Testimony of Doug Riggs, NGrC

In Support of SB436 - - KidsLink

February 21, 2013

Chair Monnes Anderson and Members of the Committee:

Over the past several months, we have worked closely with a large group of stakeholders, advocates, patient groups, providers, insurers, and others on issues surrounding Coordinated Care Organizations. We've helped organize and participate in 17 forums, conferences and seminars in 13 cities around the state, from LaGrande to Medford, Salem to Sisters, Astoria to Bend.

We've heard a great deal of excitement about the opportunity for collaboration through the CCO process, and we've been genuinely impressed by the amazing progress being made in communities around the state. In Roseburg and Bend and St. Helens and Portland and LaGrande and Hood River and in countless communities, remarkable progress is being made. CCOs are working to bring better health care and greater efficiencies to the Medicaid population.

CCO reform, however, isn't the only reform effort taking place.

The Governor is well into a major overhaul of educational programs. And many of these programs have a direct impact on health. For instance

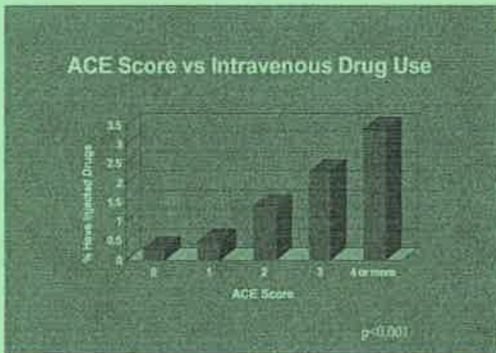
-- **The Early Learning Council** includes Healthy Start, Babies First, Head Start, Relief Nurseries, first steps to success, and many others.

--**The Youth Development Council** includes programs from the 36 Children and Families Commissions, which use Youth Investment funds for a variety of intervention, A/D, prevention and other programs that also impact the health and well being of our youth. Behavioral and physical (and oral) Health is often a fundamental building block for educational success.

This bill seeks to encourage a thoughtful discussion - - over a reasonable period of time - - on ways to integrate and maximize these various programs. The amendments to the bill clarify that we are seeking to use existing processes that CCOs will be undertaking anyway - - such as community needs assessments and updates of transformation plans - - as well as existing Community Advisory Councils to begin the discussion. Since every CCO has School Based Health Centers in their territory, and since SBHCs typically interact with programs from both the health side and the education side of the reform equation, it seemed like a natural fit to suggest that we consider ways to best utilize their services. This will vary by community, and the bill is not a mandate. Rather, it is a suggestion of a partner in undertaking this work. In many communities, the SBHC is part of a larger system - - for instance it's a part of the local Community Health Center (like Multnomah County, Virginia Garcia, La Clinica, or others). In communities where the SBHC has fewer resources, the process might be different, or the CCO and community might determine that upgrading the SBHC to connect it with a system of care might be the right approach.

Other organizations dealing with children's programs need to be at the table, including the dozens of non-profit entities working daily with OHA, DHS and the Oregon Youth Authority, Counties which are in the center of many of prevention programs, and our school system. In all cases, the bill encourages a community discussion and a community solution.

Many of you have seen the **Adverse Childhood Experiences** study. This suggests that as few as four adverse experiences by a child dramatically increase the risk of long term physical and behavioral health problems as an adult. The ACEs study suggests clearly that we need to do a better job of identifying issues and intervening early. That is a definite long term cost saver, and something that this bill could begin to put in place.



CCOs and the YDC/ELC process offer us an opportunity to more strategically focus on addressing known risks that lead to proven health and economic costs downstream. Coordination between these efforts could yield dramatic results over the long term, and that is what this bill is designed to accomplish.

I urge passage of this SB436, and appreciate the time taken today by the committee to consider this important step in the health reform process.

OREGON'S HEALTH CARE TRANSFORMATION WILL NOT BE ACHIEVED IF CHILDHOOD TRAUMA ISN'T ADDRESSED

* The "ACE" Study clearly demonstrates that Childhood Trauma negatively impacts health, quality of life, and life span. Oregon must fund children's programs which address and treat trauma.

