The National Evaluation of the
CHIPRA Quality Demonstration Grant Program

Evaluation Highlight No. 8, May 2014

The CHIPRA Quality Demonstration Grant Program

In February 2010, the Centers for Medicare & Medicaid Services (CMS) awarded 10 grants, funding 18 States, to improve the quality of health care for children enrolled in Medicaid and the Children's Health Insurance Program (CHIP). Funded by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), the Quality Demonstration Grant Program aims to identify effective, replicable strategies for enhancing quality of health care for children. With funding from CMS, the Agency for Healthcare Research and Quality (AHRQ) is leading the national evaluation of these demonstrations.

The 18 CHIPRA quality demonstration States are implementing 52 projects in five general categories:

- Using quality measures to improve child health care.
- Applying health information technology (IT) for quality improvement.
- Implementing provider-based delivery models.
- Investigating a model format for pediatric electronic health records (EHRs).
- Assessing the utility of other innovative approaches to enhance quality.

The CHIPRA quality demonstration began on February 22, 2010, and will conclude on February 21, 2015. The national evaluation of this demonstration started on August 8, 2010, and will be completed by September 8, 2015.

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CHIPRA quality demonstration States help school-based health centers strengthen their medical home features

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This *Evaluation Highlight* is the eighth in a series that presents descriptive and analytic findings from the national evaluation of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) Quality Demonstration Grant Program.[1] The *Highlight* focuses on a joint CHIPRA quality demonstration project in Colorado and New Mexico in which the quality improvement goals include integrating the patient-centered medical home (PCMH) approach into school-based health centers (SBHCs). The *Highlight* describes what motivated the States and SBHCs to adopt the PCMH approach, actions they are taking to strengthen SBHCs' medical home features, changes in the States' health care policies that are relevant to SBHCs being recognized as PCMHs, and what other States can do if they are interested in supporting SBHCs in their efforts to become medical homes.

KEY MESSAGES

- Practice facilitators can support SBHCs' adoption of quality improvement processes and their mastery of health information technology (IT), including electronic health records (EHRs), to enhance the provision of high quality, comprehensive care.
- Although some SBHCs are the primary care provider for many students, others are not, which affects their ability to function as PCMHs.
- SBHCs' ability to provide patient- and family-centered care can be improved by engaging students, caregivers, and the larger community in discussions about the role of SBHCs and the services they offer.
- Some SBHCs are overcoming challenges in providing year-round accessible, comprehensive care by collaborating with larger health care delivery systems and other providers.
- The financial advantages of PCMH recognition may change as broader State policies change.

Background

Conceived in the 1970s, the first SBHCs were "neighborhood health centers" that delivered primary care to underserved children and were located in schools.[2] By 2011, more than 1,300 SBHCs were providing primary care in 46 States.[2,3] Today, SBHCs are typically medical clinics on school campuses and sponsored by a larger medical provider in partnership with a school district.[3,4] SBHCs serve all students at a given school, and the majority of the country's SBHCs provide services to some combination of students' families, faculty, out-of-school youth, and other community members.[3]

States, school districts, and other stakeholders view SBHCs as a vehicle for enhancing access to care for students, particularly preventive services.[5] These stakeholders have growing interest in SBHCs obtaining formal PCMH recognition. The Agency for Healthcare Research and Quality (AHRQ) has defined a PCMH as a model for organizing primary care that is comprehensive, patient-centered, coordinated, accessible, and high quality and safe.[6] The School-Based Health Alliance (SBHA)—a national SBHC advocacy organization built by a diverse group of stakeholders—states that "the ideal SBHC model represents many key attributes of an advanced patient-centered primary care system for children and adolescents" and recommends that SBHCs meet PCMH goals.[7]

Given the recent focus on PCMHs at many levels of health policy and practice and the number of studies that demonstrate the effectiveness of SBHCs,[5] Colorado and New Mexico elected to use CHIPRA quality demonstration funds to work with select SBHCs in applying the PCMH concept to their operations, focusing on care for adolescents ages 10 to 21. The States launched their projects in 2010 with eight SBHCs. By 2012, a total of 16 CHIPRA quality demonstration SBHCs were in place in Colorado and New Mexico (Table 1).

