



Assessing the Need for School-Based Health Center Services in Colorado, 2015



APRIL 10, 2015

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Special thanks:

The Colorado Health Institute would like to thank Deborah Costin, executive director, Colorado Association for School-Based Health Care; Esperanza Ybarra, branch chief, health services and connections, Colorado Department of Public Health and Environment; and the School-Based Health Center Investment and Sustainability Advisory Committee for their substantive contributions to the analysis.

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Assessing the Need for School-Based Health Center Services in Colorado, 2015

A Report Prepared by the Colorado
Health Institute for the Colorado
Association for School-Based Health
Care and the Colorado Department of
Public Health and Environment

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Background

School-based health centers (SBHCs) represent an innovative model of care with the potential to improve access to health care for many of Colorado's most vulnerable children. The health centers serve students with limited access to care, often because they are low-income, uninsured or live in isolated areas.

Colorado lawmakers, the federal government and the state's philanthropic health foundations have recognized the value of SBHCs. With their support, SBHCs have expanded and multiplied in recent years. An infusion of funds from the Colorado legislature — nearly \$5.3 million beginning in fiscal year (FY) 2013-14 — positions stakeholders to examine potential growth of SBHCs in the state.¹

The Colorado Association for School-Based Health Care (CASBHC) and the Colorado Department of Public Health and Environment (CDPHE) partnered with the Colorado Health Institute to identify Colorado schools and school districts that could most benefit from the addition of a SBHC.

This report summarizes the findings from the needs assessment and outlines the criteria that were used to determine need.

Research Questions

The needs assessment addresses two key questions:

- What data are most useful in estimating the need for SBHCs?

- Based on an analysis of these data, which urban schools and rural school districts in Colorado have the greatest need for SBHCs?

What Did the Analysis Find?

The findings identify schools and districts that may benefit the most from the addition of a SBHC. Among the highlights:

- Urban schools with the highest need are primarily in Denver and Adams counties. Of the top 100 highest-need urban schools, 61 are in these two counties. The other 39 schools are in Arapahoe, El Paso, Mesa, Pueblo and Weld counties.
- Of the 21 rural school districts identified as having high need, most are on the Western Slope or in the San Luis Valley. There is a pocket of four very high-need districts in the San Luis Valley, none of which has an existing SBHC. Most of the high-need districts on the Western Slope already have a SBHC.
- Only 18 of the top 100 high-need urban schools and seven of the 21 high-need rural districts already have established SBHCs, suggesting that there is a shortage of SBHCs in the places that need them the most.

How Was the Analysis Done?

The Colorado Health Institute evaluated urban schools and rural school districts using 12 key indicators of need that fall within four categories:

- Health outcomes
- Access and utilization of care
- Health insurance coverage
- Youth risk factors

The Colorado Health Institute conducted two parallel analyses: urban and rural. Rural and urban schools have an important difference — the size of their student bodies — which could have skewed the results had they been included in the same analysis. A minimum student body of 600 was required for schools or districts to be considered in the analysis.

The map on page 18 illustrates the rural and urban classifications used. Additional information about the methodology is available in the appendix.

Results

Urban Schools

The 100 highest-need urban schools are broken into three groups — Tier 1, Tier 2 and Tier 3 — to demonstrate variation within the highest-need schools. Tier 1 represents the highest level of need, though schools in all three categories face significant challenges and could benefit from a SBHC. Schools are listed alphabetically within each tier in Table 1.

High-need schools scored a minimum of 34 on the scale used for the analysis. A score of 57 was the maximum possible score, but the highest score actually achieved was 52. Higher numbers demonstrate greater need. Map 1 on page 13 shows the locations of the 100 schools identified as having high needs.

What is a SBHC?

SBHCs are an important component of Colorado's health care safety net. They are located inside a school or on school grounds and are staffed by care providers from a variety of disciplines. Each SBHC is unique and offers a variety of services, which may include:

- Well-child and well-adolescent exams
- Immunizations
- Prevention programs, including smoking cessation
- Violence, pregnancy and substance use counseling
- Nutrition counseling
- Chronic conditions management
- Illness and injury treatment
- Mental health assessment and treatment
- Dental exams and sealants
- Health insurance enrollment assistance

Rural School Districts

The 21 highest-need rural school districts also are broken into three groups — Tier 1, Tier 2 and Tier 3 — to demonstrate variation within the highest need districts. Tier 1 represents the highest level of need, though districts in all three categories have significant need and could benefit from a SBHC. Districts are listed in alphabetical order within each tier in Table 2.

A score of 57 was the maximum possible score, but the highest score actually achieved was 48. Districts with a score of 34 or higher are included in Table 2, consistent with the urban analysis. Map 2 on page 14 shows the locations of these high-need districts.

Table 1. Colorado's 100 Highest-Need Urban Schools

Tier 1 – Highest Level of Need			
School	District	County	Student Body
Abraham Lincoln High School	Denver County 1	Denver	1,509
Adams City High School	Adams County 14	Adams	1,749
Adams City Middle School	Adams County 14	Adams	774
Bruce Randolph School	Denver County 1	Denver	870
Castro Elementary School	Denver County 1	Denver	603
Crawford Elementary School	Adams-Arapahoe 28J	Adams	754
DCIS At Ford	Denver County 1	Denver	637
DCIS At Montbello	Denver County 1	Denver	723
Dupont Elementary School	Adams County 14	Adams	699
Farrell B. Howell ECE-8 School	Denver County 1	Denver	829
Florida Pitt-Waller ECE-8 School	Denver County 1	Denver	916
Global Leadership Academy	Mapleton 1	Adams	600
Godsman Elementary School	Denver County 1	Denver	607
Goldrick Elementary School	Denver County 1	Denver	617
Gust Elementary School	Denver County 1	Denver	774
Henry World School Grades 6-8	Denver County 1	Denver	787
Holm Elementary School	Denver County 1	Denver	600
Iver C. Ranum Middle School	Westminster 50	Adams	772
John F Kennedy High School	Denver County 1	Denver	1,260
Kearney Middle School	Adams County 14	Adams	783
Kepner Middle School	Denver County 1	Denver	796
Knapp Elementary School	Denver County 1	Denver	676
Kunsmiller Creative Arts Academy	Denver County 1	Denver	939
Lena Archuleta Elementary School	Denver County 1	Denver	628
Marie L. Greenwood Academy	Denver County 1	Denver	666
Marrama Elementary School	Denver County 1	Denver	617
Martin Luther King Jr. Early College	Denver County 1	Denver	1,152
McGlone Elementary School	Denver County 1	Denver	686
Munroe Elementary School	Denver County 1	Denver	646
North High School	Denver County 1	Denver	769
North Middle School Health Sciences And Technology Campus	Adams-Arapahoe 28J	Adams	879
Place Bridge Academy	Denver County 1	Denver	1,054
South High School	Denver County 1	Denver	1,370
Westminster High School	Westminster 50	Adams	2,388

Rows highlighted in purple indicate schools that already have a SBHC.

Table 1. Colorado's 100 Highest-Need Urban Schools (continued)

Tier 2 – Second Highest Level of Need			
School	District	County	Student Body
Atlas Preparatory School	Harrison 2	El Paso	677
Aurora Central High School	Adams-Arapahoe 28J	Arapahoe	2,120
Aurora West College Prep. Academy	Adams-Arapahoe 28J	Arapahoe	1,241
Bella Romero Academy of Applied Technology	Greeley 6	Weld	722
Centennial Elementary School	Greeley 6	Weld	623
Chavez/Huerta K-12 Prep. Academy	Pueblo City 60	Pueblo	1,115
Denver Center for International Studies	Denver County 1	Denver	774
East High School	Denver County 1	Denver	2,435
East High School	Pueblo City 60	Pueblo	1,024
Franklin Middle School	Greeley 6	Weld	784
George Washington High School	Denver County 1	Denver	1,424
Greeley Central High School	Greeley 6	Weld	1,421
Greeley West High School	Greeley 6	Weld	1,518
Green Valley Elementary School	Denver County 1	Denver	721
Hamilton Middle School	Denver County 1	Denver	875
Josephine Hodgkins Elementary School	Westminster 50	Adams	659
Mapleton Expeditionary School of the Arts	Mapleton 1	Adams	616
Maplewood Elementary School	Greeley 6	Weld	650
Martinez Elementary School	Greeley 6	Weld	613
Northglenn High School	Adams 12 Five Star Schools	Adams	1,784
Northglenn Middle School	Adams 12 Five Star Schools	Adams	806
Northridge High School	Greeley 6	Weld	1,051
Omar D. Blair Charter School	Denver County 1	Denver	800
Roosevelt-Edison Charter School	Colorado Springs 11	El Paso	693
Sabin World School	Denver County 1	Denver	698
Shaw Heights Middle School	Westminster 50	Adams	615
Stem Launch	Adams 12 Five Star Schools	Adams	773
The International School at Thornton Middle	Adams 12 Five Star Schools	Adams	849
The Pinnacle Charter School Elementary	Charter School Institute	Adams	1,053
Thomas Jefferson High School	Denver County 1	Denver	1,083
Thornton High School	Adams 12 Five Star Schools	Adams	1,774

Rows highlighted in purple indicate schools that already have a SBHC.

Table 1. Colorado's 100 Highest-Need Urban Schools (continued)

Tier 3 - Third Highest Level of Need			
School	District	County	Student Body
Aurora Hills Middle School	Adams-Arapahoe 28J	Arapahoe	930
Brighton High School	School District 27J	Adams	1,843
Centennial High School	Pueblo City 60	Pueblo	1,254
Central High School	Mesa County Valley 51	Mesa	1,462
Central High School	Pueblo City 60	Pueblo	826
East Middle School	Adams-Arapahoe 28J	Arapahoe	1,045
Frederick Senior High School	St. Vrain Valley Re 1J	Weld	977
Gateway High School	Adams-Arapahoe 28J	Arapahoe	1,690
Grand Junction High School	Mesa County Valley 51	Mesa	1,715
Grant Ranch ECE-8 School	Denver County 1	Denver	811
Harrison High School	Harrison 2	El Paso	862
Heath Middle School	Greeley 6	Weld	654
High Point Academy	Charter School Institute	Adams	818
Hill Campus of Arts and Sciences	Denver County 1	Denver	786
Hinkley High School	Adams-Arapahoe 28J	Arapahoe	2,094
John Evans Middle School	Greeley 6	Weld	625
Leo William Butler Elementary School	Weld County S/D Re-8	Weld	732
Mitchell High School	Colorado Springs 11	El Paso	1,317
Mountain Range High School	Adams 12 Five Star Schools	Adams	1,962
Mountain Vista Community School	Harrison 2	El Paso	726
Mrachek Middle School	Adams-Arapahoe 28J	Arapahoe	909
North Middle School	Colorado Springs 11	El Paso	660
Overland Trail Middle School	School District 27J	Adams	650
Palisade High School	Mesa County Valley 51	Mesa	1,054
Prairie View High School	School District 27J	Adams	1,795
Prairie View Middle School	School District 27J	Adams	821
Sierra High School	Harrison 2	El Paso	864
Silver Hills Middle School	Adams 12 Five Star Schools	Adams	1,089
Sixth Avenue Elementary School	Adams-Arapahoe 28J	Arapahoe	659
South High School	Pueblo City 60	Pueblo	1,355
South Middle School	Adams-Arapahoe 28J	Arapahoe	743
Thunder Valley PK-8	St. Vrain Valley Re 1J	Weld	744
Twombly Elementary School	Weld County S/D Re-8	Weld	606
W H Heaton Middle School	Pueblo City 60	Pueblo	735
York International	Mapleton 1	Adams	748

Rows highlighted in purple indicate schools that already have a SBHC.

