

Oregon Public Health Division

>> School-Based Health Center  
Innovation Grant

2016  
Summary Report



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## >> Executive Summary

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

- Increase the number of school-based health centers (SBHCs) certified as patient centered primary care homes (PCPCH)
- Improve the coordination of care of patients served by Coordinated Care Organizations (CCOs) and SBHCs
- Improve the effectiveness of the delivery of health services through SBHCs to those who qualify for medical assistance

In 2014, the Oregon SBHC State Program Office awarded grants to explore innovative approaches to school-based care to 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. Grants were awarded to six organizations: two CCOs (InterCommunity Health Network-CCO and Jackson Care Connect); two Federally-Qualified Health Centers (FQHCs) (Virginia Garcia and La Pine CHC); and two local public health departments (Multnomah County and the Public Health Foundation of Columbia County). Grantees represented seven counties in north, south and central Oregon.

Grant projects ran from July 1, 2014 to June 30, 2015. Although grantee projects varied considerably according to local need and capacity, several common themes emerged by the end of the grant period. Some grant learnings were clearly quantifiable, focusing on measurable increases in SBHC outputs, such as increasing well-child visits and achieving State PCPCH recognition. Other grant projects produced more qualitative process learnings that could be applied to the work of SBHCs and the larger healthcare systems. These projects explored relationship/partnership development; coordinating care with non-SBHC providers; maximizing the role of SBHCs within the healthcare system; and exploring alternative payment methodologies. Grantees working on both targeted and systems-level projects applied diverse strategies to meet their project goals and distilled lessons learned from this process.

Overall, grantees reported that grant projects were very successful, both in terms of producing clear achievements for individual SBHCs and in terms of creating space for SBHCs and partner agencies to pilot innovative project concepts. During the course of the grant period:

- Four grantees achieved state PCPCH recognition.

- Four grantees improved their ability to provide well-child visits (WCVs) through SBHCs.
- Two grantees successfully piloted WCV incentive programs for both youth patients and providers.
- One CCO grantee changed its policy and began to allow SBHCs to be assigned as PCPs.
- One grantee developed agreements and workflows to better serve youth experiencing mental health crisis.
- Five grantees piloted new staffing models to better coordinate health and social service referrals for SBHC clients.
- Grantees that were part of a broader medical system improved their ability to identify SBHC-specific clients and encounters within their client database.
- Two grantees purchased new EHR software to better track patient data and improve information sharing among both SBHC and non-SBHC providers.
- Two CCO grantees worked with SBHCs and other local providers to identify PCP assignment for their clients
- One grantee convened a diverse group of stakeholders, including CCOs, SBHCs and local public health, to explore alternatives to traditional fee-for-service payment methodology.

Innovation Grantees reported several common challenges during the course of the grant period including: limited organizational capacity; difficulty developing shared priorities among local partners; system and policy barriers; and data complexities. These challenges were fairly consistent among both targeted and systems-focused projects.

Individual solutions to these problems were tailored to local contexts. There are general solutions and “lessons learned” however, specific solutions may not necessarily be workable in other communities with different partners, systems, or capacity.

In general, grantees reported several common lessons learned across their projects.

- Support from the regional CCO was critical for project success. CCOs served as a partner at the table, as a convener and as a gatekeeper for developing SBHC-friendly policies.
- Grantees relied on state agencies, such as the State PCPCH Office and SBHC State Program Office, to provide technical assistance and reduce barriers to achieving project goals.

- Grant dollars often supported increased staff capacity, which proved critical to supporting innovative initiatives and quality improvement work.
- Successful projects necessitated improving internal systems, such as workflows and internal communication systems. At the same time, improvements to Electronic Health Records (EHR) and data systems allowed communities to better share information among care providers and to improve their ability to track progress on quality metrics.
- Several communities took steps to maximize the role of SBHCs within the local medical system by improving effective care delivery at SBHCs and redirecting clients from other FQHC sites to SBHC clinics.

This School-Based Health Center Innovation Grant Summary Report is intended to be a resource for other communities working to utilize and support SBHCs within a transforming health care environment. The report presents an overview of grantee projects, strategies, challenges and lessons learned. Case study reports provide an in-depth look at individual grantee projects and illustrate how individual communities adapted to challenges within a local context. SPO hopes that others will apply the general strategies and lessons learned from Innovation Grant projects to move the needle on efficient and effective care delivered through SBHCs.

## >> Background

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Since 1986, School-Based Health Centers (SBHCs) in Oregon have been created and sustained through public-private partnerships and collaborative relationships that include the local school district, county health departments, public and private practitioners, parents, students and the Oregon Public Health Division (PHD). SBHCs represent a distinctive health care model for comprehensive physical, mental, preventive and in some cases, dental, health services provided to youth in a school setting, regardless of their ability to pay. While each Oregon SBHC is uniquely situated to meet the needs of the youth in their community, all state certified SBHCs have common attributes outlined in the State Standards for Certification. The Oregon SBHC model focuses on prevention activities such as well-child exams and health assessments that address key health promotion topics including; healthy weight and development, nutrition and physical activity, mental health and substance abuse, healthy sexuality development, safety and injury prevention, oral health and family support.

SBHCs are critical access points that support the health and academic achievement of Oregon youth. SBHCs enable students to get back to the classroom faster, and have been shown to keep youth out of more costly care settings, such as urgent care and the emergency room<sup>1</sup>. Youth access SBHCs for a variety of reasons, such as affordability, convenience, developmentally appropriate services, and confidentiality. However, in many cases SBHC providers are not the primary care provider for their patients. In order to provide the most integrated and high quality care, there is a focus on care coordination and ensuring SBHCs are part of the network of providers.

