

# CHCS

Center for  
Health Care Strategies, Inc.

## RESOURCE PAPER

---

### **Improving Coordination Between School-Based Health Centers and Medicaid Managed Care**

---

By Mary Kay Pera  
New Mexico Human Services  
Department Medical Assistance Division

---

*under The Robert Wood Johnson Foundation's  
Medicaid Managed Care Program*

*December 2004*

266

## **TABLE OF CONTENTS**

Acknowledgements _____	2
Abstract _____	3
Executive Summary _____	4
Introduction _____	7
Methodology and Project Organization _____	12
Project Planning and Implementation _____	13
Project Evaluation _____	22
Findings and Lessons Learned _____	24
Project Sustainability & Diffusion _____	43
Conclusion _____	45
Bibliography _____	47
Appendices A-H _____	View online at <a href="http://www.chcs.org">www.chcs.org</a> .

## Acknowledgements

The school-based health center (SBHC)/ managed care organization (MCO) pilot project, “*Salud! Comes to Your School*,” would have been impossible without the enthusiasm and commitment of the SBHC pilot site administrative and clinical staff, state agency partners, and staff of the Medicaid MCOs, all of whom offered essential expertise and insights throughout the duration of the project. The project also recognizes and thanks its nurse consultants, Sue Gowing, RN, PA, and Paula LeSueur, RN, CFNP; psychiatrists Steve Adelsheim, MD, and Scott Nelson, MD; pediatrician Jane McGrath, MD; and behavioral health advisor Jacque Masog, MEd, whose clinical expertise was invaluable in developing and implementing the clinical practice guidelines.

The project wishes to thank Chuck Milligan, former Director of the New Mexico Human Services Department, Medical Assistance Division (HSD/MAD), who had the vision to initiate the project and apply for funding; and Carolyn Ingram, current HSD/MAD Director, for her steadfast support. Recognition also is due to Kristine Maltrud of Health Planning Associates and her colleagues Pamela Koster and Mindy Hale for their work on the project evaluation; and to Nancy Smith-Leslie and Kari Nordby for their day-to-day management of the project activities. Finally, the project wishes to express its gratitude to the invaluable staff at the Center for Health Care Strategies (CHCS) for their ongoing support, feedback, and funding of the “*Salud! Comes to Your School*” project.

Mary Kay Pera, RN, BSN, MS  
Project Administrator

## Abstract

School-based health centers (SBHCs) and Medicaid managed care organizations (MCOs), by virtue of their dissimilarities in focus and structure, often find that working together poses a set of unique and distinguishing challenges. This report describes a four-year pilot project designed to link six SBHC sites with the New Mexico Medicaid managed care program, called *Salud!*. More specifically, this report outlines the demands imposed by this pilot project upon participating SBHCs, which were faced with the challenge of fitting into the mainstream health care delivery system; and upon the Medicaid MCOs, which were required to make a number of adjustments to accommodate the SBHC/MCO relationship and bring SBHCs into their provider networks. In addition to describing these challenges, this report discusses the successes that were achieved under the pilot project, not only for the benefit of the different project partners, but also for the benefit of New Mexico's children and adolescents.

## Executive Summary

The New Mexico Human Services Department, Medical Assistance Division (HSD/MAD), together with the New Mexico Department of Health, Office of School Health (DOH/OSH), presents this final report on the pilot project titled, “To Improve Coordination Between School-Based Health Centers (SBHCs) and the Medicaid Managed Care Delivery System (*Salud!*),” also called “*Salud!* Comes to Your School.” Through the project and aided by funding from the Center for Health Care Strategies, Inc., (CHCS), these partners, as well as multiple others who play a pivotal role in shaping the delivery of school health services in New Mexico, have developed the technical, collaborative, and administrative expertise needed to link SBHCs with the New Mexico Medicaid managed care program.

Historically, SBHCs were excluded from the Medicaid system in New Mexico, which meant that although they were serving Medicaid-eligible recipients, they were not receiving any type of reimbursement. Frustration was building in 1999 as the SBHCs struggled to find a role in the new Medicaid managed care program, called *Salud!*. In response, HSD/MAD held a School Health Summit attended by health care leaders in the state, including representatives of SBHCs and MCOs, to explore how schools could participate in *Salud!*. During the summit, the idea was borne for a pilot project through which several SBHCs would be formally linked with *Salud!*.

HSD/MAD applied for funding to CHCS to support the development of the pilot program and sustain it during implementation. In May of 2000, CHCS awarded HSD/MAD with a \$500,000 three-year grant, which was later extended for a fourth year to June 30, 2004. This funding enabled New Mexico to develop the public and private partnerships to commence the project and ensure its success and eventual sustainability. The project also provided New Mexico with an opportunity to reexamine the status of its school-based health care system and address the financing, quality, and future viability of these programs.

As this report details, the “*Salud!* Comes to Your School” pilot project presented a unique set of opportunities and challenges. In summary, these included:

- Determining what services would be covered, how they would be delivered (prior authorization was ultimately eliminated), and how covered services would be reimbursed.
- Preparing SBHCs to meet the MCOs’ credentialing and quality improvement requirements.
- Developing practice guidelines for disease management, prevention, care coordination, and communication, to ensure access to and provision of quality care.
- Integrating primary and behavioral health care, both at the SBHCs and between the SBHCs and community primary care providers.
- Focusing on the total needs of the children and adolescents served.
- Making changes to the SBHCs’ and MCOs’ systems to ensure confidentiality for the provision of services to which adolescents can consent on their own.

An extensive evaluation began in the project’s first year and continued throughout its duration. Quantitative data were augmented by qualitative information, and together this research and

the subsequent analyses documented the project's progress and allowed for changes to be made as the need became evident. While some challenges remain in the project, such as communication between SBHCs and primary care providers, the evaluation shows a number of critical successes, particularly in the project's primary goal areas to explore best practices for collaboration, increase access to care, increase the provision of comprehensive and preventive services, and integrate primary and behavioral health care.

Specific project successes include:

- As Medicaid managed care network providers, SBHCs are learning to communicate more effectively with students' primary care providers, MCO case managers, and other community resources to ensure care for students who need additional support.
- The pilot sites have made policy changes to implement the project's clinical practice guidelines; integrate behavioral health and primary care; and improve their communication, charting and billing practices. These changes apply to every student who enters the centers for care, regardless of their payer source.
- The MCOs have increased their Early and Periodic Screening, Diagnosis and Testing (EPSDT) data collection efforts, initiated mailings of provider relations outreach materials, and extended some primary care services to SBHC providers.
- The project has been recognized as a leading role model for delivering EPSDT screens to adolescents by converting sports physicals to include all of the components of a wellness check.
- The pilot sites have made tremendous gains due, not only to increased revenue, infrastructure, and resources, but also to a profound sophistication in billing and service delivery that allows them to actively participate in New Mexico's health care network.
- Support for the project is clear and momentum for SBHCs is building. The institutional reluctance felt when the project began has been progressively transformed into enthusiasm for SBHCs as an innovative way to bring inclusive health care to New Mexico's children and adolescents.

These successes show that the "*Salud!* Comes to Your School" project has had a direct and measurable impact on New Mexico's children and adolescents, making quantifiable improvements that have resulted in increased utilization, better quality of care, and visible access alternatives for hard-to-reach children and their families. Through the project, SBHCs have become key participants in the New Mexico health care delivery system, and it is recognized that they have an important role to play in increasing access to needed health care for children and youth in the state.

Extensive collaboration and consensus-building proved critical to the project's overall success and its ability to address the stumbling blocks that were encountered along the way. It was through the project's collaborative structure that the state was able to cultivate and capitalize on working partnerships between multiple stakeholder groups so that each entity was involved in making decisions about the project's overall organization and administration. The legacy of these efforts is a strong foundation for school-based health care in New Mexico that includes SBHCs as key participants in the state's health care delivery system and widespread support to

sustain and institutionalize the work of the pilot project.

## Introduction

This is the final report for the pilot project titled, “To Improve Coordination Between School-Based Health Centers and the Medicaid Managed Care Delivery System (*Salud!*),” hereafter referred to as “*Salud!* Comes to Your School,” and is submitted to the Center for Health Care Strategies, by the New Mexico Human Services Department, Medical Assistance Division, in conjunction with the New Mexico Department of Health, Office of School Health.

## Project History

The New Mexico Medicaid managed care program, *Salud!* (which translates to “to your health!” in Spanish), was launched on July 1, 1997. The state Human Services Department (HSD) contracted with three MCOs – Cimarron Health Plan, Lovelace Community Health Plan, and Presbyterian *Salud!* Health Plan – to deliver the full array of services covered by the Medicaid managed care program. Most of New Mexico’s Medicaid population, including children and adolescents with special needs, are included in managed care.

