The Colorado Health Foundation™

The Colorado Health Foundation's School-Based Health Care Initiative

2012-13 Evaluation Report

Published: November 2013

About the Colorado Health Foundation

Our Vision

Together, we will make Colorado the healthiest state in the nation.

The Foundation works with its partners in three community outcomes to encourage Healthy Living, increase the number of Coloradans with Health Coverage, and ensure access to quality, coordinated Health Care.

Within these three community outcomes, we have mapped out the Funding Strategies that need to be employed in order for us to succeed. Through our work, we invest our resources to:

- Develop Healthy Schools
- Promote Healthy Communities
- Optimize Coverage in Public Programs
- Ensure Adequate and Affordable Coverage
- Improve Health Care Delivery
- Build Health Care Professionals Workforce
- Accelerate the Adoption of Health Information Technology

For more information about the Colorado Health Foundation, please visit www.ColoradoHealth.org

The Colorado Health Foundation™

Authors

Sara Geierstanger
Univeristy of California, San Francisco

Shelly Kaller
University of California, San Francisco

Sally Brown, PhD
Phillliber Research Associates

Initiative Overview

Recognizing the important role that School-Based Health Centers (SBHCs) play in the health and wellness of Colorado's children, the Colorado Health Foundation launched a four-year School-Based Health Care Initiative in June 2009 to support school-based health care in communities throughout Colorado. The SBHC Initiative supported the planning and implementation of 36 new or expanded school-based health programs over four years. Funding also supported new SBHCs and/or the integration of mental or dental health services into existing SBHCs.

Eligible organizations included schools, school districts, community health centers, community hospitals, health care providers, parent or family groups, social service agencies, business groups and youth-serving and faith-based organizations. To qualify for funding from the Initiative, prospective grantees were required to complete three steps to ensure readiness, effectiveness and sustainability:

Step 1: Complete Readiness Assessment/Apply for Planning Grant: With technical assistance from the Colorado Association for School-Based Health Care (CASBHC), applicants completed a Readiness Assessment to identify community needs, resources and partners. Once completed, applicants completed an application for a planning grant.

Step 2: Prepare a Business Plan and Financial Template: Next, to help ensure long-term sustainability while identifying a program's needs, planning grantees completed a business plan and financial template. They could then receive one of two types of planning grants:

- Through June 2013, 22 organizations were awarded planning grants of up to $20,000 to develop a multi-year business plan, convene community partners and assess necessary school-based health care services. Grantees could hire CASBHC-trained consultants, or could opt to recruit their own consultants.
- Three established clinic sites that lacked formal business plans were awarded one-year operational planning grants of up to $100,000 to develop a business plan and financial template.

Step 3: Receive Implementation Grant*:* Through June 2013, 18 organizations (representing 44 SBHC sites) received implementation grants of up to $400,000 per program site to cover operating costs, based on the funding needs identified in the business plan. The Foundation also considered modest requests to construct or renovate facilities. The vast majority (90 percent) of the sites received funding to expand their existing programs. On average, the sites have been operating for eight years; 62 percent have been operating for at least three years.

Years of SBHC Operation (N=40)	
Less than one year	18%
One to two years	20%
Three to four years	10%
Five to 10 years	18%
More than 10 years	34%
Average	8 years

Implementation grantees continued efforts to start new SBHCs, expand hours or types of services provided, and reach new populations of clients. Some grantees also used funding to aid in changing medical sponsor or health provider, improving billing procedures and remodeling clinic spaces.

Evaluation Overview

To make recent findings from the Initiative available for other communities interested in building or enhancing school-based health care, the Foundation awarded a four-year evaluation grant to a team from the University of California, San Francisco and Philliber Research Associates. The evaluation strove to determine if the Initiative was effective in moving its grantees toward self-sustainability. This evaluation report focuses primarily on the data collected in 2012-13, but where useful, data is included from previous years as well. The evaluation methods are described below:

- **Analysis of Readiness Assessments and Proposals**: Throughout the evaluation grant period, the team analyzed readiness assessments and proposals completed by each grantee to develop a clearer picture of the grantees as well as their planning groups, medical sponsors, schools, school districts and communities.

- **Planning Grantee Interviews**: The evaluation team conducted telephone interviews with 13 planning grantees during the second and third year of data collection to learn about the challenges and successes they encountered.

- **SBHC Sustainability Self-Assessment Tool**: The evaluation team constructed the SBHC sustainability self-assessment tool to assess factors considered by the field to be key to sustainability: staffing, provision of services, facility, school integration, community partnerships, management practices, marketing and outreach, and funding strategies. Indicator scores for each of these areas are reported for the grantees that completed the tool for the first time (Group 1) for the year 2010-11 (n=16), and the change in their scores in 2011-12. Of these sites, three were new SBHC sites and 13 were expansion SBHC sites. In addition, scores are reported for the 24 sites that completed the tool for the first time (Group 2) for the year 2011-12. Note: Some grantees with multiple sites could not break down data by SBHC site, so data was divided proportionally by school size.

- **Implementation Grantee Interviews**: The evaluation team conducted telephone interviews with implementation grantees in 2011 (n=8), 2012 (n=9) and 2013 (n=13) to learn about their experiences, the technical assistance they received and their use of planning-grant deliverables.

- **Key Stakeholder Interviews**: To collect feedback on the Initiative, political and social support for SBHCs and their challenges and successes in Colorado, the evaluation team conducted interviews with 11 key stakeholders in spring 2011 and nine in summer 2013.

- **SBHC Case Studies**: In spring and summer 2013, two case studies were developed: Generating Patient Revenue from Billing and Financing Services for the Uninsured. Data collection methods included in-person interviews with the six participating sites and analysis of data from their SBHC sustainability self-assessment tools.

Grantee Feedback

To assess the School-Based Health Care Initiative's technical assistance and tools, the evaluation team asked grantees to rate the helpfulness and difficulty of these resources on a five-point scale. Based on the ratings from grantees, the team calculated an average rating.

Readiness Assessment: The readiness assessment was intended to help applicants identify community needs, resources and partners. In 2012, grantees scored this tool's helpfulness a 3.79 (5 is most helpful) and it's difficulty 3.17 (5 is most challenging). The sites appreciated that it helped to establish the need for services and provided a vision and plan. However, it was challenging for many to complete because of the time required to compile detailed data across multiple sites. After submitting the readiness assessment, only a few sites reported using the information compiled for grant applications or reporting required by other funders.