ACE Study

Adverse Childhood Experiences

- Emotional Abuse
- Physical Abuse
- Sexual Abuse
- Emotional Neglect
- Physical Neglect
- Mother Treated Violently
- Household Substance abuse
- Household Mental Illness
- Parental Separation or Divorce
- Incarcerated Household Member

Social Ills

- suicide attempts
- substance abuse
- depression
- early sexual activity
- multiple sexual partners
- unintended pregnancies
- adolescent pregnancy
- fetal death
- health – related quality of life
- risk for intimate partner violence
- sexually transmitted diseases
- smoking
- early initiation of smoking

Any 4 of these experiences put children in these pipelines

98% of Children in out of home care have a trauma history.
51% have 7+ trauma events
80% have 4+ trauma events **

Chronic Physical Illness

- lung disease
- heart disease
- liver disease
- cancer
- skeletal fracture
- diabetes
- premature death

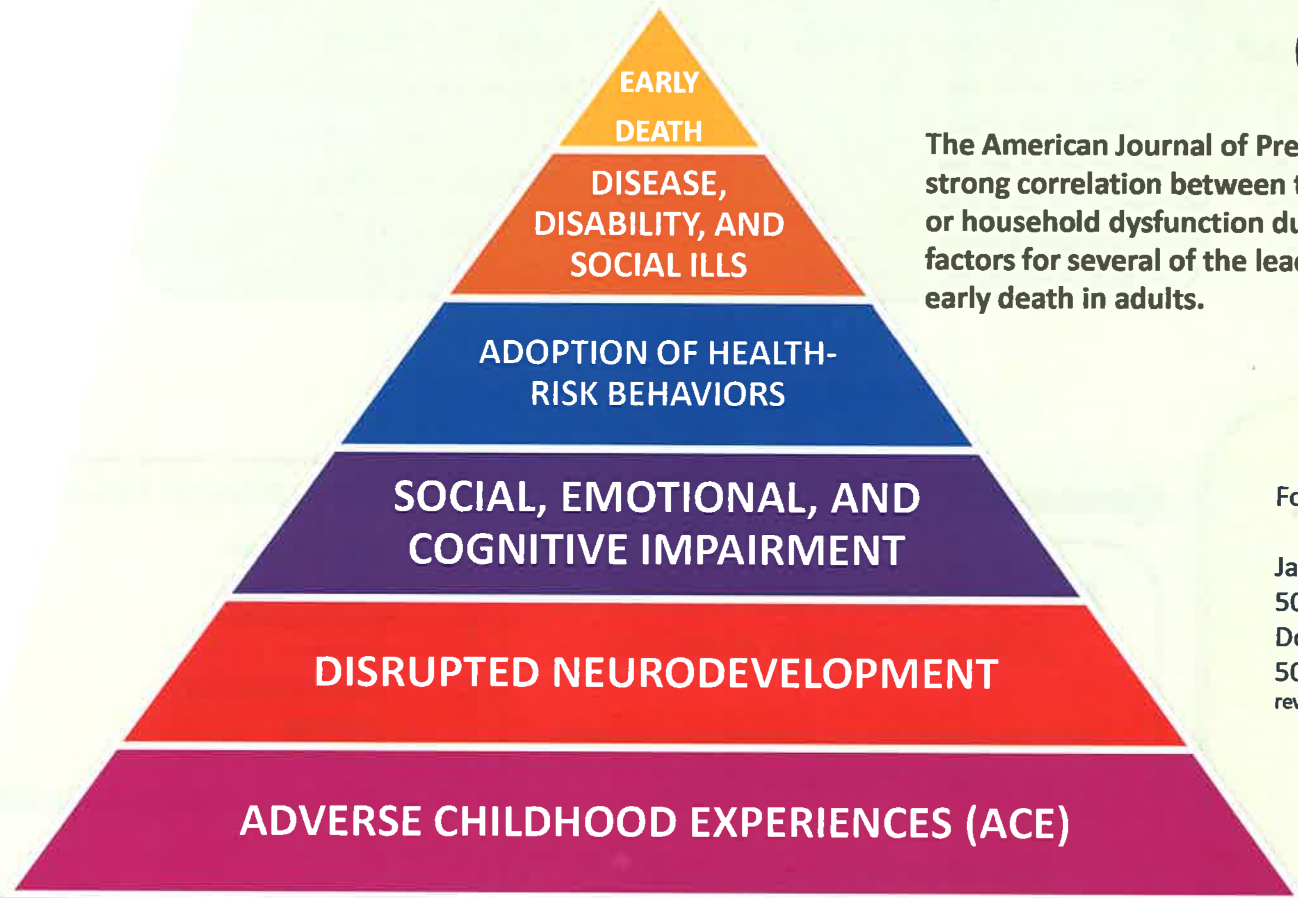
Save taxpayer dollars and save children's lives – Fund programs that prevent the pipeline

