Adolescent and School Health Program - Public Health Division - Oregon Health Authority

Kate O' Donnell, MPH Rosalyn Liu, MPH Melanie Potter

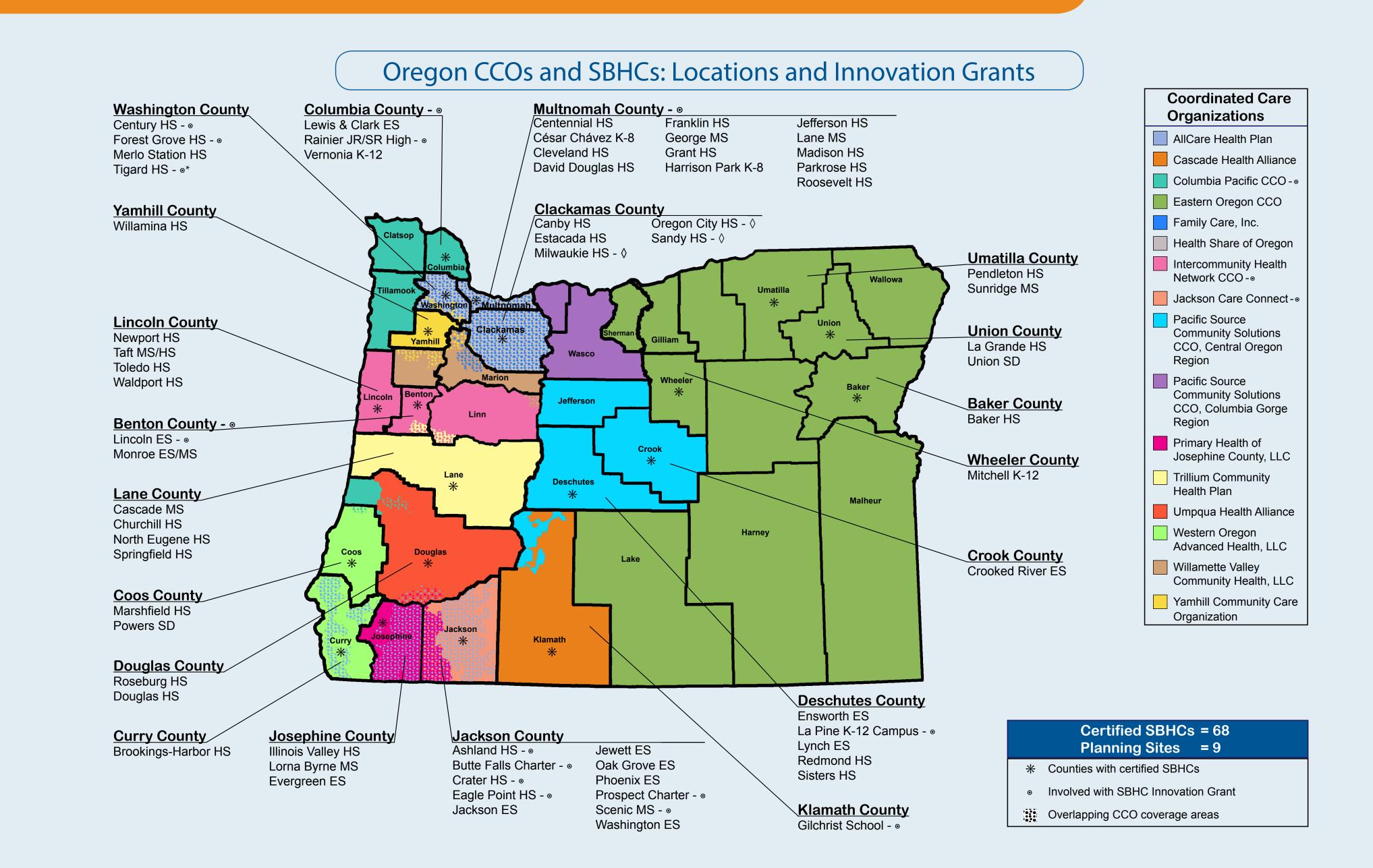
# Background

School-Based Health Centers (SBHCs) have been operating in Oregon since the early 1980s as a unique partnership between public and private entities. With the passage of the Affordable Care Act, Oregon developed Coordinated Care Organizations (CCOs), known nationally as Accountable Care Organizations (ACOs), which focus on ensuring a healthy population through person-centered care in a cost-effective manner. SBHCs are natural partners in health care reform to help ensure a healthy population of children and adolescents.

The 2013 Oregon Legislature passed House Bill 2445, which allocated approximately \$750,000 in funding to the Oregon Health Authority (OHA) to incentivize organizations to accomplish one or more of the following goals:

- Increase the number of SBHCs certified as patient centered primary care homes (PCPCH)
- 2. Improve the coordination of care of patients served by CCOs and **SBHCs**
- 3. Improve the effectiveness of the delivery of health services through SBHCs to those who qualify for medical assistance

In April 2014, the Oregon SBHC State Program Office released a Request for Grant Applications for SBHC medical sponsors and CCOs to explore innovative approaches to school-based care that accomplish one or more of the above goals and support Oregon's Triple Aim goals of a healthy population through quality care at a lower cost.



