted] to confirm your School-Based Health Centers contact information.
3. Complete the 2021-22 National Census of school-based health centers in Spring 2022.

d. Options for expanding insurance reimbursement

Insurance, Billing, and Reimbursement



75% of client's have public or private insurance and the SBHC can bill and may be reimbursed for these client's services.

Source: DPH SBHC Year-end Reports.

School-Based Health Center Expansion Working Group

Established PA 21-35, Section 16

Thursday January 20th
10:00 am to 11:30 am

Microsoft Teams meeting
Join on your computer or mobile app
Click here to join the meeting
Or call in (audio only)
+1 860-840-2075,,553658173# United States, Hartford
Phone Conference ID: 553 658 173#
Find a local number | Reset PIN
Learn More | Meeting options

School-Based Health Center Expansion Working Group

Established PA 21-35, Section 16

Wednesday January 26th
10:00 am to 11:30 am

Microsoft teams link to be sent soon

Ann.Gionet@ct.gov

Christine.Velasquez@ct.gov

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CDC's Social Vulnerability Index (SVI)

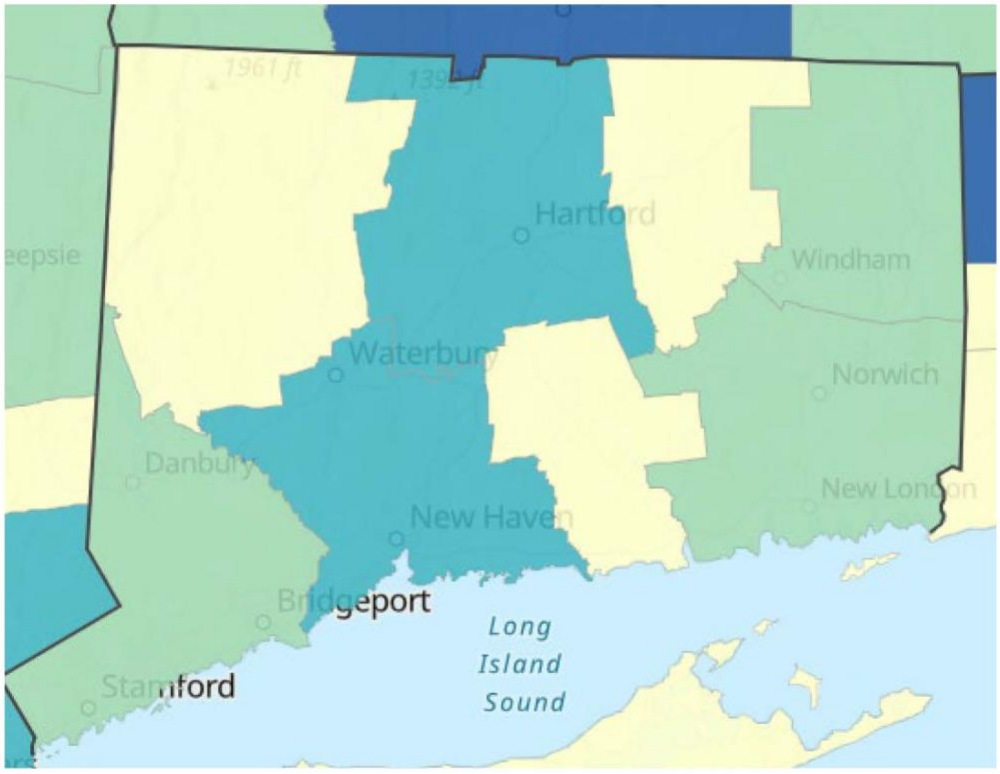
SVI Home
Fact Sheet
Data & Tools Download
Publications & Materials
SVI Interactive Map
Prepared County Maps

SVI Interactive Map

Click the symbol in the upper left of the map to display the Map Details and Legend. Click the Details tab to display Map Tips, which explain how to explore the map. Click the Map Legend tab to display and interact with the layers comprising the map for the selected year.

Link to previous interactive SVI Map

Connecticut SVI by County from CDC

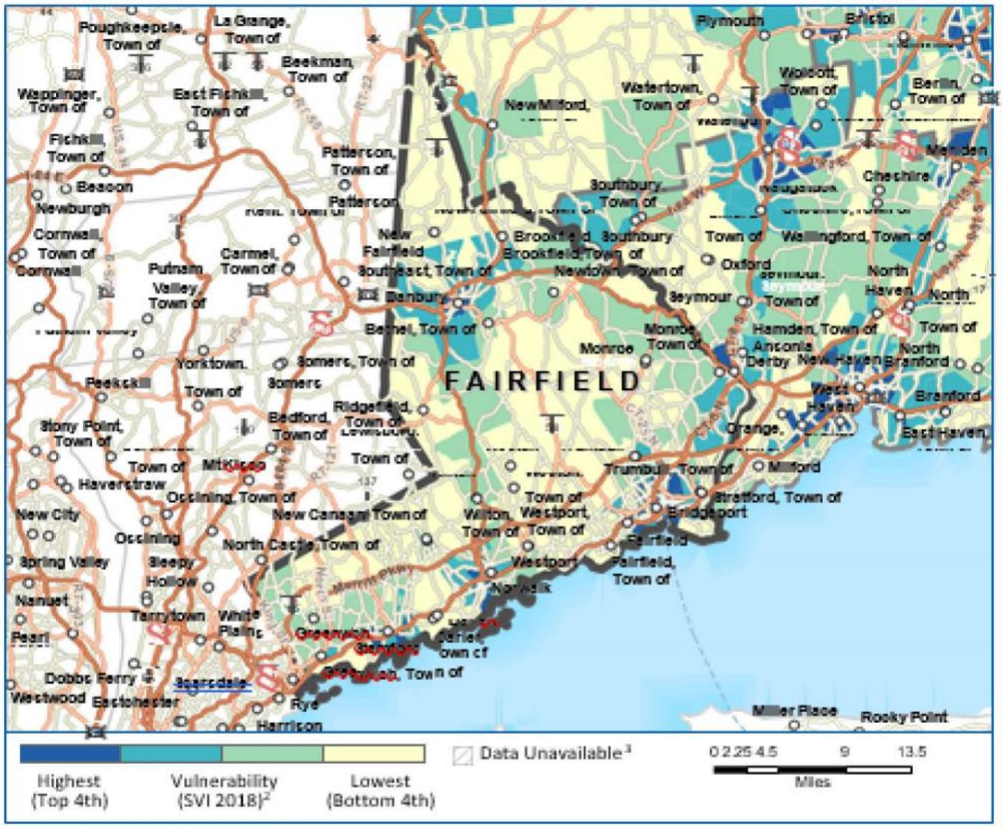


CDC Social Vulnerability Index 2018

Fairfield County, Connecticut

PART 1

Overall Social Vulnerability[1]

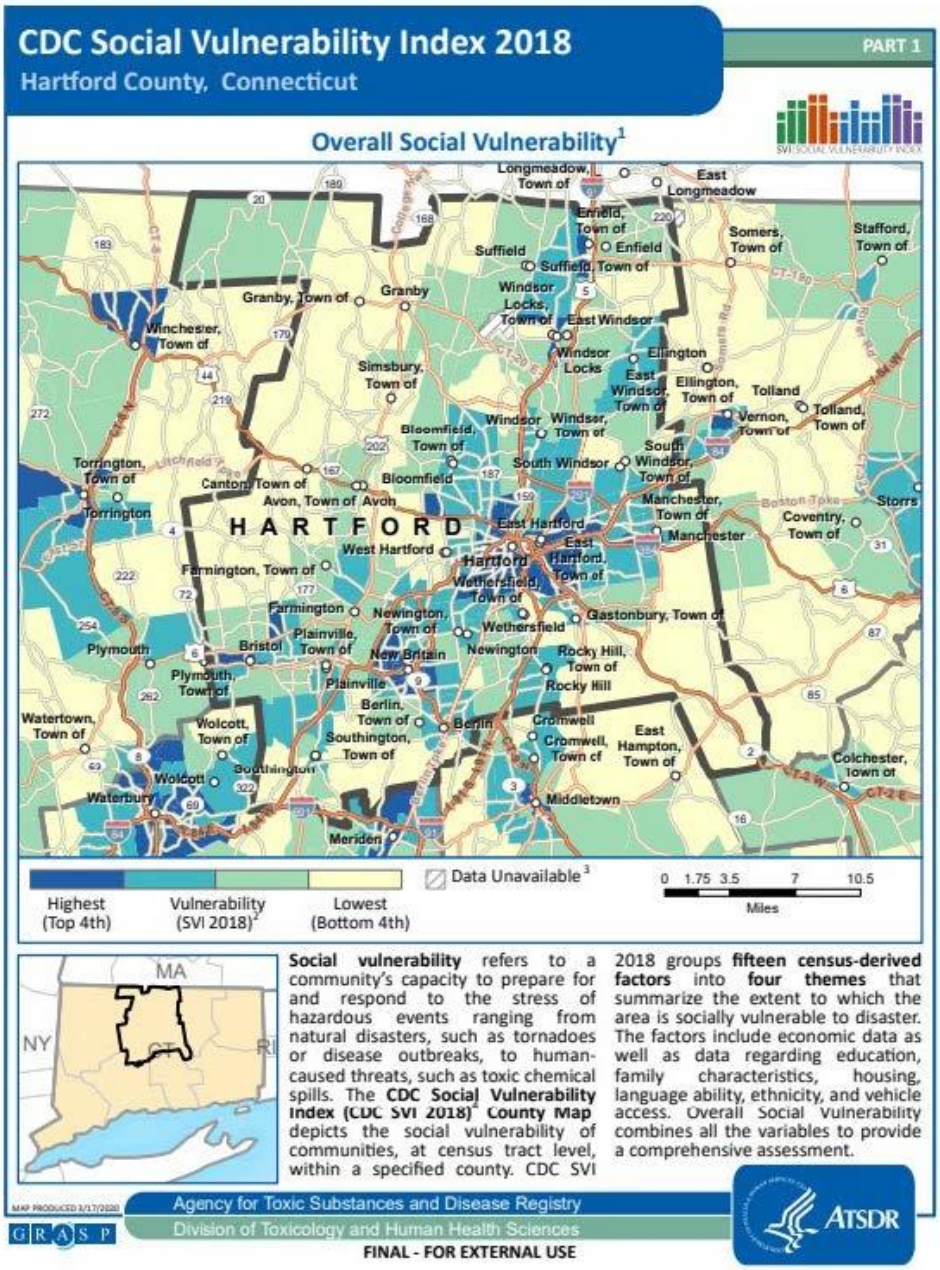


Social vulnerability refers to a community's capacity to prepare for and respond to the stress of hazardous events ranging from natural disasters, such as tornadoes or disease outbreaks, to human-caused threats, such as toxic chemical spills. The **CDC Social Vulnerability Index (CDC SVI 2018)' County Map** depicts the social vulnerability of communities, at census tract level, within a specified county. CDC SVI 2018 groups **fifteen census-derived factors** into **four themes** that summarize the extent to which the area is socially vulnerable to disaster. The factors include economic data as well as data regarding education, family characteristics, housing, language ability, ethnicity, and vehicle access. Overall Social Vulnerability combines all the variables to provide a comprehensive assessment.

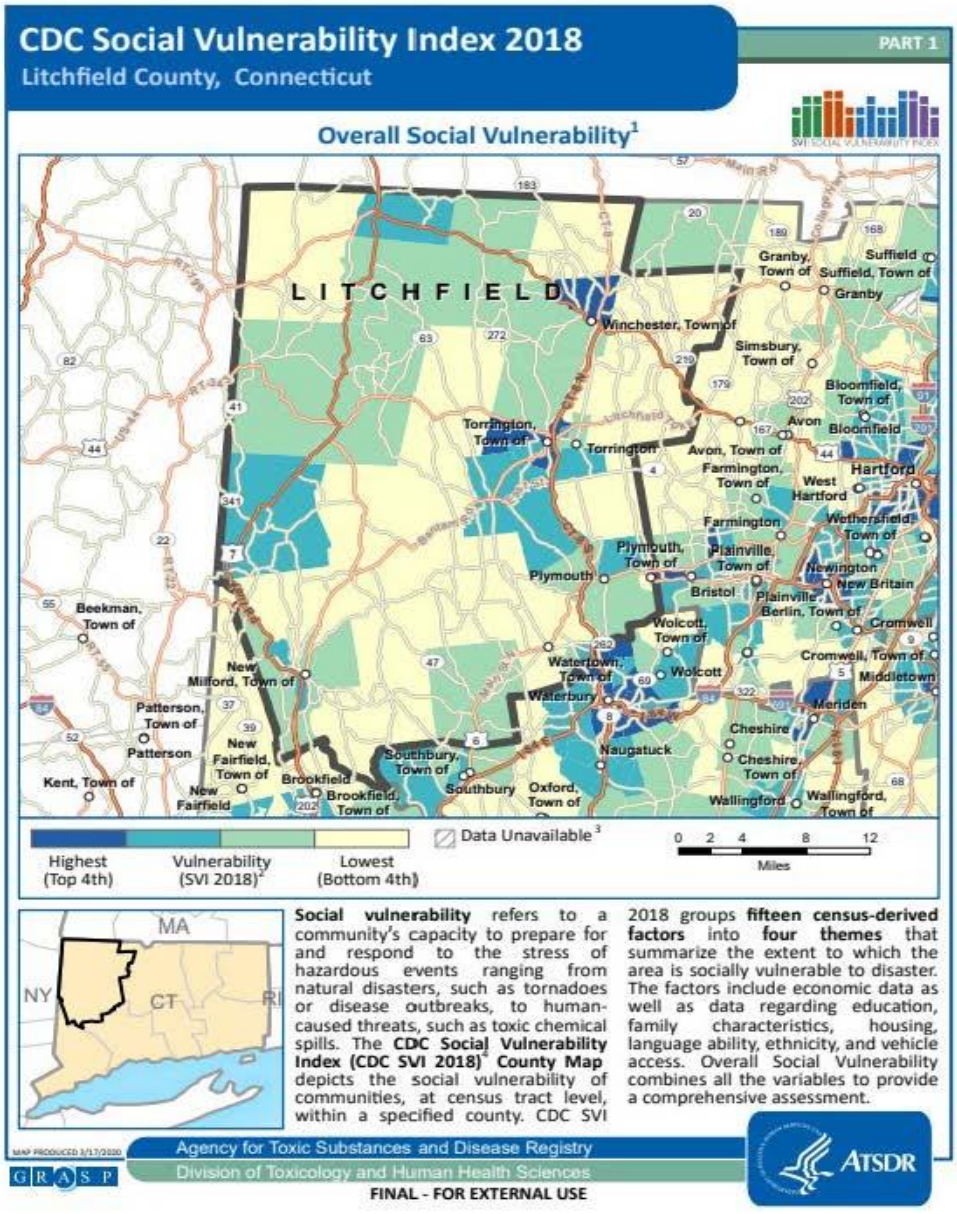
Agency for Toxic Substances and Disease Registry