For more information about SBHCs in Oregon, including certification standards, visit the SBHC State Program Office website at [www.healthoregon.org/sbhc](http://www.healthoregon.org/sbhc)

In 2013, the Oregon Legislature passed House Bill 2445<sup>2</sup> which defined SBHCs in Oregon statute and began a discussion on how best to utilize and support SBHCs in a transforming health care environment. HB 2445 required the Oregon Health Authority to convene a work group to develop recommendations for the effective and coordinated use of SBHCs for children who qualify for medical assistance. The HB 2445 work group developed recommendations for:

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<sup>1</sup> Guo JJ, Jang R, Keller KN, McCracken AL, Pan W, Cluxton RJ. Impact of School-Based Health Centers on Children with Asthma. *The Journal of Adolescent Health*. Oct 2005;37(4):266-274

<sup>2</sup> <https://olis.leg.state.or.us/liz/2013R1/Downloads/MeasureDocument/HB2445/Enrolled>

1. Optimizing the effective and efficient use of school-based health centers by coordinated care organizations, including effective coordination of care and reimbursement;
2. Ensuring the coordination and disclosure of protected health information by school-based health centers in accordance with ORS 414.679 and
3. Developing financial incentives to:
  - Increase the number of SBHCs certified as patient centered primary care homes (PCPCH) without requiring SBHCs to be certified as patient centered primary care homes;
  - Improve the coordination of the care of patients served by CCOs and SBHCs; and
  - Improve the effectiveness of the delivery of health services through SBHCs to children who qualify for medical assistance.

A full list of the work group recommendations can be found in the HB2445 SBHC work group Summary Report, available at:

[http://public.health.oregon.gov/HealthyPeopleFamilies/Youth/HealthSchool/SchoolBasedHealthCenters/Documents/HB2445\\_WorkgroupReport.pdf](http://public.health.oregon.gov/HealthyPeopleFamilies/Youth/HealthSchool/SchoolBasedHealthCenters/Documents/HB2445_WorkgroupReport.pdf)

This report focuses on recommendation #3, the use of the incentive funds, referenced above. The incentive funds allowed CCOs, health systems and SBHCs to implement innovative projects that focus specifically on how best to utilize and support SBHCs.

Based on the work group recommendations, the SBHC State Program Office (SPO) released a request for proposals to support local innovation that addressed one or more of the three goals outlined by the legislation. The SBHC Innovation Grants supported larger projects that involved systems change and produced learnings that can be shared with the entire SBHC community. In addition, some funds supported more targeted activities such as achieving PCPCH recognition.

## >> Grantees

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The SBHC SPO awarded grants to 6 organizations: two CCOs (InterCommunity Health Network-CCO and Jackson Care Connect); two FQHCs (Virginia Garcia and La Pine CHC); and two local public health departments (Multnomah County and the Public Health Foundation of Columbia County). Grantees represented seven counties in north, south and central Oregon.

Table 1 summarizes grant recipients, partner agencies, and project focus areas.

**Table 1: 2014-2015 School-Based Health Center Innovation Grantees**

County	Recipient	Partners	Focus Areas
Benton	InterCommunity Health Network CCO	Benton County Health Services, Lincoln SBHC, Lincoln Elementary School, Corvallis School District	Improve coordination of care; Strengthen school-community-SBHC linkages; Increase well-child checks; Improve clinical referral systems; Increase client enrollment in medical home; Increase OHP enrollment.
Columbia	Public Health Foundation of Columbia County	Columbia Pacific CCO; Rainier SBHC	Achieve PCPCH recognition for Rainier SBHC; Establish hospital privileges with local hospital systems; Examine workflows, care coordination systems, screening and intervention strategies; Complete multiple Plan-Do-Study-Act (PDSA) cycles to streamline work, develop best practices.
Deschutes & Klamath	La Pine Community Health Center	La Pine SBHC, Gilchrist SBHC	Achieve PCPCH recognition at La Pine and Gilchrist SBHCs; Improve EHR infrastructure; Enhance patient care coordination; Increase well-child checks; Track the impact of the SBHC on missed classed time.
Jackson	Jackson Care Connect CCO	Community Health Center, La Clinica, Jackson County Mental Health, Crater SBHC, Eagle Point SBHC, Ashland SBHC, Scenic SBHC, Butte Falls SBHC, Prospect SBHC	Achieve PCPCH recognition at Prospect and Scenic SBHCs; Improve care coordination between SBHCs, CCOs, behavioral health providers, and primary care providers; Pilot universal SBIRT services and improved clinical workflows and reporting; Explore and enhance clinic capacity to provide adolescent well visit.
Multnomah	Multnomah County Health Department	Oregon School-Based Health Alliance, Health Share, FamilyCare, Washington County Health and Human Services, Clackamas County Public Health	Convene collaborative work group comprised of CCO and Tri-County SBHC representatives to address the unique needs of SBHC care coordination and effectiveness of the delivery of health services; Explore alternate payment methodology (APM) for SBHCs.
Washington	Virginia Garcia Memorial Foundation and Health Center	Forest Grove SBHC, Century SBHC, Tigard SBHC, Health Share, FamilyCare	Increase utilization of SBHC services; Develop and implement new workflows and referral networks to increase access to SBHCs; Increase well-child checks and adolescent well visits.

Table 2 provides basic utilization “snapshot” for grantee SBHCs during the project year. As indicated in the chart, SBHC grant participants reflect the diversity of the SBHC model in Oregon. SBHCs are located in urban, suburban and rural locations and therefore vary considerably in client utilization and populations served.