Table 1. SBHCs in Colorado and New Mexico, 2012–2013 School Year[a]

	Colorado	New Mexico
Statewide		
Number of SBHCs	52	79
Sponsoring agencies	FQHCs, RHCs, hospitals, school districts, universities, physician groups, and medical clinics	FQHCs, regional education cooperatives,[b] universities, and medical clinics
CHIPRA quality demonstration		
Number of SBHCs[c]	7	9
Number of rural sites	6	8
Sponsoring agencies	FQHCs (2) FQHC look-alikes[d] (2) School district in partnership with physician group (1) Private, nonprofit medical services organizations (2)	FQHCs (6) University (3)

FQHC: federally qualified health center; RHC: rural health clinic

a Colorado Department of Health Care Policy and Financing. School-Based Health Center Improvement Project (SHCIP) CHIPRA Quality Demonstration Semiannual Progress Report, January 1, 2013, through June 30, 2013. Denver, CO: Centers for Medicare and Medicaid Services; August 2013.

b Organizations that provide technical assistance to participating school districts and schools. See http://www.sde.state.nm.us/Directory/regional%20education%20cooperatives.pdf for more information.

c In the 2013–2014 school year, Colorado and New Mexico each have 10 SBHCs in the demonstration, for a total of 20 sites.

d FQHC look-alikes are health centers that meet all requirements of FQHCs but do not receive a grant under section 330 of the Public Health Service Act. See http://bphc.hrsa.gov/about/lookalike/index.html for more information.

The data for this *Highlight* come primarily from semi-structured, face-to-face interviews conducted in the spring and summer of 2012 by the national evaluation team with State CHIPRA quality demonstration staff, SBHC staff, and other stakeholders. Other data come from the States' joint application for the CHIPRA quality demonstration submitted to the Centers for Medicare & Medicaid Services (CMS) in January 2010, semiannual progress reports submitted to CMS in February and August 2013, and follow-up phone calls from the national evaluation team to State CHIPRA quality demonstration staff in October 2013.

Findings

States build on SBHCs' PCMH features to improve quality of primary care

Colorado and New Mexico made strengthening SBHCs' PCMH features a priority under the CHIPRA quality demonstration because of SBHCs' de facto role as medical homes, providing primary care for many children, especially adolescents. In some rural areas, SBHCs are the only primary care providers for children and adolescents.

> "For a lot of kids, these SBHCs are their primary provider. In the poorer areas, parents . . . can't take off work, and they can't drive. It's very convenient for parents to have an SBHC to treat [their children],"
>
> — New Mexico Demonstration Staff, April 2012

Specifically, the States took advantage of the opportunity presented by the CHIPRA quality demonstration to build upon the SBHCs' existing PCMH infrastructure. Prior to the CHIPRA quality demonstration, a few participating SBHCs were already recognized as PCMHs. Several others, though not formally recognized, possessed a number of medical home features.

Many SBHCs were already working toward providing more comprehensive preventive services by screening their adolescent patients for depression and obesity. For example, the SBHCs in New Mexico were using a paper version of the Student Health Questionnaire (SHQ),[8] and one SBHC in Colorado was using the Rapid Assessment for Adolescent Preventive Services (RAAPS)[9] to screen patients for health and behavioral risk factors.

> ". . . you can't have improvement in clinical quality unless you integrate a medical home approach."
>
> — Colorado Demonstration Staff, April 2012

States use multiple strategies to strengthen SBHCs' PCMH features

Colorado and New Mexico help demonstration SBHCs improve quality by incorporating many PCMH features into their daily operations. States use three basic strategies to do this:

1. Hiring practice facilitators to work with SBHCs on quality improvement projects.
2. Encouraging SBHCs to engage youth and families.
3. Facilitating collaboration between SBHCs and other providers.

States use practice facilitators to help SBHCs with data-driven improvement. A commitment to high quality and quality improvement is one feature of a PCMH. Both States are using grant funds from the CHIPRA quality demonstration to pay for practice facilitators[10] (known in these States as quality improvement coaches) to help SBHCs incorporate many PCMH features into their operations.

Practice facilitators guide SBHCs in reviewing their data, facilitating quality improvement projects, and setting quality improvement goals through site visits, Webinars, and telephone calls. For example, practice facilitators help SBHCs establish registries for patients with certain conditions (e.g., depression) in order to monitor them for appropriate followup and referrals to specialists. They also help SBHCs collect data on patient needs through routine screenings using tablet computers. In the first few years of the demonstration, practice facilitators also helped some SBHCs transition from paper screenings to electronic screenings on tablets. Colorado and New Mexico, as well as the stakeholders and health care providers in both States, expect these activities to yield positive results in several areas, particularly in reproductive health, behavioral health, and preventive care.

Practice facilitators are specifically focusing on helping SBHCs use health IT to enhance clinical quality. While all SBHCs in Colorado were using EHRs before the CHIPRA quality demonstration began, practice facilitators helped some New Mexico SBHCs transition to EHRs. Practice facilitators also taught SBHCs how to use their EHRs for population management, such as identifying the charts that should be selected for biannual medical record reviews.

Two quality improvements in particular can be tied directly to these efforts: (1) an EHR "trigger function" that reminds SBHC providers when patients are due for preventive services and (2) visit templates, which some SBHCs created to ensure that all components of well-child visits, sexually transmitted infection screenings, and depression and anxiety visits are addressed and documented. Specifically, staff at SBHCs that used these enhanced capabilities reported improvements in communication and in the coordination of care between on-site staff and outside providers.

