

## AAP | 01\_Where Does School-based Health Fit Within Medical Home Discussion Panel #1 Policy

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Welcome, everyone, to the first of three in the discussion panel series entitled Where Does School-based Health Fit Within Medical Home? Today, we are excited to be discussing the role of policy in school-based health care. Next slide, please. This panel is being recorded for educational purposes. It will be available via the National Resource Center for Patient/Family-Centered Medical Home website. And the recording will be shared in the near future. For participants who do not wish to be part of this recording, please disconnect from the panel at this time.

All participants have been muted during this panel. So please keep yourself muted to reduce any distractions and background noises. Live captioning has been turned on for this panel to increase accessibility for participants. Please look to the bottom left hand corner of the screen and click on the textbox to enable captions. Additionally, an American Sign Language interpreter is live signing for the panel as well. Please utilize the Q&A box for any questions that you have as the presentation moves forward. If time allows, the discussion panel will address those questions. If not, the questions will be saved and utilized for technical assistance and for future educational opportunities. The chat box is also available to share comments and resources.

The National Resource Center for Patient/Family-Centered Medical Home is a cooperative agreement between the Maternal and Child Health Bureau and the American Academy of Pediatrics. We are grateful to the Maternal and Child Health Bureau of the Health Resources and Services Administration for the funding of our Resource Center, so we can implement educational opportunities like this discussion panel. None of the presenters of this panel have conflicts of interest with the information being presented.

We would like to acknowledge that where the headquarters of the American Academy of Pediatrics lies in Itasca, Illinois is the original lands of these tribal nations having resided in these lands or migrated through them. We can and should actively give voice to and solicit experiences from indigenous communities and all marginalized communities to inform our collective efforts to meaningfully, equitably, sustainably, and effectively address the needs of families from these diverse communities.

OK, great. And now I am thrilled to introduce our esteemed panelist. Dr. Nathaniel Beers is the executive vice president of community and population health and a general and developmental behavioral pediatrician at Children's National Hospital. He specializes in systems and policy issues at the intersection of health care and schools for children with disabilities. We also have Dr. Robert Keder, a developmental behavioral pediatrician at Connecticut Children's and an assistant professor of pediatrics at the University of Connecticut School of Medicine. He specializes in working with children with special health care needs and supporting schools and their families to help them reach their best potential.

And lastly, we have Dan Walter who is a senior policy and governmental affairs analyst in state advocacy at the American Academy of Pediatrics providing strategic counsel to state American Academy of Pediatrics chapters, and internal Academy committees, and leadership on issues of access to care, telehealth care, mental health, oral health, and others. Dan holds a bachelor's degree from Marquette University and a master's degree in public affairs from the O'Neill School of Public and Environmental Affairs at Indiana University.

Before we get started with our discussion, I'd just like to share a quick note about advocacy. As a federally funded technical assistance center, we do not engage in any advocacy work through our project. Therefore, today's discussion will focus strictly on education. However, there are plenty of opportunities to get involved in advocacy through the American Academy of Pediatrics. And more information on how to get connected to advocacy efforts will be shared at the end of this discussion.

OK, great. Now we can begin our conversation. So glad to have all of you here with us today. Dan, I'd like to start with you. As we know there have been a few significant policies impacting school-based health care recently. This will be a two part question. To start, in August of 2022, the Centers for Medicaid and Medicare Services released an informational bulletin sharing information on the funding, documentation, and expansion of services for school-based health services funded through Medicaid. And our team will share a link to that resource in the chat. So Dan, what does all of this mean for school-based health care?

Thanks, Jamie. And thank you to the National Center for hosting this conversation. They couldn't be more timely. Great question. I see that the link to the information bulletin has been posted in the chat. It makes sense to start with funding for-- Medicaid funding for school-based services, generally. And something that was known as the-- it is known as the free care rule in the Medicaid program that dates back all the way to 1997, when the federal Centers for Medicare and Medicaid Services, then I think it was called [INAUDIBLE] at the time, said that schools couldn't use Medicaid to pay for services, if they were also being provided to others in the community for free, hence the free care rule. This was an interpretation of federal Medicaid law and was mentioned in federal policy and guidance.

The only way a school could use Medicaid to pay for services under the free care rule was if the student was enrolled-- it met three criteria. The student was enrolled in Medicaid, had an IEP, and that the service was specifically related to that IEP, which this effectively prohibited schools from accessing Medicaid to pay for a lot of services. What happened is that in 2014 CMS then reversed that decision and said that federal Medicaid dollars could be used to fund school-based services, which is great. However, since that time, we've only really seen 18 states take up that option. There are six more states that are working on it. But still we're looking at over half of states that haven't taken up this option to use Medicaid to fund the services.