*1998 -The Center for Disease Control and Kaiser Permanente study – 17,000 participants
**2012 - Colorado Health Foundation Outcome Study

ACHIEVE OUTCOMES, RETURN ON INVESTMENT, AND SAVINGS

An investment in children today means they will not become the next chronically ill adults with complex, expensive needs. We can build healthy children, who become educated and working adults, and who will raise their own healthy families. Support evidence-based programs and services for children that address or prevent trauma!

Without intervention, Adverse Childhood Experiences (ACE) can be deadly.



Mechanisms by which adverse childhood experiences influence health and well-being throughout a lifespan

The American Journal of Preventative Medicine found a strong correlation between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of chronic illness and early death in adults.

For more information, contact:

Janet Arenz, OACP Executive Director
503-399-9076 OR
Doug Riggs, NGrC President
503-597-3866

rev. 1.18.13

Oregon School-Based
Health Care **Network**

PO Box 12191
Portland, OR 97212
503.813.6400
www.osbhcn.org

Oregon School-Based Health Care Network Recommended Amended Language for SB 436:

Each coordinated care organization shall work within its community needs assessment and include in its transformation plan a strategy and road map for working with school-based health centers to help coordinate the effective and efficient delivery of care in their community. The plan shall focus on primary care, mental health, and oral health, addressing promotion, prevention, early intervention, and treatment improvements. Such a plan shall take into consideration research, including the "Adverse Childhood Experiences" reports, and shall identify funding sources and additional funding that may be needed to meet the goals of the program. The plan shall consider whether the existing SBHC network is adequate to meet the need in its community and identify recommendations that could improve the system, including the addition or improvement of electronic medical records, billing systems, and/or integration with a larger health system or community clinic could further advance the success of the efforts.