FINAL - FOR EXTERNAL USE

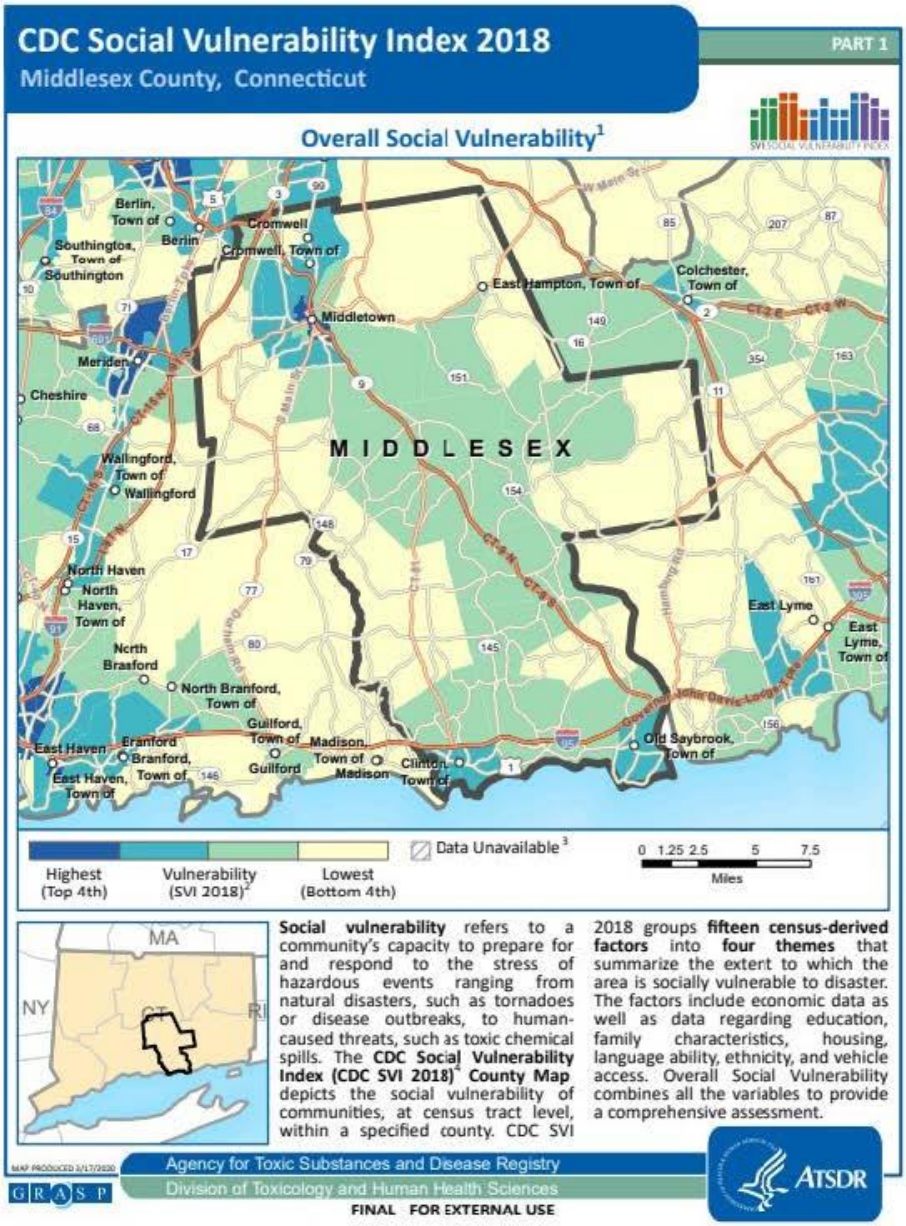
Connecticut, Hartford County SVI



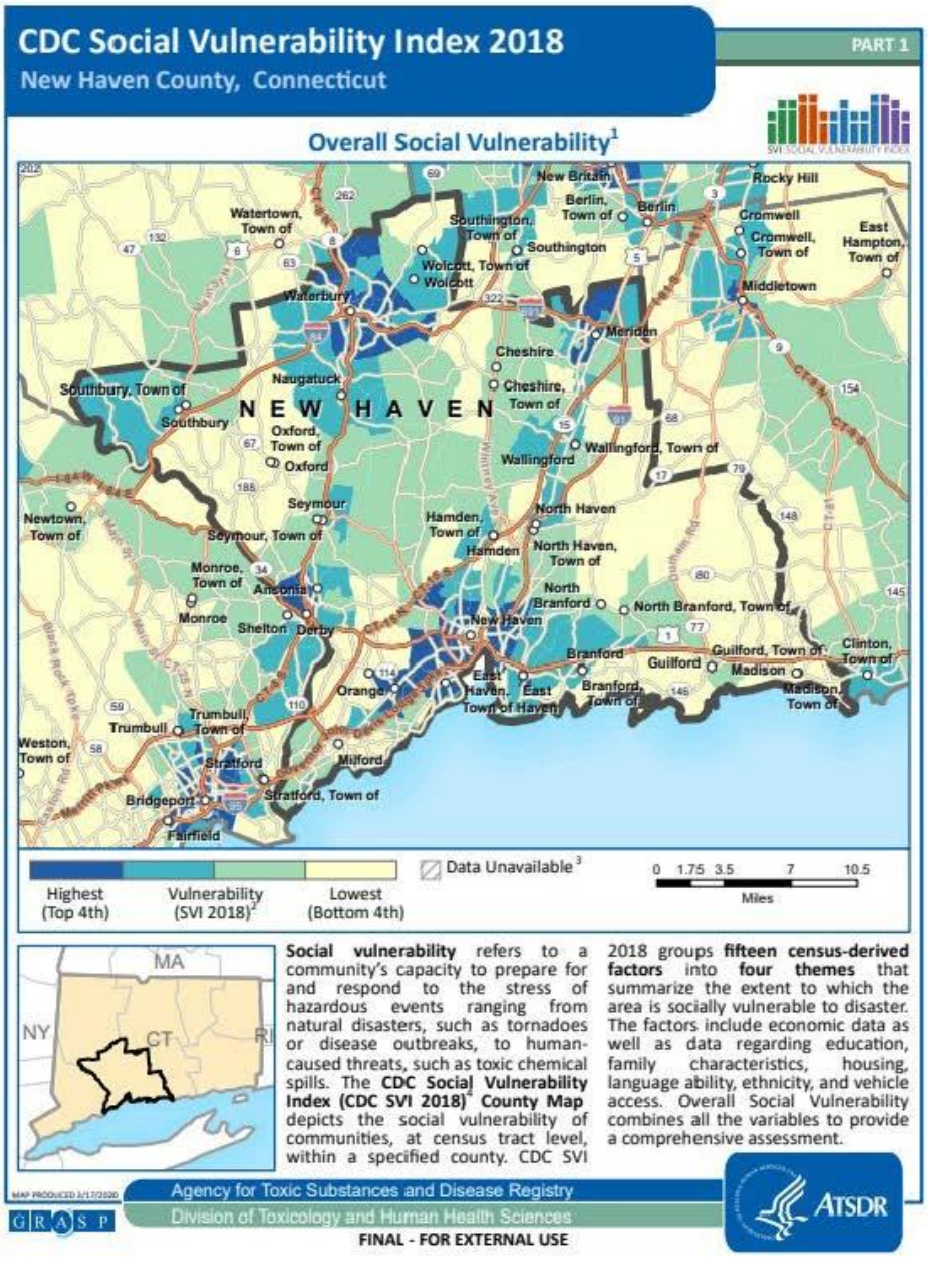
Connecticut, Litchfield County SVIs



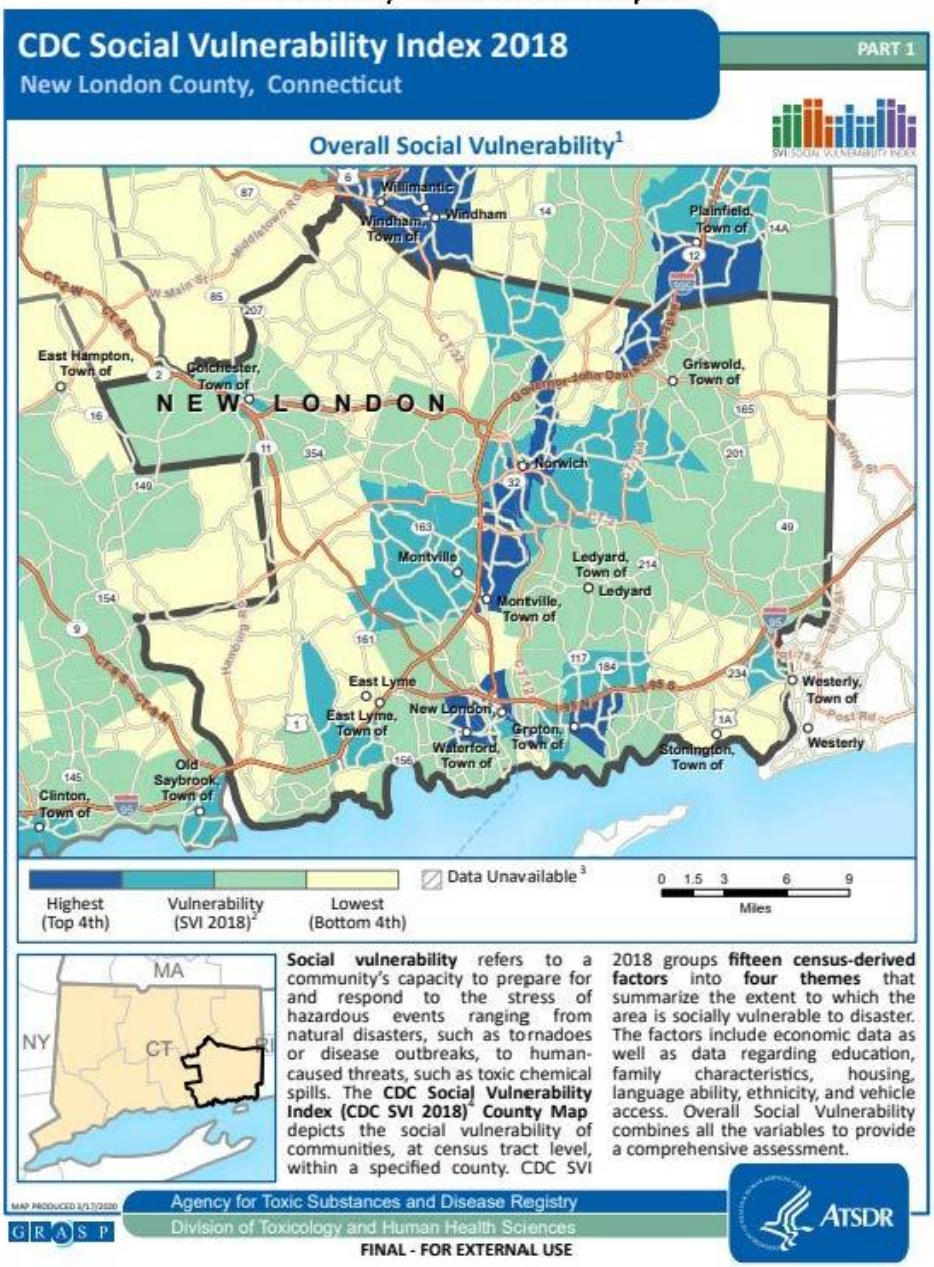
Connecticut, Middlesex County SVI



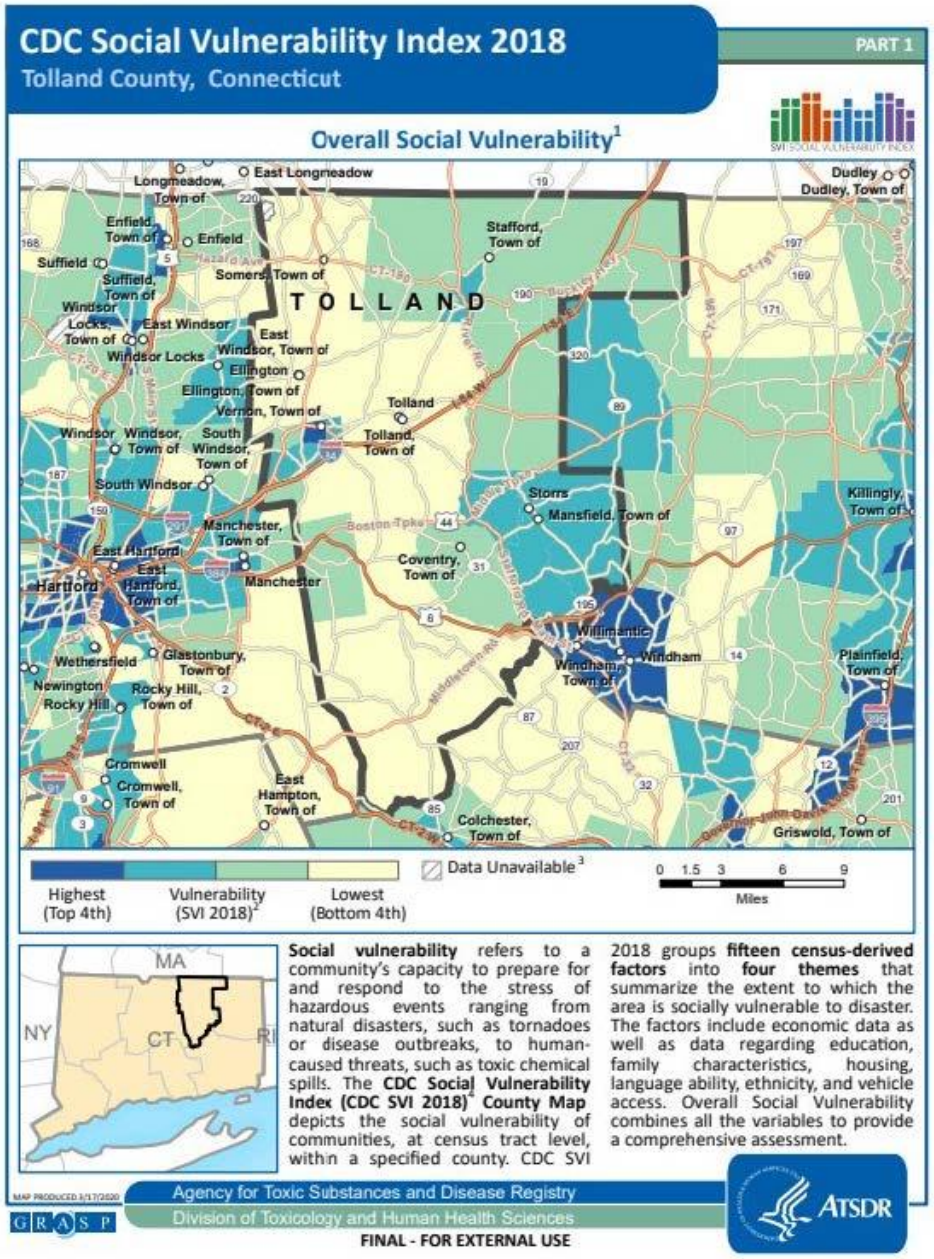
Connecticut, New Haven County SVI



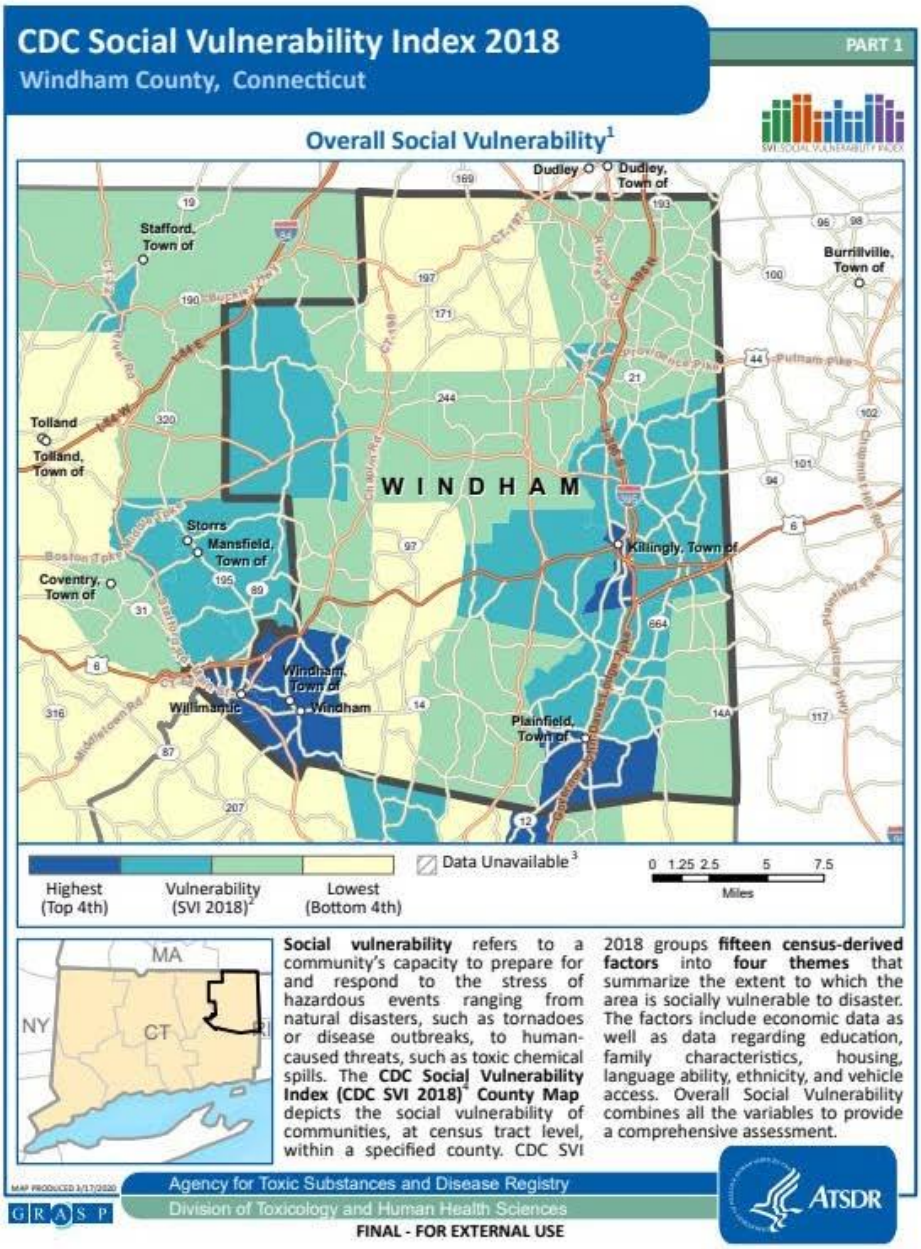
Connecticut, New London County SVI



Connecticut, Tolland County SVI



Connecticut, Windham County SVI



What is Shortage Designation?