<b>Table 2: Grantees &amp; Basic Utilization Data (July 1 2014 – June 30 2015)</b>						
County	SBHC	Location	# Visits	# Clients		
				Total	Aged 5-11	Aged 12-21
Benton	Lincoln ES	Urban	5,893	1,770	241	263
Columbia	Rainier Jr/Sr HS	Rural	635	254	37	145
Deschutes	La Pine K-12	Rural	1,646	927	57	223
Jackson	Ashland HS	Urban	2,514	584	3	564
Jackson	Butte Falls Charter	Rural	301	96	33	67
Jackson	Crater HS	Suburban	2,293	320	0	320
Jackson	Eagle Point HS	Suburban	2,268	460	7	443
Jackson	Prospect Charter	Rural	473	182	45	67
Jackson	Scenic MS	Suburban	1,129	195	28	172
Klamath	Gilchrist K-12	Rural	815	381	45	84
Multnomah	Centennial HS	Urban	1,814	680	124	558
Multnomah	Cesar Chavez K-8	Urban	836	269	168	102
Multnomah	Cleveland HS	Urban	1,752	600	36	565
Multnomah	David Douglas HS	Urban	2,669	963	200	765
Multnomah	Franklin HS	Urban	1,776	544	43	507
Multnomah	George MS	Urban	913	293	125	179
Multnomah	Grant HS	Urban	1,173	551	27	523
Multnomah	Harrison Park MS	Urban	472	195	119	78
Multnomah	Jefferson HS	Urban	1,105	340	26	314
Multnomah	Lane MS	Urban	358	169	82	87
Multnomah	Madison HS	Urban	2,065	668	55	613
Multnomah	Parkrose HS	Urban	2,532	1,021	134	885
Multnomah	Roosevelt HS	Urban	1,682	498	24	474
Washington	Century HS	Suburban	1,177	506	161	320
Washington	Forest Grove HS	Rural	1,161	514	150	323
Washington	Tigard HS	Suburban	1,594	690	205	428

## >> Project Goals & Strategies

Although grantee projects varied considerably according to local need and capacity, several common themes emerged by the end of the grant period. Some grant learnings were clearly quantifiable, focusing on measurable increases in SBHC outputs, such as service provision. Other grant projects produced more qualitative producing process learnings that could be applied to the work of SBHCs and the larger healthcare systems.

## Increasing well-child visits

Four grantees chose to focus on well-child visits (WCVs), as a way of delivering efficient and effective care through SBHCs. The well-child visit, a recommended best practice of the American Academy of Pediatrics, is a required key performance measure for Oregon SBHCs by the SBHC State Program Office. SBHCs are well-positioned to support CCOs in achieving the CCO Incentive Measure related to the WCV (adolescent well visit). Some SBHCs reported challenges providing WCVs due to primary care provider (PCP) assignment, care coordination, information sharing, and/or parent/guardian familiarity with new WCV recommendations. As a priority for both SBHCs and CCOs, grantees applied different strategies to address these barriers and increase WCV provision through the SBHC.

### Strategies

- Many grantees adjusted **data tracking systems** to specifically assess their SBHCs' progress in meeting preventive health service quality metrics, such as the WCV. Grantees that were part of a broader medical system improved their ability to identify SBHC-specific clients and encounters within their client database. Updates to data systems in some cases allowed for better targeted outreach to patients and families. In other cases, SBHCs acknowledged that there is more work to be done to correctly and efficiently track patients and metrics.
- Grantees mobilized **partner agencies and/or client navigators** to engage underserved communities in the healthcare system and promote the annual WCV. Many conducted targeted outreach to clients who were overdue for WCVs. One grantee reported, “[The navigators] found that many parents didn’t realize that their child was due for another WCV – and they encouraged the parents to make an appointment with the child’s PCP.”
- In an effort to increase the number of clients receiving WCVs, SBHCs partnered with CCOs to offer **patient and/or provider incentives** of varying amounts. (See Case Study below)
- In order to accommodate an increase in demand for services at both SBHCs and main FQHC clinics, several grantees **expanded primary care hours** to evenings and weekends and/or redirected pediatric clients from main FQHC clinic sites to underutilized SBHCs.
- SBHCs **modified clinical workflows and policies** to increase the number of WCVs provided through the SBHC. One grantee conducted a gap analysis to assess the SBHC’s provision of age-appropriate preventive services; subsequently the SBHC changed its procedure to encourage clients to receive WCVs in place of sports physicals.

### Case Study: La Pine Community Health Center

La Pine CHC operates two SBHCs in Central Oregon – La Pine SBHC in Deschutes County and Gilchrist SBHC in Klamath County. La Pine recently took on medical sponsorship for these two SBHCs, assuming this role in July 2014. In partnership with Central Oregon Health Council, La Pine CHC provided an incentive for adolescents aged 15-21 to receive a WCV at one of their SBHCs. Participants had the option to choose a \$50 Amazon Gift Card, a \$50 gas card, or certificate for a skid car training (\$90 value).

The incentive period lasted from 3/4/2015 to 6/12/2015. The program was advertised in local papers, promoted at school assemblies and health classes, and spread through word of mouth. SBHC staff report WCVs increased during the incentive period.

Some challenges were reported with the roll-out of this pilot project. La Pine CHC had difficulty reaching out to eligible clients using the demographic information on file with the CCO. Furthermore, a few clients had already received WCVs from another provider earlier in the year and were subsequently billed for the duplicate visit.

Overall La Pine CHC staff felt the incentive program was successful in meeting its goal to increase WCVs among SBHC clients. According to one SBHC provider:

*“Most of the kids do not regularly receive primary care and this was a great way to familiarize them with the medical system and the benefits it provides. Most teens were very open with the big issues they were facing, including meth and other drug abuse, depression, suicidal thoughts, self-harm, grieving a friend or close family member who committed suicide, and homelessness. Most of these instances, the kids were open to referrals to [Deschutes County Behavioral Health] and/or other agencies, but even when they weren't, I do strongly believe that this initial encounter started a positive connection and rapport between the child/young adult and the medical community.”*

### Case Study: Jackson Care Connect CCO

Jackson Care Connect (JCC) CCO partnered with two SBHC medical sponsors, La Clinica and Rogue Community Health (RCH), to pilot a WCV incentive program. La Clinica operates seven SBHCs and RCH operates four SBHCs in Jackson County. In partnership with JCC, La Clinica and RCH provided an incentive to adolescents to receive a WCV at their primary care clinics, including SBHCs. Participants were eligible to receive a \$10 iTunes gift card.