So what happened in August of last year, as you mentioned, CMS put out this great information bulletin that highlighted the authorities that Medicaid has to fund school-based services. Informational bulletins from CMS don't set new policy, they kind of explain existing authorities. It was actually part of a twofer. CMS also put out the same day, another great information bulletin related to Medicaid and CHIP and their ability to fund mental health services, in particular, for kids and lift it up a lot of great examples of states programs doing that in many different ways.

But this information bulletin was specific to schools and school-based services and discussed things like the importance of states taking up the free care rule first and foremost. But then the authority of Medicaid to use or to pay for things like outreach and enrollment, to use EPSDT to its-- to maximize EPSDT, which I should say is the Early and Periodic Screening, Diagnosis, and Treatment benefit. It's the gold standard of pediatric benefits in the Medicaid program. It basically says that children have to be screened for any needs they may have. And then the T of EPSDT is treatment, and that Medicaid really has to provide those services.

So it's really the backbone of the Medicaid program for kids in the country. But just to say that states can use EPSDT in the school-based settings to expand those services, that they can contract with managed care. Most kids are in Medicaid programs are in managed care in this country, so states can use their authorities to fund school-based services through managed care. A lot of great stuff is in there in terms of just expanding Medicaid into schools. And we hope it is a catalyst for states to take up that option and to build or enhance existing services.

Great. Thank you so much, Dan, for that great explanation. Before we move on to part two of this question, I just wanted to give an opportunity for Rob and Nathaniel to respond, if you have anything else you'd like to add. So, Rob, why don't we start with you?

Hi, everyone. Again, my name is Rob Keder And I'm one of your friendly neighborhood developmental and behavioral pediatricians on this call. Coming to you today from Hartford, Connecticut, also the unceded territories of the Poquonocks and the Tunxis. I approach this as one of the panelists as someone who works with schools but partners by doing telehealth based from our own private office clinical setting and then outreaching and partnering to provide services with schools.

This has offered some unique opportunities because it allows kids to have access to care when there might not already be a school-based health provider there. And it allows for better inclusion for us with the school team members, including the school nurse and/or teachers and other staff who have input in the child's life. But the funding proposed here does allow for more enriching and supportive method where we can help reduce the number of missed school hours for kids and really provide services at the heart of the child's community.

Great. Thanks so much, Rob. And, Nathaniel, is there anything else you'd like to add?

- Yeah, I think Dan did a really great job of explaining the lay of the land around Medicaid within schools. I think, in a previous incarnation, I actually ran special education for D.C. public schools. And one of the barriers that, I think, school systems have struggled with that we have some space to help support them given the fact that many of us have figured out how to bill Medicaid effectively is the documentation requirements that Medicaid has in order for school systems to be able to draw down these free care rule dollars, right?

And so I think many school systems lack the data infrastructure to make sure that they are effectively tracking the Medicaid numbers as well as tracking the services received and provided in ways that can be captured such that they could actually effectively claim for those Medicaid dollars. And that has been a big barrier. And as they expand out into other areas beyond just special education services which school systems have done a better job of figuring out. It creates even more of those documentation issues.

And so thinking of ourselves in the pediatric community as a resource for school systems in lots of different ways. We advise them often in, as Rob said, right, in what the medical needs are, the developmental needs are of a child. But we actually have a space to help support them with some of the work that we've done in our revenue cycle work to bill Medicaid to make sure that we're helping them understand what types of infrastructure might benefit them in order to be able to move forward in that space because there are a ton of opportunities.

Like Rob, I'm a developmental behavioral pediatrician. But I actually also oversee all of the school nurses in D.C. public schools right now. And there's a lot of services that we're providing for free because we haven't effectively figured out ways to capture that work that is more than just putting on band-aids and giving ice for bumped heads, or checking people's temperatures. There's a whole ton of more work that our school nurses are doing that is actually a billable service beyond some of the telehealth work that Rob was talking about as well.

Great. And hopefully there will be a space that as schools are able to more leverage this relationship that there can be strategies shared and broadly promoted to help others across the country to be able to effectively leverage these dollars. Dan, for part two then of this question, so continuous coverage requirements ended on March 31, which we all know. So state Medicaid agencies are now in the process of redetermining eligibility for enrollees which is known as the Medicaid unwinding. So could you please share with us then some more information on the Medicaid unwinding and its impact on school-based health care? Our team is going to also be adding a link to the Academy's resources on Medicaid winding to the chat as you're sharing with us.