Shortage designation identifies an area, population, or facility experiencing a shortage of health care services.

There are several types of shortage designations:

- Health Professional Shortage Areas (HPSAs)
- Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs)
- Exceptional Medically Underserved Population (Exceptional MUP)
- Governor's-Designated Secretary-Certified Shortage Areas for Rural Health Clinics

What is a Health Professional Shortage Area (HPSA)?

HPSAs (PDF - 398 KB) can be geographic areas, populations, or facilities. These areas have a shortage of primary, dental or mental health care providers.

What is a geographic HPSA?

A shortage of providers for an entire group of people within a defined geographic area

What is a population HPSA?

A shortage of providers for a specific group of people within a defined geographic area (e.g., low-income, migrant farm workers)

What is a facility HPSA?

Other Facility (OFAC)

Public or non-profit private medical facilities. They serve a population or geographic area with a shortage of providers.

Correctional Facility

Medium- to maximum-security federal and state correctional institutions

Youth detention facilities with a shortage of providers

State/County Mental Hospitals

State or county hospitals with a shortage of mental health providers (mental health designations only)

Automatic Facility HPSAs (Auto-HPSAs)

Facilities that we automatically designate as HPSAs based on statue or through regulation. These include:

- **Federally Qualified Health Centers (FQHCs)**
  - Provide primary care to an area or group of people in need.
  - Offer a sliding fee scale.
  - Provide complete services.
  - Have an ongoing quality assurance program; and
  - Have a governing board of directors.

  All organizations receiving grants under Health Center Program Section 330 of the Public Health Service Act are FQHCs.

  Read the Centers for Medicare and Medicaid Services (CMS)'s [Medicare Benefit Policy Manual: Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services (PDF - 510 KB).
- **FQHC Look-A-Likes (LALs)**
  - Community-based health care providers
  - Meet the requirements of the HRSA Health Center Program
  - Don't receive Health Center Program funding
- **Indian Health Facilities**
  - Federal Indian Health Service (IHS), tribally run and Urban Indian health clinics
  - Provide medical services to members of federally recognized tribes and Alaska Natives
- **IHS and Tribal Hospitals**
  - Federal Indian Health Service (IHS) and tribally run hospitals
  - Provide medical services to members of federally recognized tribes and Alaska Natives
- **Dual-funded Community Health Centers/Tribal Clinics**
  - Health centers that receive funding from tribal entities and HRSA
  - Provide medical services to members of federally recognized tribes and Alaska Natives
- **CMS-Certified Rural Health Clinics (RHCs)***
  - Outpatient clinics located in non-urbanized areas that are Centers for Medicare and Medicaid Services (CMS) certified and

meet NHSC Site requirements (e.g., accept Medicaid and CHIP and provide services on a sliding fee scale).

Which federal programs use HPSAs?

The National Health Service Corps (NHSC) created shortage designation. It helps us distribute participants to where they're needed most.

Other federal programs use shortage designations for resource distribution.

Dental Care
Mental Health

What is a Maternity Care Target Area (MCTA)?

An MCTA is a Maternity Care Health Professional Target Area. MCTAs are located within existing primary care HPSAs.

What is a Medically Underserved Area/Population (MUA/P)?

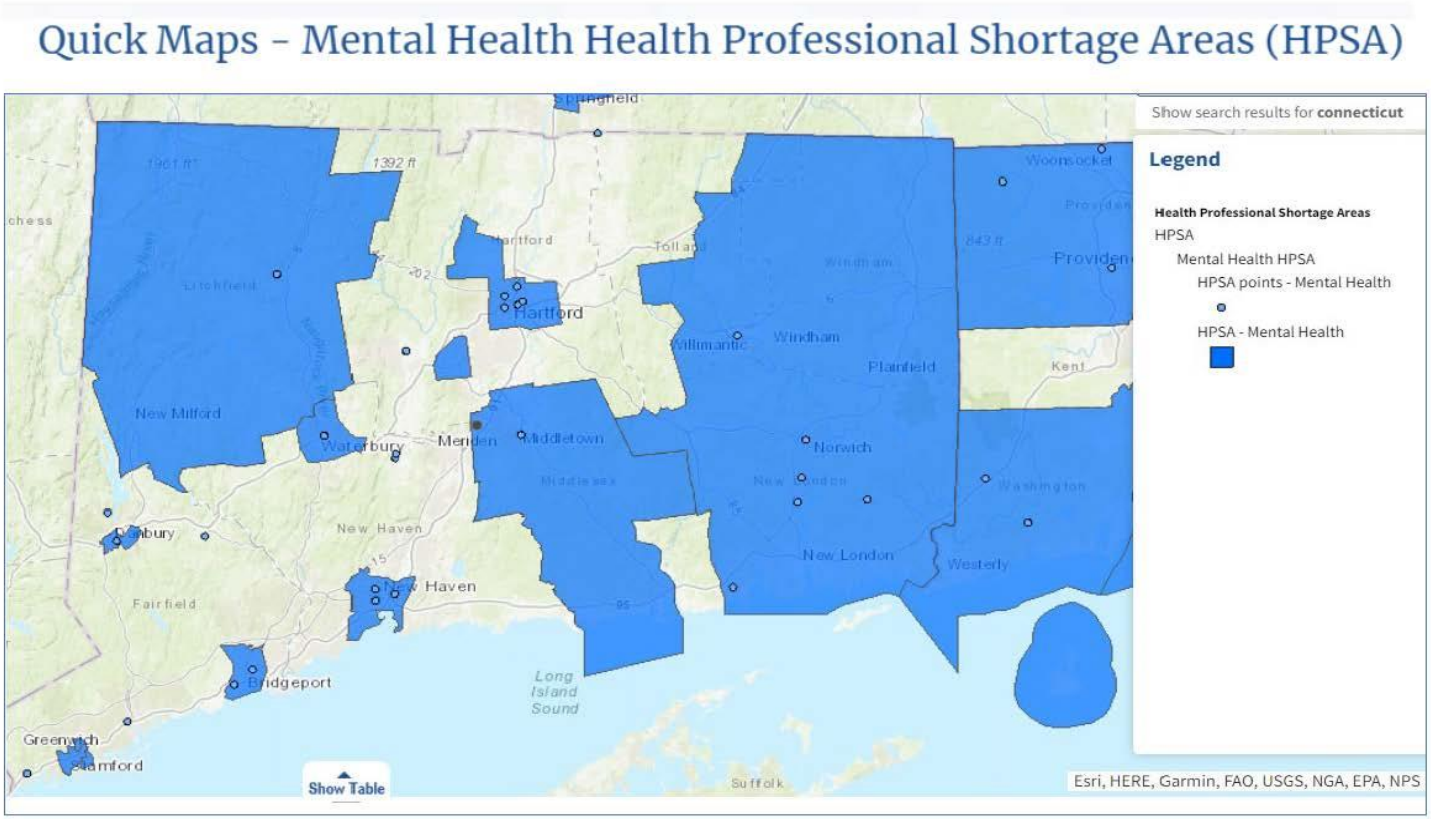
MUAs and MUPs identify geographic areas and populations with a lack of access to primary care services. These designations help establish health maintenance organizations or community health centers.

MUAs have a shortage of primary care health services within geographic areas such as:

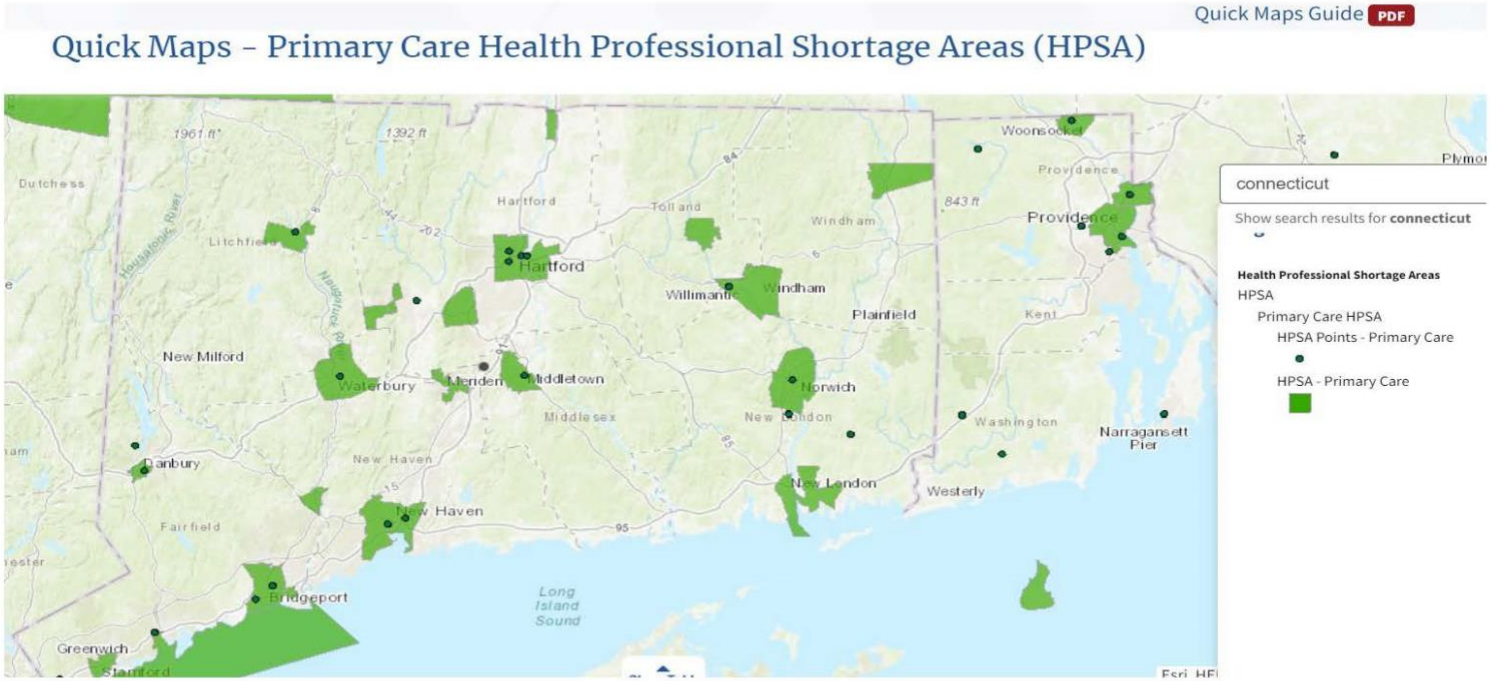
- a whole county;
- a group of neighboring counties;
- a group of urban census tracts; or
- a group of county or civil divisions.

MUPs have a shortage of primary care health services for a specific population subset within a geographic area. These groups may face economic, cultural, or language barriers to health care.

HRSA Mental Health HPSAs in Connecticut



HRSA Map of Connecticut HPSA



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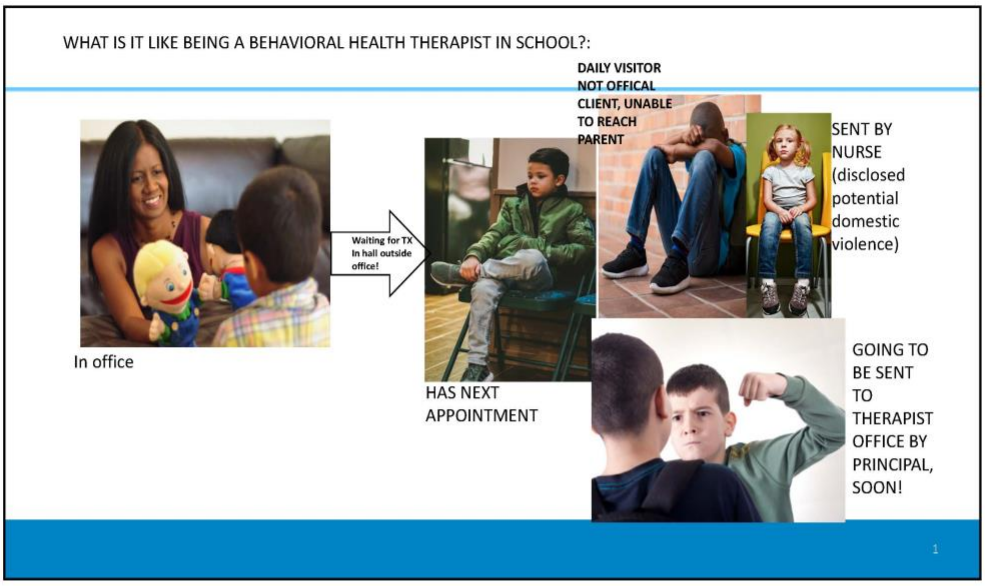
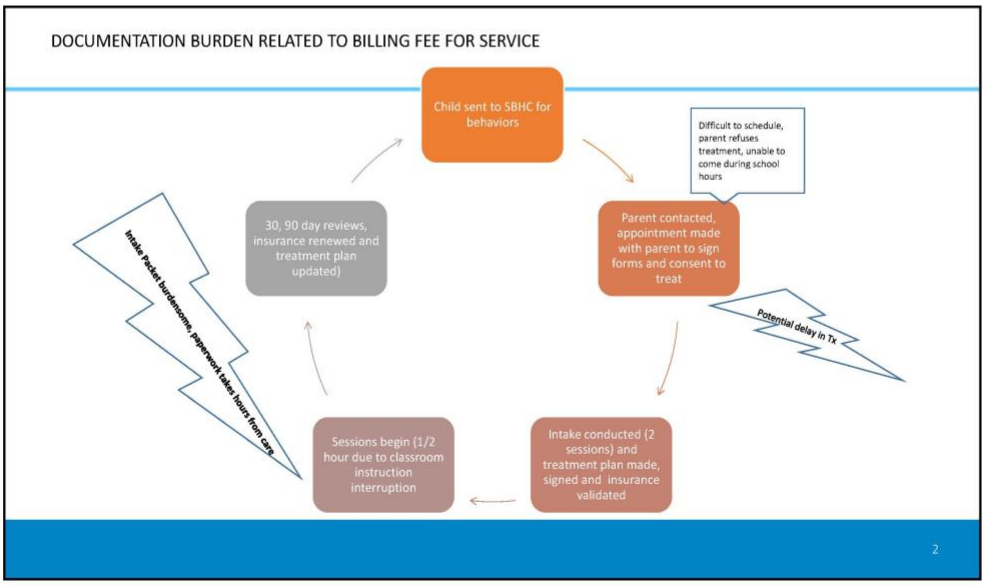

WHAT IS IT LIKE BEING A BEHAVIORAL HEALTH THERAPIST IN SCHOOL?:
DAILY VISITOR NOT OFFICAL CLIENT, UNABLE TO REACH PARENT
SENT BY NURSE (disclosed potential domestic violence)
Waiting for TX In hall outside office!
In office
HAS NEXT APPOINTMENT
GOING TO BE SENT TO THERAPIST OFFICE BY PRINCIPAL, SOON!
1

1


DOCUMENTATION BURDEN RELATED TO BILLING FEE FOR SERVICE
Child sent to SBHC for behaviors
Difficult to schedule, parent refuses treatment, unable to come during school hours
Parent contacted, appointment made with parent to sign forms and consent to treat
Potential delay in Tx
Intake conducted (2 sessions) and treatment plan made, signed and insurance validated
Sessions begin (1/2 hour due to classroom instruction interruption
Intake Packet burdensome, paperwork takes hours from care
30, 90 day reviews, insurance renewed and treatment plan updated)
2

2

DCF Psychiatric Out Patient Clinics for Children Licensing Requirements

26 pages of regulations, including guidelines

Requirements related to Treatment of Client:

17a-20-41 Assessment

- Written report
- Detailed assessment
- Psycho social individual and family assessed

17a-20-42 Treatment Plan

- BY SECOND APPOINTMENT from entry into clinic (first clinical appointment); written, signed, dated when written
- Plan must include measurable and time-bound goals and objectives
- Projected discharge date
- Child should sign if they can sign their name
- Person entering Progress notes must include job title and qualifications

3

3

17a-20-43 Treatment Plan Review

- Review every 90 days; documented and signed by parent/guardian and clinician
- Who participated in review
- Progress or lack of progress must be documented
- Any significant revisions requires new written treatment plan signed by guardian and child