Before the advent of *Salud!*, New Mexico had achieved limited success in creating a school-based system of health care for children and adolescents. Students were seen in SBHCs and referrals were made to other providers, including behavioral health providers (BHPs), as appropriate. At the time, it was deemed desirable – but not critical – that the SBHC provider communicate with the student’s primary care provider (PCP) about the services he or she was receiving at the SBHC. This arrangement, which failed to foster coordination of care or develop a true medical home for the student, was fundamentally changed under *Salud!*, which required that a child’s PCP be accountable for the provision of services, the coordination of care, and the authorization of most referrals to specialty care.

During this same time period, New Mexico SBHCs were experiencing reimbursement difficulties, not unlike those of SBHCs in other states.<sup>1,2,3</sup> SBHCs in New Mexico were historically supported by a patchwork of funding that included federal and state contributions, funds generated by the Medicaid School-Based Services program, local grants, and some tribal contributions and financing from the Indian Health Service; however, none of these financial supports was sufficient for the adequate support of SBHC programs. In addition, SBHCs were not reimbursed by Medicaid or by any other private, third-party payers. In reality, if SBHCs were to have any chance of achieving long-term viability and sustainability, their participation in the broader health care delivery system, including Medicaid managed care, would prove essential.<sup>4</sup>

---

<sup>1</sup> Hacker, K. “Integrating School-Based Health Centers into Managed Care in Massachusetts.” *Journal of School Health*, November 1996; 12 (9): 317-321.

<sup>2</sup> Lear, J.G., Montgomery, L.L., Schlitt, J.J., and Richett, K.D. “Key Issues Affecting School-Based Health Centers and Medicaid.” *Journal of School Health*, March 1996; 66 (3): 83-88.

<sup>3</sup> Critical Issues in Financing School-Based Health Care. National Assembly on School-Based Health Care. September 1999.

<sup>4</sup> Brindis, C.D. and Sanghvi, R.V. “School-Based Health Clinics: Remaining Viable in a Changing Health Care Delivery System.” *Annual Review of Public Health*. 1997; 18: 567-587.

At the start of *Salud!*, New Mexico mandated that the MCOs make every effort to include school-based clinics as network providers or provide an equivalent level of access to services in the school setting.<sup>5</sup> Despite this requirement, priorities associated with bolstering the new managed care delivery system took precedence over ensuring MCO participation in school-based health care, resulting in increased frustration on the school level with the overall managed care system. HSD intervened in the winter of 1999 by holding a School Health Summit to explore how schools might begin to participate in *Salud!*.

One recommendation that resulted from the discussions that took place at the summit was to develop and implement a pilot project that would formally link several SBHC sites with the *Salud!* MCOs. HSD, as the leader of this initiative, committed to seek funding that would help to launch the project. A group of interested parties, comprised of representatives from the HSD Medical Assistance Division (MAD); DOH; the New Mexico Children, Youth and Families Department (CYFD) and Public Education Department (PED); the three *Salud!* MCOs; a community PCP; and an advocacy group, was convened to discuss how best to proceed. This group later became the SBHC/MCO pilot project Advisory Board and continued to advise and inform the project throughout its tenure.

In July 1999, New Mexico applied to the Center for Health Care Strategies, for funding to develop, manage, and support the proposed pilot project, and received approval for a three-year grant in May 2000. The project, which was divided into Phase I (year one) and Phase II (years two and three), was initially slated to run from May 15, 2000, to May 14, 2003, but was subsequently extended through the end of June 2004.

### **Choosing the SBHC Pilot Sites**

One of the earliest undertakings of the pilot project Advisory Board was to identify potential SBHC sites according to a set of specific criteria. It was determined that the selected sites would be DOH-funded SBHCs, which are required to provide onsite primary care, mental health, and substance abuse services, and to comply with established state SBHC standards and statutes. Other selection criteria included geographic distribution; the volume of services provided; diversity in the ages and ethnicities of the student population; potential for replication beyond the pilot project; experience in school health; demonstrated cooperation and collaboration with the local community; demonstrated school district and provider relationships; and established relationships with community PCPs. The pilot sites that were selected are located in urban, rural and frontier areas of New Mexico, and consist of two elementary schools, four middle schools, and nine high schools.

### **Finding and Fulfilling Common Needs**

A second and formidable task of the pilot project Advisory Board was to understand and consider the different needs of the key project partners – SBHCs, MCOs, and PCPs – and what would entice them to collaborate on the project together. The Advisory Board conducted a

---

<sup>5</sup> New Mexico Managed Care Policies, Section 606.1997.

literature search and discussion ensued regarding how to accommodate the needs of each respective project partner. These discussions provided the basis of the project's planning phase.

## School-Based Health Center Needs

Adequate reimbursement is essential for the long-term viability and sustainability of SBHCs, and it quickly became apparent that the pilot sites saw the project as their first opportunity to bill for the services they provided. The project also was viewed as a chance for SBHCs to access new resources for meeting students' medical and behavioral health needs through the MCOs. According to New Mexico statistics, one of the most important health areas needing improvement is the provision of preventive services to adolescents.<sup>6</sup> Both the MCOs and the state agency partners recognized the pivotal role that SBHCs could play in identifying the unmet needs of this adolescent population and in providing appropriate and timely interventions that could result in overall health status improvements to New Mexico's youth.

## Student Needs

SBHCs are especially attractive places to adolescents when they are seeking health care. The most substantial barriers to adolescents accessing health care services are well-documented, and include concerns about lapses in confidentiality; the unavailability or inaccessibility of certain programs; inexperience in accessing the health care system; a lack of provider sensitivity; and personal denial of health problems.<sup>7</sup> One study showed that adolescents are more likely to seek care for physical symptoms rather than behavioral health concerns, and that SBHCs can be the first to identify and assess the substance abuse or other mental health needs at the root of those physical complaints.<sup>8</sup> Students who are taken to visit their PCP by a parent may hide symptoms, resulting in a failure to identify their health needs. Because SBHCs see students "as they are," SBHCs provide a critical bridge to medical services for students overcoming the factors cited above. In addition, SBHC treatment means less time absent from class for students, and less time away from work for parents.

## MCO Needs

The MCOs are required to be credentialed by the National Committee for Quality Assurance (NCQA) regarding quality, access, preventive care, and health education<sup>9,10</sup> and realized that they could benefit from their contracts with SBHCs as important access points to the health care system for many children and adolescents. Research shows that children with access to SBHCs are less likely to require emergent or urgent care; are more likely to receive screens for high risk behaviors; and more likely to obtain at least one comprehensive health supervision

---

<sup>6</sup> HCFA-416: Annual EPSDT Participation Report, New Mexico. FFY 2002.

<sup>7</sup> Santelli, J., Vernon, M., Lowry, R., Osorio, J., DuShaw, M., Lancaster, N.P., Song, E., Ginn, E., and Kolbe, L.J., "Managed Care, School Health Programs, and Adolescent Health Services: Opportunities for Health Promotion." *Journal of School Health*. December 1998; 68 (10): 434-439.

<sup>8</sup> Kaplan, D.W., Calonge, B.N., Guernsey, B.P., and Hanrahan, M.B. "Managed Care and School-Based Health Centers." *Archives of Pediatric and Adolescent Medicine*. January 1998; 15: 25-33.

<sup>9</sup> New Mexico Medicaid Managed Care Contract, 1997.

<sup>10</sup> Koppelman, J. and Lear, J.G. "Partnering with School-Based Health Centers: Connecticut's Medicaid Managed Care Experience." *Managed Medicare & Medicaid*, July 11, 1999.

visit per year.<sup>11,12,13</sup> SBHCs also are in a unique position to identify children’s health needs and to intervene before these needs become more serious or even life-threatening. All of these factors can result in possible cost-savings to the MCOs.

Research also shows that adolescents with access to SBHCs are more likely to initiate a mental health or substance abuse visit, leading to significant improvement in their overall access to treatment.<sup>14</sup> In addition, behavioral health services provided in the SBHC can be integrated with school interventions to maximize the effectiveness of care. Improved coordination and continuity of primary and behavioral health care can be achieved simply by virtue of the student being on the school grounds. And, since the student does not require transportation to health care services, the associated costs to the MCO can be reduced.

### PCP Needs

SBHCs also can be an important resource to community PCPs, who are responsible under the *Salud!* program for supervising, coordinating, and providing primary health care to their members; initiating referrals for specialist care; and maintaining care continuity. SBHCs, which may see students more frequently than community PCPs, can help PCPs understand more about their patients and keep them well, whether by addressing acute care needs or managing any long-term, chronic conditions.<sup>15</sup>

Interestingly, the research that was initially utilized in designing the project, as well as research found in a more recent publication on SBHC/MCO arrangements,<sup>16</sup> supports the project findings that are subsequently discussed in this report regarding the perception of SBHC clinicians, students, MCOs, and PCPs about the role of SBHCs.

---

<sup>11</sup> Santelli, J., Kouzis, A., and Newcomer, S. “School-Based Health Centers and Adolescent Use of Primary and Hospital Care.” *Journal of Adolescent Health*, October 1996; 19: 267-275.