States aid SBHCs in engaging students and families. States help SBHCs engage students and families because students need to use SBHCs as medical homes in order for SBHCs to function as PCMHs. Patient and family engagement was challenging for some SBHCs when the demonstration began. For example, one SBHC attempted to conduct well-child visits for all Children's Health Insurance Program enrollees at its school. SBHC staff contacted caregivers, asking them to schedule appointments for their children, but most were not interested in doing so. SBHC staff learned that many families were using the SBHC for acute care only and using another primary care provider for preventive services such as well-child care.

The States hired a youth engagement specialist, who works with SBHCs to identify areas to increase youth engagement. This specialist works with practice facilitators to host youth engagement trainings and health literacy Webinars for SBHC staff. SBHCs use the information from these trainings to conduct a variety of activities to increase youth engagement. SBHCs hosted open houses for students and parents so they could learn more about SBHC services, an approach that effectively prompted

caregivers to sign consent forms and raised awareness of SBHC services. SBHCs also formed school health advisory councils through which they can solicit input on their services and operations from students, parents, and school administrators.

Some SBHCs also have youth advisory groups, forums for students to provide input on and lead activities related to SBHCs. A youth advisory group at one SBHC worked with the city mayor's office to create "School-Based Health Center Day," on which the mayor, the superintendent of schools, and the local media toured the SBHC; the group's goal was to raise community awareness about the SBHC. Another youth advisory group worked with its SBHC to cosponsor a student dance at which SBHC substance abuse services were advertised.

> "We've learned that youth engagement needs to be at the forefront because it pertains to medical homes . . . if you don't have a youth-friendly environment, then students aren't going to walk into their clinic."
>
> — Colorado Demonstration Staff, April 2012

States developed the Youth Engagement with Health Services (YEHS!)[11] survey to measure students' engagement with SBHCs. The survey allows States and CHIPRA quality demonstration SBHCs to learn about patients' experiences at SBHCs and to determine whether students know how to access the health center. SBHCs administer surveys via tablet computers and find this technology to be effective in attracting youth to an SBHC.

The States' practice facilitators analyze the survey data collected and send aggregated results to the SBHCs to guide engagement activities, including activities encouraging students to be fully informed partners in their own care. For example, some SBHCs are working on improving health literacy and teaching adolescents how to advocate for their own health. "There's a balance between engaging the family and encouraging young people to 'own' their health. We're . . . teach[ing] youth to be their own consumers and advocates so that when they transition to adulthood, they know how to be active in their own health care," according to Colorado CHIPRA quality demonstration staff. SBHCs created and distributed pamphlets on the questions youth should ask during a clinic visit and how to ask them.

States facilitate collaboration to increase SBHCs' accessibility and comprehensiveness. Accessibility and comprehensive care are additional features of a PCMH that can be challenging for SBHCs. For instance, some SBHCs close during the summer vacation. Others are sponsored by relatively small entities that cannot provide care after hours. To address these barriers, States are acting as a convener of stakeholders interested in supporting SBHCs and are establishing collaborative environments for CHIPRA quality demonstration SBHCs to work with other providers. States can facilitate the development of formal relationships between the SBHCs and providers who could see SBHC patients when the SBHC is closed.

Both Colorado and New Mexico established advisory committees to guide their work under the CHIPRA quality demonstration. These advisory committees include a variety of stakeholders representing multiple payers and other organizations. SBHCs find that these advisory committees, along with SBHC alliances and health councils, are natural places to begin the search for partners.

Although contracts or memoranda of understanding govern some SBHC-provider relationships, others may be based on less formal agreements. Whether formal or informal, relationships with other providers do not take the place of formal medical sponsors,[4] but they do help SBHCs expand access and comprehensiveness of care.

SBHCs use a range of mechanisms to collaborate with other providers to bring a wider pool of staff—and therefore more services—within reach. A prime example of existing comprehensive care is the integration of primary care and behavioral health care, the flagship service of SBHCs. All CHIPRA quality demonstration SBHCs in both States have qualified primary care and behavioral health providers on site, which is not typical for primary care practices generally.[12]

Some SBHCs develop contracts with partners to staff dieticians, dental hygienists, and care coordinators to provide services on site. The CHIPRA quality demonstration SBHCs also use telehealth to connect their patients with services not provided on site—especially in rural communities. SBHCs use telehealth to facilitate interaction between patients and off-site specialists, as well as for SBHC providers to consult with off-site specialists. For instance, one SBHC used telehealth to consult with an off-site psychiatrist.