# Grant Project Strategies

SBHC Challenge:

SBHC Challenge:

Strategies

Grantees

Strategies

Grantees

SBHC Challenge:

Grant funds were used to support larger, systems-level innovation projects as well as smaller, targeted projects to meet the goals outlined in HB 2445. During the course of the grant, several SBHC-specific challenges or gaps emerged related to PCPCH recognition, care coordination, and effective health service delivery. Although projects varied considerably among the grantees, a number of common strategies were employed to address these challenges which are highlighted in the following boxes.

SBHC Challenge:		
Improving policies and workflows		
Strategies	<ul> <li>Develop workflows for patient care coordination, communication to parents/patients, tracking of specialty referrals, and capturing client information from other providers</li> <li>Examine alternative staffing models to facilitate efficient care, including Client Navigators</li> <li>Conduct patient/staff satisfaction surveys</li> </ul>	
Grantees	<ul> <li>Intercommunity Health Network CCO</li> <li>The Public Health Foundation of Columbia County</li> <li>La Pine Community Health Center</li> <li>Jackson Care Connect CCO</li> <li>Virginia Garcia Memorial Health Center</li> </ul>	

Assigning SBHC providers as Primary Care Providers (PCP)

• Change CCO policy to permit SBHC providers to be assigned as

Run quarterly reports to track unassigned patients to increase

Oregon Health Plan (Medicaid) enrollment and outreach and

Hire dedicated staff to coordinate health and social service

Meet regularly with local partners, including school, mental

health providers, social service agencies, health department,

Develop systems to track referral completions and conduct gap

• Track PCPs through EHR and client intake forms

• The Public Health Foundation of Columbia County

enrollment in medical home

Jackson Care Connect CCO

Coordinating care with local providers

referrals for SBHC clients

hospitals and school nurses

analysis of referral system

Jackson Care Connect CCO

Intercommunity Health Network CCO

Virginia Garcia Memorial Health Center

Intercommunity Health Network CCO

• La Pine Community Health Center

### SBHC Challenge: Increasing clients with well-child visits (WCV) Replace sports physicals with WCV Employ patient and provider incentives and conduct targeted outreach to increase WCV Mobilize partner agencies and client navigators to engage Strategies underserved communities • Expand primary care hours and direct clients from main FQHC clinics to SBHCs • The Public Health Foundation of Columbia County La Pine Community Health Center Grantees Jackson Care Connect CCO Virginia Garcia Memorial Health Center

### SBHC Challenge: Achieving state PCPCH recognition • Implement strategies to meet PCPCH program requirements Complete multiple PDSA cycles to refine workflows and care Strategies coordination systems Apply for recognition through State PCPCH program • The Public Health Foundation of Columbia County • La Pine Community Health Center Grantees Jackson Care Connect CCO

### SBHC Challenge: Improving data functionalities • Establish data sharing agreement between SBHC medical sponsor, CCO and local health department Upgrade EHR infrastructure and equipment • Improve EHR reporting to document client need for preventive Strategies services, client PCP, and referrals • Audit payor mix, collection rates, schedule fill and appointment no show rates • Intercommunity Health Network CCO The Public Health Foundation of Columbia County

Grantees	<ul> <li>La Pine Community Health Center</li> <li>Jackson Care Connect CCO</li> </ul>	
SBHC Challenge:		
Exploring alternatives to traditional payment methods		
Strategies	<ul> <li>Convene workgroup comprised of SBHC medical sponsors, local public health, payors, CCOs, and state government to explore viable alternate payment methodology/ies (APMs)</li> <li>Define unique value of SBHCs and identify traditionally non-reimbursable SBHC services</li> <li>Secure funding to identify pilot participants and implement pilot in 2015-2016 school year</li> </ul>	t e a p
Grantees	Multnomah County Health Department	

# Grantee Project Challenges

—Staff turnover

—Partner willingness to actively participate in collaborative meetings

—Identifying client's primary care provider (PCP)

—CCO policies that do not allow SBHC providers to be assigned as PCP —Tracking completed referrals

—Sharing information, both internally (mental/behavioral health and physical health) and externally (specialty providers, assigned PCP)

—Parent/provider "buy in" to yearly well-child visits

—Limited provider capacity to see increasing numbers of Oregon Health Plan

(OHP) clients and provide preventive services, such as well-child visits

—Standardizing coding for services provided (SBIRT, well-child visits)

# Inital Findings / Lessons Learned

As pilot projects draw to a close in June 2015, several initial findings have emerged.

 Innovation Grant projects provided an opportunity to regularly convene CCOs and SBHC medical sponsors, which reportedly strengthened the relationships between these entities.

—CCOs increasingly appreciated how the SBHC model aligns with CCO goals and has potential to mitigate health provider shortages.

-Regular contact with CCOs led to systemic policy changes, such as permitting SBHC providers to be assigned as PCPs, working together to meet requirements for the State PCPCH application, and sharing information among safety net health providers and schools.