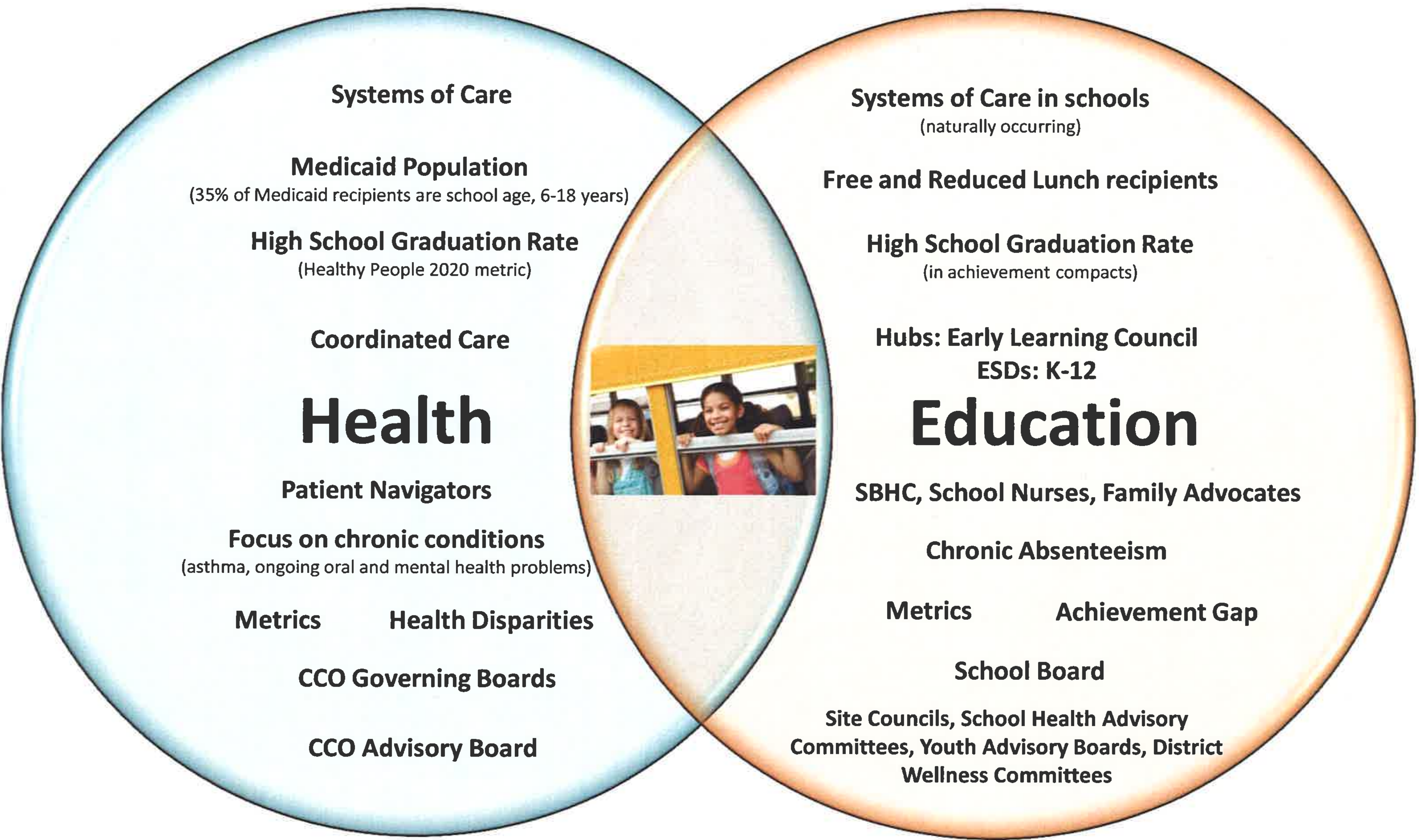
The plan shall seek to improve the integration of all services that meet the needs of children and families, including, but not limited to programs associated with:

The Early Learning Council
The Youth Development Council
The Healthy Start Family Support Service program
Relief nurseries in the region
The medical assistance programs in the regional
Public health department programs that offer preventative health services programs to children
Community health centers
Community mental health services
Oral health services
Other children's health programs
Hospitals

The CCO shall submit the plan to their respective Community Advisory Councils for review and approval.

Contact Paula Hester at 503-813-6408 or paula@osbhcn.org.

Aligning Reforms:
The Intersection of Health and Education



Healthy Kids Learn Better Coalition, 2012

Oregon School-Based Health Care Network

Patient Centered Primary Care Home and the SBHC

Position

The Oregon School-Based Health Care Network recommends that:

1) School-Based Health Centers (SBHCs) align their business and clinical practices, activities and quality to mirror Oregon's Patient Centered Primary Care Home (PCPCH) Standards.
2) Medical sponsors provide for an infrastructure that will move SBHCs to PCPCH certification.
3) Medical sponsors and Coordinated Care Organizations (CCOs) work together to ensure that every child treated in an SBHC has an electronic health record for use at the SBHC and within the framework of coordinated care.
4) CCOs recognize, reimburse and invest in SBHCs to meet the goals of better health, increased access to care and lower costs.

Relevance

The school-based health care model is child-centered and prevention-oriented primary and mental health care, delivered in an easily accessible and supportive environment located on school grounds.

School-based health care is based on best and evidenced-based practices, integrated within the school and promotes the health and educational success of school-aged children and adolescents.