Business Plan: Planning grant recipients developed multi-year business plans, describing their project's purpose, the problem to be addressed, school and district information, organization and management structure, marketing and communications plans, and financial and situational needs. In 2012, grantees scored the business plan's helpfulness a 4.00 (5 is most helpful) and its difficulty 3.80 (5 is most challenging). In 2012 and 2013, most grantees reported that they had gone back to use the Business Plan in the past year, but few had updated it. The business plan helped grantees lay out their goals and objectives and they referred to it during the implementation phase to ensure they were on track for meeting their goals and deliverables, and as a resource in producing new grant proposals. Some reported that the main challenge was making the document clear and concise.

Financial Templates: Grantees completed financial templates to project estimates of revenues and costs for the next four years of the site's operation. In 2012, grantees scored the financial template's helpfulness a 4.20 (5 is most helpful) and it's difficulty 4.20 (5 is most challenging). Several grantees needed assistance completing financial templates and many were not confident in the accuracy of their projections. Challenges included differences between what was asked for and how their lead medical agency or SBHC tracked data and accurately estimating billing revenue. Despite these difficulties, grantees reported that the tool was helpful and that they have referenced it to plan budgets for upcoming years, to update strategic plans, and to gauge their SBHC's productivity and financial viability.

Sustainability Self-Assessment Tool: In 2013, grantees scored the SBHC sustainability self-assessment tool's helpfulness a 4.10 (5 is most helpful) and its difficulty 3.20 (5 is most challenging). The tool was helpful as a reminder of areas to focus on regarding sustainability, "to help us see where we are doing well and what we need to improve." To improve the tool, grantees suggested that program level versus site level data would be easier to provide, that trainings on how to complete the tool would be helpful, and continued partnerships with other organizations to share data is appreciated to reduce the amount of data needed in reporting. One grantee said, "I do hope we have to complete the tool again," because they feel that their data will gain strength and accuracy.

Sustainability: Grantee Self-Assessments and Interviews

Sustainability Factor No. 1: Facility

Facility Indicators: A sufficiently large and well-equipped facility is important to a SBHC's success. The size of the SBHC clinics ranged from 90 to 2,500 square feet, with an average of 849 square feet. All grantees in both Group 1 and Group 2 scored at or near full implementation for each of the facility indicators. There were no substantial changes in 2011-12 for Group 1.

Facility Indicators 1=Not in Place/Considered 2=In Planning 3=Partially Implemented 4=Fully Implemented	Group 1 2010-11 Baseline (N=16)	Group 1 Change from 2010-11 to 2011-12 (N=16)	Group 2 2011-12 Baseline (N=24)
SBHC includes at least the following functional elements:			
Access to computers and telecommunications equipment	4.00	0	4.00
One exam room	4.00	0	4.00
A designated waiting/reception area	3.81	0.13	4.00
A counseling room/private area	3.88	0	4.00
Functional areas are designed to facilitate privacy; confidentiality; safety; and secure storage	3.75	0.06	4.00
SBHC occupies a dedicated space on school campus used exclusively for the purpose of providing SBHC services	4.00	-0.13	4.00
Average Score	**3.92**	**0.01**	**4.00**

Although they score highly in the indicators listed above, grantees wrote about additional facility needs:

- "Space is a major challenge in this SBHC that used to be a photo lab. We recently held a meeting with the principal, the district administrator in charge of facilities, the nurse practitioner/clinic coordinator, and me to determine if it's possible to re-design the space in order to enlarge the clinic and make the current clinic space more effective."
- "There is no toilet in the one-room clinic so adolescent patients have to walk down the school hallway with empty specimen containers to get to the bathroom where they can collect specimens. Then they have to walk back down the hall with the specimens - hopefully without other students or staff seeing it. It would be much more confidential if a toilet could be installed in the clinic."
- "Students must walk through a small conference room where meetings are held in order to get to the clinic. This is due to the fact that there is no entrance from the hallway into the clinic. This is not ideal."
- "There was a huge challenge, prior to having our own building, as the space was so very small and the confidentiality for the children was challenged, as they waited in the front area of the elementary school. This was addressed by raising money to build a SBHC."

Sustainability Factor No. 2: Staffing

Staffing Indicators: Interaction with clients, school staff and administration promotes the positive perception of SBHCs within the community. Also, the quality of care delivered impacts client outcomes and satisfaction. In 2011-12, the average score for the staffing indicators was near full implementation for both Group 1 and Group 2, with Group 1 sites having reported improvements from baseline in developing their organizational charts and written job descriptions.

Staffing Indicators 1=Not in Place/Considered 2=In Planning 3=Partially Implemented 4=Fully Implemented	Group 1 2010-11 Baseline (N=16)	Group 1 Change from 2010-11 to 2011-12 (N=16)	Group 2 2011-12 Baseline (N=24)
Annual assessment of staff training needs and provision of training of staff as indicated	3.50	0.38	3.96
Organizational chart with clear lines of authority and supervision	3.50	0.38	3.92
Hiring strategies to meet student cultural and language needs	3.69	0.19	3.96
Written job descriptions for all staff involved in SBHC operations	3.75	0.06	3.92
Average Score	**3.61**	**0.25**	**3.94**

Number of Staff: On average, the SBHC sites had 0.76 full time equivalent (FTE) staff members serving in the role of primary care and 0.9 FTE staff members serving in the roles of mental health provider and clinical support staff. They also had, on average, 1.7 other staff, which might include the clinic coordinator, outreach worker and administrative assistance. Of the five sites that reported having dental providers, they had on average 0.03 FTE dental staff members. Very few of the SBHC sites reported any turnover in these positions during the past year.

Type of Staff	Primary Care – Health (n=40)	Mental Health (n=35)	Clinical Support (n=35)	Primary Care – Dental (n=5)	Other Staff (n=33)
FTE (mean)	0.76	0.89	0.90	0.03	1.70
FTE turn over (mean)	0.06	0.06	0.12	0.0	0.15

Spotlight: Staffing Challenges: Although "having an organizational chart with clear lines of authority and supervision" scored high for both groups, some grantees did mention that the lack of a strong clinical liaison between the SBHC and the school district and/or someone to oversee the staff from the multiple SBHC partnerships was a challenge. A few sites that had recently changed sponsors mentioned that lines of authority and responsibilities for the various staffing duties (clinical and administrative) were not yet clarified. Another staffing challenge is delivering clinical services when providers are also required to wear multiple hats and perform vital administrative functions (front desk support, billing, coding, etc.).

Sustainability Factor No. 3: Provision of Services

Services Indicators: In 2011-12, the average score for the services indicators was also near full implementation for both Group 1 and Group 2, with Group 1 sites having reported improvements from baseline in conducting needs assessment of student health and reducing the barriers to access. It is important to note that for Group 2 at baseline, conducting needs assessments was their lowest scoring indicator.