Yeah, absolutely. You're very quick with the links. The unwinding is probably the biggest thing to happen to Medicaid in a very long time. And certainly, we can't talk about school-based funding for school-based health services, if kids don't have Medicaid. So really quickly, Congress as part of the Families First Coronavirus Response Act shipped a whole bunch more money to states. And in exchange, they had to keep everyone enrolled in the program for the public health emergency. That changed with the omnibus package at the end of the year. And states are now in the process of unwinding, as you say, or returning to normal operations. So they're making sure that everyone who's on Medicaid is still eligible for the program.

We know a lot of children are going to lose coverage because of this redetermination process. What we don't want to see is what they call procedural disenrollments. Really children who lose coverage because they don't get back to-- they don't either receive the forms or they don't return information needed to process the re-enrollment in time. So with respect to school-based services, it's going to be a 14 month process for states to go through this unwinding period. Some states are going to try and do it a little bit faster. But most of them are going to take the whole year to 14 months to do this. So over these 14 months, we're going to see children lose coverage unfortunately.

For school-based services, a couple of things. One is that obviously there's just the funding issue. If you're not enrolled in Medicaid, it's a barrier to receiving that funding, or to funding those services in schools. But secondly, this is going to take up a lot of bandwidth of Medicaid programs. There's been reporting related to how ready they are to actually process all of these redeterminations. So that's going to be a lot of work. So standing up, school-based services may take additional bandwidth that they simply don't have or need to augment to be able to do.

Our main message at this point is for everyone to-- all children to-- all families to update the contact information with the state so that when the state reaches out, they can be ready to respond right away. And really schools play a critical role in capturing kids' where they are. And my children are at Chicago Public Schools. I received a text, email, and voicemail, and the letter was available in eight different languages saying, if my kids were on Medicaid to get my contact information updated. So the more schools can do that, I think we can capture more kids and make sure that those who are eligible retain that coverage and also those who are no longer eligible move on to CHIP and/or marketplace coverage, so we don't see losses in coverage as much as we can.

Great. Thanks so much, Dan. No doubt, Nathaniel and Rob this greatly impacts a lot of your families and patients that you see. So definitely want to hear your thoughts on the matter as well. Nathaniel, why don't we start with you this time?

Great. Thank you. Right, I mean, I think first and foremost, we need to thank the AAP for getting resources out to pediatricians to make sure that we can be well informed and help support our patients and families. And I think for each of you, those resources that they put in the chat are incredibly helpful in thinking that through. As Dan noted, I think there's a role that schools can play in this as well. One of the spaces that we've been working on here in D.C. is rather than wait for the timeline that D.C. decides to implement this change, encouraging families to proactively move forward with their own submission of their eligibility materials so that they're not waiting until they get that notification.

I think as Dan noted, it's incredibly important to make sure that updated contact information is available. We know that one of the major reasons that children and family are disenrolled is because of lack of responsiveness claimed by the Medicaid agencies to providing that re-enrollment information. And often that is due to the wrong contact information being within the system. And so that is a really critical point there. It puts at risk huge amounts of funding. And so when we talk about our special education services, for sure.

But when we think about school-based health centers, when we think about the capacity to do creative things, like Rob and I are doing around telehealth and really pushing services, medical services into schools through telehealth means, that is all at risk, if those children are losing that Medicaid funding. Because the reality is that in many jurisdictions, even with the ending of many pandemic regulations around telehealth, most providers have been more effective at getting reimbursed by Medicaid for telehealth services than some of the other payers. And so even if a family is able to switch over to another payer but is eligible for Medicaid, they may put at risk some of the services that they've been able to get to date because of the more comprehensive array of coverage that many Medicaid plans provide in the pediatric space.

And so it is important wraparound service. When we think about our kids with disabilities and the additional support that those kids who are available for the community benefit waiver, or sometimes referred to as the Katie Beckett Waiver, right, that is another space where that eligibility determination is so critical for those additional services that are helping that child stay out of an institutional placement, which is a part of what we have responsibility for within the school system to help them be in the least restrictive environment possible. So those alignments are really important in that coverage issue.

Great. Thanks so much. Clearly a lot of moving pieces and a lot of considerations that families have to make, and the support that they can receive from their schools and providers is a great resource to have. Rob, is there anything else you'd like to add before we move on?

Not much just highlighting exactly what Dan and Nathaniel have said. If you can get a chance to look at the links. There are some great resources and handouts for your offices and practices, if you're a medical provider. But really these changes allow for better access to equitable care. Because one of the challenges that removing this does would potentially put at risk kids who are in school districts that might not otherwise have access to funding or services that they could utilize without having access to Medicaid and insurance-based services to compensate within their district. So this is really helpful and make sure families have it. And I would also add to notify many families as we're working with individual families who just aren't answering calls or picking up messages, there's been that general level of overload. But this is something to really highlight as important for them and to double check as an item.