SBHCs ensure easier access to comprehensive health care for all students through preventive health, care coordination, and health education services, integral components of this model.

SBHCs are specifically named in the legislation as an eligible provider of care with which CCOs can contract. The basis easily aligns with PCPCH standards and CCO mandates.

Coordination

As a vehicle of service provision, the CCOs will establish working relationships with health care providers that can demonstrate high quality services resulting in increased health and reduced cost. Oregon's Health Policy and Research office established key standards for practices to be recognized as a Patient Centered Primary Care Homes, and effectively make providers responsible for coordinating those services within the area and population they serve—even if they do not directly provide such services.

Oregon's PCPCH Standards

Access to care: Get the care you need, when you need it.
Accountability: Responsible for getting you the right care.
Comprehensive: Get all the care, information and services you need.
Continuity: Work to improve health over time.
Coordination and integration: Help navigate the system to meet your needs.
Patient and family-centered: Involve patients and their families in their care.

Position Statement: School-Based Health Centers and The Patient-Centered Medical Home

Purpose and Relevance: The patient-centered medical home (PCMH) is an innovative care delivery model designed to provide comprehensive primary care services to people of all ages by fostering partnerships between patients, families, health care providers and the community.[1] The main characteristics of the PCMH, a concept developed by the American Academy of Pediatrics (AAP), are that care to children and adolescents is coordinated, continuous, accessible, comprehensive, culturally competent, and uniquely suited to each patient.[2] School-based health centers (SBHCs) have long integrated the essential components of the PCMH in their delivery of services to children, adolescents, and their families. At its core, the ideal SBHC model represents many key attributes of an advanced patient-centered primary care system for children and adolescents.

- SBHCs enhance ***access*** to ***high quality*** primary care by situating services in the most accessible location for young people: their schools.[3,4,5]
- Because of their proximity and routine access to children and adolescents, SBHCs serve as the first (and sometimes only) contact or access point for ***continuous*** and ***comprehensive*** care for young people with complex medical, behavioral and social needs.[6]
- SBHCs utilize an interdisciplinary team approach to deliver ***coordinated*** primary care across physical, behavioral, emotional and social dimensions of health – and within the context of family and community, as appropriate.[7]
- SBHCs effectively conduct behavioral and medical screenings to identify and manage chronic illness such as asthma and diabetes, sexually transmitted diseases, mental health disorders, and substance abuse, providing opportunities for early detection and identification of potential health problems within a population of school-aged children and adolescents.[8,9,10,11]

Position Statement: NASBHC makes the following recommendations to assure that SBHCs are best positioned to serve the goals of the PCMH:

- Organizations developing PCMH standards and recognition programs should identify SBHCs among eligible primary care provider types.
- SBHCs should strive to adhere to PCMH standards required by public and private payers. Pursuit of PCMH recognition by SBHCs demonstrates the highest level of commitment to quality improvement and patient care.
- SBHCs must communicate encounter information with patients' designated primary care provider to ensure optimal coordination across primary care

partners, regardless of their ability to meet PCMH standards. Furthermore, communication between SBHCs and other providers caring for the child or adolescent should be reciprocal.

- SBHCs must assure that patient encounters in their clinic are attributed directly to the school site in order to be fully acknowledged and accounted for their specific contributions to the achievement of quality measures.

- Public and private payers should recognize the PCMH model of care as a mechanism to enhance the quality of primary care services and to improve care coordination for children and adolescents; and policies should not restrict utilization of – or compensation for – services provided at SBHCs.

Description of the Issue: National and state health care reforms place particular emphasis on enhancing the role of primary care, including the promotion of innovative care delivery models such as the PCMH. As a result, most states have developed or are in the process of developing PCMH payment programs designed to reward providers for delivering more effective health care and for ensuring care coordination across providers. PCMH recognition of SBHCs at national, state and local levels will help ensure that they are fundamental to this and other health care reform initiatives, including the formation of accountable care organizations.

Summary: NASBHC recommends practices and policies that recognize and reward the SBHC model in meeting the goals of a PCMH for children and adolescents.

References

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