<sup>12</sup> Kaplan, et al., op.cit.

<sup>13</sup> Kaplan, et al., op.cit.

<sup>14</sup> Kaplan, et al., op.cit.

<sup>15</sup> Taras, H.L., “Managed Health Care and School Health. *Pediatric Annals*. December 1997; 26 (12): 733-736.

<sup>16</sup> Harvey, J., Vaquerano, L., Nolan, L., and Sonosky, C. *School-Based Health Centers and Managed Care Arrangements: A Review of State Models and Implementation Issues*. Center for Health Services Research and Policy, School of Public Health, The George Washington University, July 2002.

## Methodology and Project Organization

After selecting the project pilot sites and initiating discussions regarding the needs of each group of project partners, it was determined that the first year of the project be committed to organizational and planning activities, and that implementation would begin during the 2001-2002 school year. The project Advisory Board met extensively during the initial planning phase, and continued to inform the course of the project as it progressed in the subsequent years of implementation. Working teams were convened to assist with specific planning and implementation activities, including:

- Developing the SBHC/MCO contracts.
- Facilitating communication with community PCPs.
- Addressing clinical issues.
- Advising on behavioral health issues.
- Ensuring confidentiality.
- Collecting data.
- Designing a project evaluation model, which was initiated during the first year of implementation and continued throughout the project's tenure.

It should be noted that while the pilot SBHCs serve all students who come to the clinic for care regardless of their ability to pay, this project evaluation focused only on services provided during the project period to children and adolescents enrolled in the New Mexico Medicaid managed care program.

## Project Planning and Implementation

This section of the report focuses on specific activities related to the project's initial planning and subsequent implementation phases, including development of the SBHC/MCO contract and the project's scope of covered services; defining the roles and relationships of SBHCs and community PCPs; managing service utilization and ensuring confidentiality; developing best practice guidelines for the SBHCs; engaging in the processes of credentialing and quality improvement required by the MCOs; providing training to SBHC providers; and facilitating interagency relationships.

### The SBHC/MCO Contract

A contract development team was convened to recommend a SBHC/MCO contract template that included requisites such as the scope of covered services, communication, data exchange, maintenance of medical records, credentialing, quality improvement, confidentiality, and reimbursement. The team reviewed New Mexico MCO network provider contract templates, as well as SBHC/MCO contracts in use in other states.<sup>17,18</sup> Each MCO wanted stipulations that were specific to their respective business practices; however, it was agreed that all the template provisions would be basic to and included in each SBHC/MCO contract to ensure standardization and avoid negative experiences in other states using multiple contract models.<sup>19</sup> The contract template that was developed for use under the pilot project can be found at Appendix A.

### Scope of Covered Services

Concurrent with the efforts of the contract team, a clinical team consisting of the project administrator, nurse consultant, state agency clinical representatives, and medical directors from each of the MCOs, was convened to recommend a scope of covered services based on the services that were typically provided by SBHCs. Their recommendations focused primarily on urgent care, Early Periodic Screening Diagnostic and Treatment (EPSDT) services, health guidance, and prevention. The list of covered services is included at Appendix B.

Building on the work of this clinical working team, a behavioral health advisory team also was convened consisting of several psychiatrists, the behavioral health directors from each of the MCOs, and other behavioral health clinicians. In addition to making recommendations regarding a scope of covered services for behavioral health counseling and other services, this team was instrumental in developing the best practice guideline for managing depression; planning the health education sessions on alcohol and substance use; and conceptualizing how behavioral health services could be provided in an SBHC environment and coordinated with physical health services.

---

<sup>17</sup> "Guidelines for Contracting with Managed Care." *Making the Grade*. 1998

<sup>18</sup> Honig, M.H. *School-Based Health Centers and Managed Care: Contracting Issues and Options*. Center for Health Care Strategies, Inc., July 2000.

<sup>19</sup> Hacker, K. op.cit.

## Roles of SBHCs and PCPs

There were extensive discussions by the project Advisory Board regarding the appropriate and most effective type of working relationship between the pilot SBHCs and the students' PCPs in their local communities. It was agreed that the SBHCs would act as a resource to PCPs but not be designated as PCPs because they could not meet the state's PCP criteria. (For example, SBHCs are not open 24 hours per day, seven days a week.) PCPs, which include physicians, pediatricians, nurse practitioners, and physician assistants, continue to be responsible for supervising, coordinating, and providing primary health care to their respective *Salud!* members around the clock; and it remains their role to initiate referrals for most specialty care and maintain the continuity of patient care as set forth in their contracts with the MCOs.

In addition, the project Advisory Board emphasized the importance of communication between the pilot SBHCs and student PCPs, and agreed that the pilot sites would make every effort to inform PCPs when one of their patients was treated in the SBHC. To facilitate SBHC clinicians' communication with the students' PCPs, a simple, one-page communication, referral and notification form was developed and printed on duplicate paper, with one copy for the SBHC chart and one to be forwarded to the PCP when a student seen by an SBHC clinician for treatment. Concerns about maintaining confidentiality for adolescents consenting for services on their own were addressed by requiring that PCPs would be notified when confidential services were provided, but that the nature of these services would not be revealed without the patient's consent. Outreach to PCPs was largely initiated through personal contacts; however, the Advisory Board members worked together to develop and publish articles in professional and MCO provider newsletters. Project staff continue to address the challenges associated with communication between SBHCs and community PCPs, which are discussed in subsequent sections of this report.

## Utilization Management

During the initial discussions of the project Advisory Board, utilization management (UM) proved to be an area of contention. Given the open nature of the SBHC service setting and the often unplanned way that students present to the centers for care, SBHC staff were concerned that they would be required to call the MCOs for approval every time a member visited the clinic for services, something that would have added a significant administrative burden to their day-to-day practices. At the same time, the MCOs were concerned about an ensuing loss of control over UM and the potential for duplicate services and, by extension, duplicate payments to SBHCs and PCPs.

A care coordination team was assembled to determine how best to fit SBHCs into the MCO UM process. While the MCOs envisioned the SBHCs as a sort of "urgent care" model, under which the coverage of confidential services could be easily accommodated and incorporated into existing UM processes, the SBHCs wondered how chronic care visits and certain health prevention services could be handled. The MCOs ultimately agreed to cover services without prior approval, and it should be noted that there has been no evidence of duplicative services or

payments since the onset of implementation. In fact, project data suggest that students who are seen in the SBHCs generally do not receive services elsewhere.

## Practice Guidelines

Early in the project, it was agreed that a set of clinical practice guidelines would be essential to the achievement of targeted outcomes. The guidelines that are discussed in this section of the report have provided invaluable direction to the SBHCs' primary and behavioral health clinicians, MCOs, and PCPs in the areas of care coordination and case management; communication; information-sharing; the provision of preventive health screens; and the management of certain conditions, such as asthma, depression, and obesity/type-2 diabetes.

## Care Coordination and Case Management

The first guidelines that were developed were designed to outline recommended care coordination and case management processes. Targeted case management for medically at-risk individuals under age 21 and for pregnant women and their infants was part of the *Salud!* Medicaid benefit package; therefore each MCO already was required to cover these services. Care coordination, which is broad in concept and has emerged as "best practice" in Medicaid managed care, became a requirement under the *Salud!* contracts beginning July 1, 2001, and is designed to assist members with multiple and complex, special physical, cognitive, and behavioral health care needs.<sup>20,21,22</sup> A special focus also was implemented at that time on children with special health care needs. The project Advisory Board recognized that SBHCs were uniquely positioned to help to identify these children and adolescents and to make referrals to the MCOs for care coordination and appropriate follow-up. The practice guidelines for care coordination and case management can be found at Appendix C.

## Communication

Effective patient care coordination, which is dependent upon forging meaningful communication links between SBHCs and PCPs, behavioral health clinicians, MCOs, and parents, is one of the most critical and challenging components of the SBHC/MCO relationship.<sup>23,24</sup> The project Advisory Board, together with the coordination team, was clear that the communication process had to be as simple as possible, particularly given the already extensive paperwork of SBHC and PCP practices. SBHC Advisory Board members identified typical scenarios in their day-to-day operations and, in turn, a corresponding communication process was developed for each. A one-page communication, notification, and referral form was developed and printed on duplicate paper to ensure one copy for the SBHC chart and one to be

---

<sup>20</sup> Rosenbach, M.L. and Young, C.G., *Care Coordination and Managed Care: Emerging Issues for States and Managed Care Organizations*. Mathematica Policy Research, Inc., June 2000.

<sup>21</sup> Rosenbach, M.L. and Young, C.G., *Care Coordination in Medicaid Managed Care: A Primer for States, Managed Care Organizations, Providers, and Advocates*. Mathematica Policy Research, Inc., July 2000.

<sup>22</sup> Wehr, E., *Basic Elements of Care Coordination for People with Special Health Care Needs in Medicaid Managed Care*. Center for Health Care Strategies. Issue Brief, February 2000.