Great. Thanks so much, Rob. And I'll just mention briefly that all of the resources that are shared today will be available in the PowerPoint presentation. But we'll also be sending that out to all of our participants. And once the recordings are available on the website, those resources will be there as well. So just another place within the Academy that those resources will be available. We've mentioned telehealth a few times so this is a nice segue then in thinking about policy changes that came from the COVID-19 pandemic really providing us this important tool that was used certainly prior to the pandemic but absolutely through the pandemic.

And now it's not over but beyond, we might say. And certainly, it's gotten a lot of attention more recently. So we know that telehealth offers clinicians and schools and other health care systems and partners, again, this valuable tool for provision of care in alignment with the medical home model. So, Rob, just a few questions for you then to get us started. How has telehealth policies at the national and state levels impacted the provision of behavioral and mental health care for children in schools? And how have these policies supported coordination in mental health services between schools and medical homes?

Thank you. So great set of questions. Really as we entered into the pandemic with legislation putting in place a quick access to telehealth, it really opened options. Not all states had access to telehealth as a practice modality. So for many providers, there was some telehealth before, but it really was a quick changeover. One out of necessity because we had to go to telehealth based on pandemic regulations. But two, it really allowed for billing and coverage access. So once we were able to do this, it really allotted for some creative ability to address care that otherwise was just unfunded or considered outside of clinic visit care.

As a specialist, a developmental and behavioral pediatrician, this really has allowed us in our field to be able to work with and partner with schools in a way where we might be able to virtually attend a child's special education team meeting, or have a discussion with their teachers or school-based clinicians, by doing that through a telehealth visit where the family and child are present virtually on a video-based visit that we as a provider are billing from our practice. That's a little different than a school-based center running the visit and having it bill through the school-based program.

But even as general pediatricians, this has offered opportunity to really expand and meet needs in the gap of access to other things, whether it be coordinating with school nurses, working to get information with school teams. We also have resources through the AAP and have piloted like the mental health teams project. And this has offered other opportunities where we can think of how can we get other specialists who don't necessarily have a quick foothold in the school system to work and communicate better with school-based professionals.

Great. Thank you so much. Nathaniel, and Dan, we'd really like to hear from you as well on this question. Dan, why don't we start with you?

Thanks, Jamie. Yeah, I guess I, would say that, as Rob mentioned, the flexibilities that Medicaid and CHIP, in particular, have had are largely state based. Throughout the pandemic, CMS, unlike what happened with Medicare where Medicare had to change policy rather quickly, states have a lot of authority with respect to how telehealth is run and how they're funded in Medicaid and CHIP. And as Rob mentioned, I think we're hearing that Medicaid in particular is just very good at-- they've made a lot of those flexibilities permanent, first and foremost. We're seeing states also move towards some of the pay parity paying the same whether or not they see-- whether or not a clinician sees you in person or via telehealth.

Those kinds of things make it possible for these services to be provided. And I think we'll continue to see that. We want to make sure too that those services are provided by pediatricians who have relationships with the kids and are giving that-- it's an extension of the medical home is what I'm trying to say, and not others-- other providers coming in and sort of fragmenting care. So that's one piece that kind of leaves throughout different state policies that we try to educate on. But yeah, it has really allowed clinicians, as speaking as a non-clinician here, but to see children where they are, at least that's what we're hearing from our members and that includes schools.

Great. Thank you so much. Nathaniel, anything else that you would like to add?

Yeah, I mean, I think the first thing I can't emphasize enough what Rob talked about. And I'll be a little more explicit, right, that telehealth and the change in policies and the change in our readiness to be able to provide that service as pediatricians means that there is a whole host of things that we were doing for free that we can actually be reimbursed for, right. The number of IEP meetings that I have called into over my career for free because a family was struggling with a school and struggling with being heard, and I'm sure Rob as well prior to the pandemic.

I was doing a lot of that as well is very different. I actually also sometimes went in person, which also is an unbillable service because I'm out of my office and not actually available to bill outside that office. And so this telehealth opportunity really shifts the capacity that pediatricians have to support their families who are struggling in the special education space, in particular, around connecting into that IEP meeting, getting paid for that connection, and actually being able to participate actively.

The second piece, I think that is really important to not lose sight of as we sort of start to reach the end of the pandemic is as states are returning out of public health emergencies, making sure that they are maintaining some of the regulatory flexibility is really important for us as pediatricians to be paying attention to. In a space like Washington D.C. where we're sitting across three jurisdictions and making sure that cross jurisdictional work, right, when we're crossing state lines with our telehealth work is also being supportive effectively is really, really critical in a space that impacts the capacity that pediatricians who may be in a different state than the school district that they are dealing with need to make sure that they have engaged in that space.