Table 2. Colorado's 21 Highest-Need Rural School Districts

Tier 1 – Highest Level of Need		
District	County	Students in District
Alamosa Re-11J	Alamosa	2,046
Center 26 Jt	Saguache	657
Garfield 16	Garfield	1,050
Garfield Re-2	Garfield	4,818
Lake County R-1	Lake	1,110
Moffat County Re: No 1	Moffat	2,241
Monte Vista C-8	Rio Grande	1,128
Montrose County Re-1J	Montrose	6,200
Tier 2 – Second Highest Level of Need		
Fort Morgan Re-3	Morgan	3,205
Fremont Re-2	Fremont	1,450
Montezuma-Cortez Re-1	Montezuma	2,837
North Conejos Re-1J	Conejos	1,005
Roaring Fork Re-1	Garfield	5,628
Rocky Ford R-2	Otero	805
Trinidad 1	Las Animas	1,019
Tier 3 - Third Highest Level of Need		
Archuleta County 50 Jt	Archuleta	1,323
Burlington Re-6J	Kit Carson	828
Canon City Re-1	Fremont	3,650
Eagle County Re 50	Eagle	6,520
Lamar Re-2	Prowers	1,664
Summit Re-1	Summit	3,287

Rows highlighted in purple indicate districts that already have a SBHC.



Considerations

Size of Student Body

This analysis focuses on the need for SBHCs and does not take into account many potential sustainability factors, such as community buy-in or revenue mix, that can contribute to the longevity of a SBHC. CDPHE and the Colorado Health Foundation are undertaking the next step by collaborating on a sustainability study.

The only sustainability measure applied to the needs assessment was the student body size of a school or district. It is important that schools are large enough to maintain an adequate patient panel. A minimum student body size of 600 was applied to schools and districts in this analysis, a criterion that is consistent with recommendations from those working in the field. Some schools and districts that were identified as having very high needs hover at or near this threshold. Because student enrollment can change from year to year, this could impact a school's eligibility for a SBHC in the future. Student body size was also one of the 12 core metrics used to assess need for a SBHC.

Why are Some Existing SBHCs Not on the List?

Of the urban Colorado schools that already have SBHCs, about half are represented on the list of high needs. Most other schools with existing health centers were not scored because they did not have at least 600 students.

Some of these smaller schools are able to sustain a SBHC by opening their doors to children in the community. Most programs provide services to children beyond the host school, according to a 2013-14 school year survey of Colorado SBHCs. In fact, only 10 SBHCs report that students enrolled in the host school are the only group eligible for care. In some cases, students from feeder schools are

eligible, while other clinics offer services to any child in the district. Ten SBHCs provide services to any child from birth to age 21, regardless of where they live or, in the case of school-age children, which school they attend.² Note that some urban schools identified as high need may already be in close proximity to a SBHC, or may be a feeder school to a school with an existing SBHC.

What About High-Need Schools in Lower-Need Regions?

Several urban schools known to have high concentrations of low-income students show only moderate need under this analysis. This is contrary to what might be expected. One reason is that many of the 12 metrics used in the analysis are not available at the school-level; instead, they are available at the district, county or regional level. A weight was applied to the school-level youth risk factor metrics to help account for this.³

A closer look at those three school-level indicators — percentage of students on free and reduced price lunch, percentage of students who are English language learners and truancy rates — yields important findings. Focusing solely on these data shows several schools with very high-need student bodies that are in lower-need counties.

Schools in Aurora, in particular, present a unique case. Aurora is Colorado's third largest city and straddles multiple counties and school districts.

Aurora West College Preparatory Academy, for example, is ranked in the highest-need categories for all three school-level indicators. However, because the school is in Arapahoe County, it adopts the relatively low-need

Table 3. Schools With Very High Needs That Do Not Appear in Tier 1

School	District	County
Alameda International High School	Jefferson County R-1	Jefferson
Atlas Preparatory School	Harrison 2	El Paso
Aurora Central High School	Adams-Arapahoe 28J	Arapahoe
Aurora West College Preparatory Academy	Adams-Arapahoe 28J	Arapahoe
Gateway High School	Adams-Arapahoe 28J	Arapahoe
Greeley Central High School	Greeley 6	Weld
Greeley West High School	Greeley 6	Weld
Hinkley High School	Adams-Arapahoe 28J	Arapahoe
Mapleton Expeditionary School Of The Arts	Mapleton 1	Adams
Northridge High School	Greeley 6	Weld
Roosevelt Edison Charter School	Colorado Springs 11	El Paso
South Middle School	Adams-Arapahoe 28J	Arapahoe
Stein Elementary School	Jefferson County R-1	Jefferson

Rows highlighted in purple indicate schools that already have a SBHC.

characteristics of that county, since many of the 12 indicators used for the analysis are available only at the county or Health Statistics Region (HSR) level.⁴ Table 3 shows the schools with very high needs at the school-level that do not appear in Tier 1 due to the county-level data. Three of the schools are not listed in any of the tiers because they had composite scores below 34.

The Data Are Part of a Larger Health Landscape

This report uses data-driven methods to identify schools and districts that may have the most to gain from a new SBHC. Though the analysis provides important findings, it is important to consider each community individually because there can be additional needs, or support systems, that are not captured in the data.

Existing safety net clinics, for example, are an

important piece of the health care puzzle, yet they are not directly reflected in the analysis. Map 3 and Map 4 in the appendix display schools and districts identified as having high need in the context of their greater community. Schools and districts are shown alongside federally qualified health centers (FQHCs), community safety net clinics, community mental health centers and rural health clinics.

These two maps also illuminate which high-need schools and districts are not located close to existing safety net facilities. Map 4, for example, shows that Moffat County RE: 1 is a very high-need school district, yet there are no FQHCs, community safety net clinics or rural health clinics within its boundaries. An interactive map of all safety net clinics is available at www.coloradohealthinstitute.org/key-issues/detail/safety-net-1/colorados-health-care-safety-net.

Safety net clinics, too, must be interpreted in

the context of the larger health landscape. Community clinics may vary in their capacity, and families may face barriers to accessing care even through those clinics with existing capacity. Transportation, inability to take time

off from work or limited clinic hours may be challenges for low-income families. These barriers to care could be alleviated by having a SBHC on school grounds.



Conclusion

Colorado has experienced steady growth in the number and reach of its SBHCs over the past decade. A recent injection of state dollars and continued interest in the SBHC model positions stakeholders to further develop the SBHC network.

Using a core set of indicators, the Colorado Health Institute identified urban schools and rural school districts with the greatest potential to benefit from new SBHCs or the expansion of an existing SBHC.

The urban schools with the highest need are in Denver and Adams counties. The highest-

need rural districts without existing SBHCs are primarily located in the San Luis Valley.

The analysis identified several schools and districts with existing SBHCs as having high needs. However, most schools and districts that were identified as being high need do not yet have a SBHC.

This report serves as a launching point for communities to further engage and dig deeper. Assessing other factors — such as the sustainability of potential SBHC sites — will contribute to the long-term success of new SBHCs.

Appendix: Methods

Geographic Crosswalks

The Colorado Health Institute conducted two parallel analyses for this needs assessment: an urban analysis that measured need among urban schools and a rural analysis that measured need among rural school districts.

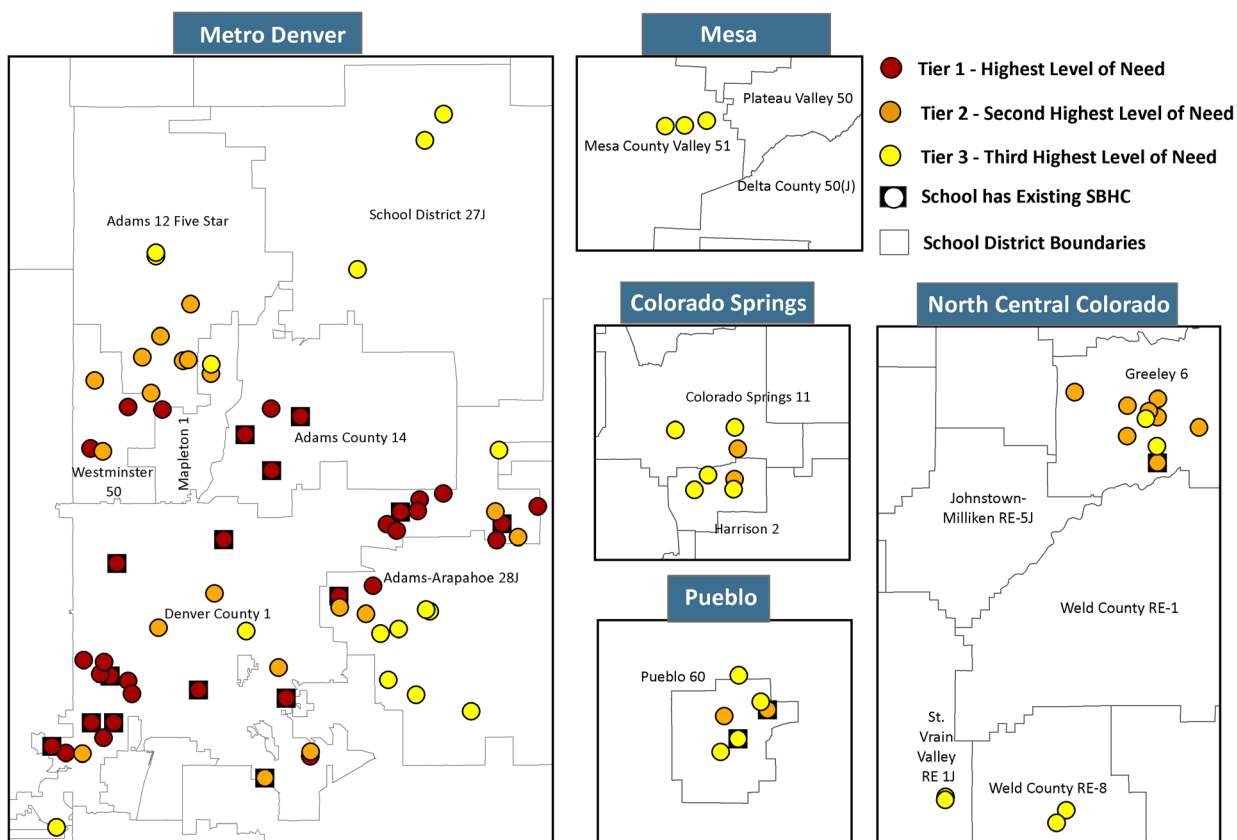
To identify whether schools and districts would be included in the rural or urban analysis, the Colorado Health Institute used rural and urban county designations created by the Office of

Management and Budget. These designations are consistent with those used in 2014 by the Colorado Rural Health Center.⁵ The Colorado Health Institute did not differentiate between rural and frontier counties. Map 5 illustrates the rural and urban classifications used for this analysis.