—Grantees employed several strategies to increase the number of well-child visits provided to SBHC clients. Some grantees found that targeted outreach and incentives for clients and parents increased well-child visits. Others found provider incentives and increased primary care hours to be most effective.

—The ability to effectively obtain information about preventive and acute care provided outside the SBHC necessitated new workflows and information sharing via Electronic Health Record.

—Early evidence suggests implementation of new staffing models, including "member services" departments, office health assistants, receptionists, and/ or data analysts led to increased utilization and improved SBHC ability to conduct outreach and coordinate client care.

# Next Steps

Innovation Grant funding provided an opportunity for local communities to explore different approaches to advance Oregon health system transformation efforts through school-based health. As grantees continue to build upon these initial efforts, the SBHC State Program Office will apply lessons learned through training and technical assistance to SBHCs and CCOs. A final report will be shared with partners, CCOs, and local SBHCs by late Summer 2015.

# Strengthening relationship with CCO

• Regularly convene CCO, FQHCs, and County Mental Health to address sustainability and coordination challenges Strategies • Share information with CCO to clarify SBHC model • Intercommunity Health Network CCO The Public Health Foundation of Columbia County Grantees

Jackson Care Connect CCO

# Grantee Information

**Intercommunity Health Network CCO Benton County** 

**Project Partners** 

 Benton Community Health Center Corvallis School District

 Lincoln Elementary School SBHC Number of well-child checks performed by quarter:

• Q4 (4/1/14 to 6/30/14): 68

**Project Milestones** • Q1 (7/1/14 to 9/30/14): 50 • Q2 (10/1/14 to 12/31/14): 61

# **Public Health Foundation of Columbia County**

**Project Partners** 

**Project Milestones** 

**Project Milestones** 

**Columbia County** 

 Columbia Pacific CCO • Rainier Jr./Sr. High School SBHC

 Working relationship established between SBHC Coordinator and CCO, opening door for agreements about PCP assignment, billing, and PCPCH recognition requirements

 Workflows developed to better track preventive health service provision, patient assignment, and specialty care referrals

### La Pine Community Health Center **Deschutes and Klamath Counties**

• La Pine K-12 SBHC

**Project Partners** 

 Gilchrist School SBHC • # clients aged 12-21 who were provided well-child visit:

• Q1 (8/14/14 to 9/26/14): 6

• Q2 (9/27/14 to 12/27/14): 18

• Q3 (1/1/15 to 3/31/15): 36



# **Jackson Care Connect CCO**

**Jackson County** 

**Project Partners** 

Rogue Community Health

• La Clinica

 Jackson County Mental Health Crater High School SBHC

• Eagle Point High School SBHC

 Ashland High School SBHC Scenic Middle School SBHC

Butte Falls Charter School SBHC

 Prospect Charter School SBHC CCO changed policy to allow SBHC providers to be

assigned as Primary Care Providers (PCP) • # eligible patients screened using SBIRT tools at Crater

**Project Milestones** High School SBHC:

• Q1 (9/1/14 to 9/20/14): 46

• Q2 (9/30/14 to 12/31/14): 82

• Q3 (1/1/15 to 3/31/15): 146

# Multnomah County Health Department

**Multnomah County** 

 Oregon School-Based Health Alliance CareOregon

Family Care CCO

 Washington County Health and Human Services **Project Partners** Clackamas County Public Health

Virginia Garcia Memorial Health Center

Oregon Health Authority

• All Multnomah County SBHCs, Clackamas County SBHCs and Washington County SBHCs

**Project Milestones** 

• Convene diverse stakeholder group with representatives from SBHC medical sponsors, local public health, payors, CCOs, and state government committed to developing viable alternate payment methodology/ies (APMs) to support SBHC sustainability

## Virginia Garcia Memorial Health Center **Washington County**

• Forest Grove High School SBHC • Century High School SBHC

**Project Partners** • Tigard High School SBHC

• Patients aged 12-21 seen in the last year who have been administered an SBIRT screen: **Project Milestones** 

• Q2 (9/1/14 to 11/30/14): 5 • Q3 (12/1/14 to 2/28/15): 78

# Definitions

### **Oregon Health System Transformation** In 2011, the Oregon legislature passed legislation to transform the way services

are delivered through the Oregon Health Plan (Medicaid). These changes have been guided by the Triple Aim. **Oregon Triple Aim** 

1. Improve the lifelong health of all Oregonians 2. Increase the quality, reliability and availability of care for all Oregonians

3. Lower or contain the cost of care so it is affordable for everyone

**Coordinated Care Organizations** 

Also known as Accountable Care Organizations. A network of health care

providers who have agreed to work together in their local communities to deliver health care and coverage for people who receive health care under the Oregon Health Plan. There are 16 CCOs operating in communities around Oregon. **Patient-Centered Primary Care Homes** 

# Also known as Patient-Centered Medical Homes. A health care clinic that has

been recognized by the State for their commitment to patient-centered care and in compliance with state PCPCH standards. **School-Based Health Centers** 

SBHCs evaluate the needs of populations they serve with a particular focus on wellness, prevention, and chronic disease management. SBHCs provide quality person-centered care using a cost-effective care model that focuses on prevention.