17a-20-44 Discharge and Aftercare Procedures

- Within 30 days of date of discharge, signed written discharge summary required
- Services provided
- Treatment needs that remain
- Follow up services specified; who will provide follow up
- Recommendations for any other services
- When discharge not according to treatment plan, the reasons for unplanned discharge and actions/reasons taken by clinic

4

4

DSS Billing Requirements for Behavioral Health Clinics (children)

17 pages

17b-262-817-828

Requirements related to Treatment

17b-262-824; Need for Service; Evaluation

- Services under direction of physician; allied health professional to shall authorize care and review need for continuing care
- Psych diagnosis evaluation by qualified physician or allied health professional
- Psych diagnosis evaluation to be used in developing plan of care if care is recommended;
- 7 elements of evaluation…Family, school, medical hx….
- By second appointment from date of evaluation, plan of care must be signed; Qualified clinician to review plan of care and sign; each review and update to be signed by parent/guardian and clinician
- Follow plan of care elements at a minimum as required by DCF (17a-20-42; -43)

5

5

17b-262-828; Documentation

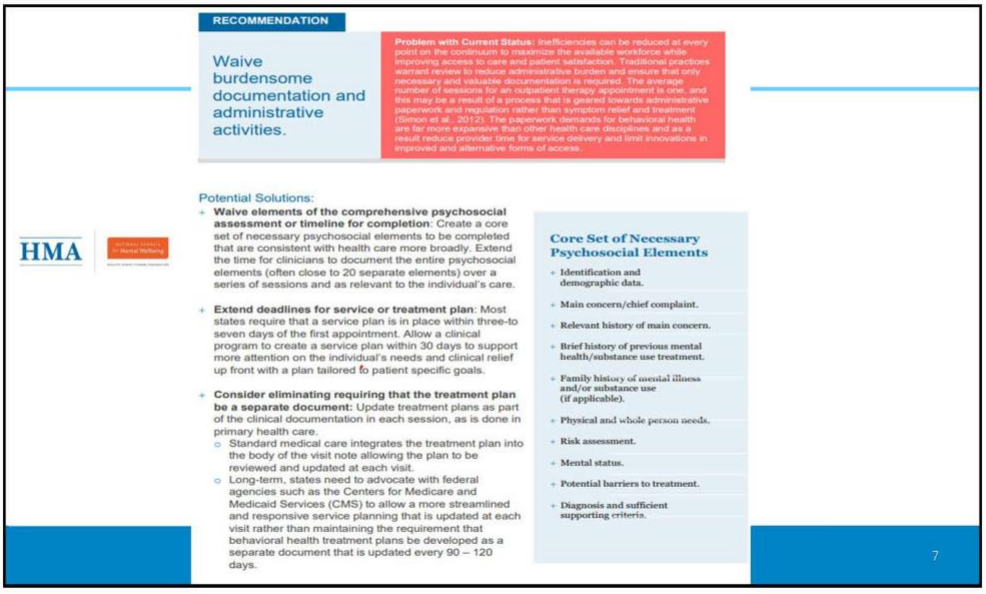
- Plan of care to be reviewed and signed within second appointment initial evaluation; includes types of treatment and frequency
- Sign each update with 30 days of periodic review (by parent/guardian and clinician)
- Documentation of service: type of service, date, modality, location or site; start and stop time of service; date documentation entered
- Name and credentials of each clinician providing services and date
- Progress notes: notes in the patient's EMR to be provided/signed no later than 30 days after providing the service

17b-262-828; Supervision and Progress Notes

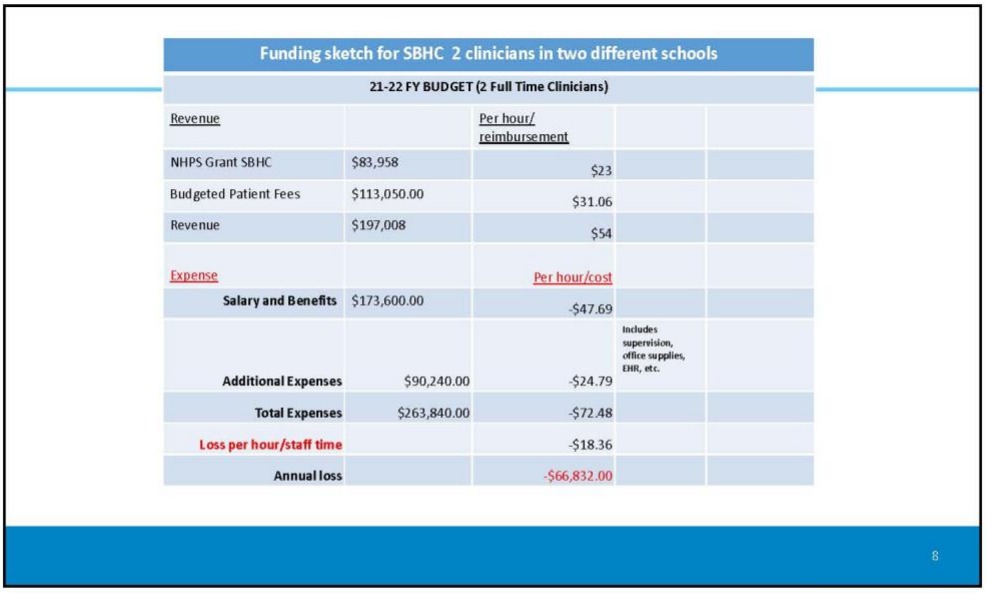
- Progress notes: for services provided by unlicensed clinician, evidence of supervision, the name and credentials of such supervisor, date of supervision, and date signed by supervisor;
- Supervisor's signature must be within 30 days of when supervision occurred
- Treatment services shall document the intervention, and progress as related to the goals in plan of care

6

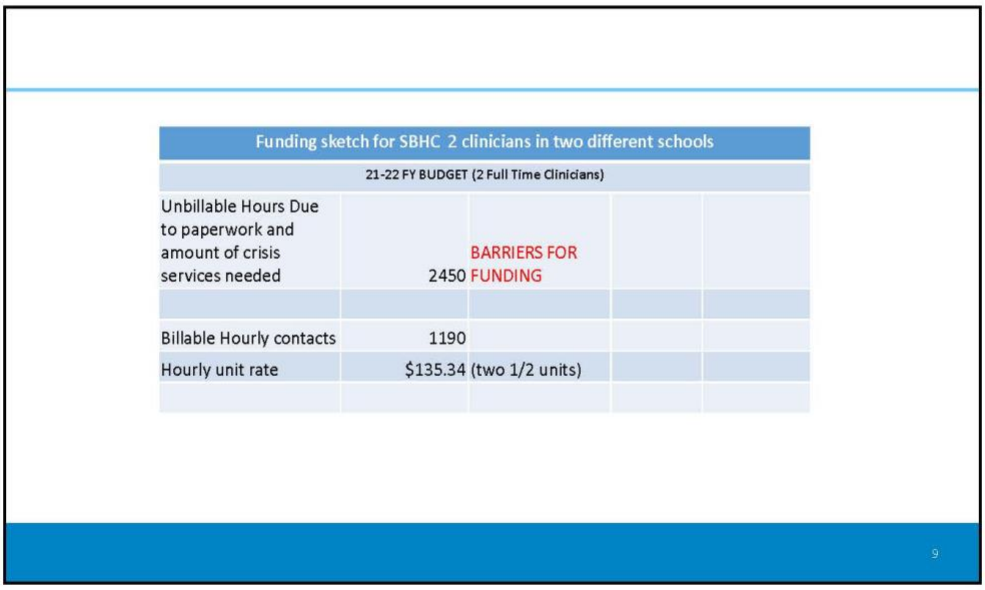
6


RECOMMENDATION
Waive burdensome documentation and administrative activities.
Problem with Current Status: Inefficiencies can be reduced at every point on the continuum to maximize the available workforce while improving access to care and patient satisfaction. Traditional practices warrant review to reduce administrative burden and ensure that only necessary and valuable documentation is required. The average number of sessions for an outpatient therapy appointment is one, and this may be a result of a process that is geared towards administrative paperwork and regulation rather than symptom relief and treatment (Simon et al., 2012). The paperwork demands for behavioral health are far more expansive than other health care disciplines and as a result reduce provider time for service delivery and limit innovations in improved and alternative forms of access.
Potential Solutions:
Waive elements of the comprehensive psychosocial assessment or timeline for completion: Create a core set of necessary psychosocial elements to be completed that are consistent with health care more broadly. Extend the time for clinicians to document the entire psychosocial elements (often close to 20 separate elements) over a series of sessions and as relevant to the individual's care.
Extend deadlines for service or treatment plan: Most states require that a service plan is in place within three-to seven days of the first appointment. Allow a clinical program to create a service plan within 30 days to support more attention on the individual's needs and clinical relief up front with a plan tailored to patient specific goals.
Consider eliminating requiring that the treatment plan be a separate document: Update treatment plans as part of the clinical documentation in each session, as is done in primary health care.
Standard medical care integrates the treatment plan into the body of the visit note allowing the plan to be reviewed and updated at each visit.
Long-term, states need to advocate with federal agencies such as the Centers for Medicare and Medicaid Services (CMS) to allow a more streamlined and responsive service planning that is updated at each visit rather than maintaining the requirement that behavioral health treatment plans be developed as a separate document that is updated every 90 – 120 days.
Core Set of Necessary Psychosocial Elements
Identification and demographic data.
Main concern/chief complaint.
Relevant history of main concern.
Brief history of previous mental health/substance use treatment.
Family history of mental illness and/or substance use (if applicable).
Physical and whole person needs.
Risk assessment.
Mental status.
Potential barriers to treatment.
Diagnosis and sufficient supporting criteria.
HMA
7

7


Funding sketch for SBHC 2 clinicians in two different schools
21-22 FY BUDGET (2 Full Time Clinicians)
Revenue
Per hour/ reimbursement
NHPS Grant SBHC $83,958 $23
Budgeted Patient Fees $113,050.00 $31.06
Revenue $197,008 $54
Expense
Per hour/cost
Salary and Benefits $173,600.00 -$47.69
Additional Expenses $90,240.00 -$24.79
Includes supervision, office supplies, EHR, etc.
Total Expenses $263,840.00 -$72.48
Loss per hour/staff time -$18.36
Annual loss -$66,832.00
8

8



Funding sketch for SBHC 2 clinicians in two different schools				
21-22 FY BUDGET (2 Full Time Clinicians)				
Unbillable Hours Due to paperwork and amount of crisis services needed	2450	BARRIERS FOR FUNDING		
Billable Hourly contacts	1190			
Hourly unit rate	$135.34	(two 1/2 units)		

9

9

c.8

School-Based Health Center Expansion Working Group

January 26, 2022
Microsoft Teams Meeting
10:00am – 11:30pm

Meeting Summary

Membership Attendees: Ann Gionet (Co-Chair), Dana Robinson-Rush, John Frassinelli, Tim Marshall, Alice Forrester (Co-Chair), Jill Holmes Brown, Melanie Wilde Lane, Lena Bahar, Rep. Jonathan Steinberg, Rep. Bill Petit, Sen. Cathy Osten, Lisa LeMasler, Susan Halpin, Jane Hylan.
Other Attendees: Christine Velasquez, Selma Alves, Johanna Davis, Amy Soto, Jason Lang, Jay Aronson, Amanda Pickett, Tricia Orozco, Mary Katherine Wildeman, Melanie Bonjour, Lisa Baxter, Denise Tafuto, Jamie LoCurto, Chlo-Anne Bobrowski, Evan Dantos, Brian Sullivan, Sherry Linton Massiah, Christine Jardim, Erin Janicek, Heather Dawson, Jared Picco, Lisa Otto, Melanie Flaherty, Sandi Fairbairn, Christine Fallon, EG, Ellen Carol

Item	Action	Follow Up
1. Introductions	• Ann Gionet (Co-Chair) started the meeting and welcomed everyone. Ann asked all committee members to add their names and organizations in the chat.	
2. Welcome / Public Comment	Ann Gionet • Ann asked if anyone wanted any changes made to the minutes. The minutes are in the chat. • Jill Holmes Brown made a motion to approve the minutes with the spelling of her name corrected. Melanie Wilde-Lane seconded. • Minutes were approved with change by the committee. • Ann opened up the meeting for public comment. No public comment.	DPH to send out: • DPH PPT
3. Review PA 21-35 Section 16	Ann Gionet presented a. Geographic regions where additional SBHC may be needed, b. Options to expand or add services at existing SBHCs, c. Methods to expand telehealth services, d. Options for expanding insurance reimbursement, e. Options to expand access. f. Submit a report on findings and any recommendations for the strategic expansion of school-based health center services, no later than 2.1.2022 • Ann Gionet introduced Dana Robinson-Rush from DSS • www.ctdssmap.com – follow instructions to go to Medical Clinic. A CSV file will come up which is similar to an Excel spreadsheet. This shows the procedure codes and what is active/inactive. This if the SBHC is enrolled as a medical clinic. • Some SBHCs are an FQHC. They do not have a fee schedule; they have an individual rate	

	approved by Health Resources and Services Administration (HRSA). They would have the FQHC bill on their behalf and be reimbursed. • Rep. Bill Petit asked a question regarding SBHC and FQHC. Dana – there is no difference in the payment itself. The FQHC bills for the SBHC. There is no incentive/disincentive to move people to one place versus another. • Alice Forrester stated that her rates as an ECC are significantly lower than FQHC rates. But you cannot send someone out of the school to the FQHC. • Sara LeMaster said the model lets them address needs of multiple populations they serve in a comprehensive manner. • Johanna Davis asked to see the flat rates the FQHCs have. Dana will check to see if it is on the DSS website. Rates were shared in the meeting chat and are attached.	

4. Discussion of a. and b.	Ann Gionet turned the conversation to Johanna Davis
	• SBHC and other Mental Health Services – Reviewed
	  • Started with 1049 Schools from SDE – from 245 districts
	  • Eligible schools 999 – 50 cut because they were preschool only, small school population, or multiple schools at 1 site (HS and MS at same location would count as 1)
	  • 694 Schools with no services – pulled out sites in towns with high SVI and were medical or mental health HPSA
	  • 150 schools remained – ranked SVI score, population, mental health HPSA, and medical HPSA
	  • 14 towns in the 150 sites and 3 with no DPH funded sites
	• Expanding existing SBHC sites with additional services
	  • 305 SBHC and DCF licensed (excludes full time sites)
	  • We have clinics already in almost all the high needs areas (not all funded by DPH)
	  • Can go into CDC website to pull up SVI map by county
	  • Jill Holmes Brown wants to remind people that even though we have a SBHC in one school in a high needs area, a school a mile away may have no services. We need to look at and include that as well.
	  • Johanna Davis said she is keeping that in mind as she does the points system.
	  • Tim Marshall will there be examples of other children's mental health models?
	  • Alice Forrester- we will be including examples within the document with details shared in the appendix.
	  • Ann Gionet – a lot of good work is coming out of the Children's Behavioral Health Implementation meeting and that is being factored in.
	  • Johanna Davis – with the expanded we want to make sure telehealth is available and a possible way of expanding since some of the SBHCs have a wait list for behavioral health services. This is a large load because they see the clinician several times. We are looking at who has a	

	wait list and how many students are on that list. • Ann Gionet – we can find out information from our funded SBHCs on what are needed. SBHCs are reporting creative community relationships to address the increase in children who are in need of mental health services. • Johanna Davis – it is easier to look at hours from our funded sites, and we can see from the School Based Health Alliance mapping tool, but we do not know hours for all sites. All the data/recommendations, when it comes to using them to award funds, we can correct any misinformation that is in there (showed as FT but actually PT) • Lisa Otto – Child and Family, New London High school: significant behavioral health needs and limited capacity of SBHC. Pilot – establish supported space for students on wait list…can access OCC clinicians via telehealth. Intake including parents and guardians. Not a large volume of time. Should increase ability to serve and keep kids in class.	
5. Discussion of c., d., and e.	• Ann Gionet asked if there were other methods/ideas that the group has that we could put in the report regarding c and d. • Johanna Davis – excited about seeing reimbursement rates because this has been something desired for a long time. This is important to show with the money we are giving out because they will need to be able to sustain themselves somewhat. • Tim Marshall – expanding insurance reimbursement is viable. CT DSS is considering switching the outpatient clinic to a rehab option which can extend to multiple other sites. Continue to review the outpatient rate structure and reimbursement and address additional challenges. • Susan Halpin - association of health plans: different market segments. Make sure focus attention on those areas most likely to be reimbursement mechanism. Something is outside the scope of the state legislature 38a-72e This requires any health insurance company licensed in CT at the request of any SBHC to offer a contract with that health center. ACA exchange market – mandate same kind of provision for SBHC as an essential community provider. This group needs to look at reimbursement mechanisms. • Melanie Wilde Lane – there is no actual mandate. It says the insurers MAY contract not SHALL with the SBHCs. Susan Halpin – it says each health insurer shall, at the request of any SBHC offer to contract ….on the same terms and conditions offered to providers…. • Johanna Davis – about 25% of our clients have no insurance. Any bit of reimbursement sites can get is helpful.	
6. Final meeting date	• Next Meeting Date: January 31 **January 31, 2022 10:00 am -11:30 am** Microsoft Teams meeting Join on your computer or mobile app Click here to join the meeting **Or call in (audio only)**	

	+1 860-840-2075,,553658173# United States, Hartford Phone Conference ID: 553 658 173#	

c.9

Public Act No. 21-35

AN ACT EQUALIZING COMPREHENSIVE ACCESS TO MENTAL, BEHAVIORAL AND PHYSICAL HEALTH CARE IN RESPONSE TO THE PANDEMIC.