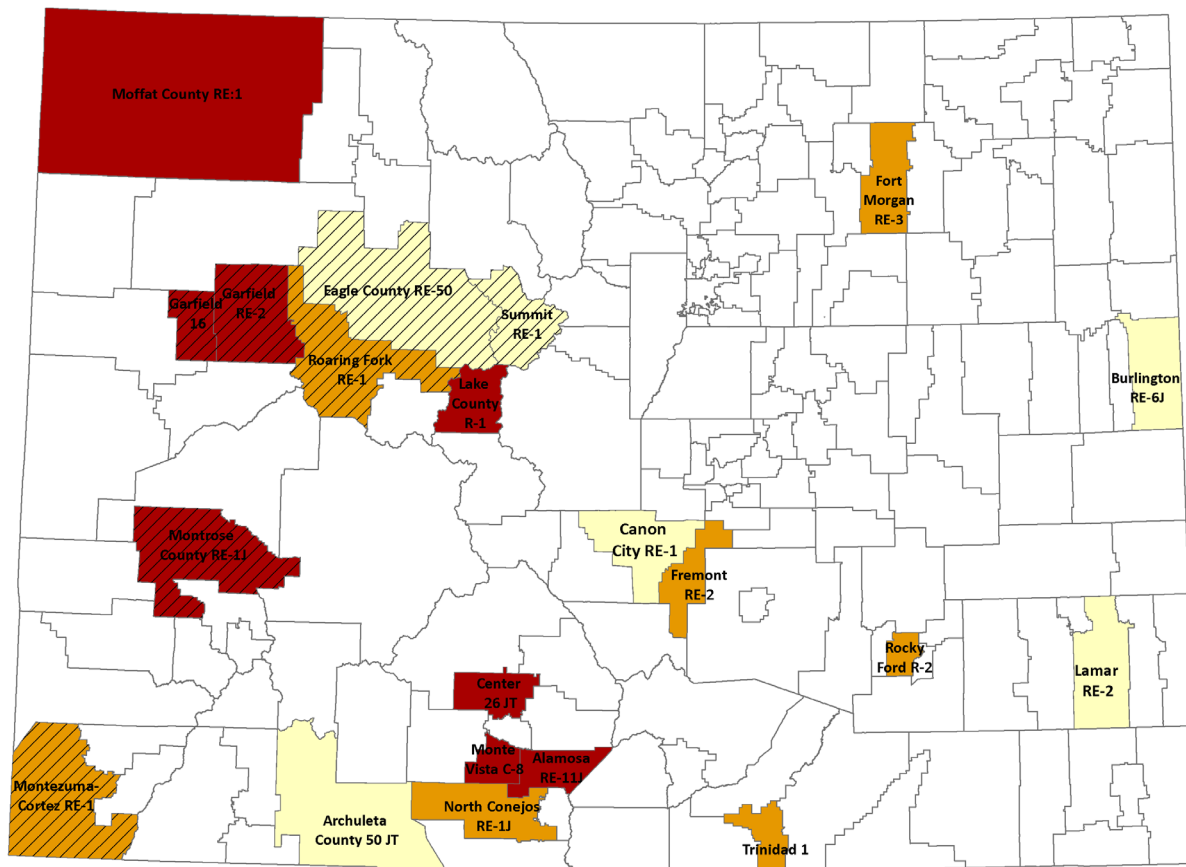
Urban Analysis

School-level data were used whenever possible. When this level of data was not available, school

Map 1. Colorado's 100 Highest-Need Urban Schools, 2015



Map 2. Colorado's 21 Highest-Need Rural School Districts, 2015



■ Tier 1 - Highest Level of Need
 ■ Tier 2 - Second Highest Level of Need
 ■ Tier 3 - Third Highest Level of Need
 District Has Existing SBHC

district, county or HSR-level data were used. Schools were then assigned the value for the region where they are located. For example, uninsured estimates are not available at the school-level, so all schools within the Denver Public School (DPS) district were assigned the DPS uninsured rate.

Rural Analysis

Similarly, school district-level data were used whenever possible for the rural analysis. When district-level data were not available, county or HSR-level data were used. Schools districts were assigned the value for the region where they are located.

Because some school district boundaries do not

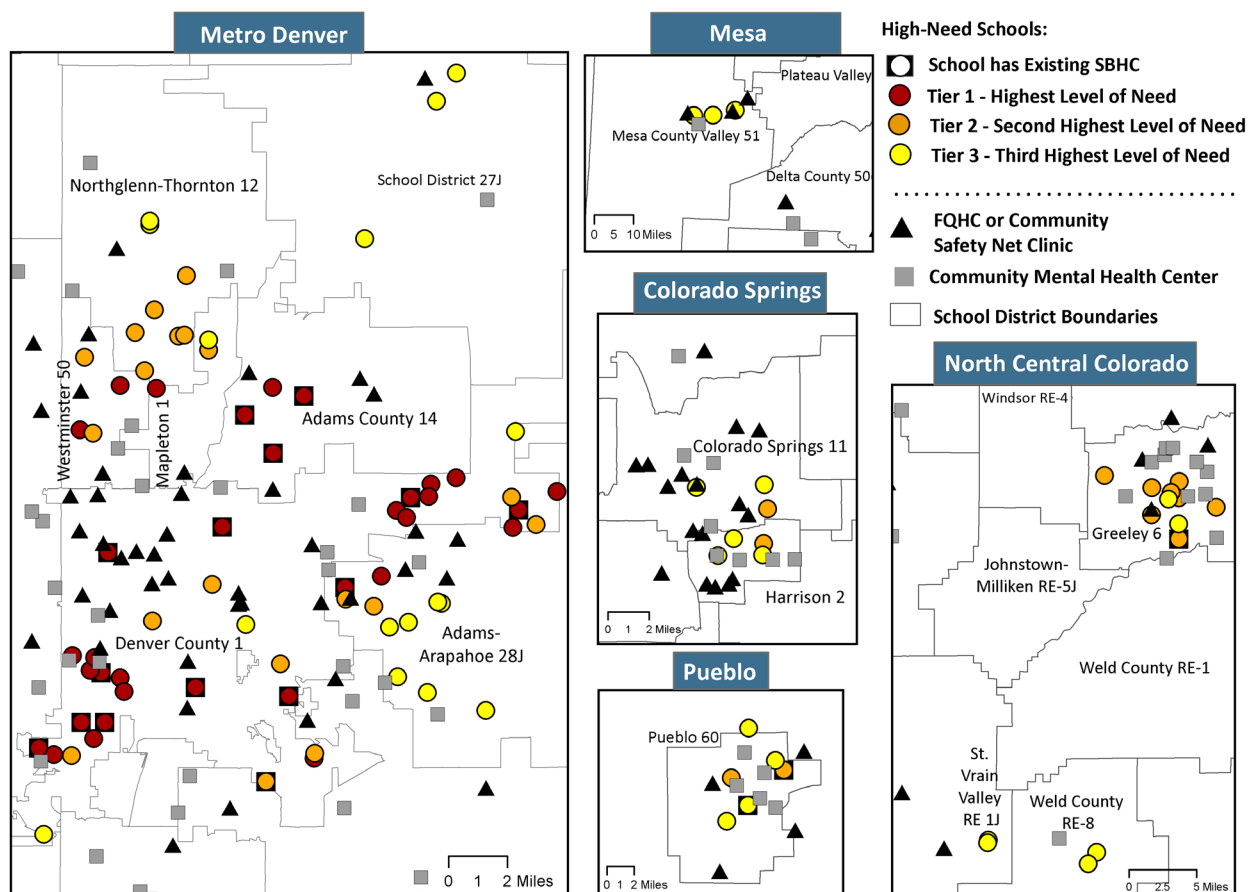
align with county or HSR boundaries, CHI used a school district-to-county crosswalk from the Colorado Department of Education (CDE).⁶

For data available only at the county-level, CHI was able to calculate a synthetic district estimate by allocating a portion of the county population to a school district's boundaries. The population allocation methodology was obtained from the Census Center at the University of Missouri.⁷ CHI used this methodology for the rural analysis to estimate district-level teen fertility rates and the percentage of children covered by Medicaid.

Minimum Criteria

School Type: All elementary, middle and high schools that are represented in CDE's statistics,

Map 3. Colorado's 100 Highest-Need Urban Schools and Neighboring Safety Net Clinics, 2015



including both public and charter schools, were considered in the needs assessment. Online schools were not considered.

Student Body Size: Schools need enough students to maximize the impact of a SBHC and maintain a caseload that is cost-effective. Schools and districts were considered only if they had at least 600 students. This criteria is frequently cited as the minimum number of students needed to sustain a SBHC. Student body size was also one of the 12 core indicators used for the analysis.

Free and Reduced Price Lunch: Schools and districts were excluded from the analysis if fewer than 300 students were enrolled in the free and

reduced price lunch program. The percentage of students on free and reduced price lunch was also one of the core indicators used for the analysis.

Defining Need

Twelve indicators were selected for the needs assessment. The indicators were chosen based on a review of potential measures that capture need, as defined by the literature and the mission of SBHCs, as well as our experience with data and analytical work related to SBHCs.