Services Indicators 1=Not in Place/Considered 2=In Planning 3=Partially Implemented 4=Fully Implemented	Group 1 2010-11 Baseline (N=16)	Group 1 Change from 2010-11 to 2011-12 (N=16)	Group 2 2011-12 Baseline (N=24)
Conducts needs assessment of student health before implementation and ≥3 years thereafter	3.38	0.44	3.29
In collaboration with school staff, addresses barriers to access including proximity, safety, transportation and hours	3.69	0.31	3.96
Arranges for 24-hour, seven days per week coverage for services	3.06	0.25	3.88
Follows clinical practice guidelines with formalized standards of care that address all aspects of program operation	3.56	0.13	4.00
Conducts outreach to enroll students and encourage SBHC use	3.94	0.06	4.00
Has an administrator for overall program management, quality of care, coordination with school and collaborating partners	3.94	0.06	4.00
Extends eligibility to all students attending SBHC host school[1]	4.00	0	4.00
Makes efforts to ensure program and services are welcoming and respect the diverse culture of students and families served	4.00	0	4.00
Complies with federal and state regulations (e.g., ADA, HIPPA)	3.94	0	4.00
Has a system for gathering student and parent feedback	3.69	0	3.75
Has inter-professional care management that includes coordination of care among all health care staff in the SBHC	3.63	-0.19	4.00
Average Score	**3.71**	**0.10**	**3.90**

Utilization Rate and Hours of Service: Successful SBHCs have designed and tailored services to best meet their school community's needs. In 2011-12, the SBHCs reported that their utilization rate, which is the number of unique users compared to the school's total population, was 70 percent[2]. On average each SBHC provided 2,056 visits per year to 546 clients. They SBHCs were open on average 33 hours per week during the school year and six hours per week in the summer months.

Spotlight: Integrated Care: The grantees described the advantages of their integrated care model in which primary care, mental health and even oral health services are coordinated. The grantees reported that 72 percent of services provided in 2011-12 were for primary care, 23 percent of services were for behavioral health services, and 5 percent were for dental health services.

[1] May choose to extend eligibility to other youth in the community and/or students attending other schools.
[2] Some sites serve a larger population than just their student population, resulting in a utilization rate > 100 percent.

Primary Care Services: All sites provided on-site comprehensive health assessments (100 percent), medication prescriptions (100 percent), and acute and chronic illness treatment (100 percent). Virtually all provided sports physicals (98 percent), screenings (vision, hearing, scoliosis) (92 percent), immunizations (88 percent) and nutrition counseling (88 percent). The majority also provided on-site pregnancy testing (95 percent), sexual risk assessment and counseling (92 percent), Chlamydia and Gonorrhea testing (80 percent), HIV testing (77 percent) and HPV immunizations (70 percent).

Behavioral Health Services: Nearly all of the sites provided on-site standardized behavioral risk assessment (97 percent), mental health treatment (88 percent), and assessments (86 percent). Many sites reported that they would like to expand their behavioral health services to meet the growing needs. One wrote, "We also need more funding for a full-time therapist at this SBHC. There is tremendous need for behavioral health services for this large (1,800 students) population of under-served adolescents. With no way to bill for mental health and only an occasional small grant, there isn't a way to financially sustain more mental health. Yet there is a high demand for these services and all funding sources want school-based health centers to be integrated."

Dental Health Services: The majority of sites provided on-site dental hygiene education (80 percent). Some provide dental screening/risk assessment (48 percent), fluoride varnish (30 percent), dental cleaning (20 percent) and sealants (18 percent).

Sustainability Factor No. 4: Funding Strategies

Funding Strategies Indicators: Effective funding strategies ensure that SBHCs have reliable revenue sources. At baseline, Group 2 grantees were at or near full implementation for each funding indicator. Group 1 neared full implementation by 2011-12 in each area, except billing policies and systems. Group 1 made the most progress in implementing sliding scale payments.

Funding Strategies Indicators 1=Not in Place/Considered 2=In Planning 3=Partially Implemented 4=Fully Implemented	Group 1 2010-11 Baseline (N=16)	Group 1 Change from 2010-11 to 2011-12 (N=16)	Group 2 2011-12 Baseline (N=24)
Has a sliding fee scale that facilitates care for users of SBHC regardless of ability of user to pay	3.31	0.50	3.96
Conducts outreach and application assistance to families with students eligible for Medicaid, and CHP+	3.81	0.19	4.00
Has a process for getting the funds generated from Medicaid and third party billing returned to the operating budget of the SBHC	3.44	0.13	4.00
Has an effective and efficient billing system	3.25	0.06	3.83
Has written billing policies for SBHCs[3]	3.38	-0.07	3.96
Average Score	**3.44**	**0.16**	**3.95**

Patient Revenue: Group 1 reported an average increase in patient revenue from 2010-11 to 2011-12 of $7,301 from Medicaid, a federal-state program that provides health insurance to low-income Americans. Although becoming credentialed to bill private insurance is resource intensive[i], they also reported an average increase of nearly $3,000 from this source. However, there was an average decline of $1,244 in revenue from Colorado Health Plan *Plus* (CHP+), a low-cost health insurance for uninsured children whose families earn too much to qualify for Medicaid, but cannot afford private insurance.[ii]

Group 2 in 2011-12 reported average patient revenue from Medicaid of $96,468, from CHP+ $15,220, and from private insurance $13,342. These amounts are much higher than Group 1 revenue both at baseline in 2010-11 and at follow-up in 2011-12.

Mean Patient Revenue	Group 1 2010-11 Baseline Mean (N=16)	Group 1 Change from 2010-11 to 2011-12 (N=16)	Group 2 2011-12 Baseline Mean (N=24)
Medicaid	$30,230	$7,301	$96,468
CHP+	$4,753	($1,244)	$15,220
Private Insurance	$1,793	$2,861	$13,342
Patient Self Pay	n/a	n/a	$1,248
Other Patient Revenue	n/a	n/a	$42
CHAMPUS, TRICARE, Other government	$14	$88	$86
Total	**$40,183**	**$9,634**	**$126,405**

[3] Includes processes for recording, charging, billing, and collecting for services rendered.

Spotlight: Improved Billing Systems: Grantees described their successes at improving their billing systems to collect additonal patient revenue:

- "We are now successfully billing Medicaid and CHP+ insurances and continue to see increases in revenue on a monthly basis."
- "We moved forward with our new medical sponsor, and started the process of preparing for implementation of an electronic health record and a billing process. These efforts, when implemented, will allow us to provide quality care…and generate revenue for the SBHC."
- "We are making a transition to external billing from internal billing; it will save about $30,000/year and hopefully improve the billing process and thus, increase revenue."
- "We are taking several steps to improve our coding including training by an external billing consulting firm, training by our new electronic health records system, and coding trainings at every meeting of the providers."