CT Department of Public Health
School Based Health Center Program
Ann Gionet, Co-Chair SBHC Expansion
Alice Forrester, Co-Chair SBHC Expansion
Johanna Davis
Christine Velasquez
Angela Jimenez

Welcome

School-Based Health Center Expansion Working Group Members

Please type your name & organization in the chat

Use the raise your hand feature

Information to share with the working group, email:
Ann.Gionet@ct.gov or Christine.Velasquez@ct.gov

PA 21-35 Access to health care in response to COVID
Section 16

A working group to develop recommendations for the strategic expansion of school-based health center (SBHC) services in the state.

a. Specific **geographic regions** where additional SBHC may be needed,

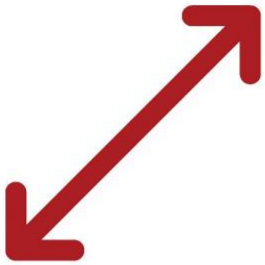
b. Options to **expand or add services** at existing SBHCs,

c. Methods for providing additional supports to expand **telehealth services**,

d. Options for expanding insurance reimbursement,

e. Options to expand access to School-based health centers or expanded school-based health center sites, specifically mental health.

f. Submit a report on findings and any recommendations for the strategic expansion of school-based health center services to Public Health and Appropriations Committees, no later than 2.1.2022



a. Specific geographic regions where SBHC may be needed

b. Options to expand or add services at existing SBHCs

SBHCs and other Mental Health Services- Reviewed

- Started with 1049 Schools from SDE - from 245 districts
  - Public Schools
  - Regional Schools
  - Public Charter Schools
  - Magnet Schools
  - Technical High Schools
- Schools with SBHCs or DCF licensing Sources used for identifying potential Health Services in Schools
  - 90 DPH funded SBCs (24 different contractors)
  - 221 Health Centers Communities and FQHCs (18 different providers)
  - 171 School Based Health Alliance (SBHA)
  - 220 DCF Licensed (24 different licensed providers)
  - 44 DPH Licenses for SBHC
  - 203 HRSA FQHCs with SBHC
- List of eligible Schools 999 – 50 cut see below
  - Preschool only
  - Small School Population
  - Multiple schools at one site (ex. HS and MS at same location would count as 1)

Possible NEW SBHCs in CT

- 694 Schools with no Services
  - (DCF included here – counted in expanded sites)
  - Pulled out sites in towns with high SVI
  - And were a Medical or Mental Health HPSA
- 229 Schools remaining – Added scores
  - Ranked SVI score 1-6
  - Ranked population 1-6
  - Mental Health HPSA 0-1
  - Medical HPSA 0-1
- 157 Schools scores ranging from 5-13 (there are in increments of .5)
  - 21 towns within the 157 sites
  - 8 of which have no DPH funded sites

Expanding Existing SBHCs sites with Additional services

- 305 SBHCs and DCF licensed
  - Exclude Full time Sites
- _____ part-time SBHCs and DCF Sites *(still need to add in site hours)*
  - Rank sites by hours of services from - 0.05 - 4.5
    - .05 = 1 day a month
    - 4.5 = 4 1/2 days a week
  - Rank SVI for sites by town - 1-4
  - Rank population by site - 1-4
  - Mental Health HPSA - 0-1
  - Medical HPSA - 0-1
- Scores totals 2.05 – 14.5

c. Methods for providing additional supports to expand telehealth services

d. Options for expanding insurance reimbursement

School-Based Health Center Expansion Working Group

Established PA 21-35, Section 16

Monday January 31st
10:00 am to 11:30 am

Microsoft Teams meeting
Join on your computer or mobile app
Click here to join the meeting
Or call in (audio only)
+1 860-840-2075,,553658173# United States, Hartford
Phone Conference ID: 553 658 173#


Ann.Gionet@ct.gov
Christine.Velasquez@ct.gov

c.10

FQHC RATES	*Index*	*2.10%*	*1.80%*	*1.60%*	*1.20%*	*0.40%*	*0.60%*	*0.80%*	*0.80%*	*0.80%*	*1.10%*	*1.20%*	*1.40%*	*1.50%*	*1.90%*	*1.40%*
MEDICAL	**Provider Number**	**Date Effective 10/1/2007**	**Date Effective 10/1/2008**	**Date Effective 10/1/2009**	**Date Effective 10/1/2010**	**Date Effective 10/1/2011**	**Date Effective 10/1/2012**	**Date Effective 10/1/2013**	**Date Effective 10/1/2014**	**Date Effective 10/1/2015**	**Date Effective 10/1/2016**	**Date Effective 10/1/2017**	**Date Effective 10/1/2018**	**Date Effective 10/1/2019**	**Date Effective 10/1/2020**	**Date Effective 10/1/2021**
Charter Oak Health Center	4236007	$ 131.63	$ 134.00	$ 136.14	$ 137.78	$ 138.33	$ 139.16	$ 140.27	$ 141.39	$ 142.52	$ 144.09	$ 145.82	$ 147.86	$ 150.08	$ 152.93	$ 155.07
Community Health & Wellness Torrington	4247872	$ 130.39	$ 132.74	$ 134.86	$ 136.48	$ 137.03	$ 137.85	$ 138.95	$ 140.06	$ 141.18	$ 142.74	$ 144.45	$ 146.47	$ 148.67	$ 151.49	$ 153.61
Community Health Center	4236346	$ 143.00	$ 145.57	$ 147.90	$ 149.68	$ 150.28	$ 151.18	$ 152.39	$ 153.61	$ 154.84	$ 156.54	$ 158.42	$ 160.64	$ 163.04	$ 166.14	$ 168.47
Community Health Services	4235570	$ 136.50	$ 142.00	$ 144.27	$ 146.00	$ 146.59	$ 147.47	$ 148.65	$ 149.84	$ 151.03	$ 152.70	$ 154.53	$ 156.69	$ 159.04	$ 162.06	$ 164.33
Connecticut Institute for Communities, Inc.	8004668			$ 145.03	$ 146.77	$ 147.36	$ 148.24	$ 149.43	$ 150.62	$ 151.83	$ 153.50	$ 155.34	$ 157.51	$ 159.88	$ 162.92	$ 165.20
Cornell Scott-Hill Health Corporation	4235900	$ 121.95	$ 124.15	$ 126.13	$ 127.64	$ 128.16	$ 135.00	$ 136.08	$ 137.17	$ 138.27	$ 139.79	$ 141.46	$ 143.44	$ 145.60	$ 148.36	$ 150.44
Fair Haven Community Health	4235736	$ 131.72	$ 134.09	$ 136.24	$ 137.87	$ 138.42	$ 139.25	$ 140.37	$ 141.49	$ 142.62	$ 144.19	$ 145.92	$ 147.96	$ 150.18	$ 153.04	$ 155.18
Family Center Greenwich	8066994									$ 152.98	$ 154.66	$ 156.52	$ 158.71	$ 161.09	$ 164.15	$ 166.45
First Choice Health Center	4236164	$ 130.30	$ 132.65	$ 134.77	$ 136.38	$ 136.93	$ 137.75	$ 138.85	$ 139.96	$ 141.08	$ 142.64	$ 144.35	$ 146.37	$ 148.56	$ 151.39	$ 153.51
Generations Family Health Center	4235695	$ 130.86	$ 142.00	$ 144.27	$ 146.00	$ 146.59	$ 147.95	$ 149.13	$ 150.33	$ 151.53	$ 153.20	$ 155.03	$ 157.20	$ 159.56	$ 162.59	$ 164.87
Intercommunity, Inc	8047966								$ 145.00	$ 146.16	$ 147.77	$ 149.54	$ 151.63	$ 153.91	$ 156.83	$ 159.03
Norwalk Community Health Center	4236172	$ 137.71	$ 140.19	$ 142.43	$ 144.14	$ 144.72	$ 145.59	$ 146.75	$ 147.92	$ 149.11	$ 150.75	$ 152.56	$ 154.69	$ 157.01	$ 160.00	$ 162.24
Optimus Health Care	4234788	$ 147.18	$ 149.83	$ 152.23	$ 154.06	$ 154.67	$ 155.60	$ 156.85	$ 158.10	$ 159.37	$ 161.12	$ 163.05	$ 165.33	$ 167.81	$ 171.00	$ 173.40
Southwest Community Health Center, Inc	4236130	$ 135.79	$ 138.23	$ 140.44	$ 142.13	$ 142.69	$ 143.55	$ 144.70	$ 150.39	$ 151.59	$ 153.26	$ 155.10	$ 157.27	$ 159.63	$ 162.66	$ 164.94
Staywell Health Center	4235976	$ 140.57	$ 143.10	$ 145.39	$ 147.13	$ 147.72	$ 148.61	$ 149.80	$ 151.00	$ 152.20	$ 153.88	$ 155.73	$ 157.91	$ 160.27	$ 163.32	$ 165.61
United Community	4235934	$ 130.01	$ 132.35	$ 134.47	$ 136.08	$ 136.63	$ 137.45	$ 138.55	$ 139.65	$ 140.77	$ 142.32	$ 144.03	$ 146.04	$ 148.23	$ 151.05	$ 153.17
Wheeler Clinic	8065431									$ 147.61	$ 149.23	$ 151.02	$ 153.14	$ 155.44	$ 158.39	$ 160.61
TOTAL/AVG MEDICAL		**$ 134.43**	**$ 137.76**	**$ 140.33**	**$ 142.01**	**$ 142.58**	**$ 143.90**	**$ 145.05**	**$ 146.44**	**$ 147.92**	**$ 149.55**	**$ 151.35**	**$ 153.46**	**$ 155.77**	**$ 158.73**	**$ 160.95**
DENTAL																
Charter Oak Health Center	4235992	$ 128.66	$ 130.98	$ 133.09	$ 134.69	$ 135.23	$ 136.04	$ 137.13	$ 138.22	$ 139.33	$ 140.86	$ 142.55	$ 144.55	$ 146.72	$ 149.50	$ 151.60
Community Health & Wellness Torrington	8024018				$ 130.00	$ 130.52	$ 131.30	$ 132.35	$ 133.41	$ 134.48	$ 135.96	$ 137.59	$ 139.52	$ 141.61	$ 144.30	$ 146.32
Community Health Center	4236354	$ 139.50	$ 142.01	$ 144.28	$ 146.01	$ 146.60	$ 147.47	$ 148.65	$ 149.84	$ 151.04	$ 152.70	$ 154.54	$ 156.70	$ 159.05	$ 162.07	$ 164.34
Community Health Services	4236099	$ 120.27	$ 134.00	$ 136.14	$ 137.77	$ 138.32	$ 139.15	$ 140.27	$ 141.39	$ 142.52	$ 144.09	$ 145.82	$ 147.86	$ 150.08	$ 152.93	$ 155.07
Connecticut Institute for Communities, Inc.	8058757										$ 139.80	$ 141.48	$ 143.46	$ 145.61	$ 148.38	$ 150.45
Cornell Scott-Hill Health Corporation	4235893	$ 128.38	$ 142.00	$ 144.27	$ 146.00	$ 146.59	$ 147.46	$ 148.64	$ 149.83	$ 151.03	$ 152.69	$ 154.53	$ 156.69	$ 159.04	$ 162.06	$ 164.33
Fair Haven Community Health	8050183							$ 137.00	$ 138.10	$ 139.20	$ 140.73	$ 142.42	$ 144.41	$ 146.58	$ 149.37	$ 151.46
Family Center Greenwich	8068285									$ 139.49	$ 141.02	$ 142.71	$ 144.71	$ 146.88	$ 149.67	$ 151.77
First Choice Health Center	4236156	$ 122.49	$ 124.69	$ 126.69	$ 128.21	$ 128.72	$ 129.50	$ 130.53	$ 131.58	$ 132.63	$ 134.09	$ 135.70	$ 137.60	$ 139.66	$ 142.31	$ 144.31
Generations Family Health Center	4235687	$ 133.62	$ 140.00	$ 142.24	$ 143.95	$ 144.52	$ 145.39	$ 146.55	$ 147.73	$ 148.91	$ 150.55	$ 152.35	$ 154.48	$ 156.80	$ 159.78	$ 162.02
Norwalk Community Health Center	8066587										$ 141.02	$ 142.71	$ 144.71	$ 146.88	$ 149.67	$ 151.77
Optimus Health Care	4234770	$ 120.08	$ 122.24	$ 124.20	$ 125.69	**$ 135.00**	$ 135.81	$ 136.90	$ 137.99	$ 139.10	$ 140.63	$ 142.31	$ 144.31	$ 146.47	$ 149.25	$ 151.34
Southwest Community Health Center, Inc	4236122	$ 127.63	$ 129.93	$ 132.01	$ 133.59	$ 134.12	$ 134.93	$ 136.01	$ 141.63	$ 142.76	$ 144.33	$ 146.07	$ 148.11	$ 150.33	$ 153.19	$ 155.33
Staywell Health Center	4235968	$ 116.71	$ 118.81	$ 120.71	$ 122.16	$ 122.65	$ 123.38	$ 124.37	$ 125.37	$ 126.37	$ 127.76	$ 129.29	$ 131.10	$ 133.07	$ 135.60	$ 137.50
United Community	4236106	$ 116.81	$ 118.91	$ 120.81	$ 122.26	$ 122.75	$ 123.49	$ 124.47	$ 125.47	$ 126.47	$ 127.86	$ 129.40	$ 131.21	$ 133.18	$ 135.71	$ 137.61
Wheeler Clinic	8064502									$ 139.49	$ 141.02	$ 142.72	$ 144.71	$ 146.89	$ 149.68	$ 151.77
TOTAL/AVG DENTAL		**$ 125.42**	**$ 130.36**	**$ 132.44**	**$ 133.67**	**$ 135.00**	**$ 135.81**	**$ 136.91**	**$ 138.38**	**$ 139.49**	**$ 140.94**	**$ 142.64**	**$ 144.63**	**$ 146.80**	**$ 149.59**	**$ 151.69**
MENTAL HEALTH/SUBSTANCE ABUSE																
Charter Oak Health Center	4236015	$ 148.43	$ 151.10	$ 153.52	$ 155.36	$ 155.98	$ 156.92	$ 158.17	$ 159.44	$ 160.72	$ 162.48	$ 164.43	$ 166.74	$ 169.24	$ 172.45	$ 174.87
Community Health & Wellness Torrington	8033022				$ 150.00	$ 150.60	$ 151.50	$ 152.72	$ 153.94	$ 155.17	$ 156.88	$ 158.76	$ 160.98	$ 163.40	$ 166.50	$ 168.83
Community Health Center	4236338	$ 164.35	$ 167.31	$ 169.99	$ 172.03	$ 172.72	$ 173.75	$ 175.14	$ 176.55	$ 177.96	$ 179.92	$ 182.07	$ 184.62	$ 187.39	$ 190.95	$ 193.63
Community Health Services	4235588	$ 137.84	$ 150.00	$ 152.40	$ 154.23	$ 154.85	$ 155.77	$ 157.02	$ 158.28	$ 159.54	$ 161.30	$ 163.23	$ 165.52	$ 168.00	$ 171.19	$ 173.59
Connecticut Institute for Communities, Inc.	8050622									$ 167.52	$ 169.36	$ 171.40	$ 173.79	$ 176.40	$ 179.75	$ 182.27
Cornell Scott-Hill Health Corporation	4235918	$ 181.52	$ 184.79	$ 187.75	$ 190.00	$ 190.76	$ 191.91	$ 193.44	$ 194.99	$ 196.55	$ 198.71	$ 201.10	$ 203.91	$ 206.97	$ 210.90	$ 213.86
Fair Haven Community Health	8057841							$ 164.82	$ 166.14	$ 167.47	$ 169.31	$ 171.34	$ 173.74	$ 176.35	$ 179.70	$ 182.21
Family Center Greenwich	4172912										$ 169.36	$ 171.39	$ 173.79	$ 176.40	$ 179.75	$ 182.27
First Choice Health Center	8057168								$ 166.14	$ 167.47	$ 169.31	$ 171.34	$ 173.74	$ 176.35	$ 179.70	$ 182.21
Generations Family Health Center	8003942			$ 161.54	$ 163.48	$ 164.13	$ 165.12	$ 166.44	$ 167.77	$ 169.11	$ 170.97	$ 173.02	$ 175.45	$ 178.08	$ 181.46	$ 184.00
Intercommunity, Inc	8062433									$ 167.47	$ 169.31	$ 171.34	$ 173.74	$ 176.35	$ 179.70	$ 182.22
Norwalk Community Health Center	8066726									$ 167.47	$ 169.31	$ 171.34	$ 173.74	$ 176.35	$ 179.70	$ 182.22
Optimus Health Care	4235926	$ 169.12	$ 172.16	$ 174.91	$ 177.01	$ 177.72	$ 178.78	$ 180.21	$ 181.66	$ 183.11	$ 185.12	$ 187.34	$ 189.97	$ 192.82	$ 196.48	$ 199.23
Southwest Community Health Center, Inc	4236148	$ 140.90	$ 143.44	$ 145.74	$ 147.49	$ 148.08	$ 148.97	$ 150.16	$ 151.36	$ 152.57	$ 154.25	$ 156.10	$ 158.29	$ 160.66	$ 163.71	$ 166.00
Staywell Health Center	4235984	$ 154.83	$ 157.62	$ 160.14	$ 162.06	$ 162.71	$ 163.68	$ 164.99	$ 166.31	$ 167.64	$ 169.49	$ 171.52	$ 173.92	$ 176.53	$ 179.89	$ 182.41
United Community	4235942	$ 141.35	$ 143.89	$ 146.20	$ 147.95	$ 148.54	$ 149.43	$ 150.63	$ 151.83	$ 153.05	$ 154.73	$ 156.59	$ 158.78	$ 161.16	$ 164.23	$ 166.52
Wheeler Clinic	8043074									$ 167.47	$ 169.31	$ 171.34	$ 173.74	$ 176.35	$ 179.70	$ 182.22
TOTAL/AVG MENTAL HEALTH		**$ 154.79**	**$ 158.79**	**$ 161.35**	**$ 161.96**	**$ 162.61**	**$ 163.58**	**$ 164.89**	**$ 166.20**	**$ 167.52**	**$ 169.36**	**$ 171.39**	**$ 173.79**	**$ 176.40**	**$ 179.75**	**$ 182.27**
Community Health Programs (Great Barrington, MA) Medical	8073872										$ 146.21	$ 147.96	$ 150.04	$ 152.29	$155.18	$157.35
Mashanpequot Medical	8068236					$ 142.58	$ 143.90	$ 145.05	$ 146.44	$ 148.24	$ 149.87	$ 151.67	$ 153.79			
Northwest Community (Pascoag, RI) Dental	8040358						$ 135.81	$ 135.81	$ 137.99	$ 137.99	$ 137.99	$139.65	$141.60	$143.72	$146.46	$148.51
Northwest Community (Pascoag, RI) Medical	8057218									$ 166.00	$ 166.00	$167.99	$170.34	$172.90	$176.18	$178.65
Wood River Health Services (Hope Valley, RI) Dental	3124609								$ 137.99	$ 137.99	$ 137.99	$ 139.65	$ 141.60	$ 143.72	$146.46	$148.51
Wood River Health Services (Hope Valley, RI) Medical	3124617								$ 146.21	$ 146.21	$ 146.21	$ 147.96	$ 150.04	$ 152.29	$155.18	$157.35
Mashanpequot Medical - State Plan change	8068236	**Rate Period**	**Rate**													
		1/1/19 - 12/31/19	$ 455.00													
		1/1/20 - 12/31/20	$ 479.00													
		1/1/21- 12/31/21	$ 519.00													
		1/1/22- 12/31/22														