The incentive period lasted from 9/1/2014 to 12/31/2014. JCC generated a list of all members eligible for a WCV, which was then shared with La Clinica and RCH. Both entities worked to reach out to eligible patients through phone calls and direct mail.

JCC and its SBHC partners did not find this strategy alone to be effective. The grantees cited several barriers to success, including:

- Provider capacity to meet demand for services, even with expanded primary care hours;
- Parent/provider lack of familiarity with the relatively new recommendation to provide WCVs annually;
- Incorrect demographic information for JCC members, which hampered SBHC outreach efforts.
- Parents/clients often did not return phone calls, even if contact information was correct; and
- For children who could not self-consent to health services, working parents had difficulties finding time to bring them in for WCVs

Between 11/1/2014 and 12/31/2014, JCC partnered with La Clinica to offer an additional incentive (\$100) for providers to complete WCVs among eligible clients. Participating clinics found this additional incentive to be effective in helping JCC exceed its 2014 improvement target (26.1%) of providing WCVs to eligible JCC members. During the 2014 measurement year, 27.7% of adolescent and young adult (12-21) JCC members received at least one WCV. Overall, during the 2014-2015 school year, La Clinica provided a total of 196 WCVs. JCC plans to expand this incentive program to RCH in the future.

## Achieving State PCPCH Recognition

Three grantees representing five SBHCs used grant funds to help their SBHCs employ innovative strategies to meet the PCPCH Standards for Recognition. To achieve State PCPCH recognition, SBHCs must navigate a unique set of challenges such as capacity and relationships with local providers.

### Strategies

- Achieving and maintaining PCPCH recognition requires **dedicated staff time**. Some grantees identified existing staff to oversee clinical compliance with PCPCH standards and undertook intensive **internal assessments** to identify gaps and assess readiness to apply for PCPCH recognition. One grantee used grant funds to hire a dedicated staff position to lead its PCPCH recognition efforts, which proved crucial to its success (see “Case Study,” below).
- SBHCs that are not connected to larger medical systems often struggle to provide continuous access to clinical advice by telephone 24 hours, 7 days a week, which is a “Must Pass” PCPCH standard. After first exploring employing existing SBHC staff to staff the line on an “on call” basis, one grantee ultimately signed a **contract with a nurse triage line**, making after hours nurse advice available to clients at 3 SBHC clinics in rural communities.
- Navigating the PCPCH standards and providing the necessary data to ensure standards are met takes staff time and expertise. Grantees undergoing PCPCH recognition for the first time relied heavily on the **state PCPCH Program** to support them through their readiness review. The state PCPCH Program helped grantees feel confident in their application by explaining the intent of the standards. In addition, the PCPCH Program accepted 6 months of encounter data from multiple grantees when they were unable to provide the required twelve months of data; two of the grantee clinics had only recently opened and two other grantee clinics had recently obtained a new medical sponsor, making twelve months of data impossible to provide.
- Grantees relied heavily on their **CCO partnership** for support. One CCO convenes a monthly Learning Collaborative to assist clinical partners in developing the system redesign required to achieve and sustain the clinical culture change required to adapt operations to the PCPCH model, as well as performance improvement on OHA metrics. Another CCO met frequently with the SBHC Coordinator to provide guidance on PCPCH standards and provide feedback on revised clinical policies and workflows.

Through the support of Innovation Grant dollars, four SBHCs were able to achieve PCPCH recognition during the grant period. One grantee intends to apply the lessons learned from this process to apply for recognition at other SBHCs within its system.

### Case Study: The Public Health Foundation of Columbia County

The Public Health Foundation of Columbia County (TPHFCC) operates SBHCs in three rural communities in Columbia County. In partnership with Columbia Pacific CCO, TPHFCC used Innovation Grant funding to achieve PCPCH recognition at Rainier SBHC.

TPHFCC hired a full-time SBHC Coordinator who was crucial to achieving PCPCH status for Rainier SBHC. The coordinator worked with a CCO representative to navigate PCPCH requirements and work with SBHC clinic staff to develop feasible strategies for the clinic to meet these requirements.

TPHFCC encountered some challenges meeting PCPCH Standards related to developing a written agreement with a local hospital provider and providing continuous access to clinical advice by telephone. In both cases, TPHFCC relied on its relationship with Columbia Pacific CCO, as well as the expertise of other local SBHC systems and the State PCPCH office, to bring local partners to the table to create agreements with Rainier SBHC.

In addition to achieving Tier 3 PCPCH recognition, TPHFCC reported several significant impacts from the Innovation Grant investment. Rainier SBHC is now eligible for quality pool funding through CCO incentive metrics and the CCO now assigns patients to the SBHC. In revising its workflows and policies/procedures, Rainier SBHC increased clinical efficiency and thereby its ability to see more patients. The Rainier community now views the SBHC as a medical home. The SBHC should be able to independently leverage additional dollars and continue to move towards financial sustainability.

The SBHC Coordinator position proved so successful that TPHFCC intends to leverage additional dollars to continue employment on a part-time basis to support the clinic through this transition. The Coordinator will also work with another SBHC within TPHFCC's system to move it towards PCPCH recognition.

## Relationship/partnership development

Several grantees worked to build relationships with local partners, including CCOs and local providers, and to communicate the value of SBHC services.

This included developing recognition among potential partners that SBHCs offer services beyond primary care, such as onsite mental health and oral health services.