<sup>23</sup> Hacker, K. op.cit

<sup>24</sup> American Academy of Pediatrics Committee on School Health. "School Health Centers and Other Integrated School Health Services." *Pediatrics*. February 2000.

forwarded to the PCP when a student was seen by an SBHC clinician for treatment. The practice guidelines that were established for communication and PCP notification can be found at Appendix D.

## **Disease Management**

Given New Mexico's high incidence of chronic diseases such as asthma, obesity/type-2 diabetes and, particularly among adolescents, depression, the project Advisory Board agreed to focus on the development of resources and guidelines in identifying and managing the treatment of these three diseases. The project's asthma practice guidelines were developed based on the recommendations of the CHCS Best Clinical and Administrative Practices (BCAP) workgroup on Achieving Better Care for Asthma together with the DOH asthma guidelines; and all three of the practice guidelines are based on nationally recognized standards and represent extensive work by the project nurse consultant and clinical advisors. These practice guidelines can be found at Appendix E.

## **Prevention**

In state fiscal year 2002, New Mexico's overall EPSDT screening ratio for all age groups under the *Salud!* program was 62 percent, reflecting a 43 percent screening ratio among recipients between the ages of 10 and 14, and a 39 percent ratio for those between 15 and 18 years of age – figures that leave significant room for improvement.<sup>25</sup> The “*Salud!* Comes to Your School” project represented a critical opportunity to increase the state's EPSDT screening ratio, particularly among adolescents, who often do not receive any type of adequate health screen.

Building on recognition that the sports physical was one of the services provided most frequently by SBHCs, the Advisory Board implemented guidelines to convert sports physicals into complete EPSDT health screens that include a comprehensive health and developmental history; unclothed physical examination; administration of appropriate immunizations; specific laboratory tests; vision and hearing screens; dental services; and anticipatory guidance appropriate to the student's age. Through grant funding from CHCS, the project purchased needed medical equipment for the pilot sites to permit them to meet all of the requisites comprising a full EPSDT screen.

A Teen Health Questionnaire also was designed for administration to high school students, as well as questionnaires for adolescents in middle school or junior high, and for parents of elementary school children. These questionnaires, which were printed in both Spanish and English, were designed to help SBHC clinicians identify at-risk students and gain insights to assist with their evaluation of and response to the students' health needs. The practice guidelines for conducting EPSDT screens are found at Appendix F.

## **Informed Consent and Confidentiality**

---

<sup>25</sup> HCFA-416: op.cit.

At the beginning of every school year, SBHCs attempt to obtain demographic information about students and parental consent to provide treatment. When a student presents to the SBHC for care and there is no record of this signed consent, the SBHC will contact the student's parents or a legal guardian. Medication is not administered without parental consent.

However, New Mexico law mandates that adolescents have rights to consent for treatment of sexually transmitted infections, family planning services, behavioral health services, and pregnancy testing without the knowledge of their parents or legal guardians.<sup>26</sup> Protection of these rights has been a persistent area of concern, particularly for SBHCs, who report that adolescents are sometimes reluctant to talk to their PCPs about confidential matters out of a fear that the PCP will then tell their parents. Adolescents are often more comfortable discussing these issues with SBHC staff who, while always encouraging parental or guardian involvement to students, are committed to protecting the rights of patients to consent for and receive these confidential services.

The MCOs shared this concern with the pilot sites, and worked to make internal adjustments to their claims processing systems so that explanations of benefits about treatment for confidential services would not be forwarded to the homes of recipients. While this addressed concerns about student confidentiality in one respect, the MCOs still wanted to ensure that students' PCPs would have information about treatment that their patients received during these confidential visits. Although it was difficult for the Advisory Board to reach consensus on the type and scope of information that should be shared for confidential services, it was ultimately agreed that PCPs would be notified when confidential services were provided, but that the nature of these services would not be revealed without the patient's consent. The practice guidelines that were developed to protect an adolescent's right to consent to certain services can be found at Appendix G.

## **Credentialing and Quality Improvement**

New Mexico Medicaid managed care regulations stipulate that MCOs must meet certain quality standards in areas such as UM; continuous quality improvement; provider credentials; member rights and responsibilities; the provision of preventive health services; maintenance of medical records; health data reporting; and confidentiality. The state also requires that MCOs be accredited by the NCQA; and all three of the MCOs for the Medicaid *Salud!* program have achieved this designation. These requirements apply not only to the MCOs, but also to the providers in their service delivery networks which, under the project, included the pilot sites. Four of the SBHC pilot sites were sponsored by entities that were already credentialed and included as MCO network providers; however, two of the selected pilot sites were new to the accreditation process and found it to be a rigorous and sometimes frustrating experience to meet these new standards of operation.

## **SBHC Administrative Responsibilities**

---

<sup>26</sup> English, A. and Kenney, K.E. *State Minor Consent Laws: A Summary, 2<sup>nd</sup> Edition*. Center for Adolescent Health & the Law, 2003.

Most SBHCs have few support staff, if any, to handle the administrative requirements of a busy center. In addition, each of the selected centers had limited infrastructure and resources, and needed computers, fax machines, and medical equipment. Through grant funding from CHCS, the project was able to assist in meeting some of these fundamental needs by purchasing computers and medical equipment for each participating site.

Adding to these logistical concerns, project participation required effective coordination of student care. While the MCOs agreed to cover services without prior authorization, the sites were still charged with verifying *Salud!* membership; identifying and notifying students' PCPs when one of their patients was seen; and making referrals to the MCOs if it was determined that the student could benefit from care coordination or case management. Throughout the course of the project, the pilot SBHCs became proficient in identifying student Medicaid eligibility and ascertaining PCPs; however, making referrals to the MCOs for care coordination and case management continued to pose a challenge to the participating sites. These challenges are discussed further in the evaluation section of this report.

There was another administrative burden associated with the Medicaid “free care” rule, which prohibits the use of Medicaid funds to pay for services that are available free of charge to everyone else in the community.<sup>27,28,29, 30</sup> This means that SBHCs must identify all possible payers when they provide services, including Medicaid and private third-party payers and, where the student has no public or private third-party payer, establish a sliding-fee-for-service scale.

Medicaid providers are required to bill a private third-party payer, when there is one, before billing Medicaid. However, because there are no commercial insurers in New Mexico that recognize and pay SBHCs for the services they provide, the pilot SBHCs were not required to bill private payers before the Medicaid MCO.

## Claims Payment Issues

In addition to the administrative challenges that pilot sites faced in getting started, payment and claims issues also posed a tremendous hurdle for both the SBHCs and MCOs. Although the MCOs supported the SBHCs receipt of patient care revenue to sustain long-term viability, they expressed reservations about the potential for duplication of services and payment between the SBHCs and student PCPs (MCOs often had risk-based capitated arrangements with their PCPs). The MCOs ultimately agreed to pay the SBHCs Medicaid fee-for-service rates for covered services without prior authorization and, nearing the end of the project, began moving away from capitated contracts with PCPs and toward payment to PCPs on a Medicaid fee-for-service basis.

Another challenge with respect to billing was the creation of unique identifiers for each of the centers, which they needed in order to bill. The MCOs had to make system changes to receive

---

<sup>27</sup> *Medicaid and School Health: A Technical Assistance Guide*. Health Care Financing Administration. August 1997.

<sup>28</sup> *CMS Guidelines on Administrative Claiming*. Centers for Medicare and Medicaid Services, May 2003.

<sup>29</sup> Lear, J.L. et al, op. cit.

<sup>30</sup> *Medicaid Reimbursement in School-Based Health Centers: State Association and Provider Perspectives*. National Assembly on School-Based Health Centers. June 2000.

and process SBHC claims and to avoid the automatic mailing of explanations of benefits for confidential services. Developing an effective claims process would prove critical to the project, not only to ensure payment to the SBHCs but also to ensure accurate encounter data, which are obtained from paid claims. This required a number of system adjustments and technical assistance, as well as patience on the part of all project partners.

## **Health Education and Training**

Recognizing the importance of ongoing education and training of SBHC providers as they developed and implemented new project requirements and clinical practice guidelines, the project Advisory Board devised multiple ways to facilitate a comprehensive approach to education and building the skill-levels of providers. Annual provider update meetings were held in 2001, 2002, and 2003, which included clinical and administrative training for SBHC and MCO staff and providers. In Winter 2003 and again in Spring 2004, the project funded educational sessions to improve the skills of SBHC clinicians in identifying and treating alcohol and substance use disorders. These sessions focused on evidence-based intervention models, such as motivational interviewing and cognitive-behavioral therapy, with a particular emphasis on working with adolescents.

In Spring 2004, the project funded additional health education sessions relating to the project practice guidelines and SBHC provider health teaching of students and their parents or guardians. Materials were developed in English and Spanish that included specific information regarding depression, nutrition, preventive care, asthma, and other key issues, and could be customized based on the local needs of the SBHC community and its students, and families.