c.11

School-Based Health Center Expansion Working Group

January 31, 2022
Microsoft Teams Meeting
10:00am – 11:30pm

Meeting Summary

Membership Attendees: Ann Gionet (Co-Chair), Dana Robinson-Rush, Tim Marshall, Alice Forrester (Co-Chair), Jill Holmes Brown, Melanie Wilde Lane, Lena Bahar, Rep. Bill Petit, Sen. Tony Hwang, Susan Halpin
Other Attendees: Christine Velasquez, Selma Alves, Johanna Davis, Joe Walkovich, Jason Lang, Jay Aronson, Amanda Pickett, Melissa Meyers, Mary Katherine Wildeman, Melanie Bonjour, Lisa Baxter, Grace Fabrizio, Alison Blake, Chlo-Anne Bobrowski, Daina Perry, Brian Sullivan, Sherry Linton Massiah, Scott Newgass, Erin Janicek, Heather Dawson, Erin Saylor, Lisa Otto, Steve Hernandez, Jamie Augueira, EG

Item	Action	Follow Up
1. Introductions	• Ann Gionet (Co-Chair) started the meeting and welcomed everyone. Ann said that we requested an extension of one week for the report to the Commissioner's office and the Government Relations office. We will be sharing the draft report to the committee and asking for recommendations so we can reflect the report to show are member's input. Ann asked all committee members add their names and organizations in the chat.	
2. Public Comment/Approve minutes	• Ann Gionet opened up the meeting for public comment. No public comment. • Ann asked if anyone wanted any changes made to the minutes. There were no changes requested. • Jill Holmes Brown made a motion to accept the minutes. • Alice Forrester seconded. • Minutes were approved as written by the committee.	DPH to send out: • DPH PPT
3. Review PA 21-35 Section 16	Ann Gionet presented a. Geographic regions where additional SBHC may be needed, b. Options to expand or add services at existing SBHCs, c. Methods to expand telehealth services, d. Options for expanding insurance reimbursement, e. Options to expand access. f. Submit a report on findings and any recommendations for the strategic expansion of school-based health center services, no later than 2.1.2022 • Ann Gionet mentioned we have not yet received the approval for an extension of one week to the report.	

4. Discussion of a. and b.	Ann Gionet turned the conversation to Johanna Davis.
	• SBHC and other Mental Health Services – Reviewed
	  • Johanna Davis said she reworked the scores. Rankings are still the same. We now have 21 town with 157 schools. 8 of these towns have no DPH funded sites.
	  • The list of towns shows how many schools are in each town for the potential schools for new SBHCs.
	  • Please send comments on the list of towns for potential new SBHCs.
	  • Susan Halpin asked for clarification on the list of towns.
	• Tim Marshall confirmed that the DCF licensed sites are for outpatient providers. The secondary site may possibly have services going on. It may or may not be active. Johanna – that is why we put them under expanded because we do not know what type of services are being provided and we want to make sure they are eligible for potential funding.
	• Johanna Davis – once you receive the spreadsheet, you will be able to see each town, school, and ranking by score. If you are familiar with other schools with services already being provided, please let us know.
	• There are 305 schools that have some type of service already being provided – some medical and/or mental health services.
	• There are 36 existing SBHCs that could expand hours of service. This list will also be sent out to members.
		The presentation will be sent out for comment from members.
		
		The spreadsheets will be sent out to the members

5. Discussion of c., d., and e.	• Ann Gionet talked about the draft telehealth recommendations.
	  • Continuation of funding and support for telehealth for mental health services and medical care at SBHCs
	  • Additional support and funding for SBHC workforce expansion.
	• Tim asked if these recommendations are for all SBHC in the broadest sense or just those funded by DPH. Ann Gionet said that there are for the broadest sense of the term.
	• Dr Petit – who will be the contact person to coordinate with the mental health bill? Ann Gionet said that she and Alice Forrester are the cochairs of this committee and they will be the contact people.
	• Ann Gionet – Insurance Reimbursement recommendations
	  • Continue to explore insurance reimbursement.
	  • Investigate if a SBHC can be identified as an essential community provider to expand availability.
	• Tim Marshall said that we need to think more broadly in terms of mental health services. Every kid in a community mental health system goes to school, but few referrals come from schools. Every school should have mental health services. Ann Gionet – how can we make this broader for everyone?
	• Alice Forrester – if you want to reach the kids, you go to the schools.	

	• Amanda Pickett – how we support SBHC to sit on school teams. Not billable hours	
6. Plan for submission of report	• Ann Gionet – we will work hard to get this report out to you quickly. • We want to be a part of what is going on in the mental health workgroup • Senator Hwang encouraged DPH to send the completed report to Public Health Committee as well. • Susan Halpin said that this committee was informative and well run. • Ann Gionet said that we appreciate everyone on the call and we look forward getting this to the representatives as quickly as possible. • Please provide any comments that you have once you receive the spreadsheets and report.	

c.12

Public Act No. 21-35

AN ACT EQUALIZING COMPREHENSIVE ACCESS TO MENTAL, BEHAVIORAL AND PHYSICAL HEALTH CARE IN RESPONSE TO THE PANDEMIC.

CT Department of Public Health
School Based Health Center Program
Ann Gionet, Co-Chair SBHC Expansion
Alice Forrester, Co-Chair SBHC Expansion
Johanna Davis
Christine Velasquez
Angela Jimenez

Welcome

School-Based Health Center Expansion Working Group Members

Please type your name & organization in the chat

Use the raise your hand feature

Public comment

Approve minutes

PA 21-35 Access to health care in response to COVID
Section 16

A working group to develop recommendations for the strategic expansion of school-based health center (SBHC) services in the state.

a. Specific **geographic regions** where additional SBHC may be needed,

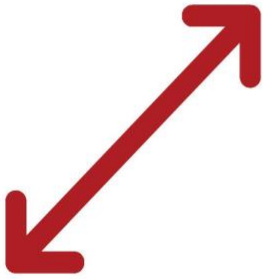
b. Options to **expand or add services** at existing SBHCs,

c. Methods for providing additional supports to expand **telehealth services**,

d. Options for **expanding insurance reimbursement**,

e. Options to expand access to School-based health centers or expanded school-based health center sites, specifically mental health.

f. Submit a report on findings and any recommendations for the strategic expansion of school-based health center services to Public Health and Appropriations Committees, no later than 2.1.2022



a. Specific geographic regions where SBHC may be needed

b. Options to expand or add services at existing SBHCs

SBHCs and other Mental Health Services- Reviewed

- Started with 1049 Schools from SDE - from 245 districts
  - Public Schools
  - Regional Schools
  - Public Charter Schools
  - Magnet Schools
  - Technical High Schools
- Schools with SBHCs or DCF licensing Sources used for identifying potential Health Services in Schools
  - 90 DPH funded SBCs (24 different contractors)
  - 221 Health Centers Communities and FQHCs (18 different providers)
  - 171 School Based Health Alliance (SBHA)
  - 220 DCF Licensed (24 different licensed providers)
- List of eligible Schools 999 – 50 cut see below
  - Preschool only
  - Small School Population
  - Multiple schools at one site (ex. HS and MS at same location would count as 1)

Possible NEW SBHCs in CT

- 694 Schools with no Services
  - (DCF included here – counted in expanded sites)
  - Pulled out sites in towns with high SVI
  - And were a Medical or Mental Health HPSA
- 157 Schools remaining – Added scores
  - Ranked SVI score 1-6
  - Ranked population 1-6
  - Mental Health HPSA 0-1
  - Medical HPSA 0-1
- 157 Schools scores ranging from 4-14 (there are in increments of .5)
  - 21 towns within the 150 sites
  - 8 of which have no DPH funded sites

Potential Schools for New SBHCs

City	Count
Bridgeport	24
Danbury	3
East Hartford	11
Griswold	3
Groton	3
Hartford	18
Killingly	4
Manchester	1
Montville	1
New Britain	2
New Haven	24
New London	3
Norwich	4
Stamford	8
Torrington	2
Waterbury	29
Waterford	2
West Hartford	4
West Haven	7
Winchester	1
Windham	3
TOTAL	157

Expanding Existing SBHCs sites with Additional services

- 305 SBHCs and DCF licensed
  - Exclude sites not in high SVI
- 124 part-time SBHCs and DCF Sites
  - Rank sites by hours of services from 0-5
    - 0 = 5 days a week (full time)
    - 5 = no hours
  - Rank SVI for sites by town – 1-5
  - Rank population by site - 1-5
  - Mental Health HPSA - 0-1
  - Medical HPSA - 0-1
- Scores totals ranged from 5.5-21
- Option one - offer extra funding to all 124
- Option two - offer funding to the 36 sites that have no Mental Health services
- Note –sites that have medical services can add on Mental health services more easily that mental health sites can add Medical (licensing, supplies, extra staffing)

Existing SBHCs that could Expand Hours of Service

All Potential Schools for Expansion			Schools with no Mental Health services for Expansion	
Town	Number of Sites		Town	Number of Sites
Ansonia	1		East Haven	3
Bristol	11		Enfield	5
East Hartford	4		Meriden	5
East Haven	5		Middletown	6
Enfield	9		Montville	1
Hartford	16		New Britain	7
Manchester	8		New London	1
Meriden	9		Norwich	2
Middletown	8		Stamford	4
Montville	1		Waterbury	1
New Britain	9		Winchester	1
New Haven	4		Total	36
New London	1			
Norwalk	14			
Norwich	4			
Plainfield	2			
Stamford	6			
Torrington	4			
Waterbury	2			
West Haven	1			
Winchester	2			
Windsor Locks	3			
TOTAL	124			

Teleheath recommendations

1. Continuation of funding and support for telehealth for mental health services and medical care at CT school-based health centers in order to meet student demand related to the Covid-19 pandemic and beyond.

2. Additional support and funding for SBHC workforce expansion, which would allow the hiring of more clinical staff to serve a greater number of CT's children through telehealth, mobile and in person visits to address need due to the mental health crisis.

Insurance Reimbursement Recommendations

1. Continue to explore insurance reimbursement. Focus attention on areas most likely to be reimbursement mechanisms as the present system for behavioral health reimbursement is not equal in funding amounts or documentation requirements.

.

2. Investigate if a School Based Health Center can be identified as an essential community provider to expand availability of School Based Health Centers to more communities to address rising demand of children's mental health by providing on-going screening, preventative education supports, direct behavioral health services, and linkage to community providers.

Ann.Gionet@ct.gov

Christine.Velasquez@ct.gov

Appendix D. Public Act 21-35 Language

Substitute Senate Bill No. 1

Public Act No. 21-35

AN ACT EQUALIZING COMPREHENSIVE ACCESS TO MENTAL, BEHAVIORAL AND PHYSICAL HEALTH CARE IN RESPONSE TO THE PANDEMIC.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective from passage*) It is hereby declared that racism constitutes a public health crisis in this state and will continue to constitute a public health crisis until the goal set forth in subsection (c) of section 3 of this act is attained.

Sec. 2. (NEW) (*Effective from passage*) (a) There is established a Commission on Racial Equity in Public Health, to document and make recommendations to decrease the effect of racism on public health. The commission shall be part of the Legislative Department.

(b) The commission shall consist of the following members:

(1) Two appointed by the speaker of the House of Representatives, one of whom shall be a representative of a nonprofit organization that focuses on racial equity issues and one of whom shall be a representative of Health Equity Solutions;

(2) Two appointed by the president pro tempore of the Senate, one of whom shall be a representative of a violence intervention program using

a health-based approach to examine individuals post-incarceration and policies for integration and one of whom shall be a representative of the Connecticut Health Foundation;

(3) One appointed by the majority leader of the House of Representatives, who shall be a representative of the Katal Center for Equity, Health, and Justice;

(4) One appointed by the majority leader of the Senate, who shall be a representative of the Connecticut Children's Office for Community Child Health;

(5) Two appointed by the minority leader of the House of Representatives, one of whom shall be a physician educator associated with The University of Connecticut who has experience and expertise in infant and maternal care and who has worked on diversity and inclusion policy and one of whom shall be a representative of the Partnership for Strong Communities;

(6) Two appointed by the minority leader of the Senate, one of whom shall be a medical professional with expertise in mental health and one of whom is a representative of the Open Communities Alliance;

(7) The chairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to public health;

(8) Two members of the Black and Puerto Rican Caucus, appointed by the caucus chairperson;

(9) One appointed by the Governor, who shall be a representative of the Diversity, Equity, and Inclusion Committee of the Connecticut Bar Association;

(10) The Commissioner of Public Health, or the commissioner's designee;

(11) The Commissioner of Children and Families, or the commissioner's designee;

(12) The Commissioner of Early Childhood, or the commissioner's designee;

(13) The Commissioner of Social Services, or the commissioner's designee;

(14) The Commissioner of Economic and Community Development, or the commissioner's designee;

(15) The Commissioner of Education, or the commissioner's designee;

(16) The Commissioner of Housing, or the commissioner's designee;

(17) The chief executive officer of the Connecticut Health Insurance Exchange, or the chief executive officer's designee;

(18) The executive director of the Commission on Women, Children, Seniors, Equity and Opportunity, or the executive director's designee;

(19) The executive director of the Office of Health Strategy, or the executive director's designee;

(20) The Secretary of the Office of Policy and Management, or the secretary's designee;

(21) The Commissioner of Energy and Environmental Protection, or the commissioner's designee; and

(22) The Commissioner of Correction, or the commissioner's designee.