### Strategies:

- CCOs were the lead agency on two Innovation Grant projects. In these communities, the CCOs convened multiple local agencies to **address sustainability and care coordination challenges** for SBHCs and their partners. One CCO (see “Case Study,” below) convened schools, the local FQHC, social service agencies and SBHC providers to take health care delivery beyond the clinic walls and apply it in a school/neighborhood setting. These agencies tackled challenges related to data delivery and reporting systems; clarified the different “language” each agency speaks; and created a common understanding of the value each agency brings to the care of their mutual clients.
- JCC, a CCO lead agency, convened two local FQHC medical sponsors and County Mental Health partners to **align systems to care for and better serve youth experiencing mental health crisis**. The SBHC partner cited the Innovation Grant funding as providing the necessary incentive for the CCO to bring local partners to the table. Through the grant, local stakeholders were able to “truly meet, have a voice with the CCO, and the CCO was able to listen and make changes.” A SBHC partner reported:  
  
*“One of the greatest benefits to this work has been the collaborative relationship established and the communication channels developed between JCC, Jackson County Mental Health (JCMH) and our two local FQHCs. We have successfully identified issues and moved together as a team to achieve clearly defined goals.”*
- Three non-CCO grantees were able to effectively work with their local CCO to align SBHC model with the goals of health system transformation. One grantee worked with two CCOs in the Portland metro area, as well as local public health agencies and multiple FQHC medical sponsors, to **explore alternatives to traditional fee-for-service (FFS) payment models**. Of the support the grantee received from the regional CCOs, the grantee reported:

*“The partnerships formed from participation of both Health Share of Oregon and FamilyCare were one of the greatest successes of this work. Both CCOs have showed ongoing commitment throughout the entire process and have both committed to continuing on with this work as it moves forward.”*

### Case Study: InterCommunity Health Network CCO (IHN-CCO)

IHN-CCO piloted a new staffing model to better serve clients with significant barriers to accessing health services, in partnership with Benton Community Health Services (BCHS), Corvallis School District, Lincoln Elementary School and its SBHC. BCHS operates SBHCs in two communities in Benton County.

IHN-CCO identified low income and rural Hispanic/Latinos as priority populations for outreach and engagement in the health system. IHN-CCO recognized SBHCs as an opportune venue to pilot innovative strategies to address cultural and linguistic needs of these communities. One strategy was to hire “Health Navigators” to assist clients with Oregon Health Plan (OHP) enrollment, conduct culturally appropriate outreach and better track new patient assignment and health service follow-up. Ultimately, IHN-CCO and its partners sought to improve collaboration among schools and community providers and link services across sectors.

IHN-CCO and BCHS collaborated to implement health system transformation efforts in Benton County. Innovation Grant funding helped connect these agencies with a community-level coalition of partners working to improve health outcomes for low-income, Latino and rural families in the South Corvallis region. This Healthy Kids/Healthy Communities coalition includes representatives from the school district, parent-teacher organization, Head Start, local housing services and cultural organizations. Relationships among these partners were codified in written agreements among IHN-CCO and BCHS and BCHS and Corvallis School District.

### Case Study: InterCommunity Health Network CCO (IHN-CCO), continued

As a result of the Innovation Grant project, the grantee reports:

*“I believe that our relationship is stronger as a result of this project. In fact, as a direct result of this project, we submitted a pilot proposal to IHN-CCO’s Delivery of Transformation Team to extend this project an additional year and to add on one more school. IHN-CCO accepted this proposal and we have already begun the pilot project.”*

## Coordinating care with non-SBHC providers

Five grantees selected care coordination as a focus of their Innovation Grant. CCOs led efforts to build trusting and collaborative networks among SBHCs and community providers specifically focused on referral processes and care coordination.

### Strategies

- Grantees and partner agencies had to be flexible in developing systems to coordinate care, **adapting project strategies to local needs and constraints**. Effective systems were created through iterative processes, involving regular partner meetings, data collection and evaluation.
- Information sharing between SBHC providers and other local providers presents many challenges, often times resulting in delays for clinical service and gaps in provider information. Several grantees used Innovation Grant dollars to **purchase data sharing software**. One grantee purchased a behavioral health EHR software and created staffing plans to better coordinate care for young people with mental health needs (see “Case Study,” below).
- Five grantees **piloted new staffing models** with the goal of better coordinating health and social service referrals for SBHC clients. The School/Neighborhood Navigators, hired by IHN-CCO to help clients and their families negotiate referrals to local health and social service providers and ensure these referrals had been completed. The work of these Navigators was guided by a MOU signed by the local FQHC and school district. Navigators were able to charted “touches” with clients assigned to the local FQHC in OCHIN Epic, so more complete information was accessible to the client’s entire care team.

### Case Study: Jackson Care Connect CCO

Jackson Care Connect (JCC) CCO partnered with two SBHC medical sponsors, La Clinica and Rogue Community Health (RCH), to improve the local mental health referral system. La Clinica operates seven SBHCs and RCH operates four SBHCs in Jackson County.

JCC proposed focusing on coordinating mental health services for Medicaid enrolled children, particularly timely access to services, referral tracking and information sharing. Both La Clinica and RCH purchased and implemented the Behavioral Health Navigator Epic software tool to improve information sharing among internal physical and mental health providers, as well as local primary care, specialty care and hospital providers.

RCH also worked with Jackson County Mental Health (JCMH) to receive certification to directly provide mental health services to OHP students at their SBHCs. Prior to the grant period, La Clinica received certification through JCMH and worked with RCH during the grant period to meet the requirements. Plans are in place for RCH to bring contracted behavioral health services to its 4 SBHCs. These contracts will enable RCH to bill for these services, ultimately increasing the sustainability of mental health service provision at RCH SBHCs.

JCC brought JCMH to the table to discuss developing appropriate mental health referral processes with La Clinica and RCH SBHCs. A pilot process was developed, but was found to be ineffective. JCC cited a number of reasons for this, including:

- Clients with private insurance accessed private counselors instead of JCMH.
- Many clients were already seeing JCMH providers or were having their needs met by mental health providers already onsite at their school's SBHC.
- Clients in crisis may see JCMH directly without an assessment or referral from the SBHC.
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In the wake of two completed youth suicides, JCC and its partners pivoted their attention to youth in crisis, seeking to improve coordination of services for high risk/suicidal students among Jackson County SBHCs, JCMH and hospitals. JCMH committed to hiring additional staff specifically to coordinate care for high

### Case Study: Jackson Care Connect CCO, continued

risk students, to identify high risk youth presenting at the hospital and assist with post-hospitalization coordination of services, and to provide suicide prevention education and improve the community response to suicide crises.