Measures of need for SBHCs were grouped into four categories:

1. Health outcomes
2. Access and use of health care
3. Health insurance coverage
4. Youth risk factors

The Colorado Health Institute identified indicators that illustrate need within each of these categories, using these principles to guide our choices:

- **Salience:** Only indicators that suggest high need for health services among children were considered. Adults were not included in this analysis.
- **Nonduplicative:** In cases where more than one indicator addresses the same issue — for example, usual source of care and medical home — the Colorado Health Institute used what it considered the strongest option.
- **Geographic Granularity:** The Colorado Health Institute sought indicators that are available at the school, school district or county levels. We aimed to minimize HSR-level indicators, because the data are less precise.
- **Timeliness:** Indicators that reflect the most current data available were chosen.
- **Trusted Data Sources:** Data from trusted and publicly available sources were selected.

Figure 1 summarizes the 12 indicators used for the analysis.

Other indicators were considered for this analysis but were ultimately not used.⁸

Scoring Criteria

Schools and districts were ranked based on their composite score. Quartiles were used as the primary scoring method for each indicator. For example, schools and districts that fell within the highest quartile for an indicator were assigned the highest score for that indicator. The scores for all 12 indicators were summed to calculate a composite score for each school

Figure 1. Indicators Representing Need

Health Outcomes

- a. Percentage of Children Ages 0-18 Reporting Fair or Poor General Health⁹
- b. Percentage of High School Students Reporting Depression¹⁰
- c. Teen Birth Rate per 1,000 Females Ages 15-19¹¹

Health Insurance Coverage

- a. Percentage of Children Ages 0-17 Who Are Uninsured¹²
- b. Percentage of Children Ages 0-21 Who Are Insured by Medicaid¹³

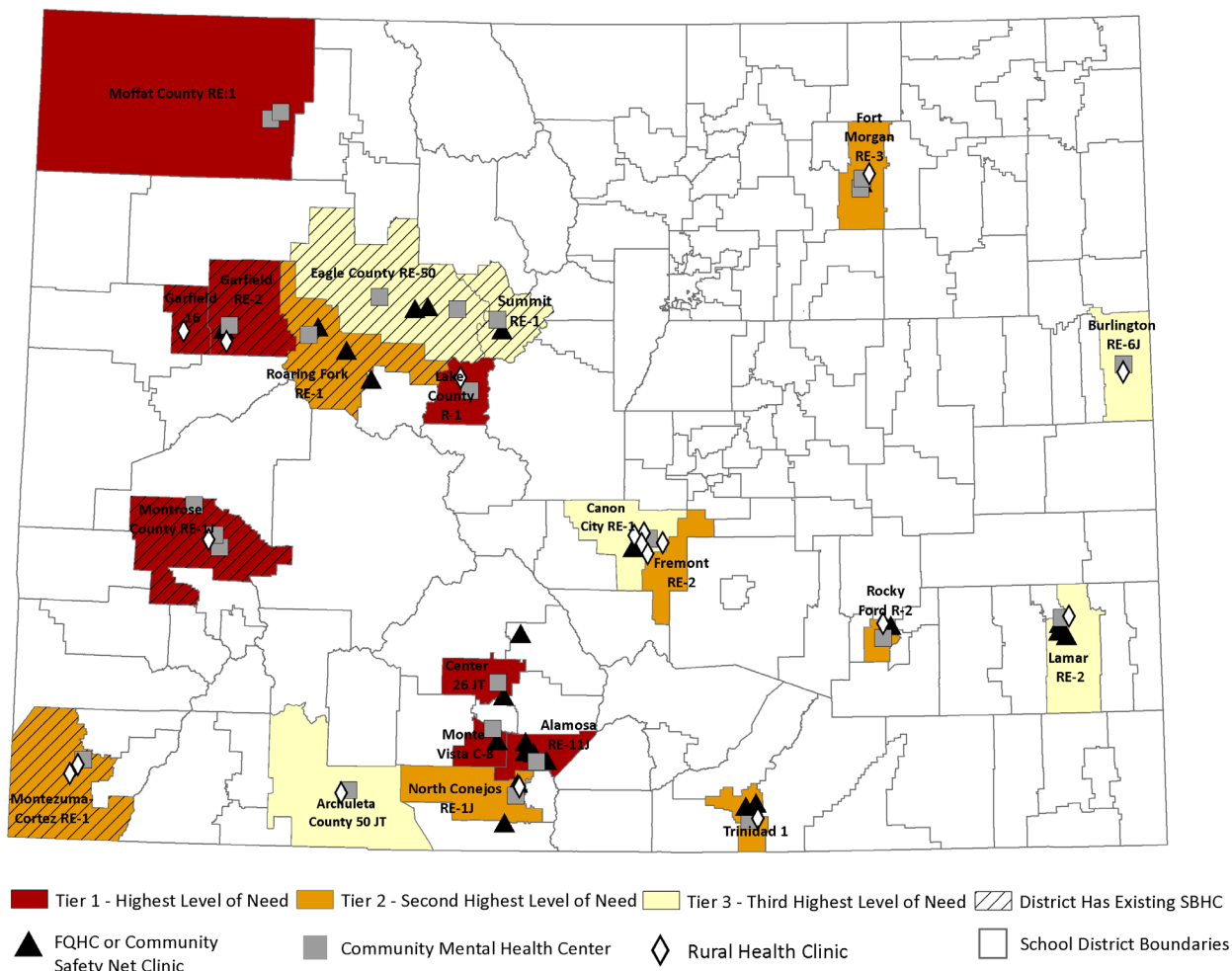
Access and Use of Health Care

- a. Percentage of Children Ages 1-14 Without a Medical Home¹⁴
- b. Percentage of Children Ages 0-18 Who Did Not Have a Dental Visit in the Past Year¹⁵
- c. Medically Underserved Area or Medically Underserved Population (MUA/MUP)¹⁶
- d. Student Body Size¹⁷

Youth Risk Factors

- a. Percentage of Students in a School/District Who Receive Free and Reduced Price Lunch¹⁸
- b. Percentage of Students in a School/District Who Are English Language Learners¹⁹
- c. Truancy Rate Among Students in a School/District²⁰

Map 4. Colorado's 21 Highest-Need Rural School Districts and Neighboring Safety Net Clinics, 2015



or school district. Those with the highest composite scores were identified as having the highest need.

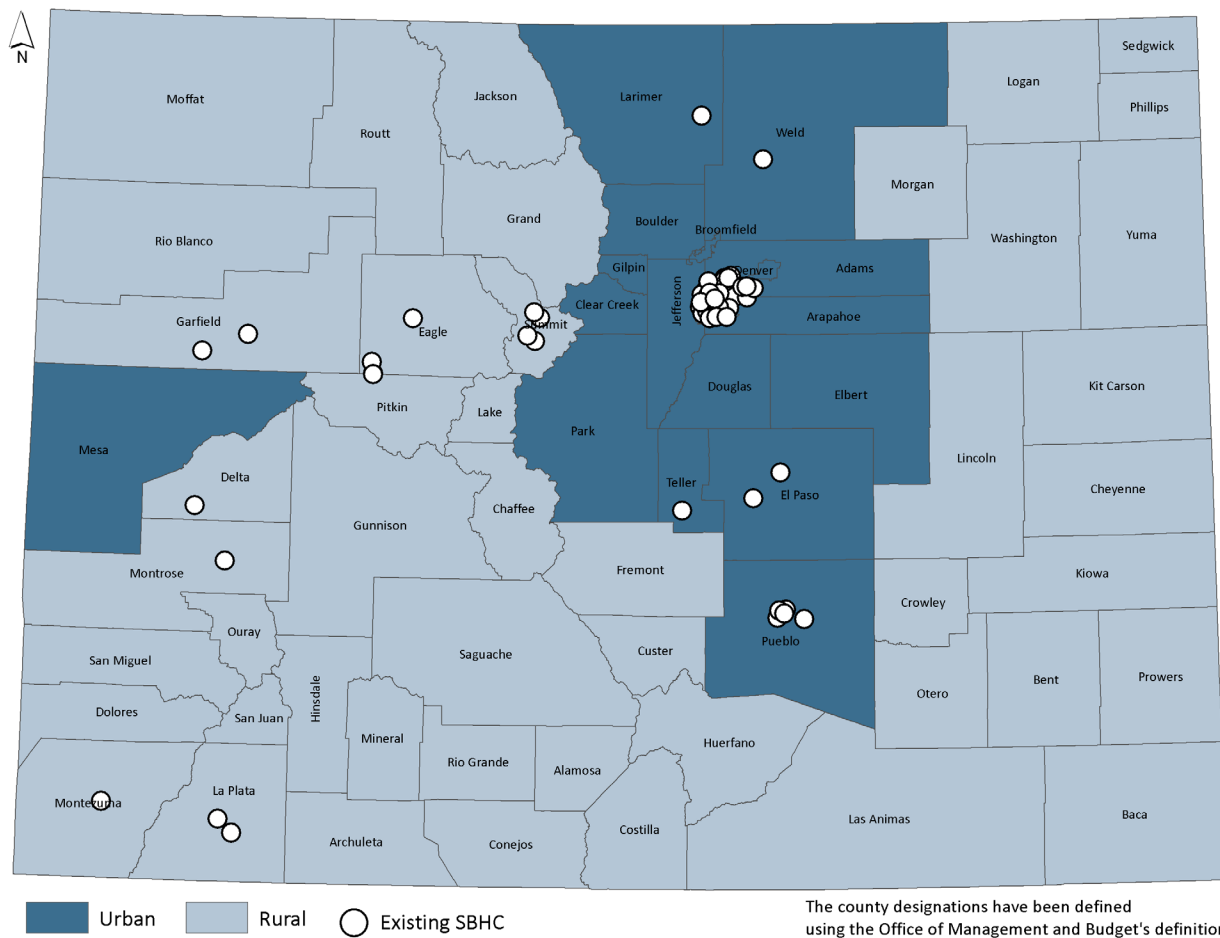
A different scoring criteria was used for the Medically Underserved Area/Medically Underserved Population (MUA/MUP) indicator given the nature of the data. Schools located in a census tract designated as a MUA or MUP and districts that have a MUA/MUP within their boundaries were given a score of one. Those not located in a MUA or a MUP were given a score of zero.

Table 4. Score Ranges for Each High-Need Tier

	Tier 1	Tier 2	Tier 3
Urban Schools	52-45	44-39	38-34
Rural School Districts	48-41	40-36	35-34

Once the scoring was complete, the Colorado Health Institute narrowed the list to only those urban schools and rural school districts that met the minimum criteria of 600 members of the student body and 300 enrolled in free or

Map 5. Urban and Rural County Designations and Existing SBHCs, 2014



reduced-price lunch. We further narrowed the focus to schools and school districts scoring in the top fiftieth percentile of need. This resulted in a list of 100 urban schools. Urban schools in the top fiftieth percentile had a minimum score of 34.