As Rob noted as well and I talked about earlier, right, we also are on the other end right where we are the host for the telehealth visit in D.C. public schools, right. So the family is at home, we're allowing them to stay at work or at home with other kids and not have to come into the school to pick their child up and connected into a provider at Children's Hospital so that you triangulate that visit across the school, the home, and the doctor's office in a way that really does support better attendance, right. The AAP has a really important push to make sure that kids go to school more often. And this telehealth opportunity does afford us to address that.

The last thing that I'll say that is really important as well is, as Dan noted, there are a lot of other actors trying to get in this game. And actually, the state of Ohio through Dr. Sarah Bodie is doing some work to try and make sure that there's some mechanism to help schools filter what really can this telehealth provider do for you, and is it actually going to meet the needs of the students that you have in your school, and are the providers going to actually be pediatric health experts who can actually provide the type of clinical care that kids deserve and need.

And so there will continue to be some ongoing conversation in that space. And I think our council on school health, I'm sure will partner together with others in the Academy to think about how we can get that information out to people about how they can support their jurisdictions and their school districts with making good decisions about telehealth providers so that they don't get trapped with someone who's just there to make a buck off of the school.

Great. Thank you so much. And, Nathaniel, we'll stay with you. And you certainly have touched on the benefits of telehealth certainly for billing purposes for sure. Other thoughts that you have for telehealth opportunities outside of physical and mental health necessarily improving the efficiency of medical home, particularly thinking about this collaboration between medical home and school-based health care, you've touched on that. But if there's more that you'd like to follow up on? Such as follow up to care impacts on children's learning due to illness or injury. Yeah, I'll stop there.

Yeah, I mean, I think there's an opportunity in telehealth that we've talked about. But there is also a lot of opportunity to think about. As I mentioned earlier, the attendance issue, right. So that kid who has pink eye and goes to the school nurse, do they really need to go to the emergency room? Does the family really need to go that evening to get that care done in order to return to school? Or can someone do a telehealth visit and allow that child to get a prescription sent to wherever the family wants it sent so that they can start treatment that evening? And that child can be back in school tomorrow with no one missing work, no one missing school, and no one going to the emergency room.

All of which are about serving our patients and families, serving the students in our school district, and also acknowledging the burden on our emergency rooms given all of the demands that they have in front of them. I think as well when we think about some of the chronic disease management, and I see some questions coming up from our friend in Boston, Rich Antonelli, around kids with more complex disease. I think that there's a space for telemedicine to support some of that care coordination and ensure that kids are getting some of that follow up care that they sometimes have been unable to connect with.

And I'll give you an anecdotal case for us here in D.C. where we had a kid who was chronic asthmatic who had ended up in the emergency six times in the month of October and November of this school year. We were able to get them connected to one of the asthma programs that we have here in D.C. at Children's National called IMPACT DC. And they were able to understand that the real issue is that mom was having some housing instability. She wasn't able to make sure that the child was getting medications and had other kids who she was trying to sort of make sure that she was taking care of.

And so until it was an acute issue, she was not addressing the issues that this child's medication requirements needed. And so we were able to set up a system where the medications were then maintained both in the school and at home through this telehealth visit to ensure that child got the medication every day with the agreement that during the school week, when the child was in school, he would get the medications at school. And that during the weekends, he would get it at home as normal.

But we've been able to keep that kid out of the emergency room since December and been able to sort of reduce the overall cost of the system but also provide higher quality care and allow the child to, one, go to school, but, two, be a kid again and not be in the emergency room on steroids every other week with that sort of chronic management issue. So I think there's a lot of opportunities when we think about chronic disease management and how we can decrease some of the burdens to our families, but also allow those providers on the receiving end of that care to be able to bill effectively for those services too.

That's great. Thanks so much. I like how you mentioned, not only it was his asthma more managed, but he got to be a kid again, which is such an important piece of pediatrics as well, allowing children to live to the fullest of their well-being. Dan, and Rob, we can take a moment to see if you have any thoughts and want to respond. Rob, we'll start with you.

Thank you. So really highlighting what Nathaniel was saying in this for kids with multiple disabilities or complex physical care needs allows opportunities to have less missed hours of school. It allows for parents to have less missed hours of work too because they can just log in, have the child at school logging in. This really does enhance care from the child's medical home. The one thing that is hopefully consistent for a child is that they have access to a medical team that persists with them. And they do develop great relationships with teachers and possibly special educators.

But we have found that working with the child in their natural environment, both at home and in the community, this really allows for better models of care, whether it be asthma or ADHD, because we really need to continue to think about ADHD as a type of disability and how we can best enhance the child's ability to access learning, even if it's through a 504 plan, or a special education program. We can do that, but we can do that by coordinating with teachers and information and get paid for it through telehealth. So this really does offer all of those unique opportunities.