JCC and these partners met frequently to identify systemic strengths and areas in need of improvement. They have agreed to continue to hold quarterly meetings to improve these systems and continue to provide critical response to mental health service needs, particularly related to suicide response and prevention.

## Maximizing the role of SBHCs within the healthcare system

To optimize the effective and efficient use of SBHCs by CCOs, four grantees collaborated on projects related to increasing SBHC utilization and primary care provider (PCP) assignment. These projects reviewed CCO policies on PCP assignment, looked at coordinating care with PCPs when the SBHC is not the assigned provider; and attempted to reduce duplication of services between SBHCs and non-SBHC PCPs.

### Strategies

- With increased access to insurance, many local health systems are struggling to meet demand for health services. Four Innovation Grant recipients saw this as an opportunity to increase utilization at SBHCs by **directing clients from overloaded primary care clinic sites to vacant appointment slots** at the SBHCs within the same system. (see “Case Study,” below)
- Two CCOs worked with SBHCs and other local providers to **identify PCP assignment** for their clients. These partners developed policies and information systems to help providers more easily obtain this information and make changes, if necessary.
- Four grantees piloted their own **internal policies and processes** to identify assigned PCP and track patient assignment. Some SBHCs ask clients to identify their PCP on clinic intake forms. Others are running regular reports in their EHR to identify unassigned clients. SBHC clinic staff then obtain this information or, if the client is unassigned, work with the CCO to assign the client to a PCP.

- Some CCOs do not allow SBHC providers to be assigned as PCPs. During the grant period, one CCO, after extensive discussion with the FQHC SBHC medical sponsors in its region, identified this issue and elected to change its policy to **allow SBHC providers to be assigned as PCPs**. This has proved helpful in cases in which youth chose to access services at the SBHC instead of at their assigned PCP.

### *Case Study: Virginia Garcia Memorial Health Center*

Virginia Garcia Memorial Health Center (VGMHC) operates SBHCs in five communities in Washington County and one community in Yamhill County. In addition, VGMHC operates five FQHC clinics in Washington and Yamhill Counties. VGMHC used Innovation Grant funding to explore innovative staffing models and increase SBHC utilization.

VGMHC planned to focus on equipping its call center staff with information about its SBHCs in order to direct clients seeking services at its main FQHC clinics to available slots at local school-based clinics. Midway through the grant, VGMHC decided to expand the scope of this work and instead form a broader “membership department.”

The membership department consists of several VGMHC staff focused on improving access for VGMHC patients. These staff reach out to newly-assigned patients to establish care and help them navigate the VGMHC system. They also support existing patients and conduct outreach for wellness and preventive services (such as WCVs) and chronic illness visits. Finally, they reach out to patients who have lost, or are in danger of losing, their Medicaid coverage to ensure they have consistent health coverage.

In addition, VGMHC changed its staffing model at individual SBHCs to increase direct care and administrative capacity. Two Office Health Assistants (OHAs) were hired for each SBHC to work with the Membership Services Team and provide administrative support. VGMHC’s OHAs are essentially Medical Assistants (MAs) with additional administrative functions. This change has shifted some administrative burden from primary care providers, while simultaneously providing supplemental clinical support.

### Case Study: Virginia Garcia Memorial Health Center, continued

VGMHC reported enthusiastic support from SBHC providers and staff for this change:

*“The FNP at Forest Grove SBHC has reported that her “life has changed” as a result of the additional support. She is less distracted by administrative duties and can focus more on meeting clinical measures. Not only can she see more patients, but patient tracking and ability to make and follow up on referrals has improved.”*

VGHMHC believes these changes are already paying off. For example, the rate of WCVs for adolescents seen in their three participating SBHCs increased 5% between Q3 of 2014 and Q3 of 2015 (March 1 – May 31), from 53% to 58%.

## Alternate Payment Methodologies

SBHCs routinely provide services that are not reimbursable under traditional payment models, such as fee-for-service. One agency used a portion of its Innovation Grant funding to support their involvement in the state Medicaid APM pilot project (coordinated through the Oregon Primary Care Association OPCA).

Through this project, sites formally receiving federally defined Prospective Payment System (PPS) rates were transitioned to a capitated equivalent for their primary care services with the expectation that this would reduce typical fee-for-service “churn” and allow providers to focus on delivering efficient and effective care for their assigned population. This work is ongoing.

### Strategy

- One grantee employed Innovation Grant funds **exclusively to explore APMs for SBHCs**. This grantee convened stakeholders from the Portland-area SBHCs, including local public health departments, FQHC medical sponsors, State government and Medicaid payors to define the unique value of SBHCs and explore innovative ways to pay for care delivered through SBHCs. These agencies have secured additional funding to continue their APM work for an additional two years. (see “Case Study,” below)

### Case Study: Multnomah County Health Department

Multnomah County Health Department (MCHD) operates 13 SBHCs in the City of Portland. MCHD used Innovation Grant funding to explore alternate payment methodologies (APMs) for Oregon SBHCs.

MCHD convened stakeholders from the Portland metro region to participate in an Alternate Payment Innovation Project (APIP) work group. Stakeholders included regional CCOs (Health Share and FamilyCare), local public health (Washington, Multnomah and Clackamas counties), State government (Oregon Health Authority Public Health Division and Medical Assistance Program Division), and FQHC medical sponsors (Virginia Garcia Memorial Health Center and Outside In). Work group members learned about and discussed various APM models and how they might apply to the SBHC setting specifically. They also brought the discussion back to their own systems to engage internal stakeholders to focus specifically on SBHC financial and encounter data.