## **Interagency Relationships**

It is important to point out that strong state interagency relationships were cultivated and strengthened through the pilot project, particularly between HSD, the state Medicaid agency, and DOH, the state department that funds and oversees 17 SBHC sites, including the pilot sites, and maintains statutory authority over school nursing. In addition, the New Mexico Children, Youth & Families Department (CYFD) worked closely with the project to develop the practice guidelines for the management of depression; and the state Public Education Department (PED) provided guidance on general school health issues. Each of these agencies serves the same student population, and the project provided a strong avenue for collaboration, coordination, and the efficient and effective use of resources and expertise.

## Project Evaluation

A comprehensive and inclusive evaluation of the project was central to determining the project's overall effectiveness, impact, and outcomes, and was viewed as the best way to support expansion of the project to other SBHCs beyond the end of funding from CHCS. The project evaluation design incorporated a multifaceted and coordinated approach utilizing both qualitative and quantitative methods, allowing for the triangulation of data across time periods and methodology. A copy of the project evaluation plan can be found at Appendix H.

### Primary Qualitative Evaluation Methods

An independent evaluator was selected for the project based on a response to a request for proposals (RFP) and contract award. The evaluator's proposed model for collecting qualitative data included:

- An evaluation of project process through eight surveys of pilot project Advisory Board members.
- Evaluations of multiple impact/outcome data sources, including:
  - Pre- and post-test surveys of SBHC administrators and providers from update sessions held in August 2001, 2002, and 2003.
  - Focus group sessions with separate groups of parents and students at each of the pilot sites during the spring of 2002 and fall of 2003.
  - One-on-one interviews of SBHC clinical providers during the spring of 2003 and of both SBHC providers and community primary care providers in the spring of 2004.
  - Onsite medical record reviews conducted during the spring of 2003 and winter of 2004.
  - Interviews of the managed care organization project partners during the spring of 2004.

### Primary Quantitative Evaluation Methods

In addition to these qualitative components, the independent evaluator developed a methodology for collecting quantitative data that included:

- Encounter data comparisons from paid claims in the Medicaid *Salud!* system between July 1, 2001, and December 31, 2003.
- Demographic and utilization data reported to the Department of Health (DOH) by SBHCs between July 1, 2001, and June 30, 2002.
- Onsite medical record reviews conducted during Spring 2003 and Winter 2004.

### Data Limitations

The broad range of both primary and secondary data collected had a number of strengths, including its diverse ability to capture both quantitative and qualitative information, its

potential for triangulation, and its consistency. While the overall quality of these data sources and subsequent analyses is high, the evaluation process presented some limitations that should be noted.

The process evaluation surveys were well-crafted and distributed on a regular basis; however, participation of Advisory Board members was voluntary, resulting in different response rates each time the survey was administered. The focus group interviews included different sets of parents and students each year. In the SBHC provider interviews, a smaller subset of providers participated in the second round of surveys than in the first (however, nearly all of the providers that responded to the second year survey also responded to the first). Only eight community PCPs were interviewed, and this was done only in the second round of provider interviews. And finally, the sample of medical records that was reviewed was a relatively small number and selected by the pilot SBHC staff.

The encounter data that were used to acquire quantitative information were taken from paid claims; therefore accuracy was dependent on the SBHC pilot sites coding and completing claims correctly, a process that took time as the pilot sites learned how to bill. Initially there was some concern that the reported encounters may have represented an undercount of services provided, and the project evaluation team was limited in its ability to judge the rate or pervasiveness of error. By definition, this dataset was not intricate enough to answer some of the more complex evaluation questions; however, the team had reasonable confidence in the conclusions that were reached from the encounter data because it was augmented by corresponding data from the qualitative evaluation.

## Findings and Lessons Learned

This section summarizes the key findings of the project evaluation.

### The Student Population

During the 2003-2004 school year, there were 12,880 students enrolled in the pilot site schools. Hispanic students were the largest ethnic group served by the pilot project at a rate of 73 percent, with Caucasian students making up the next largest ethnicity served at a rate of 20 percent, figures that correspond to the ethnic makeup of the pilot site communities. Most of the services provided by the pilot sites were to children and adolescents between six and 18 years old; the majority of those were in the 10-14 year-old and 15-18 year-old age groups. In addition, project data show that more services were provided to female students, at a rate of 72.3 percent, than to males, at a rate of 27.7 percent.

### Staffing and Hours of Operation

Most of the pilot sites were staffed by one nurse practitioner, a behavioral health clinician, and an administrative clerk or office assistant. In 2004, 41 percent of the centers were open less than 10 hours per week (compared to 43 percent in 2003); 23 percent were open between 10 and 20 hours per week (compared to 22 percent in 2003); 30 percent were open between 20 and 30 hours per week (compared to 17 percent in 2003); and six percent were open between 30 and 40 hours per week (compared to 17 percent in 2003).

### Presentation of the Data

The pilot project's four original goals provided a framework for reviewing the data and reporting the findings. These goals were:

1. To explore best practices for collaboration among the school-based health center (SBHC) pilot sites; primary care providers (PCPs) and behavioral health providers (BHPs) in the SBHC service areas; and the *Salud!* managed care organizations (MCOs).
2. To increase access to care for children and adolescents in New Mexico, specifically at the project pilot sites.
3. To increase the provision of comprehensive and preventive care to children and adolescents served at the SBHC pilot sites.
4. To increase the integration of health care delivery systems, particularly between primary and behavioral health care.

### Goal 1: To Explore Best Practices for Collaboration

This goal was developed to reflect the opportunity of the project to develop and test different models of collaboration for delivering services, ranging from clinical practice guidelines to claims payment processes.

## Implementation of Collaboration Models Presented Multiple Challenges

In the summer of 2001, during the initial project orientation with SBHC and MCO administrative and clinical staff, pre- and post-tests showed a gain in participant understanding of the pilot project goals, timelines, activities, and participant roles and responsibilities; however, several questions on the tests elicited responses that indicated some uncertainty among the project partners and offered insights into the potential challenges that lay ahead. Verbatim, these included:

- “What services are/are not reimbursable?”
- “How to code encounters to maximize chance for reimbursement?”
- “What mechanisms will ensure that confidential services to patients (e.g., STD tests) are kept confidential?”
- “What clinical situations call for relaying information to PCPs and which are not significant enough to warrant this?”
- “We need a lot more training. It is very confusing to process from step a to step b. This was a good beginning.”

Project and MCO staff provided one-on-one technical assistance to the pilot sites throughout the fall of 2001. In the spring of 2002, a meeting of 28 SBHC and MCO administrative and clinical staff and four state agency representatives was held to discuss the project’s progress and to resolve ongoing concerns. The problems requiring most immediate attention included:

- Ensuring that SBHC providers and claims were included in the MCOs’ systems.
- Identification of students’ MCO and/or PCP by SBHC administrative staff.
- Difficulty in processing claims for behavioral health.
- MCOs not receiving referrals for care coordination and case management.
- Perceptions of a limited scope of covered services.
- Difficulty of the MCOs in reading SBHC claims.
- Rejections of claims for covered services.
- The types of data that SBHCs were required to report to the MCOs.
- Challenges of SBHCs communicating with PCPs.

During that meeting, state agency staff facilitated the discussion and participants developed a plan for addressing each of the issues identified. Results of the Advisory Board process surveys conducted in June and November 2002 suggested that this meeting was a pivotal point in the project for many. The surveys elicited comments such as:

- “Ability to problem-solve with MCOs directly.”
- “SBHCs working together to troubleshoot and sharing what’s working and not working.”
- “Very appreciative of the assistance MCOs gave in case management, coding, best practices, logistics and guidelines.”
- “It [the project] has grown to work very well; there’s trust and good communication.”
- “Getting everyone at the table and successfully negotiating another project year.”

- “Just the implementation itself is a major success!”

In addition, the pre- and post-tests that were given during the SBHC administrator and provider update held in August 2002 again showed progress and pointed to the continued learning of project participants. Respondents commented that the session was “very helpful” and “interesting;” however it was suggested that the session be held for a full day to allow participants to learn all of the information presented.

In response, the SBHC administrator/provider update held in August 2003 was designed with a full-day session curriculum. The meeting discussion suggested maturation of the project and increased collaborative efforts. SBHC clinicians and the MCOs discussed their progress in implementing the practice guidelines for depression, including early identification and treatment. They also discussed issues stemming from the subject of confidentiality and protecting an adolescent’s right to consent for certain services, and identified where the MCOs needed to make additional system adjustments to ensure that explanations of benefits were not sent to the homes of students. The pre- and post-test comments from the 2003 session demonstrated a visible paradigm shift from earlier concerns about credentialing, coverage, billing, and coding, to concerns about the future of the project once the funding from CHCS expired and how to expand the project to other SBHC sites.