It does beg us, though, to pay attention to some other questions or issues, things like access to sufficient internet. Do patients and families have access to something where they have to have video on? So those are some of the things that we've been thinking about. But as states have been discussing things and offering parity, we really have seen improved care models. And it allows schools that might have less access to specialists, or specialists including general pediatricians to help with children who might present with a little bit more medical complexity and demystify that while still allowing those general pediatricians or specialists to be able to get paid and have time to access those because of parity and being able to bill it as a visit.

Great. Thank you so much. Dan, is there anything else you'd like to add to that?



Well, just to say, I think, there's so much attention being paid right now to school-based services and particularly with respect to mental health. But also there's a nice convergence happening as we're discussing here with telehealth, school-based services, and Medicaid. One thing I neglected to mention was that the Bipartisan Safer Communities Act directed CMS to update a few documents, a billing guide and a technical assistance guide, which are needed. But it's also going to stand up a Technical Assistance Center. So that will be helpful to school districts that don't yet fund services through Medicaid to do some of this work and to begin the process of standing up these programs to bill Medicaid. And also I think to lift up these models that are working well for kids as Rob and Nathaniel are clearly telling us about. I think there's going to be a lot more of that work done that we can spread across states as those programs are stood up, and as we learn more about what's working best across them.

Great. Thanks, Dan. Did you say that that's in place, or that's going to be in place, the Technical Assistance Resource?

They're going to be updating two documents, the Administrative Claiming guide and the Medicaid's Technical Assistance guide. And then they're going to be standing up a Technical Assistance Center. The Bipartisan Safer Communities Act also shipped \$50 million to states to help them plan for these to either start these services or to enhance them, if they're not doing so already. So there's a lot of attention paid to these services thanks to that piece of legislation.

Great, great. Thanks for clarifying for me. Another question that will pose out to the group. In thinking about telehealth policies and utilizations in schools and so on, I'm interested in hearing from your perspectives what the equity implications are of this work, and additionally, the privacy implications as well. And I think we'll go Rob, Dan, and Nathaniel. So, Rob, we will start with you.

So there are, as I've started to talk about a little bit, several ways to look at equity measures for this. When we're looking at it as an access to care model, it offers time equity for patients and families. It offers travel equity. But there are other things that we need to consider like broadband connectivity, access to sufficient devices, having platforms that are accessible to patients and families. If a platform is too complex and we're working with a family who might not have native English speaking capacity or might have cognitive disabilities themselves, we need to make sure that we have access to technology that is available and functional for patients and families.

But this really does offer distance equity too. Thinking about where you practice and where your child and school is in relation to say like an academic center where maybe you do have a child with a rare disease or disorder, and that specialist is a four or five hour drive away. It allows for the medical team to work and partner with the school team. It allows for the patient and family to not have to travel four hours and miss a whole day for school. But it really allows for clarification of needs.

As a developmental pediatrician, core to all of pediatrics is we try to help everyone understand the child that we're working with and taking care of. And it really does is it is an opportunity for equity and coverage and pay to have those conversations, allow for experts to demystify, and to allow somebody who's known the child, such as their general pediatrician or primary care provider, to really help explain, and advocate, and demystify some of the challenges that could be going on in this school. But likewise, it allows the school team to help explain things to patients and families.

This allows for language based equity too because then in real time as opposed to emails, we could be talking, and clarifying, and commenting on things, and sending emails or faxes right there on the spot that allow us to actually be productive and care for that child as opposed to just waiting for things to catch up and go through. And then it takes levels of bureaucracy, people, and time to get things through and done.

Great. Thanks so much, Rob. You really highlighted a lot of ways that telehealth can improve efficiencies in addition, you know, through equity, but not just for pediatricians but absolutely for the families as well and how important that is. Dan, did you have anything else you'd like to add?

Maybe not specific to telehealth, but just to say that there's so much exciting work happening in Medicaid related to health related social needs. And we've seen waivers approved and Medicaid waivers approved in a few states now that really get at nutrition support, housing supports, care for children involved in the justice system. And I think to the extent that telehealth can play a role in the future. But just that Medicaid in particular has a role in serving kids through all of these different types of services. And to the extent that as those grow, the schools can be weaved into those systems. I think it's going to be really exciting to see. So there's a lot more to come, I think, as more states make more proposals related to these types of waivers. But it's been really exciting to see CMS really push the ball forward in terms of what Medicaid can do.

Great. Thanks so much. Nathaniel, is there anything else you'd like to add?