To support the distinction between SBHCs and larger medical sponsors and systems, the work group met monthly and developed a visual model of the billable and non-billable services that SBHCs provide, including services that are typically not delivered in a traditional clinic setting (e.g., increased engagement with parents and school community in support of youth, confidential services in a trusted setting, integration of physical, behavioral and sometimes oral health services in a single setting). Multnomah County also subcontracted with OHSU's Center for Evidence Based Policy to analyze the SBHC-specific financial impact of participating in the state Medicaid APM. The analysis revealed that while the changes in reimbursement method had had no impact on the SBHCs as of yet, there was potential for SBHCs to improve their reimbursement by the switch to a per-member-per-month (PMPM) model.

After spending several meetings developing the visual model, increasing knowledge on available APMs and educating each other (CCOs, SBHCs, county health departments) about their respective roles in reimbursement and care delivery transformation, the group came to consensus that there is a critical lack of understanding of the demographic and utilization profile of Medicaid clients visiting SBHCs. Health Share volunteered to work with the group on looking at utilization, demographics and performance on CCO metrics of youth visiting the Multnomah County SBHCs compared to non-SBHC youth. The establishment of this partnership and willingness to share data is a significant step for the SBHC-

### Case Study: Multnomah County Health Department, continued

CCO relationship and is APIP work group's focus for the 2015-16 year. Once this data is extracted and analyzed, the group can move forward with developing recommendations on whether SBHCs and payors alike may benefit from an alternative payment model, or whether the current system is actually maximizing quality of care and value for SBHC clients in the Medicaid system.

## >> Challenges

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Innovation Grantees reported several challenges during the course of the grant period. Many are unique to the SBHC model as a school-based safety net access point; however others may be common to primary care providers in general.

### Capacity

Organizational capacity was a challenge for many Innovation Grantees. Three grantees experienced staff turnover, either internally or with partner agencies, which delayed progress on grant activities. Others created new staff positions at the SBHC, which sometimes necessitated extensive training and adjustments for existing staff. Grantees, particularly those seeking to increase WCVs through client outreach, also reported limited provider capacity to see increasing numbers of primary care clients.

### Shared priorities

Grantees were challenged to develop trust and/or shared priorities with partners. Several grantees had difficulty bringing local hospitals, FQHCs, or schools to the table as their projects progressed. Grantees reported barriers related to partners not prioritizing grant activities; lack of understanding of the SBHC model; creating a common "language" among all partners; and establishing systems for sharing information on a consistent basis. Some grantees were managing multiple grants with related but different priorities and struggled at times to engage necessary partners on the goals of this grant in particular.

### Systems

Several challenges were more systemic. Some CCOs initially had policies prohibiting SBHC providers from being assigned as PCPs. Many grantees also reported challenges identifying a client's assigned PCP, particularly because youth clients did

not know this information and it was often difficult to obtain otherwise. Information sharing in general, both internally (SBHC and main FQHC medical sponsor site) and externally (shared providers, assigned PCP), was a persistent challenge for grantees.

## Data

SBHC partners and health systems often use different EHR and data tracking systems, which complicated data sharing for many grantees. Grantees were often unable to track the information they needed (e.g., completed referrals) across these different systems. Inconsistent clinical service coding (e.g., WCV and Screening, Brief Intervention and Referral to Treatment (SBIRT)) further complicated information sharing, both among local partners and with the SBHC State Program Office. Many grantees had incorrect client demographic information on file, which hampered their WCV and preventive care outreach efforts.

One broader challenge is that, although many grantees experienced similar difficulties in the implementation of their Innovation Grant projects, their individual solutions to these problems were tailored to their local contexts. Therefore, specific solutions may not necessarily be workable in other communities with different partners, systems, or capacity.

## >> Lessons Learned

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Although local variation complicates identifying definitive “solutions” to SBHC-specific challenges, several lessons learned can be summarized from Innovation Grantee projects. For the purposes of this report, lessons are summarized under the three goals of the Innovation Grants, as outlined in HB 2445.

### Increase the number of SBHCs certified as PCPCH

- CCO Support. Grantees seeking to achieve PCPCH recognition cited support from their regional CCO as critical for their projects’ successes. CCOs supported grantees in formal ways, such as convening a local PCPCH Learning Collaborative, and in less formal ways, such as bringing local health systems to the table to meet with SBHC representatives. CCOs provided technical assistance for grantees working to adapt their model to meet PCPCH “must pass” measures.
- PCPCH Office Support. Open communication and relationship development with state partners reduced barriers to PCPCH recognition. The Oregon

PCPCH program worked with grantees and agreed to accept 6 months of encounter data as part of the PCPCH application instead of the required 12 months. The PCPCH program also provided technical assistance to grantees new to the PCPCH application process.

- Sufficient Staff Capacity. Innovation Grant dollars allowed some grantees to hire additional staff to support the PCPCH application process. Grantees reported that sufficient staff capacity was critical for assessing organizational readiness, employing strategies to meet PCPCH must pass measures, and applying for PCPCH recognition. SBHCs may have to partner or contract with other agencies and organizations to meet PCPCH standards.
- Clear Internal Communication. Consistent communication with clinic staff was important, particularly for clinics applying for PCPCH recognition for the first time. This was achieved by conducting internal assessments with clinic staff, developing clear policies and workflows, obtaining staff feedback on proposed changes, and providing thorough training for staff. An open dialogue helped ease the strain of culture change accompanying a shift to a PCPCH model.

## Improve coordination of care

- CCO Support. CCO support was also crucial to grantees working to improve coordination of care. CCOs acted to convene multiple local agencies to facilitate collaboration, often formalizing these relationships in written agreements. These CCO-led collaborations strategized how best to integrate physical and mental health services and better serve targeted high-risk populations. Regular meetings with CCOs and other local agencies provided space for partners to debrief current systems of care and collectively determine a path forward.
- PCP assignment processes. Understanding how PCP assignment occurs is essential to improving care coordination. SBHCs should work with their CCOs to understand their PCP assignment process, policies on services that can be performed by non-PCPs, and to ensure that they have accurate PCP listings of their patients.
- Identifying priority populations. Systems change may come in incremental steps. Focusing care coordination efforts on particular priority populations

(such as high risk youth, uninsured) may be an effective approach to initiate interagency agreements.