### **Environment for Exploring Collaboration Models Viewed as Critical to Success**

It was clear that the project Advisory Board and working teams were instrumental to facilitating collaboration and fulfilling ongoing project tasks. Some of the most telling comments that were received in the biannual Advisory Board surveys during the first two years of the project included:

- “Wonderful collaboration and relationship building.” (May 2001)
- “Expanding out into business areas that have not before been part of managed care – speaking each other’s languages and understanding each other’s businesses!” (May 2001)
- “Clinical subgroup meetings helped with communication and agreement on management guidelines.” (January 2002)
- “Advisory Board meetings leading to collaborative work on solutions and challenges.” (January 2002)

### **SBHC Providers were Central to Collaboration on Provision of Services**

The pilot project asked SBHC providers to make accommodations to their clinical practices in order to participate, including learning what services were covered and how to code and bill; making referrals for care coordination and case management; integrating behavioral and physical health care; and addressing complicated billing and coding system issues. The final year of the project was primarily focused on enhancing communication and collaboration between the pilot SBHCs and the PCPs and BHPs in their communities; continuing to resolve issues in the SBHC and MCO systems; protecting patient confidentiality; identifying Medicaid-eligible students; understanding and implementing regulations associated with the Health Insurance

Portability and Accountability Act (HIPAA); refining the clinical practice guidelines; and determining if and how the project would continue beyond the pilot phase.

Results from the SBHC provider interviews showed that 38 percent of SBHC providers in 2003, and 82 percent in 2004, believed that the project had impacted their ability to provide optimal care. The comments of those interviewed were both positive and negative, and included statements such as:

- “Sometimes paperwork and protocols [guidelines] are cumbersome.”
- “Anything that takes extra time affects patient care.”
- “Paperwork bogs down patient care, is redundant, and needs to be simplified.”
- “Case management has been helpful – they work hard for teen health center.”
- “Access to behavioral health is an advantage.”
- “Protocols [guidelines] are helpful – would like to see more, e.g., obesity, diabetes, nutrition, stress management.”
- “Believe care has improved.”
- “Positive experience – had no clue at beginning how beneficial it would be.”
- “Now that we’re finally getting paid and have new protocols [guidelines], it’s running a lot more smoothly.”
- “It’s a great success to bill successfully and be reimbursed for services.”

### **Many Lessons were Learned During Implementation of Collaborative Models**

Taken together, these comments were extremely helpful to project staff and the Advisory Board. Each time that a survey or pre-/post-test was administered, the results were evaluated and analyzed to provide an ongoing tool for informing the project’s decision-making process. In summary, the project learned that:

- The processes of credentialing the pilot site providers; linking SBHCs with PCPs; billing and claims payment; and “fitting SBHC providers into established [MCO] business practices,” were challenging, and progress was incremental over time.
- The MCOs needed to adjust their systems to accommodate this new type of health care provider in their networks and to provide an increased level of technical assistance in coding and billing.
- The Advisory Board and working teams played pivotal roles in helping to establish the collaborative relationship between the SBHCs and MCOs that was critical to the project’s overall success.
- Although the SBHC clinical providers were expected to learn new methods of practice, undertake greater amounts of paperwork, be accountable in a new way, and learn to code and bill, they were sustained by the promise of providing improved quality of care and being paid for the services they provide.
- The persistence and patience of project partners were key. By staying focused on the project goals and methodically addressing both anticipated and unanticipated issues, the collaborative relationship grew into a strong and effective partnership.

## **Goal 2: To Increase Access to Care for Children and Adolescents**

To quantify the project's progress in increasing care for children and adolescents, the project evaluator conducted analyses of encounter data on all 87 of the covered primary and behavioral health services that were provided by both the pilot SBHCs and all other providers in the community to *Salud!* members between the ages of zero and 21 who lived in the zip codes of the schools in which the pilot sites were located. This comparison encompasses encounter data on services provided between July 1, 2001, and December 31, 2003.

It should be noted that, in this presentation of the encounter data results, the term "SBHCs" refers to the pilot sites, and the term "Other Providers" refers to primary and behavioral health providers working outside of the SBHCs in the pilot site communities. In addition to encounter data analysis over the course of the project, other methods of assessing access to care included SBHC provider interviews, student and parent focus groups, and medical record reviews.

### **Encounter Data Showed Students Accessed Needed Services**

Table 1, taken from the encounter data results, shows that services provided in the SBHC pilot sites increased steadily throughout the implementation phase of the project.

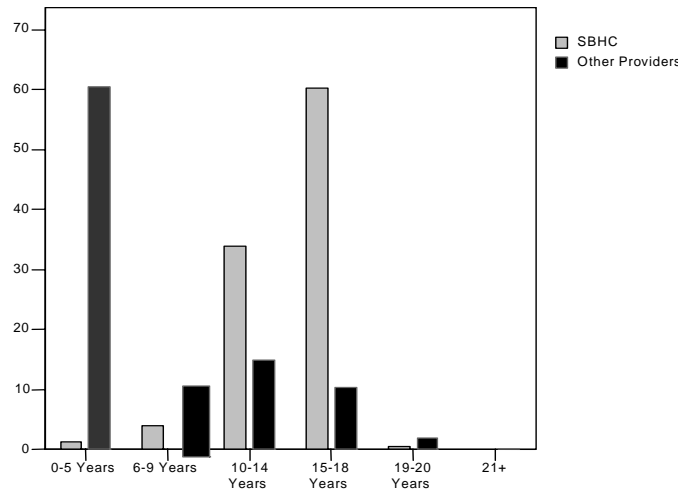
TABLE 1

Year of Service	SBHC Encounters	Unduplicated Patients
July 1, 2001 – June 30, 2002	743	309
July 1, 2002 – June 30, 2003	2,468	834
July 1, 2003 – December 31, 2003	986	439
<b>Total</b>	<b>4,254</b>	<b>1,582</b>

**SBHCs Compared Favorably with Other Providers**

Although the penetration rate of the pilot SBHCs was relatively small compared to the total population, the pilot sites, as a percentage of the whole, provided access to more of the project’s covered services to adolescents compared to other providers working in the pilot site communities serving the same population. Other providers served proportionately more children between the ages of zero and five.

FIGURE 1



**Access was Facilitated to Needed Care outside the Pilot Sites**

As noted in preceding sections of this report, the project viewed SBHCs as a key resource to PCPs in their local communities; therefore, they were required to communicate with student PCPs using the PCP Notification Form when services were provided at the pilot sites. Based on results of the SBHC provider interviews, 96 percent of the pilot site providers interviewed in 2003, and 100 percent of those interviewed in 2004, responded that they communicated with the students’ PCPs, usually by mailing or faxing the PCP Notification Form. The 2003 and 2004 medical record reviews showed a 71 percent compliance rate with this requirement.

The rate of communication from the pilot sites to community PCPs was high; however the rate of communication back from the students’ PCPs to the pilot SBHCs was low. In the provider interviews, only 46 percent of pilot site respondents in 2003, and 18 percent in 2004, said they

received communication back from PCPs, and that it generally took repeated followup or knowing the PCPs on a personal basis to generate PCP responses. In addition, the 2002 focus group interviews indicated that many students do not see their PCPs on a regular basis, even when referred to their PCP by an SBHC provider.

Both parents and students that participated in the focus groups indicated that SBHCs were “friendly,” “easy to talk to,” and “accessible,” and expressed appreciation that visiting the centers did not require students to miss school or reveal confidential services to their parents. Concurrently, most of the SBHC providers surveyed, and all of the PCPs that were interviewed in 2004, said they would like to see increased communication and more collaboration between SBHCs and PCPs. Further discussion on the SBHC/PCP relationship is highlighted in the subsequent section of this report regarding the integration of systems.

Regarding referrals to community PCPs and specialists, most of the SBHC providers interviewed (87 percent in 2003, and 100 percent in 2004) said they referred students to specialty care when the care needed by the students was outside of the sites’ scope of services, e.g., for orthopedics, severe or chronic conditions, or when on-call followup was necessary. In 2004, the pilot site providers also reported stronger relationships with school nurses, teachers, and school administrators, which resulted in still more referrals and increased access to services at the pilot sites and with community providers.

The MCO care coordinators provided another a resource for increasing student access to care; however, data show limited success in the pilot sites’ use of MCO care coordination services. Only 37 percent of pilot site providers interviewed in 2003, and 35 percent in 2004, referred students to their MCOs for care coordination or case management. Some of the comments made by providers who did not use MCO care coordination and case management resources indicated that they preferred to do their own coordination or found referrals to MCOs too complicated.

### **Students and Parents Expressed Satisfaction with Access to Care**

In the 2002 and 2003 focus group interviews, most of the participating students indicated that they used SBHCs for a wide variety of primary and behavioral health services. Some of their comments regarding the reasons for accessing care through SBHCs were:

- The sites provide “sensitive services,” that are confidential and important to them.
- SBHCs are “comfortable.”
- Students are “not judged” at the SBHCs.
- Students “trusted” the SBHC providers, and “liked female providers.”
- Students believed that SBHC “services were high quality and providers took time” and that providers “answered all questions,” and “followed-up and checked on students who came in.”