Non-Patient Revenue: Group 1 reported an average increase from 2010-11 to 2011-12 from Government non-patient revenue of $65,799 and from in-kind sources of nearly $50,000. However, there was an average decline of over $20,000 from private non-patient revenue sources. Private sources of non-patient revenue in 2011-12 for Group 2 brought in approximately twice as much as government or in-kind sources.

Mean Non-patient Revenues	Group 1 2010-11 Baseline Mean (N=16)	Group 1 Change from 2010-11 to 2011-12 (N=16)	Group 2 2011-12 Baseline Mean (N=24)
Government	$55,844	$65,799	$38,615
Private	$74,836	($20,081)	$79,826
In-Kind	$46,364	$49,899	$42,083
TOTAL	**$132,769**	**$147,406**	**$160,524**

Clinic Expenses: The largest source of clinic expenses for both Group 1 and Group 2 was salaries and benefits. Group 1 reported an overall average increase in clinic expenses from 2010-11 to 2011-12 of $127,053; most of this was for salaries and benefits and in-kind costs.

Clinic Expenses	Group 1 2010-11 Baseline Mean (N=16)	Group 1 Change from 2010-11 to 2011-12 (N=16)	Group 2 2011-12 Baseline Mean (N=24)
Salaries and Benefits	$130,872	$46,179	$178,170
In-Kind Costs	$44,744	$59,034	$42,083
Program Costs	$16,538	$12,883	$17,582
Administrative Costs	$15,766	$8,958	$3,438
TOTAL	**$207,921**	**$127,053**	**$241,272**

Sustainability Factor No. 5: Management Practices

Management Indicators: Group 1 grantees scored lower than Group 2 at baseline in management indicators. However, Group 1 reported improvements in 2011-12 in outcome tracking and monitoring clinical or practice management measures. Group 1 lost some ground with the ongoing involvement of advisory groups (community and youth).

Management Indicators 1=Not in Place/Considered 2=In Planning 3=Partially Implemented 4=Fully Implemented	Group 1 2010-11 Baseline (N=16)	Group 1 Change from 2010-11 to 2011-12 (N=16)	Group 2 2011-12 Baseline (N=24)
Has data collection systems and capacity to collect data in place to track student health and academic outcomes	2.69	0.63	3.96
Has at least two clinical or practice management measures per year monitored and evaluated for improvement	3.31	0.31	3.96
Has a plan for continuous quality improvement	3.50	0.25	3.96
Provides evidence of ongoing involvement of the designated health care provider in clinical policies and procedures development, records review, and clinical oversight	3.56	0.20	4.00
Has a written policy addressing exchange of information between the SBHC provider staff and school health staff in accordance with HIPAA and FERPA	3.19	0.19	4.00
Has a written record of progress toward selected measures	3.19	0.13	3.96
SBHC develops an annual budget that describes all sources and uses of funding, including the estimated value of in-kind support	3.88	0.06	3.96
A single, integrated electronic health record facilitates the provision of care for the youth who use the SBHC	3.13	0.06	3.96
Obtains signed parent/guardian consent (or student permission) to obtain school health services records or share SBHC records	4.00	0	4.00
Prior to implementation, new SBHC develops a business plan Periodically updates business plan/strategic plan	3.75	-0.06	3.96
Collects financial data and are capable of reporting revenues and expenses by commonly accepted line items	3.75	-0.13	3.96
Establishes or works with an existing community advisory council to assist in planning and implementation	3.94	-0.50	3.88
Solicits youth involvement through membership on advisory council/committee, or another formalized mechanism	2.94	-0.56	3.00
Average Score	**3.45**	**0.04**	**3.89**

Spotlight: Electronic Health Records: Most grantees have implemented EHR for clinical practice management and billing purposes. Some sponsoring agencies pay third party billers to process the claims, while others use in-house billing staff. Grantees and stakeholders emphasized the importance of an investment in billing infrastructure through initial and ongoing training of staff in billing and coding. Staff members also need feedback on which services actually get reimbursed. As one stakeholder said, "If it just goes to a black hole, they'll never learn. There needs to be a feedback loop." Another said, "A coding and billing assessment, by provider, shows where money is being left on the table." Another advantage of EHRs is the ability to generate reports showing levels of patient care and outcomes, for internal quality improvement and for various accreditations and funders.

Sustainability Factor No. 6: School integration

School Integration Indicators: Another important determinant for sustainability is how well the SBHC integrates and coordinates with the school. The Group 1 sites reported lower levels of school integration than the Group 2 sites at baseline. However, the Group 1 sites reported major improvements in 2011-12 in being a major partner in school-wide programs, advocating for school health programs/policies, seeking joint funding opportunities, participation in school-wide committees and having a policy about the roles of the SBHC and school nurse. Additionally the mean scores for support, engagement and collaboration (detailed tables are presented on the next page) were converted to a four-point scale and added to the table below.

School Integration Indicators 1=Not in Place/Considered 2=In Planning 3=Partially Implemented 4=Fully Implemented	Group 1 2010-11 Baseline (N=16)	Group 1 Change from 2010-11 to 2011-12 (N=16)	Group 2 2011-12 Baseline (N=24)
SBHC is a major partner in the school-wide programs (i.e., nutrition/health programs, school events, peer education/ mediation)	2.50	0.69	3.21
SBHC advocates for school level health programs and policies, (i.e., school improvement plans, accreditation, school curriculum plans)	1.88	0.69	4.00
School/district seeks joint funding opportunities with the SBHC to obtain or expand resources/programs for SBHC	3.00	0.63	3.00
SBHC staff members are active members of any school-wide committee that meets at least monthly	3.44	0.40	3.50
SBHC has written policy about delineating roles and responsibilities of SBHC and the school nurse	3.25	0.38	3.54
SBHC is involved in decision-making regarding school level health programs and policies	1.94	0.20	3.61
SBHC gives consideration to co-locating its personnel with the school health staff, such as the school nurse	2.88	0.19	3.63
SBHC staff gives in-services to school staff or serves as consultants to teachers on health-related issues	3.69	0.13	3.33
SBHC advocates for district-wide health programs and policies (i.e., wellness policies)	2.44	0.13	3.79
Strong communication and coordination exists between SBHC staff and school/district health staff	3.75	-0.13	4.00
Average School Stakeholder Support	3.94	-0.11	3.55
Average School Stakeholder Engagement	2.66	0.02	2.79
Average School Health Provider Collaboration	3.12	0.17	3.52
Average Score	**2.96**	**0.26**	**3.50**

School Stakeholder Support and Engagement: The next two tables show that overall school administration, teacher, student and staff support for SBHCs is higher than their actual engagement. When asked about the barriers to engaging students, grantees explained that often the students who are involved are the joiners or high achieving students. Others said that they simply do not have the SBHC staff time required to do youth engagement work in a meaningful way. Group 2 grantees reported higher levels of student engagement. Examples of how SBHCs have engaged youth including youth advisory boards, asking students to create signs, artwork and posters for the SBHCs, and peer health education.