- Sufficient Staff Capacity. SBHCs working to improve coordination of care also benefitted from having dedicated staff to support these efforts. Staff provided additional administrative capacity (e.g., drafting policies and workflows) and directly facilitated client care coordination (e.g., Client Navigators).
- Effective Workflows. Creating or improving existing policies and workflows for care coordination was important. Two grantees who operate both SBHCs and separate FQHC clinic sites worked to align the policies and procedures at both clinics in order to standardize care coordination operations across the organization. Others implemented workflows to better share information with non-SBHC providers.
- Modernized EHR/Data Systems. Some EHR and information system issues were addressed during the grant period. Five grantees signed agreements to share data across organizations or purchased new EHR software to facilitate data sharing. Continuous evaluation and refinement of new systems and data sharing agreements further helped refine these systems.

## Improve effectiveness of delivery of health services

- CCO Commitment to SBHC-Friendly Policies CCOs played a critical role in improving the effectiveness of health service delivery through SBHCs. CCO-led policy changes have the potential to greatly influence the SBHC's role within the broader healthcare system. For example, one CCO grantee changed its policy to allow SBHC providers to be assigned as PCPs during the grant period. CCOs also created systems to better help providers identify who a client's assigned PCP is and, if the client requests it, to make changes to client PCP assignment.
- Identifying SBHC claims. In order to truly understand SBHC utilization and the impact of any initiatives, data systems must allow providers and CCOs to look at SBHC-specific claims and encounters.
- Modernized EHR/Data Systems. Improved EHR and information systems greatly enhance the effectiveness of SBHC service delivery. Three grantees worked with data systems to better define the services provided at SBHCs, including client "touches" unique to SBHCs. Others standardized how clinical services are tracked and coded (e.g., WCV, SBIRT). These improvements in EHR and data infrastructure allowed medical sponsors, CCOs and local

partners to better track and understand the value of services provided at local school-based clinics.

- Implement Clinical Improvements. Grant funding enhanced SBHC capacity to implement clinical improvements and increase clinic efficiency. Several grantees conducted internal assessments, which led to improved workflows and the implementation of standardized screening tools (e.g., CRAFFT).
- Robust Financial Incentives. Several grantees participated in CCO-led pilot programs to incentivize WCVs. One grantee reported that somewhat large (\$50 value) incentives were effective in incentivizing youth clients to receive WCVs. While another grantee reported less success with client incentives, they found more success with provider incentives (\$100) to offer WCVs.
- Maximizing Role of SBHC within Medical Systems. Grantees took several steps to maximize the role of the SBHC within the local health system, thereby improving the effectiveness of health service delivery both at the SBHC and other local clinics. Several grantees encouraged clients to seek services at SBHCs rather than main FQHC clinic sites that were over capacity. Others offered expanded hours at SBHCs to accommodate increased demand for primary care services. One grantee identified clients who utilized SBHCs for acute care and, if unassigned, provide education about the role of a PCP and support the client to choose a PCP. For SBHCs that are part of a larger health care system, the system should ensure that membership and appointment-making staff are aware of the SBHC and the services it provides in order to maximize SBHC use.
- Exploring alternative payment methodologies. Assessing the current and future payment methodologies for SBHCs is slow-moving and methodical work. To do this work well, it is important to have significant buy-in from multiple partners, including payors, providers, medical sponsors, billing/financial experts and state Medicaid staff. Partners must set some common definitions and terms for the discussion, commonly define the scope of both billable and non-billable services that SBHCs provide, and concisely communicate this to all partners at the table and their parent organizations.

## >> Conclusions/Next Steps

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Innovation Grant funding provided an opportunity for local communities to explore different approaches to advance Oregon health system transformation efforts through

school-based health centers. As grantees continue to build upon these initial efforts, the SBHC State Program Office will share lessons learned with SBHCs and CCOs through training and technical assistance opportunities.

In partnership with the Oregon School-Based Health Alliance, SPO will support regional facilitated conversations with CCOs, local public health, SBHCs, community providers and education partners during the 2015-2017 biennium. These conversations will explore community level challenges identified by lead agencies. Some conversations will convene Innovation Grant recipients to continue to build upon their initial pilot project successes. Other gatherings will seek to apply Innovation Grantee lessons learned in new communities.

SPO has developed several publications and documents to enable SBHCs to better share information about the SBHC model with local stakeholders, including CCOs, local providers and education partners. The publications include a general fact sheet about the Oregon SBHC model, as well as annual utilization data reports for individual SBHCs. Having CCOs and local stakeholders as equal partners at the table proved critical for Innovation Grant projects; these publications provide a way to begin to develop a relationship with these agencies.

SPO will share lessons from Innovation Grant projects with communities exploring the SBHC model for the first time. Individuals and organizations planning to open a SBHC in a new community have the opportunity to apply grantee strategies as they build their SBHC model from the ground up. These general strategies, adapted to a local context, will ensure that new SBHCs will open on strong footing.

Health system transformation has created both opportunities and challenges for the SBHC model. By providing high quality patient-centered care in an accessible location, SBHCs are a crucial component of the overall health care delivery system. SBHCs serve vulnerable populations and are at times the only effective health care access point for the youth they serve. In a changing health care environment, innovation solutions are required to continue to maximize the role of SBHCs within the broader health system and increase the effectiveness and efficiency of care delivered through SBHCs. The SBHC State Program Office can now apply lessons learned from Innovation Grant projects to provide partners with opportunities to build capacity and improve practice in order to better support the needs of Oregon youth.



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