I think they've covered the equity side of that question. I'll dig into the privacy side of the question because we can't have a school-based services conversation without the discussing the elephant in the room between HIPAA and FERPA and acknowledge that continues to be a challenge. Because while we all think that HIPAA has been a challenge for us on the health care side, we have learned to work together effectively as medical teams providing services for individual patients and being able to do that. I think the FERPA interpretation is at the whim of every school district and whoever the legal counsel is at the moment wins the day.

And so there is a lot of challenge even with more and more federal guidance on how FERPA should and shouldn't be utilized. That has continued to be a barrier to care and continue to do that. I know from some previous conversations with Rob that he does do some really good work in thinking about how to get some blanket waivers to try and make sure that there can be bidirectional information sharing. And so thinking about that as an important piece of the privacy conversation. But that's just one piece of the privacy conversation with the broader school context.

When we start overlaying telehealth on top of that, one of the biggest barriers to actually implementing the telehealth program in the D.C. schools has been ensuring that there was an appropriate space that afforded the patient the appropriate level of privacy during that telehealth visit. And we have many schools where we've not yet been able to implement the program, not because we don't have the equipment or the budget to be able to do what we need to do, but because they've not been able to identify space within the health suite or near the health suite that could be utilized for that telehealth visit for the school nurse still to be engaged with other kids in the school that might need care. And so there is this piece of that.

And then the second piece is as we talk about mental and behavioral health as we talked about earlier in the great winds in increasing access through telehealth for those services acknowledging that creates an even higher degree of need for that privacy, ensuring that it is a safe space, not just a private space, that student can be in, particularly if they are going to be disclosing sensitive information about their mental or behavioral health needs.

And so those are really important policy things for people to be thinking about as well as implementation components for people who want to think about how telehealth can support the broader set of needs. And really start to address some of the inequities that exist in our health care system for kids because of either language, or poverty, or race, and making sure that we don't forget that there are also some privacy related issues that we have to address within that space.

Great. Thank you so much. You had mentioned, Nathaniel, Rob, you do some really great work around waivers. So I'm wondering if you wouldn't mind sharing with our participants any strategies or recommendations from successes you've seen in your work.

Thank you. And Thank you, Nathaniel, for that highlight. Trying to be preventative or potentially even just reactive as families need it, really anticipating that a community based conversation can be at the child's best interest. It's really important. And one way to do that is to try to develop a practice model around who are children that you think you're going to need to work with their community or school-based providers, and how do we invite that team-based collaboration. But that first starts with not just the physical piece of paper, but actually acknowledging buy in from families.

One of the benefits of a medical home is that there is that core relationship. And this harps back to the concept of relational health. But we have to also acknowledge that there equity issues based around systemic traumas that families might experience and not allowing them to feel in the driver's seat of broad based communication can be frightening and retraumatizing. We have to step back and think, how can we invite the family to feel that they are in the driver's seat of their child's health care and help invite them to empower us to communicate with one another. But really make sure that we're letting them know that we are including them in communications.

So having an opportunity for a release of information or consent that would let us communicate from HIPAA to FERPA and cross those intersections is great, but we have to really teach and talk with families about what that is. We have to really advocate that this is at the family's interest. And that when it comes to live communication, that we're offering them the opportunity to be present, even if it's through carbon copying them on an email, or just letting them in on a three way phone call, or a video based visit to do that.

Great. Thank you so much. We're just about 13 minutes before the end of our session. And we have one more question left. If we have time, we can get to a few of the questions that have come through the Q&A. So a priority audience for the work that we do here at the National Resource Center for Patient/Family-Centered medical home is Title V programs. I'm really interested from your three perspectives what Medicaid policy or policies Title V and other school-based health care partners can leverage for provision of support for children and families. I was also wondering, and, Dan, we can start with you. You know, you were talking about the burden that's going to be on Medicaid with the unwinding and eligibility. And I first wondering, if there's an opportunity for Title V to be able to support that work and to be a resource for families who are going through this process as well.

That's a great question. Yeah, I think we've seen-- well, so states have the opportunity as they conduct the unwinding to treat populations differently or to address different populations at different times. And we've seen a number of states really take the right care to make sure that children with special health care needs have the most amount of time to go through this process.

So part of it, obviously, we don't want to see any disruptions in care but particularly acute for children with special health care needs. So to the extent that states and Title V can just continue to spread the word about this unwinding the need to maintain and really to treat this as a special case-- this population has a special case in making sure that states are doing really all they can to keep those children enrolled. And if they're no longer eligible for Medicaid for some reason, to transition to other appropriate coverage. So great question and very germane.

I think with respect to Title V, generally, with children and special needs-- special health care needs, we're talking about three programs, school-based services, Medicaid, and Title V that really treat the same population. We have the same goals here. We want Medicaid to be able to fund services. Title V is very good at helping families navigate Medicaid funding, which can be kind of Byzantine for kids who might be eligible through different waivers, as Nathaniel mentioned, the Katie Beckett Waiver. And so to the extent that Title V can bring that expertise to school-based services, I think, from a policy perspective is really important because they're the ones who really can help those families in those settings.