To maintain consistency between urban and rural, the Colorado Health Institute narrowed the rural school district list to those with a score of at least 34. This resulted in a list of 21 school districts — approximately the top fiftieth percentile of scores for the rural school districts as well.

We then tiered the top 100 high-need schools

and 21 districts into roughly equal-sized groups based on their level of need and distribution of scores. Schools and districts with the highest scores were placed in the first tier and represent the highest level of need. Table 4 illustrates the tiers broken out by score.

The high-need urban schools in Tiers 1-3 are displayed in Table 1 and Map 1. The high-need rural school districts are displayed in Table 2 and Map 2.

Questions about the analysis may be directed to Natalie Triedman at TriedmanN@ColoradoHealthInstitute.org.



End Notes

¹ SB13- 230. (2013). FY 13-14 Budget for the Colorado Department of Public Health and Environment.

² Survey data from the 2013-14 school year will be published later in 2015. Survey data from the 2012-13 school year are available in the Colorado Health Institute's *The Evolving Role of School-Based Health Centers in Colorado* (2014). <http://bit.ly/19nsmwy>.

³ We did not apply a weight to the student body size metric, given that school size is not a youth risk factor.

⁴ A map of Colorado's 21 HSRs can be found at <http://www.chd.dphe.state.co.us/HealthDisparitiesProfiles/dispHealthProfiles.aspx>.

⁵ Colorado Rural Health Center. Colorado: County Designations, 2014. <https://coruralhealth.org/wp-content/uploads/2013/10/2014.Colorado-County-Designations.pdf>

⁶ Colorado Department of Education. Pupil Membership by County, District, Race/Ethnicity, and Percent Minority. (2013). <http://www.cde.state.co.us/cdereval/pupilcurrentdistrict>

⁷ Missouri Census Data Center. Geographic Correspondence Engine. <http://mcdc.missouri.edu/websas/geocorr12.html>

⁸ Contact the Colorado Health Institute for a detailed explanation of the measures that were considered but ultimately omitted from the analysis.

⁹ Colorado Health Institute analysis of the 2013 Colorado Health Access Survey.

¹⁰ Healthy Kids Colorado Survey, 2013. http://www.chd.dphe.state.co.us/topics.aspx?q=Adolescent_Health_Data.

¹¹ Colorado Certificates of Live Birth compiled by the Colorado Department of Public Health and Environment, 2000-2013. <http://www.cohid.dphe.state.co.us/scripts/htmsql.exe/NativityPub.hsrl>.

¹² U.S. Census Bureau. American Community Survey, 2009-2013. <http://factfinder.census.gov/faces/nav/jsf/pages/searchresults.xhtml?refresh=t>.

¹³ Colorado Health Institute analysis of data from the Colorado Department of Health Care Policy and Financing and the Colorado Demography Office, 2014.

¹⁴ Colorado Department of Public Health and Environment. Colorado Child Health Survey, 2013.

¹⁵ Colorado Health Institute analysis of the 2013 Colorado Health Access Survey.

¹⁶ U.S. Health Resources and Services Administration, 2014. <http://muafind.hrsa.gov/>.

¹⁷ Colorado Department of Education, 2013.

¹⁸ Colorado Department of Education, Fall 2013.

¹⁹ Colorado Department of Education, October 2013.

²⁰ Colorado Department of Education, School-Year 2013-2014. <http://www.cde.state.co.us/cdereval/truancystatistics>.



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School-Based Health Care State Policy Survey: 18 State Governments Commit Resources to SBHCs EXECUTIVE SUMMARY

The School-Based Health Alliance surveys state public health and Medicaid offices periodically to assess state-level public policies and activities that promote the growth and sustainability of school-based health centers (SBHCs). A survey for fiscal year (FY) 2014 found no change in the number of states (18) that reported investments explicitly dedicated to SBHCs since the FY2011 survey.

State Investment in SBHCs

For school year 2013-14, 18 states directed funding totaling \$85.1M to 915 SBHCs—a decrease of five percent from 2010-11 (tables 1-2). State general funds represent the largest funding source (80 percent, followed by “other” (14 percent), which includes Social Services Block Grant and Medicaid Match, Title V MCH Block Grant (4 percent), and Tobacco Settlement (2 percent).

Over the last 15 years, the number of state SBHC initiatives has decreased by 51 percent, from 37 to 18. Total state investments in SBHCs, however, have grown 118 percent, despite a challenging state budgetary climate in the most previous years (tables 2-3). Three states (CO, MI, NM) increased their SBHC funding allocation more than threefold (table 4).

State general revenue has consistently comprised the largest proportion of funding for state SBHC programs, increasing from 68 percent of total state funding in FY1996 to 80 percent of total funding in FY2014. The largest decrease in proportion of funding over time is Tobacco Settlement, which declined from 37 percent of total state funding in FY2002 to 2 percent in FY2014 (table 2).

Policies that Support SBHCs

States that direct funds to SBHCs report holding programs accountable by setting and monitoring standards, requiring certification, and collecting performance data. The SBHC performance indicators most frequently identified by the states include Body Mass Index (BMI) assessment, well child visits, immunizations, and mental health (tables 5-6).

Of the 18 states that fund SBHCs, 13 have enacted meaningful Medicaid policies that assure reimbursement for care delivered to Medicaid enrollees in SBHCs, including primary care prior authorization waivers and mandated managed care organization contracts and/or reimbursement (table 7).

States with SBHC Program Offices (and number of school-based health centers), FY2014

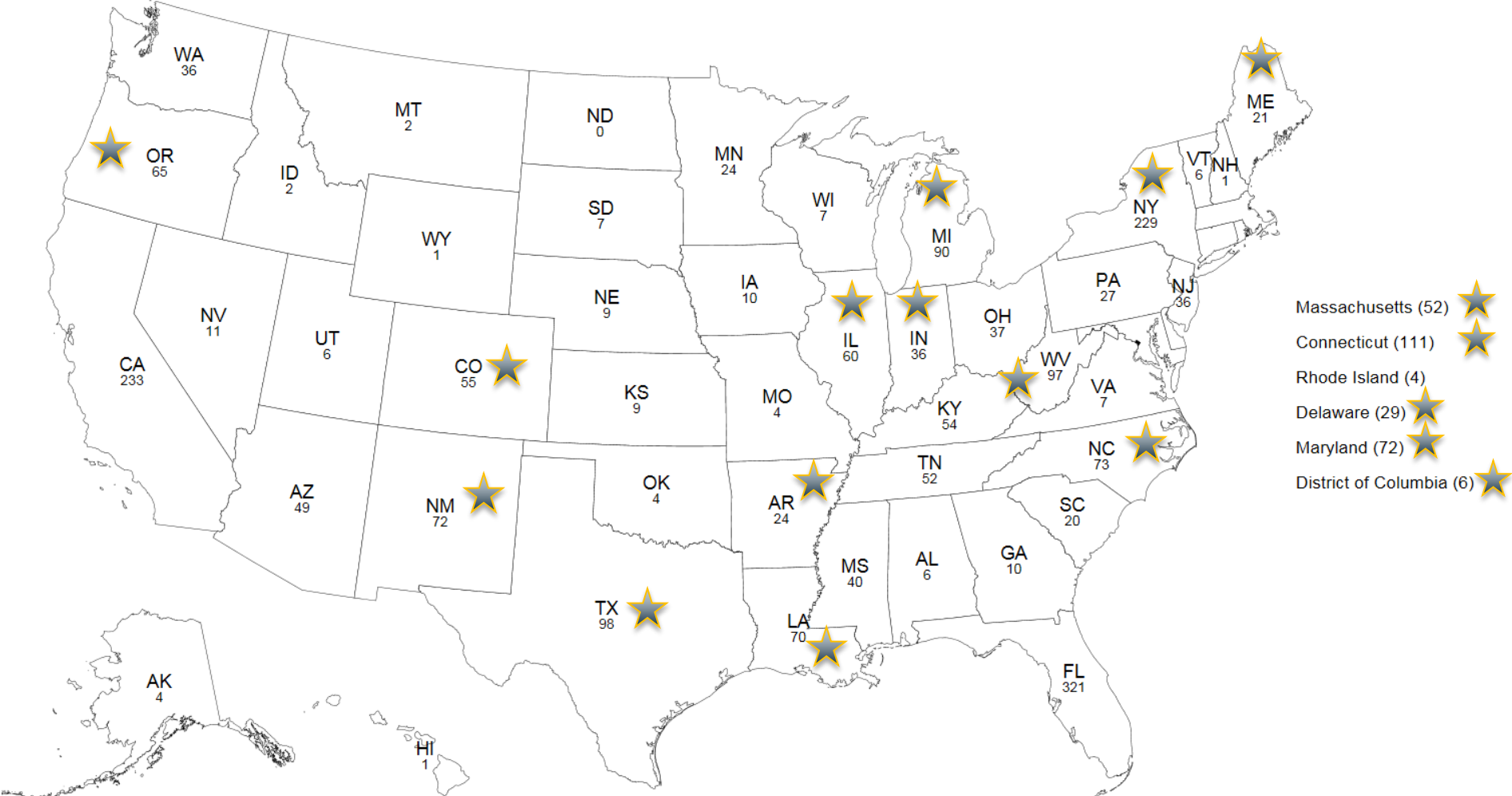


Table 1. State-Directed Funding for SBHCs, by Funding Source

State	SBHCs Funded	Total SBHCs*	Total	State General Fund	Tobacco Settlement	Title V MCH Block Grant	Other
AR	21	24	\$2,000,000	\$2,000,000	--	--	--
CO	47	55	\$5,200,000	\$5,200,000	--	--	--
CT	94	111	\$12,336,716	\$12,048,716	--	\$288,000	--
DC	6	6	\$2,025,000	\$2,025,000	--	--	--
DE	29	29	\$5,235,300	\$5,235,300	--	--	--
IL	41	60	\$4,118,117	\$1,279,000	\$942,200	\$845,917	\$1,051,000
IN	2	36	\$200,000	--	--	\$200,000	--
LA	64	70	\$8,734,531	\$8,734,531	--	--	--
MA	34	52	\$2,958,292	\$2,958,292	--	--	--
MD	71	72	\$2,800,000	\$2,800,000	--	--	--
ME	16	21	\$699,700	\$219,130	\$480,410	\$160	--
MI	70	90	\$13,500,000	\$3,500,000	--	--	\$10,000,000
NC	32	73	\$1,377,664	\$1,377,664	--	--	--
NM	52	72	\$3,534,100	\$2,534,100	--	--	\$1,000,000
NY	218	229	\$12,282,352	\$10,400,000	--	\$1,882,352	--
OR	65	65	\$6,800,000	\$6,800,000	--	--	--
TX	3	98	\$250,000	--	--	\$250,000	--
WV	50	97	\$1,027,100	\$1,027,100	--	--	--
Total	915	2315**	\$85,078,872	\$68,138,833	\$1,422,610	\$3,466,429	\$12,051,000