Level of Support 1=Very Opposed; 2=Somewhat Opposed; 3=Neutral or Not Aware; 4=Somewhat Supportive; 5=Very Supportive	Group 1 2010-11 Baseline (N=16)	Group 1 Change from 2010-11 to 2011-12 (N=16)	Group 2 2011-12 Baseline (N=24)
School administration	4.88	0	4.46
Teachers (n=39)	4.88	-0.07	4.46
School district/school board	4.94	-0.13	4.38
Other school staff	4.94	-0.25	4.46
Students	4.94	-0.25	4.46
Average Score	**4.92**	**-0.14**	**4.44**

Levels of Engagement 1=Little to No Awareness; 2=Aware, but not involved; 3=Takes small "easy" actions; 4=Takes larger, more difficult actions; 5=Independently initiates action	Group 1 2010-11 Baseline (N=16)	Group 1 Change from 2010-11 to 2011-12 (N=16)	Group 2 2011-12 Baseline (N=24)
School administration	4.00	0.19	3.92
Teachers	3.00	0.13	3.13
School district/ school board	3.50	0.06	3.58
Other school staff	3.25	0.06	3.17
Students	2.88	-0.31	3.67
Average Score	**3.33**	**0.03**	**3.49**

School Health Provider Collaboration: Reported levels collaboration between the SBHCs and school health providers is quite high. Many sites coordinate their SBHC provider and school nurse schedules to maximize service coverage. One, "If a client has a problem beyond the scope of the school nurse's care, she'll reschedule the client when the SBHC provider is there. That's the beauty of the model."

Levels of Collaboration with the SBHC 1: Minimal; 2: Basic at a Distance; 3: Basic On-Site; 4: Close in a Partly Integrated System; 5: Close in Fully Integrated System	Group 1 2010-11 Baseline (N=16)	Group 1 Change from 2010-11 to 2011-12 (N=16)	Group 2 2011-12 Baseline (N=24)
School nurse	3.63	0.31	4.33
Other health providers at the school	3.94	0.25	4.50
School counselors/ behavioral health staff	4.14	0.06	4.38
Average Score	**3.90**	**0.21**	**4.40**

School District In-Kind Support: For Group 1 and 2 combined in 2011-12, the average amount of school district in-kind support was $31,567 in 2011-12. Most sites reported that these in-kind amounts were accurate and not challenging to estimate. However, estimating the value of clinic space was most challenging. Nearly all sites expect the same levels of school-district in-kind support next year.

Combined Group 1 & 2: 2011-12 School District In-Kind Support, Yearly (N=40)	**Mean**	**Range**
Facility (Space, Utilities, Janitorial, Maintenance, Security)	$21,895	$1,500 – $320,408
Staff (Mental Health, Other Clinical, Administrative, Other)	$9,210	$0 – $59,114
Technology (Telephones, Internet, Staff, IT Support)	$463	$0 – $5,000
TOTAL	**$31,567**	**$1,530 - $327,203**

Sustainability Factor No. 7: Community Partnerships

Community Partnerships Indicators: Securing strong community partners and obtaining their support and engagement is a huge part of sustainability for SBHCs. All grantees had fully implemented stakeholder participation, and were at near full implementation for community partnerships. Additionally the mean scores for support, engagement and collaboration (detailed tables are presented following this table) were converted to a four-point scale and added to the table below.

Community Partnership Indicators 1=Not in Place/Considered 2=In Planning 3=Partially Implemented 4=Fully Implemented	Group 1 2010-11 Baseline (N=16)	Group 1 Change from 2010-11 to 2011-12 (N=16)	Group 2 2011-12 Baseline (N=24)
Solicits participation from other key community stakeholders	4.00	0	4.00
With signed release, communicates with primary care provider to avoid duplication and improve coordination of care	3.75	-0.06	3.71
Average Parent and Local Community Support	3.86	-0.15	3.37
Average Parent and Local Community Engagement	2.18	0.08	2.22
Average Lead Medical Agency and Community Partner Collaboration	3.22	-0.12	3.78
Average Score	**3.40**	**-0.05**	**3.42**

Support from parents and the local community is much higher than their actual engagement. Taking time to be involved in their school is a challenge given their economic challenges. One grantee explained, "Families are strapped, they might have several children and/or several jobs so it is hard to get parental involvement. They do give feedback [in our satisfaction survey] and the ratings are high." Another echoed this by saying, "Even though parents are very grateful for services, they don't have energy and time to go get involved. Most live day to day and it is hard to get them involved."

Level of Support 1=Very Opposed; 2=Somewhat Opposed; 3=Neutral or Not Aware; 4=Somewhat Supportive; 5=Very Supportive	Group 1 2010-11 Baseline (N=16)	Group 1 Change from 2010-11 to 2011-12 (N=16)	Group 2 2011-12 Baseline (N=24)
Parents	4.88	-0.13	4.38
Local community	4.75	-0.25	4.04
Average Score	**4.82**	**-0.19**	**4.21**

Levels of Engagement 1=Little to No Awareness; 2=Aware, but not involved; 3=Takes small "easy" actions; 4=Takes larger, more difficult actions; 5=Independently initiates action	Group 1 2010-11 Baseline (N=16)	Group 1 Change from 2010-11 to 2011-12 (N=16)	Group 2 2011-12 Baseline (N=24)
Local community	2.88	0.19	2.83
Parents	2.56	0	2.71
Average Score	**2.72**	**0.10**	**2.77**

Community Collaboration: However, collaboration with the lead medical agency and other community partners is quite high, particularly with Group 2 grantees at baseline.

Levels of Collaboration with SBHC 1: Minimal; 2: Basic at a Distance; 3: Basic On-Site; 4: Close in a Partly Integrated System; 5: Close in Fully Integrated System	Group 1 2010-11 Baseline (N=16)	Group 1 Change from 2010-11 to 2011-12 (N=16)	Group 2 2011-12 Baseline (N=24)
Your lead medical agency	4.13	0.13	4.96
Other community partners	3.93	-0.43	4.47
Average Score	**4.03**	**-0.15**	**4.72**

Community In-Kind Support: For Group 1 and 2 combined in 2011-12, more in-kind support was provided from the lead agency than from other community agencies. Most of these contributions were for staff.