(c) Any member of the commission appointed under subdivisions (1) to (8), inclusive, of subsection (b) of this section may be a member of the

General Assembly. All initial appointments to the commission made under subdivisions (1) to (9), inclusive, of subsection (b) of this section shall be made not later than sixty days after the effective date of this section. Appointed members shall serve a term that is coterminous with the appointing official and may serve more than one term.

(d) The Secretary of the Office of Policy and Management, or the secretary's designee, and the representative appointed under subdivision (1) of subsection (b) of this section as a representative of Health Equity Solutions, shall serve as chairpersons of the commission. Such chairpersons shall schedule the first meeting of the commission, which shall be held not later than sixty days after the effective date of this section. If appointments under subsection (b) of this section are not made within such sixty-day period, the chairpersons may designate individuals with the required qualifications stated for the applicable appointment to serve on the commission until appointments are made pursuant to subsection (b) of this section.

(e) Members shall continue to serve until their successors are appointed. Any vacancy shall be filled by the appointing authority. Any vacancy occurring other than by expiration of term shall be filled for the balance of the unexpired term.

(f) A majority of the membership shall constitute a quorum for the transaction of any business and any decision shall be by a majority vote of those present at a meeting, except the commission may establish such committees, subcommittees or other entities as it deems necessary to further the purposes of the commission. The commission may adopt rules of procedure.

(g) The members of the commission shall serve without compensation, but shall, within the limits of available funds, be reimbursed for expenses necessarily incurred in the performance of their duties.

(h) The commission, by majority vote, shall hire an executive director to serve as administrative staff of the commission, who shall serve at the pleasure of the commission. The commission may request the assistance of the Joint Committee on Legislative Management in hiring the executive director. The executive director may hire not more than two executive assistants to assist in carrying out the duties of the commission.

(i) The commission shall have the following powers and duties: To (1) support collaboration by bringing together partners from many different sectors to recognize the links between health and other issues and policy areas and build new partnerships to promote health and equity and increase government efficiency; (2) create a comprehensive strategic plan to eliminate health disparities and inequities across sectors, in accordance with section 3 of this act; (3) study the impact that the public health crisis of racism has on vulnerable populations within diverse groups of the state population, including on the basis of race, ethnicity, sexual orientation, gender identity and disability, including, but not limited to, Black American descendants of slavery; (4) obtain from any legislative or executive department, board, commission or other agency of the state or any organization or other entity such assistance as necessary and available to carry out the purposes of this section; (5) accept any gift, donation or bequest for the purpose of performing the duties described in this section; (6) establish bylaws to govern its procedures; and (7) perform such other acts as may be necessary and appropriate to carry out the duties described in this section, including, but not limited to, the creation of subcommittees.

(j) The commission shall engage with a diverse range of community members, including people of color who identify as members of diverse groups of the state population, including on the basis of race, ethnicity, sexual orientation, gender identity and disability, who experience inequities in health, to make recommendations to the relevant state

agencies or other entities on an ongoing basis concerning the following: (1) Structural racism in the state's laws and regulations impacting public health, where, as used in this subdivision, "structural racism" means a system that structures opportunity and assigns value in a way that disproportionally and negatively impacts Black, Indigenous, Latino or Asian people or other people of color; (2) racial disparities in the state's criminal justice system and its impact on the health and well-being of individuals and families, including overall health outcomes and rates of depression, suicide, substance use disorder and chronic disease; (3) racial disparities in access to the resources necessary for healthy living, including, but not limited to, access to adequate fresh food and physical activity, public safety and the decrease of pollution in communities; (4) racial disparities in health outcomes; (5) the impact of zoning restrictions on the creation of housing disparities and such disparities' impact on public health; (6) racial disparities in state hiring and contracting processes; and (7) any suggestions to reduce the impact of the public health crisis of racism within the vulnerable populations studied under subdivision (3) of subsection (i) of this section.

(k) Not later than January 1, 2022, and every six months thereafter, the commission shall submit a report to the Secretary of the Office of Policy and Management and the joint standing committees of the General Assembly having cognizance of matters relating to public health and appropriations and the budgets of state agencies, in accordance with the provisions of section 11-4a of the general statutes, concerning (1) the activities of the commission during the prior six-month period; (2) any progress made in attaining the goal described in subsection (c) of section 3 of this act; (3) any recommended changes to such goal based on the research conducted by the commission, any disparity study performed by any state agency or entity, or any community input received; (4) the status of the comprehensive strategic plan required under section 3 of this act; and (5) any recommendations

for policy changes or amendments to state law.

Sec. 3. (NEW) (*Effective from passage*) (a) The Commission on Racial Equity in Public Health, established under section 2 of this act, shall develop and periodically update a comprehensive strategic plan to eliminate health disparities and inequities across sectors, including consideration of the following: Air and water quality, natural resources and agricultural land, affordable housing, infrastructure systems, public health, access to quality health care, social services, sustainable communities and the impact of climate change.

(b) Such plan shall address the incorporation of health and equity into specific policies, programs and government decision-making processes including, but not limited to, the following: (1) Disparities in laws and regulations impacting public health; (2) disparities in the criminal justice system; (3) disparities in access to resources, including, but not limited to, healthy food, safe housing, public safety and environments free of excess pollution; and (4) disparities in access to quality health care.

(c) Not later than January 1, 2022, as part of such plan, the commission shall determine, using available scientifically based measurements, the percentages of disparity in the state based on race, in the following areas: (1) Education indicators, including kindergarten readiness, third grade reading proficiency, scores on the mastery examination, administered pursuant to section 10-14n of the general statutes, rates of school-based discipline, high school graduation rates and retention rates after the first year of study for institutions of higher education in the state, as defined in section 3-22a of the general statutes;

(2) health care utilization and outcome indicators, including health insurance coverage rates, pregnancy and infant health outcomes, emergency room visits and deaths related to conditions associated with exposure to environmental pollutants, including respiratory ailments, quality of life, life expectancy, lead poisoning and access to adequate

healthy nutrition and self-reported well-being surveys; (3) criminal justice indicators, including rates of involvement with the justice system; and (4) economic indicators, including rates of poverty, income and housing insecurity. It shall be the goal of the state to attain at least a seventy per cent reduction in the racial disparities set forth in subdivisions (1) to (4), inclusive, of this subsection from the percentage of disparities determined by the commission on or before January 1, 2022.

(d) Upon completion of the initial comprehensive strategic plan, and thereafter of any update to such plan, the commission shall submit the plan to the joint standing committee of the General Assembly having cognizance of matters relating to public health, in accordance with the provisions of section 11-4a of the general statutes, and to any other joint standing committee of the General Assembly having cognizance of matters relevant to what is contained in such plan, as determined by the commission.

Sec. 4. (*Effective from passage*) (a) As used in this section, "structural racism" means a system that structures opportunity and assigns value in a way that disproportionally and negatively impacts Black, Indigenous, Latino or Asian people or other people of color, and "state agency" has the same meaning as provided in section 1-79 of the general statutes. The Commission on Racial Equity in Public Health, established under section 2 of this act, shall determine best practices for state agencies to (1) evaluate structural racism within their own policies, practices, and operations, and (2) create and implement a plan, which includes the establishment of benchmarks for improvement, to ultimately eliminate any such structural racism within the agency.

(b) Not later than January 1, 2023, the commission shall submit a report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having

cognizance of matters relating to government administration. Such report shall include the best practices established by the commission under this section and a recommendation on any legislation to implement such practices within state agencies.

Sec. 5. (*Effective from passage*) The Commissioner of Public Health shall study the development and implementation of a recruitment and retention program for health care workers in the state who are people of color. Not later than February 1, 2022, the commissioner shall report the results of such study, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to public health. Such report shall include any legislative recommendations to improve the recruitment and retention of people of color in the health care sector, including, but not limited to, recommendations for the implementation of such recruitment and retention program.

Sec. 6. (*Effective from passage*) The Department of Energy and Environmental Protection shall perform an assessment of racial equity within environmental health quality programs administered by said department. Not later than January 1, 2022, the department shall submit a report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to the environment. Such report shall include the results of such assessment and any legislative recommendations to improve racial equity within such programs.

Sec. 7. (*Effective from passage*) (a) As used in this section, "cultural humility" means a continuing commitment to (1) self-evaluation and critique of one's own worldview with regard to differences in cultural traditions and belief systems, and (2) awareness of, and active mitigation of, power imbalances between cultures.

(b) The Office of Higher Education, in collaboration with the Board

of Regents for Higher Education and the Board of Trustees of The University of Connecticut, shall evaluate the recruitment and retention of people of color in health care preparation programs offered by the constituent units of the state system of higher education and the inclusion of cultural humility education in such programs. Not later than January 1, 2022, the office shall submit a report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to higher education. Such report shall include the results of such evaluation and any legislative recommendations to improve the recruitment and retention of people of color in such programs and include additional cultural humility education in such programs.

Sec. 8. Subsection (b) of section 2-128 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) Not later than January first, annually, the executive director of the commission shall submit a status report, organized by subcommission, concerning its efforts in promoting the desired results listed in subdivision (1) of subsection (a) of this section to the joint standing committee of the General Assembly having cognizance of matters relating to appropriations and the budgets of state agencies in accordance with the provisions of section 11-4a. <u>On and after January 1, 2022, such report shall include the status of amendments to the joint rules of the House of Representatives and the Senate concerning the preparation of racial and ethnic impact statements pursuant to section 2-24b.</u>

Sec. 9. (*Effective from passage*) (a) There is established a gun violence intervention and prevention advisory committee for the purpose of advising the joint standing committees of the General Assembly having

cognizance of matters relating to public health and human services on the establishment of a Commission on Gun Violence Intervention and Prevention to coordinate the funding and implementation of evidence-based, community-centric programs and strategies to reduce street-level gun violence in the state. The committee shall: (1) Consult with community outreach organizations, victim service providers, victims of community violence and gun violence, community violence and gun violence researchers and public safety and law enforcement representatives regarding strategies to reduce community violence and gun violence; (2) identify effective, evidence-based community violence and gun violence reduction strategies; (3) identify strategies to align the resources of state agencies to reduce community violence and gun violence; (4) identify state, federal and private funding opportunities for community violence and gun violence reduction initiatives; and (5) develop a public health and community engagement strategy for the Commission on Gun Violence Intervention and Prevention.

(b) The committee shall be composed of the following members:

(1) Two appointed by the speaker of the House of Representatives, one of whom shall be a representative of the Connecticut Hospital Association and one of whom shall be a representative of Compass Youth Collaborative;

(2) Two appointed by the president pro tempore of the Senate, one of whom shall be a representative of the Connecticut Violence Intervention Program and one of whom shall be a representative of Regional Youth Adult Social Action Partnership;

(3) Two appointed by the majority leader of the House of Representatives, one of whom shall be a representative of Hartford Communities That Care, Inc. and one of whom shall be a representative of CT Against Gun Violence;

(4) Two appointed by the majority leader of the Senate, one of whom shall be a representative of Project Longevity and one of whom shall be a representative of Saint Francis Hospital and Medical Center;

(5) One appointed by the minority leader of the House of Representatives, who shall be a representative of Yale New Haven Hospital;

(6) One appointed by the minority leader of the Senate, who shall be a representative of Hartford Hospital;

(7) One appointed by the House chairperson of the joint standing committee of the General Assembly having cognizance of matters relating to public health, who shall be a representative of You Are Not Alone (YANA);

(8) One appointed by the Senate chairperson of the joint standing committee of the General Assembly having cognizance of matters relating to public health, who shall be a representative of Mothers United Against Violence;

(9) One appointed by the executive director of the Commission on Women, Children, Seniors, Equity and Opportunity, who shall be a representative of the Health Alliance for Violence Intervention; and

(10) Two appointed by the Commissioner of Public Health, who shall be representatives of the Department of Public Health's Injury and Violence Surveillance Unit.

(c) All initial appointments to the committee shall be made not later than thirty days after the effective date of this section. Any vacancy shall be filled by the appointing authority.

(d) The president pro tempore of the Senate shall select the chairperson of the committee from among the members of the

committee. Such chairperson shall schedule the first meeting of the committee, which shall be held not later than sixty days after the effective date of this section. The committee shall meet not less than bimonthly.

(e) The administrative staff of the Commission on Women, Children, Seniors, Equity and Opportunity shall serve as administrative staff of the committee.

(f) Not later than January 1, 2022, the committee shall submit a report on its findings and recommendations to the joint standing committees of the General Assembly having cognizance of matters relating to public health and human services, in accordance with the provisions of section 11-4a of the general statutes. The committee shall terminate on the date that it submits such report or January 1, 2022, whichever is later.

Sec. 10. (*Effective from passage*) The Department of Public Health shall conduct a study on the state's COVID-19 response. Not later than February 1, 2022, the Commissioner of Public Health shall submit a preliminary report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to public health regarding the findings of such study. Such report may include the commissioner's recommendations for (1) any policy changes and amendments to the general statutes necessary to improve the state's response to future pandemics, including, but not limited to, recommendations regarding provisions of the general statutes or the regulations of Connecticut state agencies that should automatically be waived in the event of an occurrence or imminent threat of an occurrence of a communicable disease, except a sexually transmitted disease, or a public health emergency declared by the Governor pursuant to section 19a-131a of the general statutes in response to an epidemic or pandemic, and (2) how to improve administration of mass vaccinations, reporting and utilization of personal protective equipment

supply during a public health emergency, cluster outbreak investigation and health care facilities' care for patients. As used in this section, "COVID-19" means the respiratory disease designated by the World Health Organization on February 11, 2020, as coronavirus 2019, and any related mutation thereof recognized by said organization as a communicable respiratory disease.

Sec. 11. (NEW) (*Effective from passage*) (a) On and after January 1, 2022, any state agency, board or commission that directly, or by contract with another entity, collects demographic data concerning the ancestry or ethnic origin, ethnicity, race or primary language of residents of the state in the context of health care or for the provision or receipt of health care services or for any public health purpose shall:

(1) Collect such data in a manner that allows for aggregation and disaggregation of data;

(2) Expand race and ethnicity categories to include subgroup identities as specified by the Community and Clinical Integration Program of the Office of Health Strategy and follow the hierarchical mapping to align with United States Office of Management and Budget standards;

(3) Provide the option to individuals of selecting one or more ethnic or racial designations and include an "other" designation with the ability to write in identities not represented by other codes;

(4) Provide the option to individuals to refuse to identify with any ethnic or racial designations;

(5) Collect primary language data employing language codes set by the International Organization for Standardization; and

(6) Ensure, in cases where data concerning an individual's ethnic origin, ethnicity or race is reported to any other state agency, board or

commission, that such data is neither tabulated nor reported without all of the following information: (A) The number or percentage of individuals who identify with each ethnic or racial designation as their sole ethnic or racial designation and not in combination with any other ethnic or racial designation; (B) the number or percentage of individuals who identify with each ethnic or racial designation, whether as their sole ethnic or racial designation or in combination with other ethnic or racial designations; (C) the number or percentage of individuals who identify with multiple ethnic or racial designations; and (D) the number or percentage of individuals who do not identify or refuse to identify with any ethnic or racial designations.

(b) Each health care provider with an electronic health record system capable of connecting to and participating in the State-wide Health Information Exchange as specified in section 17b-59e of the general statutes shall, collect and include in its electronic health record system self-reported patient demographic data including, but not limited to, race, ethnicity, primary language, insurance status and disability status based upon the implementation plan developed under subsection (c) of this section. Race and ethnicity data shall adhere to standard categories as determined in subsection (a) of this section.

(c) Not later than August 1, 2021, the Office of Health Strategy shall consult with consumer advocates, health equity experts, state agencies and health care providers, to create an implementation plan for the changes required by this section.

(d) The Office of Health Strategy shall (1) review (A) demographic changes in race and ethnicity, as determined by the U.S. Census Bureau, and (B) health data collected by the state, and (2) reevaluate the standard race and ethnicity categories from time to time, in consultation with health care providers, consumers and the joint standing committee of the General Assembly having cognizance of matters relating to public

health.