*Data from 2013-2014 National Census

**Total SBHCs nationwide from 2013-2014 National Census, including states that do not fund SBHCs

Table 2. State-Directed Funding for SBHCs, Totals by Source, FY1996-FY2014 (millions)

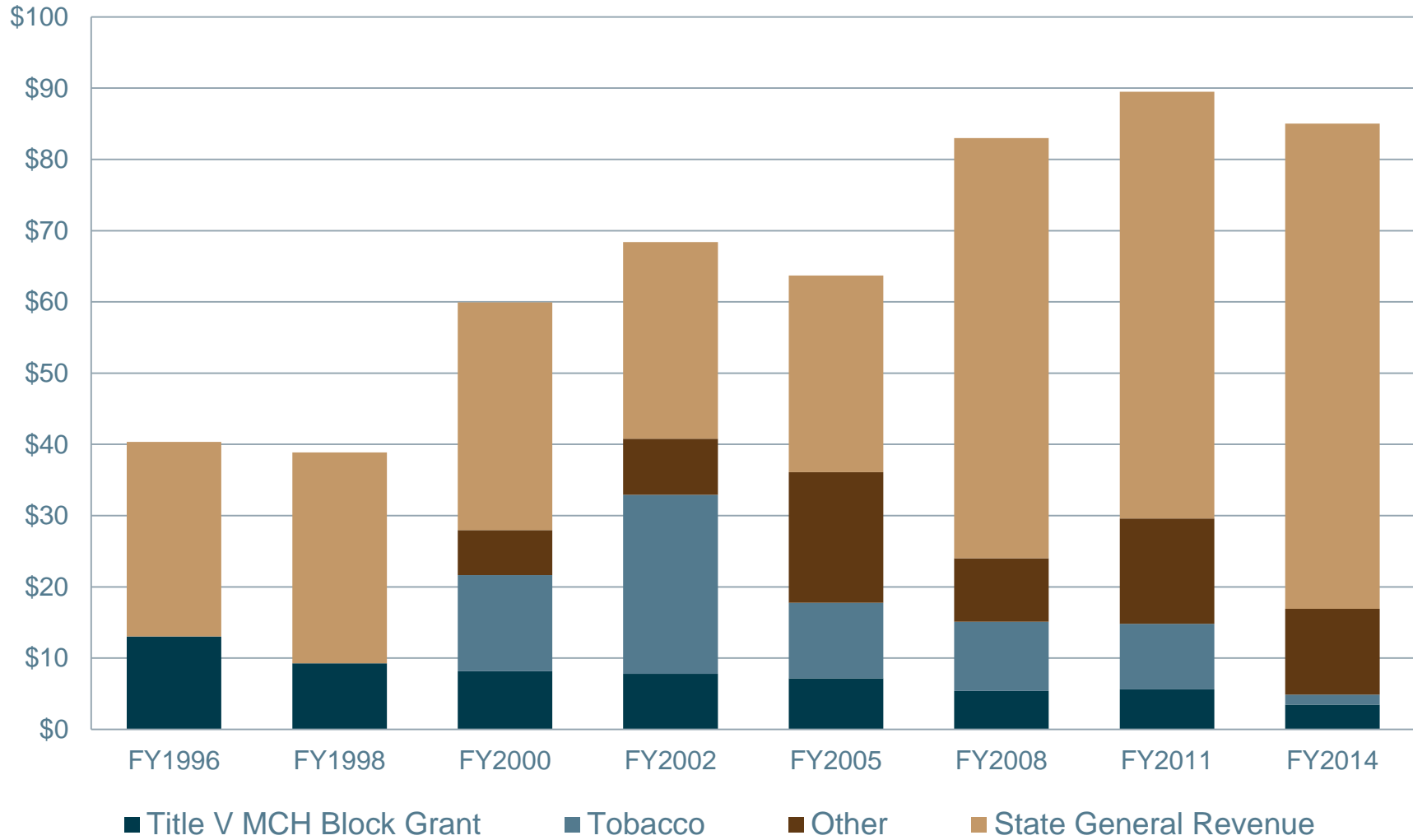


Table 3. State SBHC Programs, Funding and SBHCs, FY1998-FY2014

	FY1998	FY2000	FY2005	FY2008	FY2011	FY2014
Total State Dedicated Funds (\$M)	\$38.9	\$59.9	\$63.7	\$83.0	\$89.6	\$85.1
Total # State SBHC Programs	37	31	20	20	18	18
Total SBHCs Funded by State	650	700	738	855	875	915
Total SBHCs*	1157	1380	1651	1909	1930	2315
% state funded	56%	51%	45%	45%	45%	40%

*Data from 2013-2014 National Census

Table 4. States with Ten-plus Years Investment in SBHCs, FY2002, 2008, 2014

State	FY2002	FY2008	FY2014	% Change FY2002-2014
CO	\$375,000	\$1,699,810	\$ 5,200,000	1287%
CT	\$6,246,505	\$9,168,186	\$ 12,336,716	97%
DE	\$4,646,800	\$5,400,000	\$ 5,235,300	13%
IL	\$3,956,000	\$4,234,400	\$ 4,118,117	4%
LA	\$7,100,000	\$10,249,823	\$ 8,734,531	23%
ME	\$631,376	\$745,300	\$ 699,700	18%
MD	\$3,949,941	\$2,731,206	\$ 2,800,000	-29%
MA	\$5,545,943	\$3,893,559	\$ 2,958,292	-47%
MI	\$2,892,300	\$10,671,000	\$ 13,500,000	367%
NM	\$400,000	\$3,870,000	\$ 3,534,100	784%
NY	\$19,645,000	\$22,800,000	\$ 12,282,352	-37%
NC	\$1,500,000	\$1,627,000	\$ 1,377,664	-8%
OR	\$1,313,512	\$2,838,000	\$ 6,800,000	418%
WV	\$900,000	\$962,100	\$ 1,027,100	14%
Total	\$59,102,377	\$80,890,384	\$ 80,603,872	36%

Table 5. State Functions to Assure SBHC Accountability

State	State defines SBHCs in law or regulation	State requires SBHC certification/credential	State-funded SBHCs adhere to operating standards
AR			X
CO	X		X
CT			X
DC			
DE	X	X	X
IL	X	X	X
IN			
LA	X	X	X
MA			X
MD		X	X
ME			X
MI		X	X
NC			X
NM		X	X
NY	X		X
OR	X	X	X
TX	X		X
WV			X

Table 6. SBHC Performance Indicators Tracked by State Program Office

State	Annual risk assessments	Immunization status	Depression Screening	BMI assessment	Physical exams/well child visits	Enrollment as % of student body	Users as a % of SBHC enrollees
AR						X	X
CO	X	X	X	X	X	X	X
CT	X	X	X	X	X	X	X
DC		X		X	X	X	
DE	X	X	X	X	X		X
IL	X	X		X			
IN					X	X	X
LA	X	X	X		X	X	X
MA	X						
MD	X	X	X	X	X	X	X
ME	X		X	X	X	X	X
MI	X	X	X	X	X	X	X
NC	X	X	X	X	X	X	X
NM	X			X	X	X	
NY		X	X	X	X	X	
OR	X			X	X		
TX		X		X	X	X	X
WV*							

*this data was unavailable for FY2014

Table 7. State Policies Pertaining to Medicaid and SBHCs

Define SBHCs as Provider Type	Waive Preauthorization for SBHCs	Waive Preauthorization for Specific SBHC Services	Managed Care Organizations Required to Reimburse and/or Contract with SBHCs
Delaware	Illinois	Colorado	Delaware
Illinois	Louisiana	Connecticut	District of Columbia
Indiana	Michigan	Indiana	Illinois
Louisiana	North Carolina	Maine	Maryland
Maine	West Virginia	Maryland	Michigan
New Mexico			New Mexico
North Carolina			
West Virginia			

School-Based Health Centers Successfully Engage Alternative Payment Models

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Disclosure: Dr. Bynum and Dr. Wong currently sit on the Board of Directors of the national School-Based Health Alliance (www.sbh4all.org). Dr. Bynum is the Chair of the Outreach and Engagement Committee, and Dr. Wong is the Chair of the Policy and Advocacy Committee at the Alliance.

Executive Summary

This article complements a previously published article co-authored by Ben L. Bynum, M.D., and Winston F. Wong, M.D., both members of the Board of Directors of the national School-Based Health Alliance in Washington, D.C. That article entitled “A Place for School-Based Health Centers in the New Era of Alternative Payment Models in Medicaid” was published in the *Journal of Health Care Finance* in June 2016. The article argued that school-based health centers are uniquely positioned to serve at-risk youth living in underserved communities through a community-based delivery model that can offer integrated primary care, behavioral health and oral health services. The article contended that school-based health centers should be strategically included in alternative payment model (APM) pilot programs – particularly those that aim to serve children enrolled in Medicaid, living in low income and rural areas – because school-based health centers are a high quality, low cost delivery model. This article deepens the analysis and highlights three organizations that are successfully implementing alternative payment models by leveraging the value-add of school-based health centers in underserved communities.

These three organizations represent a spectrum of delivery models with diversity in corporate structure, balance sheet size, geography, total patients served, number of delivery sites and scope/types of services. They include a Medicaid-based, pediatric Accountable Care Organization (ACO) participating in a full medical risk model in Ohio, a Colorado-based nonprofit pediatric clinic network receiving a per member per month (PMPM) payment for care coordination for kids enrolled in Medicaid, and a county health department certified as a Federally Qualified Health Center (FQHC) reimbursed through a flat rate, prepaid revenue model in Oregon. These case studies serve as important lessons to aid school-based health centers across the country in approaching payor(s) about the viability of participating in alternative payment models, which in turn, may provide a stable source of operating revenue.