Financial advantages of PCMH recognition may change in a dynamic policy environment

Primary care practices frequently seek formal PCMH recognition to benefit from the payment incentives that many payers offer to recognized PCMHs. When the CHIPRA quality demonstration began, SBHCs in Colorado took advantage of an already existing program through the Colorado Department of Health Care Policy and Financing that paid higher rates for some preventive care services to SBHCs that were recognized as PCMHs by the department. However, as of June 2013, these higher rates were no longer offered because of the Accountable Care Collaborative (ACC) program being implemented to reform the Medicaid delivery and payment system in Colorado.[13] Colorado's CHIPRA quality demonstration staff are exploring reimbursement policies that align with the ACC program to offer financial incentives for SBHCs that meet PCMH standards.

> "With changes both nationally and in the State with Centennial Care, PCMH is part of that, and so we need to work together to figure out how SBHCs can get [PCMH] recognition and stay in the system in the same way as other clinics are because they are such an important part of care . . . especially for adolescents who are so often underserved."
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> — New Mexico Demonstration Staff, October 2013

Like Colorado, New Mexico is working to align its goal of SBHCs becoming PCMHs with its Medicaid reform program, Centennial Care,[14] and sees SBHCs playing a role in the Medicaid restructuring process. Stakeholders are hoping that Centennial Care will increase the number of Medicaid-eligible services that SBHCs can bill for, which may make SBHCs more financially sustainable. It is possible that SBHCs recognized as PCMHs through the National Committee for Quality Assurance (NCQA), the certifying agency used by many organizations in the State, will be reimbursed at a higher rate in the future when they bill Medicaid. To encourage and help SBHCs prepare for NCQA's assessment, practice facilitators developed a tool designed around NCQA's PCMH criteria. To date, one of New Mexico's demonstration SBHCs has applied for NCQA recognition.

Some stakeholders in New Mexico question the value of SBHC efforts to seek formal recognition as medical homes for two reasons. First, although SBHCs play a significant role in filling gaps in service delivery, they typically do so only under the auspices of another medical provider. Second, it can sometimes take years for even freestanding primary care practices to become recognized as PCMHs and receive the associated reimbursements, so the time and labor involved for SBHCs to do so might not be justified.

Conclusions

Colorado and New Mexico are taking action to improve care at SBHCs by helping them to strengthen their medical home features. To do this, the States are hiring practice facilitators to work with SBHCs on quality improvement projects, encouraging advanced use of EHRs, and hiring a youth engagement specialist to help SBHCs engage patients and families. Additionally, both States are facilitating the development of informal and formal collaborations with larger health systems or provider networks to increase accessibility and comprehensiveness of care. As Medicaid expansions and other system reforms underway in both States continue to change the health care environment, the States anticipate that the goal of obtaining PCMH recognition for SBHCs will align with these broader reform efforts.

Implications

States interested in helping SBHCs enhance their medical home features may want to:

- Assess the demand from patients, families, SBHC staff, and other stakeholders for SBHCs to function as PCMHs. To do this, States may need to quantify how many students lack access to a PCMH and whether caregivers are willing to use the SBHC as a source of preventive care for their children.
- Assess what PCMH features SBHCs already have to determine gaps and potential areas of focus for State intervention.
- Engage with caregivers, students, and school administrators through such forums as SBHC open houses and school health advisory councils to facilitate discussion of how students and families can use SBHCs as medical homes.
- Promote the use of practice facilitators and health IT, including advanced EHR use and telehealth, that can facilitate SBHC efforts to provide high quality, accessible, comprehensive care.
- Help SBHCs partner with larger health care provider systems or networks so that they can provide accessible, continuous, comprehensive care year round.
- Determine how best to align SBHCs with reform initiatives, such as medical home programs and

accountable care organizations, and assess how these initiatives may affect the financial sustainability of SBHCs.

Endnotes

1. We use the term "national evaluation" to distinguish our work from the activities undertaken by evaluators who are under contract with the CHIPRA quality demonstration grantees to assess the implementation and outcomes of the State-level projects. The word "national" should not be interpreted to mean that our findings are representative of the United States as a whole.
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4. All SBHCs are administered by a partnership between a medical sponsor and a school district. Although contracts with each SBHC differ, school districts often provide facility space and utilities. Medical sponsors hire staff and manage billing, support the clinical activities of an SBHC, share organizational policies and procedures with the SBHC, and often provide care for SBHC patients when the SBHC is closed. School districts and medical sponsors may also form partnerships with specialists and other providers, such as a local mental health authority, on behalf of the SBHC.
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Use the tabs and information boxes on the Web page to:

- Find out about the 52 projects being implemented in the 18 CHIPRA quality demonstration States.
- Get an overview of the projects in each of the five CHIPRA quality demonstration grant categories.
- View reports that the national evaluation team and the State-specific evaluation teams have produced on specific evaluation topics and questions.
- Learn more about the national evaluation, including the objectives, evaluation design, and methods.
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