Sec. 12. Section 19a-59i of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*): There is established a maternal mortality review committee within the department to conduct a comprehensive, multidisciplinary review of maternal deaths for purposes of identifying factors associated with maternal death and making recommendations to reduce maternal deaths.

(a) The cochairpersons of the maternal mortality review committee shall be the Commissioner of Public Health, or the commissioner's designee, and a representative designated by the Connecticut State Medical Society. The cochairpersons shall convene a meeting of the maternal mortality review committee upon the request of the Commissioner of Public Health.

(b) The maternal mortality review committee may include, but need not be limited to, any of the following members, as needed, depending on the maternal death case being reviewed:

(1) A physician licensed pursuant to chapter 370 who specializes in obstetrics and gynecology, appointed by the Connecticut State Medical Society;

(2) A physician licensed pursuant to chapter 370 who is a pediatrician, appointed by the Connecticut State Medical Society;

(3) A community health worker, appointed by the Commission on Women, Children, Seniors, Equity and Opportunity;

(4) A nurse-midwife licensed pursuant to chapter 377, appointed by the Connecticut Nurses Association;

(5) A clinical social worker licensed pursuant to chapter 383b, appointed by the Connecticut Chapter of the National Association of

Social Workers;

(6) A psychiatrist licensed pursuant to chapter 370, appointed by the Connecticut Psychiatric Society;

(7) A psychologist licensed pursuant to chapter 20-136, appointed by the Connecticut Psychological Association;

(8) The Chief Medical Examiner, or the Chief Medical Examiner's designee;

(9) A member of the Connecticut Hospital Association;

(10) A representative of a community or regional program or facility providing services for persons with psychiatric disabilities or persons with substance use disorders, appointed by the Commissioner of Public Health;

(11) A representative of The University of Connecticut-sponsored health disparities institute; or

(12) Any additional member the cochairpersons determine would be beneficial to serve as a member of the committee.

(c) Whenever a meeting of the maternal mortality review committee takes place, the committee shall consult with relevant experts to evaluate the information and findings obtained from the department pursuant to section 19a-59h and make recommendations regarding the prevention of maternal deaths. Not later than ninety days after such meeting, the committee shall report, to the Commissioner of Public Health, any recommendations and findings of the committee in a manner that complies with section 19a-25.

(d) Not later than January 1, 2022, and annually thereafter, the maternal mortality review committee shall submit a report of disaggregated data, in accordance with the provisions of section 19a-25,

regarding the information and findings obtained through the committee's investigation process to the joint standing committee of the General Assembly having cognizance of matters relating to public health, in accordance with the provisions of section 11-4a. Such report may include recommendations to reduce or eliminate racial inequities and other public health concerns regarding maternal mortality and severe maternal morbidity in the state.

[(e)**]** (f) All information provided by the department to the maternal mortality review committee shall be subject to the provisions of section 19a-25.

Sec. 13. Section 19a-490u of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

[On or after October 1, 2015, each**]** (a) Each hospital, as defined in section 19a-490, shall **[**be required to**]** include training in the symptoms of dementia as part of such hospital's regularly provided training to staff members who provide direct care to patients.

(b) On and after October 1, 2021, each hospital shall include training in implicit bias as part of such hospital's regularly provided training to staff members who provide direct care to women who are pregnant or in the postpartum period. As used in this subsection, "implicit bias" means an attitude or internalized stereotype that affects a person's perceptions, actions and decisions in an unconscious manner and often contributes to unequal treatment of a person based on such person's race, ethnicity, gender identity, sexual orientation, age, disability or other characteristic.

Sec. 14. (*Effective from passage*) The chairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to public health shall convene a working group to advance breast health and breast cancer awareness and promote greater

understanding of the importance of early breast cancer detection in the state. The working group shall (1) identify organizations that provide outreach to individuals, including, but not limited to, young women of color and high school students, regarding the importance of breast health and early breast cancer detection; and (2) examine payment options for early breast cancer detection services available to such individuals. Not later than February 1, 2022, the working group shall submit, in accordance with the provisions of section 11-4a of the general statutes, recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to public health, regarding appropriations or legislative proposals that will improve breast cancer awareness and early detection of breast cancer.

Sec. 15. (*Effective from passage*) (a) As used in this section, "doula" means a trained, nonmedical professional who provides physical, emotional and informational support, virtually or in person, to a pregnant person before, during and after birth.

(b) The Commissioner of Public Health shall conduct a scope of practice review pursuant to sections 19a-16d to 19a-16f, inclusive, of the general statutes to determine whether the Department of Public Health should establish a state certification process by which a person can be certified as a doula. The commissioner shall report, in accordance with the provisions of section 11-4a of the general statutes, the findings of such committee and any recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to public health on or before February 1, 2022.

Sec. 16. (*Effective from passage*) (a) There is established a working group to develop recommendations for the strategic expansion of school-based health center services in the state. The working group shall consider, but need not be limited to, the following: (1) Specific geographical regions of the state where additional school-based health

centers may be needed, (2) options to expand or add services at existing school-based health centers, (3) methods for providing additional support for school-based health centers to expand telehealth services, (4) options for expanding insurance reimbursement for school-based health centers, and (5) options to expand access to school-based health centers or expand school-based health center sites, which may include establishing school-based mental health clinics. As used in this subsection, "school-based mental health clinic" means a clinic that (A) is located in or on the grounds of a school facility of a school district or school board or of an Indian tribe or tribal organization, (B) is organized through school, community and health provider relationships, (C) is administered by a sponsoring facility, and (D) provides on-site mental, emotional or behavioral health services to children and adolescents in accordance with state and local law, including laws relating to licensure and certification.

(b) The working group shall consist of the following members:

(1) The Commissioner of Public Health, or the commissioner's designee;

(2) The Commissioner of Social Services, or the commissioner's designee;

(3) The Commissioner of Children and Families, or the commissioner's designee;

(4) The Commissioner of Education, or the commissioner's designee;

(5) The Insurance Commissioner, or the commissioner's designee;

(6) The chairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to public health, or the chairpersons' designees;

(7) The ranking members of the joint standing committee of the General Assembly having cognizance of matters relating to public health, or the ranking members' designees; The chairpersons of the joint standing committee of the General Assembly having cognizance of matters relating to appropriations, or the chairpersons' designees;

(8) The ranking members of the joint standing committee of the General Assembly having cognizance of matters relating to appropriations, or the ranking members' designees;

(9) Two persons designated by the Connecticut Association of School Based Health Centers;

(10) One person designated by the Community Health Center Association of Connecticut;

(11) One person designated by the Connecticut Association of Healthcare Plans;

(12) One person designated by Connecticut Health Center, Inc.; and

(13) One person who is a children's mental health service provider, appointed by the Commissioner of Children and Families.

(c) The cochairpersons of the working group shall be the Commissioner of Public Health, or the commissioner's designee, and a member of the working group appointed pursuant to subdivisions (6) to (9), inclusive, of subsection (b) of this section, elected by the members of the working group. The cochairpersons shall schedule the first meeting of the working group, which shall be held not later than sixty days after the effective date of this section.

(d) Not later than February 1, 2022, the working group shall submit a report on its findings and any recommendations for the strategic expansion of school-based health center services, in accordance with

section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to public health and appropriations. The working group shall terminate on the date that it submits such report or February 1, 2022, whichever is later.

Sec. 17. (*Effective from passage*) (a) For the fiscal years ending June 30, 2022, and June 30, 2023, the Department of Mental Health and Addiction Services shall, within available appropriations, increase access to mobile crisis services throughout the state by expanding such services' hours of operation to include nights and weekends.

(b) The Department of Mental Health and Addiction Services shall develop a plan to increase access to mobile crisis services throughout the state by making such services available twenty-four hours per day and seven days per week. Not later than January 1, 2022, the Commissioner of Mental Health and Addiction Services shall submit a report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committees of the General Assembly having cognizance of matters relating to public health and appropriations, regarding such plan. Such report shall include any legislative recommendations necessary to implement such plan.

Sec. 18. (*Effective from passage*) (a) As used in this section:

(1) "Peer support services" means all nonmedical mental health care services and substance use services provided by peer support specialists; and

(2) "Peer support specialist" means an individual providing peer support services to another individual in the state.

(b) There is established a task force to study peer support services and to encourage health care providers to use such peer support services when providing care to patients. Such study shall include, but need not

be limited to, an examination of methods available for the delivery and certification of peer support services and payment mechanisms for such services.

(c) The task force shall consist of the following members:

(1) Two appointed by the speaker of the House of Representatives, one of whom has personal experience with psychiatric or substance use disorders;

(2) Two appointed by the president pro tempore of the Senate, one of whom has personal experience with psychiatric or substance use disorders;

(3) One appointed by the majority leader of the House of Representatives;

(4) One appointed by the majority leader of the Senate;

(5) One appointed by the minority leader of the House of Representatives, who has personal experience with psychiatric or substance use disorders;

(6) One appointed by the minority leader of the Senate, who has personal experience with psychiatric or substance use disorders;

(7) The Commissioner of Mental Health and Addiction Services, or the commissioner's designee; and

(8) Two persons appointed by the Governor, one of whom has personal experience with psychiatric or substance use disorders.

(d) Any member of the task force appointed under subdivision (1), (2), (3), (4), (5) or (6) of subsection (c) of this section may be a member of the General Assembly.

(e) All initial appointments to the task force shall be made not later than thirty days after the effective date of this section. Any vacancy shall be filled by the appointing authority.

(f) The speaker of the House of Representatives and the president pro tempore of the Senate shall select the chairpersons of the task force from among the members of the task force. Such chairpersons shall schedule the first meeting of the task force, which shall be held not later than sixty days after the effective date of this section.

(g) The administrative staff of the joint standing committee of the General Assembly having cognizance of matters relating to public health shall serve as administrative staff of the task force.

(h) Not later than January 1, 2022, the task force shall submit a report on its findings and recommendations to the joint standing committee of the General Assembly having cognizance of matters relating to public health, in accordance with the provisions of section 11-4a of the general statutes. The task force shall terminate on the date that it submits such report or January 1, 2022, whichever is later.

Sec. 19. (NEW) (*Effective from passage*) The Department of Mental Health and Addiction Services shall develop a mental health toolkit to help employers in the state address employee mental health needs that arise as a result of COVID-19. Such toolkit shall (1) identify common mental health issues that employees experience as a result of COVID-19, (2) identify symptoms of such mental health issues, and (3) provide information and other resources regarding actions that employers may take to help employees address such mental health issues. Not later than October 1, 2021, the Department of Mental Health and Addiction Services shall post such mental health toolkit on its Internet web site. As used in this section, "COVID-19" means the respiratory disease designated by the World Health Organization on February 11, 2020, as coronavirus 2019, and any related mutation thereof recognized by said

organization as a communicable respiratory disease.

Sec. 20. Section 19a-200 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2021*):

(a) The mayor of each city, the chief executive officer of each town and the warden of each borough shall, unless the charter of such city, town or borough otherwise provides, nominate some person to be director of health for such city, town or borough. **[**, which**]** Such person shall possess the qualifications specified in subsection (b) of this section. Upon approval of the Commissioner of Public Health, such nomination shall be confirmed or rejected by the board of selectmen, if there be such a board, otherwise by the legislative body of such city or town or by the burgesses of such borough within thirty days thereafter.

(b) Notwithstanding the charter provisions of any city, town or borough with respect to the qualifications of the director of health, on and after October 1, 2010, any person nominated to be a director of health shall (1) be a licensed physician and hold a degree in public health from an accredited school, college, university or institution, or (2) hold a graduate degree in public health from an accredited institution of higher education. The educational requirements of this section shall not apply to any director of health nominated or otherwise appointed as director of health prior to October 1, 2010.

(c) In cities, towns or boroughs with a population of forty thousand or more for five consecutive years, according to the estimated population figures authorized pursuant to subsection (b) of section 8-159a, such director of health shall serve in a full-time capacity, except where a town has designated such director as the chief medical advisor for its public schools under section 10-205. **[**, and**]**

(d) No director shall, **[**not,**]** during such director's term of office, have any financial interest in or engage in any employment, transaction or

professional activity that is in substantial conflict with the proper discharge of the duties required of directors of health by the general statutes or the regulations of Connecticut state agencies or specified by the appointing authority of the city, town or borough in its written agreement with such director. A written agreement with such director shall be submitted to the Commissioner of Public Health by such appointing authority upon such director's appointment or reappointment.

(e) Such director of health shall have and exercise within the limits of the city, town or borough for which such director is appointed all powers necessary for enforcing the general statutes, provisions of the regulations of Connecticut state agencies relating to the preservation and improvement of the public health and preventing the spread of diseases therein.

(f) In case of the absence or inability to act of a city, town or borough director of health or if a vacancy exists in the office of such director, the appointing authority of such city, town or borough may, with the approval of the Commissioner of Public Health, designate in writing a suitable person to serve as acting director of health during the period of such absence or inability or vacancy and such person's start date. **[**, provided the**]** The commissioner may appoint such acting director if the city, town or borough fails to do so. The person so designated, when sworn, shall have all the powers and be subject to all the duties of such director.

(g) In case of vacancy in the office of such director, if such vacancy exists for **[**thirty**]** sixty days, said commissioner may appoint a director of health for such city, town or borough. The person so designated, when sworn, shall (1) be considered an employee of the city, town or borough, and (2) have all the powers and be subject to all the duties of such director.

(h) In case of the absence or inability to act of a city, town or borough director of health during a public health emergency declared pursuant to section 19a-131a, the appointing authority of such city, town or borough shall, with the approval of the Commissioner of Public Health, designate in writing a suitable person to serve as acting director of health during the period of such absence or inability or vacancy and such person's start date. If the city, town or borough fails to appoint such acting director of health, or fails to notify the commissioner of such appointment within thirty days, the commissioner shall appoint an acting director who meets the qualifications specified in subsection (b) of this section. The person designated as acting director of health pursuant to this subsection, when sworn, shall (1) be considered an employee of the city, town or borough, and (2) have all the powers and be subject to all the duties of such director.

(i) Said commissioner, may, for cause, remove an officer the commissioner or any predecessor in said office has appointed, and the common council of such city, town or the burgesses of such borough may, respectively, for cause, remove a director whose nomination has been confirmed by them, provided such removal shall be approved by said commissioner; and, within two days thereafter, notice in writing of such action shall be given by the clerk of such city, town or borough, as the case may be, to said commissioner, who shall, within ten days after receipt, file with the clerk from whom the notice was received, approval or disapproval.

(j) Each such director of health shall hold office for the term of four years from the date of appointment and until a successor is nominated and confirmed in accordance with this section.

(k) Each director of health shall, annually, at the end of the fiscal year, [of the city, town or borough, file with the Department of Public Health a report of the doings as such director for the year preceding] submit a

report to the Department of Public Health detailing the activities of such director during the preceding fiscal year.

[(b)**]** (l) On and after July 1, 1988, each city, town and borough shall provide for the services of a sanitarian licensed under chapter 395 to work under the direction of the local director of health. Where practical,the local director of health may act as the sanitarian.

[(c)**]** (m) As used in this chapter, "authorized agent" means a sanitarian licensed under chapter 395 and any individual certified for a specific program of environmental health by the Commissioner of Public Health in accordance with the general statutes and regulations of Connecticut state agencies.

Sec. 21. (*Effective from passage*) For the fiscal year ending June 30, 2022, the Department of Public Health shall, within available appropriations, implement the state loan repayment program for community-based health care providers in primary care settings.

Approved June 14, 2021

Appendix E. Data Links

Connecticut link for Social Vulnerability Index (SVIs) by Census Tract.
Provided by CDC
Click on layers in the legend to view desired data.
https://maps.ct.gov/portal/apps/webappviewer/index.html?id=80690e067bb04ed6a8c60dd439521382

Social Vulnerability Index (SVIs) Interactive Map.
Provided by CDC
Map of the United States
https://svi.cdc.gov/map.html

The Children's Health and Education Mapping Tool
Provided by the School Based Health Alliance in partnership with Health Landscape
This tool leverages the School Based Health Alliance Census data and Geographic Information System (GIS) technology to provide an interactive look at the intersection of school based health centers (SBHCs) and high-need areas.
Mapping Tool - School-Based Health Alliance (sbh4all.org)

HPSA Find
Provided by Health Resources & Services Administration (HRSA)
The Health Professional Shortage Area (HPSA) Find tool displays data on the geographic, population, and facility HPSA designations throughout the U.S.
HPSA Find (hrsa.gov)

Connecticut State Department of Education link to School data.
EdSight - Connecticut State Department of Education

Connecticut DPH link to look up any DPH-issued license, permit, certification or registration
eLicense Online (ct.gov)