Combined Group 1 & 2: 2011-12 In-Kind Contributions (annual) (N=40)	
Lead Agency	
Services (Billing, financial, legal)	$1,884
Donations (Medical, pharmaceuticals, lab tests, office supplies)	$5,817
Staff (Primary care, admin, mental health)	$20,943
TOTAL from Lead Agency	**$28,644**
Community Agencies	
Services (Legal, other)	$814
Donations	$0
Staff (Mental health)	$5,736
TOTAL from Other Community Agencies	**$6,549**

Sustainability Factor No. 8: Marketing and Outreach

Marketing and Outreach Indicators: Marketing and outreach has also been identified as a key element in SBHC sustainability. Group 2 grantees scored lower than the Group 1 grantees at baseline in the marketing indicators. The lowest scoring baseline indicator for Group 2 was having a clear strategy to address opposition. Group 1 had also scored low at baseline in this indicator, but had improved by 2011-12. Grantees that had not developed strategies for opposing views reported that there was not any vocal community opposition. Another low scoring indicator for both groups was having a written marketing plan. The Group 1 sites declined in this area by 2011-12. Group 1 sites improved, however, in using data or research to promote their services.

Marketing and Outreach Indicators 1=Not in Place/Considered 2=In Planning 3=Partially Implemented 4=Fully Implemented	Group 1 2010-11 Baseline (N=16)	Group 1 Change from 2010-11 to 2011-12 (N=16)	Group 2 2011-12 Baseline (N=24)
Has a clear strategy for addressing opposition from different audiences	2.93	0.47	2.04
Uses data or research to promote school health services (n=39)	3.25	0.44	3.26
Uses a variety of marketing and outreach strategies (e.g., open houses, advertising that engages and peer-to-peer outreach)	3.94	-0.06	3.00
Has crafted messages on school health services for different audiences (e.g., students, parents, school staff and the general public)	3.87	-0.33	3.04
Has a written marketing plan	2.81	-0.69	2.21
Average Score	**3.36**	**-0.15**	**2.71**

Perspectives on the Impact of Health Care Reform

A common sentiment among grantee and key stakeholder interviewees is uncertainty about how the Affordable Care Act (ACA) would affect SBHCs in Colorado. As one stakeholder said, "This is the million-dollar question." How Colorado and other states choose to move forward with health care reform will determine how SBHCs are affected. Another stakeholder commented, "It has great potential [for SBHCs] and could also pose some serious challenges going forward." Stakeholders felt that this was a critical time for SBHCs to demonstrate their value as essential community providers and as a crucial part of Colorado's safety net for youth. SBHCs will have to negotiate how they will fit into health care reform, but appear well-positioned given their history of providing care in line with the principles of the ACA.

Accountable Care Collaborative: Colorado's Accountable Care Collaborative includes seven Regional Care Collaborative Organizations (RCCOs), each responsible for developing networks of primary care providers.[iii] The RCCOs receive state funded per-member-per-month funding, and then pay qualified medical home providers a per-member-per-month rate of $4. Approximately 40 SBHCs are enrolled as primary care providers in the RCCOs. As regional providers, they must abide by several requirements, including serving as a focal point to coordinate patient care, ensuring access to 24/7 telephone coverage, and providing extended day and weekend hours.[iv]

Medicaid Expansion: Given that ACA Medicaid expansion affects adult eligibility, but not children, most did not predict significant changes in SBHC revenue. However, some hoped that enrolled parents would be more likely to enroll their children in coverage. SBHCs also do not expect their uninsured population to shrink dramatically due to Medicaid expansion. Colorado SBHCs have excelled at enrolling eligible clients in Medicaid and most remaining uninsured clients are uninsurable.

Health Insurance Exchange: Colorado's new health insurance exchange, Connect for Health Colorado, is scheduled to begin enrollment in October 2013. Interviewees speculated about the role SBHCs might play and challenges involved with this new process. One explained that in theory, Connect for Health Colorado would help the working poor, those who make too much money to qualify for Medicaid/CHP+ but not enough to afford private insurance. SBHCs could help connect families to get insured and bill for those who do enroll in these insurance plans. There is uncertainty, however, about how many SBHC clients will qualify or whether the new competitive insurance plan rates through the exchange will be low enough for families to afford. Another question is whether tax benefits will be enough of an incentive for families to purchase insurance or if they will pay the fine[4] for not having it instead. Similarly, small businesses may not be able to afford to provide insurance to their employees or larger companies may choose to pay a penalty, rather than providing health insurance. Some stakeholders thought that the exchange might help develop a culture of coverage. One said, "It will take a time, but there will be shift to people valuing and understanding health care coverage."

[4] The fee will be 1 percent of income (or $95 per adult, whichever is higher) in 2014 and will increase to 2.5 percent of income (or $695 per adult) in 2016. The fee for children is half the adult amount. In 2014 the fee for uninsured children is $47.50 per child. The most a family would have to pay in 2014 is $285.

Summary

As the School-Based Health Care Initiative draws to a close, grantees expressed appreciation for the funding, noting that they have made significant improvements by expanding SBHC services and increasing patient revenue, and still have big plans for continuing to increasing access to and quality of care. Given the challenges of securing ongoing private and government revenue, and the need to become integrated into the changing health care landscape, SBHCs recognize the importance of focusing on each of the sustainability indicators and in particular the business side of providing healthcare.

Sustainability Scores 1=Not in Place/Considered 2=In Planning 3=Partially Implemented 4=Fully Implemented	Group 1 2010-11 Baseline (N=16)	Group 1 Change from 2010-11 to 2011-12 (N=16)	Group 2 2011-12 Baseline (N=24)	2011-12 Combined Snapshot *Group 1 & 2* (N=40)[5]
Facility Indicators	3.92	0.01	4.00	3.97
Staffing	3.61	0.25	3.94	3.91
Provision of Services	3.71	0.10	3.90	3.86
Funding Strategies	3.44	0.16	3.95	3.81
Management	3.45	0.04	3.89	3.73
Community Partnerships	3.40	-0.05	3.42	3.39
School Integration	2.96	0.26	3.50	3.39
Marketing and Outreach	3.36	-0.15	2.71	2.91

As shown above, the highest scoring group of indicators for all grantees combined in 2011-12 was SBHC **facility** and **staffing** (3.97, 3.91). Grantees scored at or near full implementation on these indicators, with functional and dedicated spaces for the SBHC and clear hiring and training strategies for staff. **Provision of Services** also scored highly (3.86), as SBHCs collaborate with school partners to reach eligible clients with quality health services.

Funding and **management strategies** scored highly as well (3.81, 3.73). Grantees excel at outreach and enrollment for Medicaid, and are making strides in setting up billing systems. Some are gearing up to expand outreach efforts and deploy outreach workers to educate families on the insurance options available to them. SBHCs are eager to generate patient revenue to support unbillable services, alleviating some of the pressure financially. Group 1 reported improvements in 2011-12 in the outcome tracking and monitoring clinical or practice management measures.