Great. Thank you so much. Nathaniel, anything you'd like to share?

Yeah, to sort of add on what Dan said, right, I mean, I think certainly that sort of case management and helping families navigate that process is certainly something that Title V programs could choose to support and certainly could be helpful for the state, but also for the kids as well in being able to make sure that those kids get appropriate care. The other thing that is worth Title V directors really being in connection with their schools on is what are those services that may get uncovered with the change in the Medicaid rule.

And so are there services that they've been able to provide for the last several years because of the increased Medicaid coverage rates that they're worried that they're not going to be able to provide for some of their kids that would be eligible in the Title V programs. And so there certainly could be some gap funding that as things are sort of settling out and people figure out how to make sure that people get in the Medicaid enrollment that they should be in, but also figure out additional funding streams that Title V could function as a gap coverage for some of those kids and families in those sort of wraparound supports that they may need in order to be successful.

The final thing that I'll say in the Title V space is that there is this additional space that I think as states also start to implement the ACE Kids Act, that Title V could play a really important role in helping to support around making sure that the kids with disabilities are getting the quality of care that they need, and helping to implement the monitoring of that, and as well as ensuring that as we identify gaps in quality that they are helping to advance the field by understanding what is causing those gaps and how services might look different or feel different to ensure that high quality care is being provided for every child who is eligible for that care.

Great. Thank you so much. Before we move over to Rob, Nathaniel, would you mind just providing a quick explanation about what the ACE Kids Act is?

Sure. So it is a federal legislation that passed pre-pandemic that affords states the opportunity to really ensure that kids with disabilities are receiving high quality care, and that there is more support for care management services beyond what is already available within the Medicaid regulations currently. And so it is focused on improving the outcomes ultimately for kids and that coordination of care across the systems.

Great. Thank you so much. And, Rob, it looks like we have time for you to respond before we start wrapping up.

Thank you. So quickly to just compliment everything else that's been said, I'll throw in the perspective of how do we look at this from the little a advocacy side, which is how do we make sure that we're helping patients and families navigate all of these things. There are going to be some patients who are no longer eligible for Medicaid, talking with them, making sure that they can get access to CHIP based funding coverage or through other marketplace options will be really important because it works in our favor too is medical providers. We want to make sure that child continues to have access to care. But this is where we really need to know the players in each of our local ecosystems as we're supporting kids.

We need to think about who is there to help ensure that there is quality being delivered whether that be through some of these type of Title V programs or through other local or independent organizations, we're there to do it. And we can just think what other options and resources do we have. Do you have access to United Way? Do you have access to a care coordinator, or a case manager in your office? Is there a Medicaid program that has case based coordination in your state? And what's the level and fidelity of that? Because if not, we sometimes do need to get creative. But I think most importantly, support families through all of this. This is really stressful, so we want to be mindful about how we're there to help do that for them.

Great. Thank you so much. And I think that's a great place to end of doing what we can to support families through an even more particularly stressful time. Thank you all so much for being our panelists today. You were fantastic. Thank you, Dr. Beers, Dr. Keder, and Dan. We're thrilled to have you and your expertise in helping us through this conversation. And hopefully, this is just the beginning of more conversations that will be here to have. And certainly as the academy has more resources and supports that come out to help pediatricians and others, we will certainly be sharing those through our networks as well.

I'd also like to thank all of our participants today for joining our discussion. We will be sending an evaluation for today's panel to everyone. And we hope that you can take the less than five minutes to complete this, so we can continue to provide high quality education and training. We have the second panel of our series being held on Tuesday, April 11, that will be from 4:00 PM Eastern or starting at 4:00 PM Eastern, 3:00 PM central. The focus of this panel will be on collaboration between medical home and school-based health care really focusing on the family engagement piece through this. And we'll have two pediatricians that we're featuring and also two family partners. So we hope to see all of you there for that as well.

As I've mentioned, we have a list of resources both within the Academy. So again, as a way to continue the conversation on policy and learning more about the Academy's advocacy efforts. In addition, the Medicaid resources that we discussed today will certainly be included in that, and if there were any other resources that came through the chat, or resources that we can share to support questions that came through the chat that we weren't able to get through today, we will absolutely include that in that list as well. So lastly just wanted to share that we, as the National Resource Center for Patient/Family-Centered Medical Home, we are available for any of your technical assistance needs. So please reach out to us at any time. Otherwise, thank you, everyone, so much for joining us today. This was a great, great conversation. And we hope you have a great rest of your day. Thank you, everyone. Take care.