Similarly, the focus groups indicated high rates of satisfaction among participating parents, who commented that:

- They were aware of the wide variety of services, including confidential services, available at the SBHCs.
- SBHCs provide a “safe haven” and “good access to services.”
- SBHCs help parents because “kids don’t have to miss school” and “parents don’t have to miss work.”
- SBHCs are “kid-friendly and capable providers.”

Additionally, both parents and students demonstrated an increased awareness of the *Salud!* program over the course of the project, and indicated high satisfaction with their *Salud!* PCPs and specialists.

### **Goal 3: To Increase the Provision of Comprehensive and Preventive Care**

The project focused on four care management areas that reflected perceived needs in the student populations. These included management of asthma, depression, and obesity/type 2 diabetes; and prevention through the comprehensive Early Periodic Screening Diagnostic and Treatment (EPSDT) health screen. In federal fiscal year 2002, state data showed an overall EPSDT screening ratio for all age groups of 62 percent, with 43 percent representing ages 10 to 14 and 39 percent representing ages 15 to 18.<sup>31</sup> The pilot SBHCs reported doing sports physicals; however, these physicals did not meet all of the components of a complete EPSDT screen. The project Advisory Board viewed this as an opportunity, and collaborated with the project’s clinical working team to develop guidelines to convert all SBHC sports physicals into full EPSDT health screens. A Teen Health Questionnaire was developed to help SBHC clinicians identify at-risk students and elicit information that would enable them to evaluate and respond to the health needs of students served.

#### **Qualitative Data Showed Increased Provision of Comprehensive Care**

Data from the SBHC provider interviews show that 67 percent of those interviewed in 2003, and 82 percent in 2004, believed that they were providing more comprehensive care due to the pilot project and that more students who needed EPSDT exams received them within two to three SBHC visits. Respondents also cited the value of the comprehensive Teen Health Questionnaire risk assessment tool in identifying risk and facilitating comprehensive care. The medical record review showed rates of 80 percent compliance with all 10 key components of the EPSDT screen in 2003, and 91 percent compliance in 2004.

In the 2003 and 2004 SBHC provider interviews, many respondents stressed the prevalence of behavioral health issues among their students and the high need for increased onsite behavioral health care, including medication management, group sessions, and child psychiatry. Eighty-seven percent of the providers interviewed in 2003, and 100 percent interviewed in 2004, reported that they made a greater number of referrals during the final two years of the project, particularly to specialists, dentists, and behavioral health providers. Making referrals to specialty and dental care in urban communities appeared to be highly challenging at times due to barriers such as transportation and long waiting times for appointments. Making referrals in rural

---

<sup>31</sup> HCFA-416 op. cit.

communities was easier for primary and dental care, but more difficult for specialty care and behavioral health. As these barriers suggest, more education is needed for both providers and parents to increase their awareness of *Salud!*-covered services such as transportation and MCO accountability for ensuring access to covered services when medically necessary.

Regarding the pilot sites' use of the asthma and depression guidelines, 65 percent of the pilot SBHC providers interviewed in 2004 (compared to 50 percent in 2003) had incorporated the asthma guidelines into their practices; and 100 percent of the providers surveyed in 2004 (compared to 78 percent in 2003) had incorporated the depression guidelines. Table 2 shows the overall SBHC provider compliance rates for the practice guidelines for asthma, depression, and the provision of EPSDT health screens.

TABLE 2

Guideline	2003 Compliance Rate	2004 Compliance Rate
Asthma	73 percent	87 percent
Depression	82 percent	89 percent
EPSDT Screen	80 percent	92 percent

In both the 2003 and 2004 rounds of interviews, respondents reported that the overall coordination and integration of primary and behavioral health care had resulted in increased quality and comprehensiveness of care to students, particularly where cross-training and internal care coordination between providers had occurred.

***Quantitative Data Showed Increased Provision of Comprehensive Care***

In addition to data from the provider interviews and medical record reviews, the project evaluator also looked at the encounter data results to determine progress in the area of increased comprehensiveness of care to students in the pilot sites. For purposes of analysis, the 87 covered primary and behavioral health services were grouped into these categories:

- Evaluation and management (E&M), which includes services for symptoms or problems.
- Behavioral health, which includes services such as psychiatric evaluations; individual, group, and family therapy; and medication management.
- EPSDT, which includes comprehensive preventive evaluations.
- Counseling and risk factor analysis, which includes services to promote health and prevent illness or injury.
- Procedures and laboratory, which includes minor surgical and laboratory procedures.
- Immunizations.

Figures 2 and 3 compare the overall distribution of these services for providers in the pilot SBHCs and community PCPs.

FIGURE 2

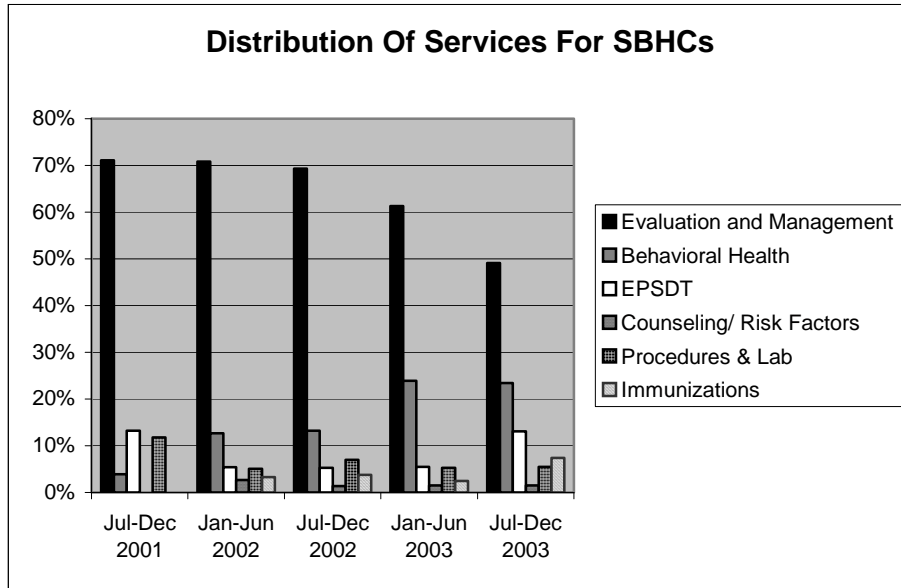
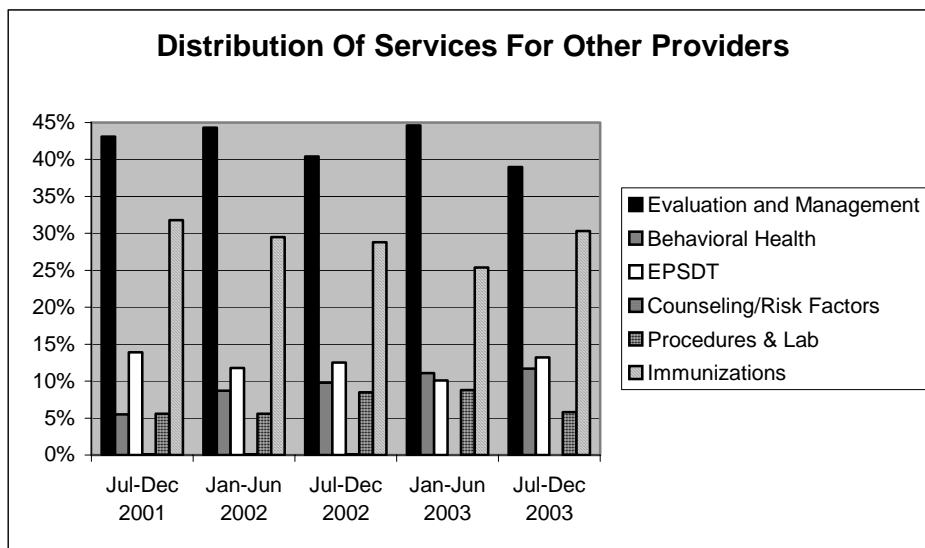


FIGURE 3



As Figures 2 and 3 show, the actual count of services provided in all categories at the SBHC pilot sites increased during each six-month period of the project until the final six-month period, when there was some turnover of SBHC staff and a change in the types of services provided (e.g., fewer E&M services and more behavioral health and EPSDT services). In addition, the data suggest that, as a percentage of the whole, SBHCs provided proportionately

more E&M, behavioral health, and counseling services to adolescents than other providers in the pilot site communities. By contrast, the data show that other providers administered a greater proportion of immunizations.