Community partnerships and **school integration** both scored lower (3.39). Grantees are building strong relationships with schools, and also enjoy strong support and collaboration with the school community. However, they could grow in areas such as joint funding opportunities with the school, involvement in school-wide programs and school staff training, and engagement with school stakeholders. The SBHCs coordinate care with other providers, solicit feedback from key community stakeholders, and enjoy strong support and collaboration from parents and the local community. However, as with the school stakeholders, actual community stakeholder engagement with the SBHCs is more limited.

The lowest scoring indicator was for **marketing and outreach** (2.91). Few SBHCs have a defined marketing plan, but many have explored strategies to reach new clients, including social media, brochures, advertisement and face-to-face outreach.

[5] Note: This combined "snapshot" summarizes scores for Group 1 at follow-up and Group 2 at baseline in 2011-12.

Spotlight: Overall Self-Assessment: Grantees were also asked at the end of the SBHC sustainability self-assessment tool to provide an assessment of their sustainability strengths. Their greatest reported strengths were services and staffing, while the two areas they rated as needing the most attention were facilities and marketing and outreach. This coincides with the indicator scales reported above, with the exception of the facility score. It seems that there are other facility factors where the grantees would like improvement.

Recommendations

Twelve key recommendations emerged from this evaluation that can help SBHCs, funders, and advocates build on the successes and momentum of the School-Based Health Care Initiative.

1. **Support SBHC Expansion:** Although the SBHCs scored high in the facility indicators, they self-reported facility as only an "average strength." In the interviews, several SBHCs mentioned that they had received capital funding to build, but many described the need for expansion to reach new populations either at an existing SBHC through increased hours of operation, inclusion of new services such as oral health care, and hiring of new staff such as a medical provider, dentist, substance abuse counselor, and health coordinator. Some SBHCs would like to renovate and expand their clinics to include dental operatives and more behavioral health and primary care rooms. Other grantees reported that they would like to open new SBHCs in underserved areas of their communities.

2. **Carefully Consider the Role of the Medical Sponsor***:* Grantees rated their collaborations with their lead agencies as very strong, and they receive generous in-kind contributions from them. When choosing a sponsor, SBHCs should take into account tangible financial and operational benefits, as well other factors such as reputation, history of working with the school district, linkages to community resources, and support for and understanding of the SBHC model. One benefit of partnering with an FQHC is receiving an all-inclusive amount per visit based upon their cost of doing business and supplemental funding from the federal government. This has been an effective model for some grantees: "Being granted the status of an FQHC has dramatically expanded the possibilities for our agency, both in terms of the grants we have received from the federal government and the additional program revenues we have access to through the Medicaid and Medicare programs." However, in exchange for this generous funding, FQHCs must adhere to many federal regulations. Recommendations for strong sponsors include sound fiscal management, support for and understanding of the SBHC model, established systems to handle medical records, savvy insurance billing capabilities and knowledge of government regulations.[v]

3. **Continue to Focus on Insurance Enrollment***:* Stakeholders thought that while one of the most essential characteristics of SBHCs is that they are public service oriented and provide care regardless of the ability to pay, it is imperative for SBHCs to maximize opportunities to enroll clients in insurance, bill for services and seek third-party reimbursement. Statewide there was a 10 percent increase in Medicaid enrollment during this period due to eligibility expansions and improved federal award bonuses for improving outreach and removing barriers to enrollment.[vi] Efforts were also aided by a new policy allowing the Free and Reduced Lunch[6] application to integrate consent to be contacted by the local health agency for Medicaid/CHP+ enrollment. In addition, the Foundation provided grants for SBHCs to determine eligibility using county data. These enrollment efforts contributed to the large increases in Medicaid revenue reported by the SBHCs.

[6] Eligibility for the National Free and Reduced Lunch Program is based on family income levels.

4. **Continue to Improve Billing Strategies:** In reflecting on the business model employed during the Initiative, some stakeholders thought that the Foundation should continue to work with grantees to complete tailored business plans and financial templates, adapting their methods based on new resources and feedback. Technical assistance and sample templates should be provided, along with training on billing. One grantee reported, "I think the Foundation's initiative has helped SBHCs take business model approach and adopt billing. SBHCs are moving in the right direction in billing for Medicaid and CHP+. They are less apt to leave the money on the table." However, SBHCs need to continue to educate not only the community (parents, families and students) about the rationale behind and importance of billing for services, but they also need to train their providers in this and in proper coding techniques. A best practice that was reported is to devote administrative resources to monitoring the quality and consistency of the service and diagnostic codes, as well as reimbursements. As one site explained, "With so little revenue coming in, it is crucial to be savvy about billing."

5. **Recognize the Cultural Shift Required for SBHC Billing***:* Another important point emphasized in the interviews is the major shift in culture that is required once an SBHC begins to bill. A stakeholder explained, "The SBHCs that are most resistant to billing have an entrenched culture. To change this requires external pressure. If you leave any room for it to be negotiated, it just doesn't happen." Some pointed out that the new SBHCs begin with the expectation that they need to bill, so there is not the built-in resistance that may occur with more established SBHCs. One stakeholder explained, "You are fighting a culture that was very prevalent in the initiation of SBHCs. The expectation was grant support, not billing revenue. You didn't worry about anything else besides doing what these kids need. Now you need a strong orientation towards running your clinic as a business." Many SBHCs are transforming from a model where they did not bill nor follow any formal business plan, to one in which they need well-supported administrative activities to ensure their sustainability.

6. **Consider the Potential of Private Insurance***:* In 2011-12, on average 13 percent of the SBHC clients at a given site were enrolled in private insurance plans, although this ranged from 0-50 percent by site. Given low rates of private insurance at these sites, they are generating little revenue from private insurance. One challenge of having private insurance is that often students or families cannot afford the co-pays or they have high deductibles. However, 2011 legislation (HB11-1019) allows SBHCs to waive co-payments and deductibles. Anecdotal evidence from some Colorado SBHCs is that not all insurance companies are aware of this legislation and have attempted to bill SBHC clients for the co-pay. SBHCs are working to educate their clients that they are not responsible for the co-pays. Another challenge of private insurance is that some students do not want the SBHC to bill insurance for fear that the billing statements would be sent home, compromising their confidentiality, especially for sensitive services. One option here is for an SBHC to charge the patient/family a flat fee for the service. There is the potential that more clients will become enrolled in private insurance plans with the Accountable Care Act, and that these plans might reimburse more for the types of preventive services provided by SBHCs.

7. **Consider Sliding Fee Scales***:* In the case study on providing SBHC services to the uninsured, two of the FQHCs had found success in generating some revenue from the uninsured by providing a sliding scale fee for service. Their experience has been that most of these patients are willing to pay these modest amounts at time of service, so that they do not need to set up a billing and collection system. While these fees do not cover the complete cost of the services, they do offset the amount that is unbillable. However, one stakeholder reported that anecdotally it does not necessarily help to offset expenses. In fact, in 2011-12, grantees reported receiving an average of only $2,230 per year from patient self-pay.