Introduction

Today, there are more than 2,300 school-based clinics in 49 states and the District of Columbia serving millions of children, from kindergarten through high school.¹ School-based health centers (SBHC) receive support and sponsorship from various components of the health care system, including Federally Qualified Health Centers (FQHC), insurers, hospitals, health systems, local health departments and school districts. SBHCs are uniquely positioned in the delivery system to bring together a number of constituents, and to have a significant impact on providing care to at-risk youth, particularly those living in low-income and underserved communities. Without school-based health centers, many of these youth, comprising Medicaid recipients and the uninsured, would have little access to a regular source of primary care, behavioral health and/or oral health services.²

Although school-based health centers fundamentally focus on prevention and anticipatory encounters, which is core to the rationale of value-based purchasing (VBP), the majority (78 percent) still operate within the fee-for-service (FFS) universe, which “rewards” healthcare providers based upon the number of

¹ School-Based Health Alliance [webpage on the Internet]. 2013-14 Digital Census Report. Available from: <http://www.sbh4all.org/school-health-care/national-census-of-school-based-health-centers/>. Accessed January 12, 2017.

² Bynum, Dr. Ben and Wong, Dr. Winston. A Place for School-Based Health Centers within the New Era of Alternative Payment Models in Medicaid. *Journal of Health Care Finance*, June 2016.

encounters, rather than overall health outcomes.³ SBHCs provide convenient access for students and utilize cultural competence in dealing with adolescents, and ultimately render high value preventive services and health education. Existing in the world of prevention, education, anticipatory guidance, counseling and proactive clinical intervention, school-based health centers embody the best of value-based purchasing, but are generally ill-equipped to substantiate costs in a fee-for-service, encounter based model. Thus, SBHCs largely undercharge for their services, resulting in all too common tenuous “bottom lines.” If SBHCs can transition to APMs, their value in generating better outcomes could be better validated as well as better compensated.

The opportunity for school-based health centers to transition to a more apt model of revenue, linked to improving health outcomes, relies on SBHCs’ evolution in an alternative payment world. Regardless of payment source, even in an era of potential Medicaid repeal, alternative payment models will continue to proliferate and be a means to promote better outcomes at a lower cost. School-based health centers make a convincing case that they can generate cost savings for payors, and benefit communities at large through better educational attainment for low-income students that utilize SBHCs, yet SBHCs still suffer from a lack of long-term financial sustainability.^{4,5}

According to a study recently published by the Brookings Institute, a growing number of SBHCs are participating in alternative payment model pilot programs. National and statewide payment and delivery reform initiatives such as State Innovation Models (SIM), Certified Community Behavioral Health Clinics (CCBHCs), California’s Capitation Payment Preparedness Program (CP3) and other reform pilots would do well to mandate that school-based health centers be strategically included in provider networks to ensure “tweens” and teens have improved access to primary care and behavioral health services. At least one in five SBHCs has some experience with alternative payment models as a part of its revenue stream. Some SBHCs receive monthly or annual capitated payments for primary care (35 percent) or for care coordination (19 percent), or “pay for performance” supplements (27 percent).⁶ The case studies presented in this article are not meant to be all-inclusive, but rather are meant to illustrate how SBHCs can leverage alternative payment models to achieve greater financial sustainability.

³ Price, Dr. Olga, School-Centered Approaches to Improve Community Health: Lessons from School-Based Health Center. Economic Studies at Brookings, No. 5; July 13, 2016.

⁴ Ran T, Chattopadhyay SK, Hahn RA, Community Preventive Services Task Force. Economic Evaluation of School-Based Health Centers: A Community Guide Systematic Review. Am J Prev Med. 2016 Jul;51(1):129-38.

⁵ Soto Mas F, Sussman AL., A Qualitative Evaluation of Elev8 New Mexico School-Based Health Centers., J Pediatr Health Care., Epub 2016 Sep 13.

⁶ Price, Dr. Olga, School-Centered Approaches to Improve Community Health: Lessons from School-Based Health Center. Economic Studies at Brookings, No. 5; July 13, 2016.

Case Studies and Examples

PARTNERS FOR KIDS

A physician-hospital organization, an affiliate of Nationwide Children's Hospital, is taking full capitated risk from five Medicaid managed care organizations across 34 counties to serve 330,000 low-income children

- ❖ *Operating sponsor is a 468 bed pediatric hospital based in Columbus, Ohio*
- ❖ *Currently operates 17 SBHCs, serving 1,750 children annually*
- ❖ *Annual budget of \$850 million, and 1,000 employees*

"Schools fit into the Partners For Kids delivery model as a part of our larger strategy to engage youth wherever we can easily find them, and our APM provides Partners with the upfront capital needed to invest and grow our SBHC model"

- *Kelly Kelleher, M.D., M.P.H., Vice President of Community Health Services*



Organizational Background: Partners For Kids (PFK) was founded in 1994, and is the nation's oldest and largest exclusively pediatric accountable care organization (ACO). Based in Columbus, Partners serves children across 34 counties in central and southeastern Ohio. The physician hospital organization (PHO) comprises 500 physicians affiliated with Nationwide Children's Hospital (NCH), and 400 independently contracted physicians. PFK employs 100 support and ancillary staff, and has an annual budget of \$850 million. PFK's vast network of providers delivers integrated primary care, behavioral health and advanced oral health services. Patients have access to care through dozens of hospitals and thousands of ambulatory care sites. The subset of sites owned and operated by NCH includes specialty care clinics, and a network of school-based health centers. Currently, PFK's network of 17 SBHCs provide access to care for 1,750 school-aged children annually, and additional children through a Mobile Unit model.

School-Based Health Center Model: After opening nine school-based health center sites in 2015, PFK aims to sponsor a growing number of SBHCs as a core strategy. The current growth plan has 75 additional sites opening by 2019. Each existing SBHC site offers both primary care and behavioral health services by direct employees. Care teams consist of a nurse practitioner, medical assistant, behavioral health specialist and a care coordinator (when needed). PFK partners with a local Federally Qualified Health Center (FQHC) for preventive oral health services. Youth that access services through a SBHC are linked to one of 85 care coordinators to help navigate the larger system. In most cases, the main hospital serves as a hub for specialty care and inpatient service referrals. An electronic medical record (EMR) links all delivery sites, including SBHCs, to support real-time knowledge transfer and further links into care coordination modules. EMR operability is important for PFK's SBHC sites because SBHCs serve as the de facto primary medical home for several thousand of PFK's pediatric members, especially for its teenage patients who exclusively access services in the school setting.

State Policy Overview - Ohio: Partners For Kids has been successful in leveraging Medicaid waivers to support APMs that allow generated savings to stay within the PDK system to support its innovation. As Ohio has shifted its pediatric population into managed care, risk-bearing provider groups such as Partners For Kids are allowed to directly contract with state managed care organizations (MCO). Ohio

recognizes PFK as an Intermediary Insurance Organization since the state's insurance code does not have a formal definition for pediatric accountable care organizations. This recognition from the state of Ohio took the cooperation of many constituents – including the governor, the Centers for Medicare & Medicaid Services (CMS), the Ohio Department of Medicaid as well as a broad range of providers across the continuum of care – to successfully launch the public-private partnership that led to Partners For Kids.⁷

Reimbursement Mechanism: A capitated reimbursement arrangement puts Partners For Kids at risk for all health related services for its 330,000 Medicaid pediatric patients. The total value of its five pediatric managed care contracts is about \$850 million which is predominantly used to cover a range of patient expenses. PFK receives its revenue from its contracted managed care organizations (MCO) – Buckeye Health Plan, CareSource, Molina, Paramount Healthcare and United – in a per member per month (PMPM) payment model. The physician hospital organization bears full risk for outpatient, inpatient, pharmacy, medical equipment and all other health related costs. PMPM payment amounts range from \$100 up to \$720 per member per month depending on the expected complexity and intensity of care. Compared to a traditional Medicaid fee-for-service (FFS) structure, PFK's Medicaid pediatric ACO model lowers the cost of care without diminishing the overall quality of care.⁸ At the physician level, Partners For Kids uses a pay-for-performance (P4P) incentive program to reward clinic sites that manage more than 500 Medicaid children per provider, maintain National Committee on Quality Assurance (NCQA) medical home status or other quality indicators and meet certain state Medicaid quality measures.

ROCKY MOUNTAIN YOUTH CLINICS

A nonprofit, private pediatric network across Colorado is being paid a monthly, per member per month fee to provide care navigation services for at-risk children through a recently launched Medicaid program

- ❖ *Operating sponsor is headquartered in Thornton, and has 15 delivery sites across Colorado*
- ❖ *Currently operates 9 SBHCs, serving over 7,000 children annually*
- ❖ *Annual budget of \$10 million, and 100 employees*

“Our APM allows us the flexibility to provide care the way we need to, and also to offer the supportive social and wraparound services our low-income patients really need.”

- *Jessica Dunbar, Executive Director*



Organizational Background: Rocky Mountain Youth Clinics (RMYC) is a nonprofit organization that serves youth ranging from newborns to age 21 in hospitals, clinics, schools and mobile units in the three largest regions in the Denver metropolitan area, along with Larimer, Montezuma and Eagle Counties. Rocky Mountain Youth Clinics was established in 1996, as Colorado's first certified medical home to 2,000 patients. Today, RMYC has an annual budget of \$10 million, has a staff of more than 100

⁷ Harvesting the Scientific Investment in Prevention Science to Promote Children's Cognitive, Affective, and Behavioral Health; National Research Council., Washington (DC): National Academies Press (US); 2015 Apr 1.

⁸ Kelleher, Dr. KJ, Cooper, J., Deans, K., et al., Cost saving and quality of care in a pediatric accountable care organization. Pediatrics. 2015 Mar;135(3):e582-9. doi: 10.1542/peds.2014-2725. Epub 2015 Feb 9.

employees and provides a range of primary care, behavioral health, oral health, preventive care and social services to more than 22,000 patients and their families through nine school-based health centers, three pediatric ambulatory care sites and three Mobile Units. In 2015, RMYC's SBHC network provided primary care, behavioral health and oral health services as well as specialized programs and services to more than 7,000 at-risk youth.

School-Based Health Center Model: RMYC's SBHCs offer services to the students enrolled at each host school, but often also to all students enrolled within the host's school district. RMYC's sites utilize spatial arrangements to support a team-based care model that allows the care team to easily meet at a central location between and during visits to coordinate care and consult. In its main clinics, each team consists of a physician assistant or nurse practitioner, medical assistant, behavioral health consultant, care navigator and referral specialist. Some of its SBHCs also provide integrated oral health services. The medical providers and dental hygienists are direct employees, as well as half of the behavioral health providers. The other half of behavioral health providers are contracted from a local community mental health center partner. In one SBHC, a local pediatric dental residency partner affiliated with Children's Hospital Colorado embeds an oral health provider to administer restorative services. RMYC's main clinics sit on medical campuses that house a wide range of pediatric specialty healthcare providers and other relevant social service organizations that RMYC's patients and families can easily be referred to.