8. **Advocate for Long-Term and Flexible Non-Patient Revenue***:* Many grantees and key stakeholders agreed that SBHCs will never be completely financially sustainable with patient revenue alone; they will likely always need ongoing public and private grant funding because SBHC services are not always billable. There will always be students and families without health insurance, either because of the financial burden or because of their undocumented status. Even with insurance, some services are not a billable benefit, or the deductibles and copayments are more than students can afford. In addition, sensitive services, including reproductive health and mental health, cannot be billed if confidentiality is to be maintained. Finally, SBHCs are expected to be available to the school for a variety of activities that are not billable such as classroom presentations, faculty education, creating a positive and healthy school climate and assisting in managing crises in the school. All of these activities are essential to the model to some degree, and grant funding will be required to support them. Group 1 grantees showed large increases in government and in-kind revenue at follow-up and many Colorado SBHCs will likely receive increased government support in the future with the new state funding becoming available.

9. **Encourage SBHC Partnerships with School-wide Programs*:*** All of the SBHCs interviewed believe that there needs to be a close working relationship between the school and the SBHC. As one site explained, "I think this coordinating piece (between school and SBHC) is vital to sustainability. If kids don't come in you can't be sustainable. It doesn't matter if you have the best billing systems, you have got to get [the students] to come in!" All sites reported that the schools were pleased with their presence because they helped keep children healthy and in school. However, some pointed out that these partnership efforts are often labor intensive, especially when working with multiple schools, and not billable. Expanding a SBHC's role at the school can also be tricky, as some SBHCs were cautious about stepping over their perceived boundaries. However, the key stakeholders stressed the importance of establishing and maintaining a viable relationship with the school, "having a school district that is behind your mission and supportive." As one stakeholder explained, "Many [medical sponsors] have never partnered with schools, so they try to operate SBHCs the same as all their other sites. Without the school integration, they don't have the understanding that they are a guest in the school and need to build those partnerships!" Another stakeholder suggested that creating MOUs with school districts could help define roles and responsibilities and strengthen partnerships. School integration was the sustainability factor that showed the most improvement in 2011-12. While support and engagement of school staff was rated higher, SBHCs could increase their efforts to get parents and the school community on board.

10. **Continue to Focus on SBHC Marketing Strategies***:* Marketing and outreach was the lowest scoring sustainability indicator. Although grantees were required to submit an outline of a marketing plan within their business plan, when surveyed in 2011-12 most reported not having a written marketing plan. One SBHC noted that they do not focus on marketing their SBHC because, "Marketing for us is scary because if it brings more patients, we may not have capacity to serve them." Another site explained that they have not had the resources to develop a marketing plan. When asked if they had a clear strategy for addressing opposition, most sites explained that they had not had a reason to do so given the high levels of SBHC support in their community. However, programs do work to increase awareness of the SBHCs through school and community outreach. Examples include using social media (Facebook, websites), the creation of an SBHC brochure, securing pro bono social media help from local marketing firms, and partnering with local businesses and nonprofits. For example, one SBHC received funds and advertisement from their local Elk's Club. Another group of SBHCs worked with a local resort to fund dental screening services, promoted with stickers carrying the resort's name. In early 2013, in response to the evaluation findings demonstrating the need in this area, the Colorado Health Foundation offered technical support assistance to all grantees participating in the Initiative. Five grantees representing 10 sites applied and received technical assistance from The Bawmann Group with a focus on marketing and social media implementation.

11. **Advocate for Changes to Behavioral Health Care Funding:** Grantees reported that paying for behavioral health services is a key challenge to SBHC sustainability in Colorado. As one explained, "There is tremendous need for behavioral health services…but with no way to bill for [these services] and only an occasional small grant, there isn't a way to financially sustain more [behavioral] health." In Colorado, five regional behavioral health organizations (BHO) are designated as Medicaid behavioral health providers. If an SBHC is not authorized to provide services for the BHO, they receive no reimbursement for the care. In addition, once the BHO reaches their quota of clients, they have no financial motivation to serve more clients. Thus SBHCs primarily rely on grant funding or in-kind services to provide these services. However, grants to provide direct services are difficult to secure. Colorado's Department of Health Care Policy and Finance (Medicaid in Colorado) is reportedly considering a change to an integrated physical/behavioral health fee for services system that would not limit the number of clients that could be seen. However, some sites caution that billing for behavioral health could impact utilization because of confidentiality concerns.

12. **Advocate for Continued State Funding:** At the state level, the SBHCs are pleased with the new Colorado state funding (a one-time annual allotment of $5.3 million became effective on July 1, 2013) and they hope that legislators will continue this funding. CASBHC led advocacy efforts to secure this funding and is working with the Colorado Department of Public Health and the Environment to plan how the money will be distributed. In thinking about continued state funding, one concern is that legislators will expect to see increased utilization when deciding about future funding, but with funds going mainly to existing SBHCs which are already close to full capacity, the number of clients might not increase in proportion to the size of the increased funding. One recommendation is for SBHCs to include local politicians and community members in advisory committees, having them visit the SBHC and finding ways for them to feel invested in the SBHC, not just in the beginning stages but throughout the life of a SBHC. Some interviewees mentioned that SBHCs need training and support regarding advocacy for SBHC funding and building partnerships.

---

[i] Colorado Association for School-Based Health Care. *Opening a School-Based Health Center in Colorado: A How-to Manual.* 2010.
[ii] Accessed on August 2, 2013 at: http://www.cchp.org/
[iii] Colorado Department of Health Care Policy and Financing. Regional Care Collaborative Organizations for the Accountable Care Collaborative Program RFP # HCPFKQ1102RCCO Final. Denver, CO 2010.
[iv] Reckling, S. School-Based Health Alliance. *School-Based Health Centers and the Patient-Centered Medical Home: Study of Medicaid Policies and Practice.* September 2013.
[v] Colorado Association for School-Based Health Care. *Opening a School-Based Health Center in Colorado: A How-to Manual.* 2010.
[vi] Prepared for The Colorado Trust by the Colorado Health Institute. *Medicaid in Colorado: How Enrollees Access and Use Health Care.* Colorado Health Access Survey. Issue Brief. 2011 Data Series, No.5.

The Colorado Health Foundation™

Connect with us on Facebook, follow us on Twitter and visit the Foundation blog.

501 South Cherry Street, Suite 1100
Denver, Colorado 80246-1325
TEL: 303.953.3600 ◦ FREE: 877.225.0839

www.ColoradoHealth.org