State Policy Overview - Colorado: RMYC is participating in Colorado's Accountable Care Collaborative (ACC), which functions as the statewide Medicaid primary care program. Implemented in May 2011, the ACC began with one practice and roughly 500 people, and now spans more than 500 practices statewide with enrollment approaching one million Coloradans. Through the ACC initiative, Medicaid patients are enrolled in primary care medical homes and are also connected to additional medical and social services. Organizations that are responsible for patient navigation, care coordination and outreach services through the ACC initiative partner with Regional Care Collaborative Organizations (RCCO). The five RCCOs (covering Colorado's seven regions) have the ability to reimburse organizations through a per member per month (PMPM) reimbursement mechanism for contracted services, including care coordination and patient navigation. RMYC has been successful in contracting with RCCOs in all of its clinics' coverage areas to be reimbursed to provide care coordination services for at-risk youth living across Colorado.

Reimbursement Mechanism: RMYC's current payor mix includes 80 percent Medicaid, and more than \$1 million a year in uncompensated care for its uninsured patients. Patient service reimbursement makes up about 85 percent of RMYC's annual revenue. As a key revenue stream, RMYC has contracted with several payors as a RCCO-delegated practice to provide care coordination services for 17,000 kids enrolled in Medicaid and CHIP.⁹ Through its RCCO contracts, RMYC is paid to provide care coordination services and referral assistance and connections to childcare, transportation and other social supports. RMYC is contracted to receive \$3 to \$5 per member per month payments to provide these essential supports for at-risk youth. Moreover, similar contracts have been negotiated with two private insurance companies, Anthem and United. These types of APM contracts with third party payors now represent almost one-tenth of RMYC's annual revenue, and is thus a key driver in the organization's financial

⁹ The Agency for Healthcare Research and Quality (2014) defines care coordination as involving "deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and this information is used to provide safe, appropriate, and effective care to the patient."

sustainability. RMYC is actively looking to grow its care navigation services to more than 20,000 kids by 2018.

MULTNOMAH COUNTY HEALTH DEPARTMENT

A county health department, certified as a Federally Qualified Health Center, is serving Greater Portland through a flat rate, prepaid arrangement with Kaiser Permanente Northwest to provide access to primary care services for hundreds of Medicaid kids

- ❖ *Operating sponsor is headquartered in Portland, with a network of 20 delivery sites*
- ❖ *Currently operates 13 SBHCs, serving over 6,600 children annually*
- ❖ *Annual budget of \$320 million, and 1,400 employees*

"We (Kaiser Permanente) recognized that we needed to be flexible in meetings kids' health needs, and because of that, SBHCs have become key pieces to achieving our goal of 'Total Health.'"

- James Schroeder, CFO/COO of Permanente Dental Associates



Organizational Background: Multnomah County is the most populous county in Oregon with almost 20 percent of the state living within its borders. The Multnomah County Health Department (MCHD) has a mission to prioritize the health needs of the most vulnerable by directly providing a range of health services in low-income communities. For fiscal year 2016, MCHD projected an annual budget of \$321.5 million, and almost 1,400 employees. During that same fiscal year, SBHCs represented \$9.25 million of the 2016 budget, with more than 60 FTEs. MCHD functions as the state's largest Federally Qualified Health Center (FQHC) network. MCHD serves a little over 70,000 patients through its seven ambulatory clinic sites, and over 6,600 at-risk youth through almost 17,000 annual visits through its 13 school-based health centers. Kaiser Permanente Northwest (KPNW) has 500,000 members and has made provisions for its school aged members to be cared for by SBHCs within the MCHD network. MCHD co-locates its integrated primary care, behavioral health and oral health clinics with several other health related services including pharmacy and Women, Infants and Children (WIC).

School-Based Health Center Model: Children seen under the Kaiser/MCHD partnership agreement receive care through a convenient, confidential and student-friendly access point. Joint Kaiser/MCHD health information technology infrastructure allows for the sharing of medical information and population and clinical outcomes data. The EPIC EHR "care anywhere" module is a critical infrastructure component which facilitates care coordination across SBHCs and KPNW. The goal of each of MCHD's SBHC is to meet at-risk youths' primary care and behavioral health needs. Staffing includes a nurse practitioner, registered nurse, medical support staff and an office assistant. Services include chronic, acute and preventive medical care, age appropriate reproductive health, immunizations, fitness and nutrition education/counseling and referrals for specialty care and social services. MCHD also offers students oral health services in the school setting. Through its partnership, Kaiser and MCHD's SBHCs encourage patients and their caregivers to seek care at the most appropriate facility.

State Policy Overview - Oregon: Oregon has an existing Medicaid 1115 waiver that launched in July 2012. The program, Oregon Health Plan, provides the state, as the payor for Medicaid services, the latitude to incorporate incentives and the inclusion of some social services under a global budget. The

waiver, granted by CMS, allows Oregon to configure a unique plan, which includes creating Coordinated Care Organizations (CCO), to address the unique needs of the uninsured and underinsured in the state. The current 16 CCOs manage primary care, behavioral health and oral health services for Oregon Health Plan (OHP) members across the state. Some CCOs are experimenting with APMS to support practice transformation and to aid providers in meeting quality performance metrics. By the end of 2012, CCOs enrolled approximately 600,000 Oregon Medicaid members (almost 90 percent of the Medicaid population), and have decreased emergency room visits and hospitalizations for certain chronic diseases in patient populations served by a Coordinated Care Organization.¹⁰

Reimbursement Mechanism: Kaiser Permanente Northwest, serving the Portland metropolitan area, entered into its “alternative payment model” agreement with MCHD in 2013. In this arrangement “commercial” (pediatric/adolescent) members can be seen at MCHD operated SBHCs, and SBHCs are reimbursed a pre-negotiated case rate for these visits. There is no cap on the number of KPNW members who wish to utilize SBHCs as an access point. KPNW members who are part of Oregon’s Medicaid program can also access care through SBHCs. The MCHD receives a flat rate, prepaid amount from KPNW based on a fee schedule as determined by state Medicaid rates for FQHCs. Services covered under this agreement include annual well-child visits, immunizations and health education services. The arrangement recognizes the value and importance of SBHCs as an entry point of care for certain school aged members of KPNW, as well as the importance of care coordination, specialty referral, and case management which a large delivery system like KPNW can provide.

Conclusion

In the wake of a new administration, changes in the direction of the Affordable Care Act and Medicaid expansion are top priorities. Under the Obama administration, a mainstay of the Affordable Care Act (ACA) was the expansion of Medicaid, the jointly funded federal and state program to provide medical care and social supports to low-income families and children. One of the hallmarks of the Affordable Care Act was to lower the income eligibility for this entitlement program. As a result, the number of uninsured children fell to record low levels not seen prior to the passage of the ACA.¹¹ Expanded Medicaid eligibility was not embraced by 23 states, effectively bifurcating the country into “expansion” and “non-expansion” states. The consequences for each state were significant in planning for the future of its Medicaid services and coverage.

In the last administration, not only were there incentives to expand Medicaid, but also support for new approaches to harness federal dollars in Medicaid to promote innovation in delivery design, and redirecting reimbursement to promote efficiency and better population outcomes. Medicaid waivers were awarded to several states that allowed State Medicaid departments to leverage federal dollars with state resources to create new mechanisms for reimbursing providers that would ostensibly provide better outcomes at lower or stabilized costs. The term “Value-Based Purchasing” (VBP) has been used to reference a cohort of new reimbursement mechanisms which channel dollars to promote different patient

¹⁰ Oregon Health Authority’s Office of Health Analytics. 2014 Performance Report, Oregon’s Health System Transformation 2014 Final Report, Published on June 24, 2015.

¹¹ Alker, Joan and Chester, Alisa. Children’s Health Coverage Rate Now at Historic High of 95 Percent. Georgetown University Health Policy Institute - Center for Children and Families. October 2016.

engagement, population management and medical therapy approaches which de-emphasize reimbursement based on volume of unit encounters (e.g. office visits), and place higher value on assuring that patients and patient panels achieve results linked to better health outcomes. “Alternative Payment Models” is a term that captures the basic underlying feature of such efforts, i.e., different mechanisms of reimbursing providers and health care systems that are premised on quality and population outcomes as opposed to volume based reimbursement.

Recognizing the real possibility that the ACA and resulting Medicaid expansion may both be subject to change and/or repeal over the next few years does not negate the necessity of payors to align reimbursement with health outcomes. Even before the recent expansion, in June 2013, more than 28 million children were enrolled in Medicaid and another 5.7 million were enrolled in Children's Health Insurance Program (CHIP).¹² From 2013 to 2015, the number of kids enrolled in Medicaid and CHIP grew by 1.7 million. This growth was largely because of the implementation of the ACA. The ACA led to the decline in the number of uninsured children in the U.S. by almost one-third (32.5 percent) during this two-year period, dropping from 5.2 million in 2013 to 3.5 million in 2015.¹³

For pediatric safety-net providers attempting to understand the potential impact of an ACA repeal and the resulting Medicaid expansion, the results would still leave more than 28 million low-income, Medicaid children in need of access to high-quality, cost effective health care services.¹⁴ Furthermore, regardless of the payment source – for instance, hypothetically, if Medicaid was completely replaced by a subsidy or tax benefit program linked to purchasing insurance on the private market – the basic principle of paying for quality of care delivered versus quantity of care delivered would remain core to reimbursement contracts. Therefore, low cost, high-quality healthcare delivery models, such as school-based health centers, will continue to play a pivotal role in delivering primary care, behavioral health and oral health in underserved communities, and in some cases, provide the wraparound social supports that low-income kids and their families need the most.

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Disclosure: Dr. Bynum and Dr. Wong currently sit on the Board of Directors of the national School-Based Health Alliance (www.sbh4all.org). Dr. Bynum is the Chair of the Outreach and Engagement Committee, and Dr. Wong is the Chair of the Policy and Advocacy Committee at the Alliance.

¹² Vernon K. Smith, Laura Snyder and Robin Rudowitz. Medicaid Enrollment: June 2013 Snapshot and CHIP Enrollment, Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation.

¹³ Alker, Joan and Chester, Alisa. Children's Health Coverage Rate Now at Historic High of 95 Percent. Georgetown University Health Policy Institute - Center for Children and Families. October 2016.

¹⁴ Arguello, Rachel, Artiga, Samantha, Rudowitz, Robin. Children's Health Coverage: Medicaid, CHIP and the ACA. The Kaiser Family Foundation - Health Reform. March 2014.