### Data Showed Increased Access to Preventive Care

One of the main ambitions of the pilot project was to visibly increase access to EPSDT health screens through the SBHC pilot sites. As noted in previous sections of this report, grant funding from CHCS allowed the project to purchase medical equipment that the sites needed to execute complete EPSDT screens. Nonetheless, achievement of this goal proved challenging. In the 2004 pilot site provider interviews, respondents pointed out that the EPSDT screening visit is lengthy, and noted that there are limited staff available in SBHCs who have the time to conduct one. Respondents also expressed concern about who should provide the appropriate follow-up (SBHC versus the student's PCP). In spite of these challenges, the number of EPSDT services provided at the pilot sites noticeably rose over the course of the project.

As Figures 4 and 5 show, the actual count of EPSDT services provided at the pilot sites continued to increase across time for students between 10 and 14 years and 15 to 18 years of age, reflecting the target population served. The number of EPSDT encounters for children between six and nine years-old remained small; for two six-month intervals of the project, there were no EPSDT encounters at all for children in that age group. Other providers had comparatively more EPSDT encounters for children between the ages of zero and five.

FIGURE 4

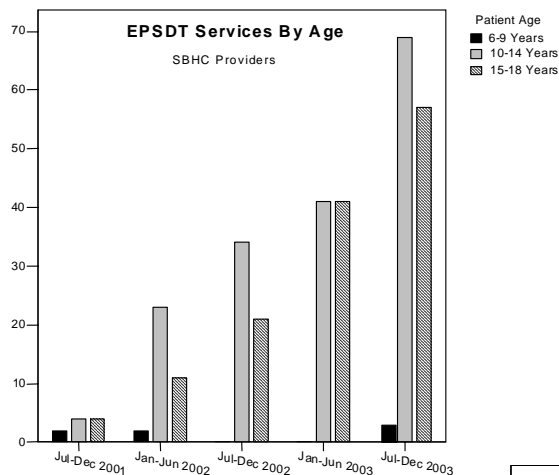
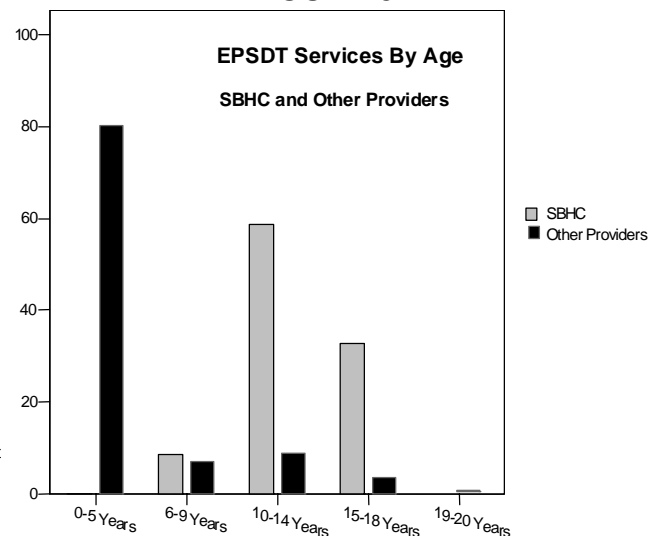


FIGURE 5



As a percentage of the whole, the pilot sites provided a larger share of EPSDT visits to adolescents than other providers in the pilot site communities. At the same time, the number of E&M services went down over the project time periods, suggesting that the increased emphasis on the lengthier EPSDT exam had an impact on the number of E&M services the SBHCs provided.

### **Health Education Helped to Foster Provision of Comprehensive and Preventive Care**

As noted in preceding sections of this report, the project was able to execute a wide variety of educational curricula that were key to building the skill-levels of pilot site providers and ensuring a comprehensive approach to care. Pre- and post-test results from the provider update trainings showed a growth in participants' knowledge of clinical issues, including prevention and early intervention, care coordination and case management, and behavioral and primary care treatment and referrals. Additional health education sessions were held in the winter of 2003 and spring of 2004 to improve the skills of SBHC clinicians in treating substance use disorders. These sessions, which included state-of-the-science evidence-based practices such as cognitive behavioral therapy and motivational interviewing, provided an emphasis on how to identify and treat adolescents with or at-risk for substance use problems. Post-surveys from those sessions documented a very high degree of satisfaction with the information provided at both sessions, and a definite applicability of that information to the SBHC environment.

In addition, respondents to the 2003 and 2004 SBHC provider interviews made specific requests for explanatory educational materials that they could use to do health teaching with both students and parents, particularly for issues such as depression and anxiety. The project responded in the spring of 2004 by contracting with a health educator to develop educational materials specific to each of the project's clinical practice guidelines, which SBHC providers could customize based on the local needs of their student and parent populations. Two health education seminars were also held to help the pilot site providers develop strategies for reaching students and their families and for using the educational materials to effect positive behavioral

change. Post-evaluations of the health education training sessions showed a high degree of satisfaction, particularly for those who attended the second session.

#### **Goal 4: To Increase the Integration of Health Care Delivery Systems**

One of the fundamental goals of the pilot project was to emphasize the importance of assessing and treating the needs of the whole child – including both primary and behavioral health needs – to all providers serving that child, whether at the SBHC pilot sites or in the local community. Traditionally, primary and behavioral health care providers have not communicated or collaborated to work with students; SBHC clinicians and community PCPs have had almost no interaction; and SBHCs and MCOs have had no relationship. Given this history, the coordination of providers and systems provided a daunting challenge to project staff and Advisory Board members.

#### **Facilitating Integration Required Frequent Attention**

The project Advisory Board designed a number of methods to promote the integration of services through communication and interdisciplinary planning and training; however evaluation data show varying degrees of success. The data suggest that integration of primary and behavioral health services was achieved in the pilot SBHCs, particularly during the last two years of program implementation. In some of the pilot sites, providers worked as integrated teams, overlapping their tasks related to administering the Teen Health Questionnaire and reviewing student responses. There also was an increase in the prevalence of onsite referrals, which the project believes was due in large part to a growing awareness among providers of each other's scopes of practice and also to increased skill levels.

Despite the progress made with integration at the SBHC level, progress was more incremental in the areas of MCO referrals for care coordination and case management, and communication between SBHC providers and the PCPs in their local communities. According to the SBHC provider interviews, only 37 percent of respondents in 2003, and 35 percent in 2004, referred students to their MCOs for care coordination or case management services, citing a preference for coordinating student care through the SBHC and a perception of complicated processes associated with referrals to the MCOs.

The provider interviews, as well as the medical record reviews conducted in 2003 and 2004, also reflected difficulties in communication and service integration between SBHCs and PCPs. In interviews conducted in Spring 2004 with eight community PCPs, five reported that they referred to SBHCs, but the other three did not have any knowledge about SBHC hours, the services they provide, or their relationship with the *Salud!* program. Those three PCPs also cited lack of a personal connection to the SBHC providers and administrators. Only two of the PCPs who were interviewed were familiar with the PCP Notification Form; however, none knew the routine procedure for processing the form once it was sent to their office. Despite these barriers, the 2004 provider surveys show agreement between both SBHC providers and community PCPs that more integration of their efforts was not only possible via increased direct communications such as meetings and presentations, but was essential to caring for children and adolescents in their communities.

It is important to note that throughout the tenure of the project, New Mexico's Medicaid managed care program was based on an integrated model of primary and behavioral health care, e.g., all three MCOs covered both primary and behavioral health care. Integrating the pilot SBHCs into the MCO networks was challenging but improved over the course of the project, as indicated in the Advisory Board process survey that was administered in November 2003. These improvements were particularly visible at the administrative level, and were a direct result of the problem-solving discussions that took place at project Advisory Board and working team meetings. By the end of the project, the integration of claims and billing processes between the SBHCs and the MCOs had been successfully established.

From the beginning, the project partners, including state agencies, SBHC administrators and clinical staff, and the MCOs, were aware of the potential role that SBHCs could play in New Mexico's overall health care delivery system. This was evidenced by their willingness to coordinate activities, modify their different systems of providing care, and increase their understanding about the services SBHCs provide, and is supported by the results of the process survey and provider survey instruments. According to the 2003 and 2004 provider surveys, this partnership and subsequent integration of systems also has expanded, and now includes other community organizations and agencies, such as social service, youth, and health care entities, and local businesses.

### **Data Showed Need for Improvement in SBHC Capacity**

Since launching the pilot project, it always has been clear that most SBHCs are challenged for resources and overall capacity. Seventy percent of the providers surveyed in 2003, and 65 percent in 2004, identified the issue of "capacity" – meaning number of providers, availability of physical space, medical equipment, and assistance with administrative activities – as a critical barrier to student access to care. When asked what would satisfy their capacity needs, providers made suggestions such as:

- "More space."
- "A place for parents."
- "More [behavioral and physical health] providers," particularly female providers.
- "Administrative assistance," particularly with billing and claims.
- "Confidential space for counseling."
- "More hours," including after-school, evening, weekend, and summer hours.
- "Prevention staff," such as health educators.
- "Increased *Salud!* enrollment," and "staff to determine Medicaid presumptive eligibility."
- "Co-facilitators for behavioral health groups."
- "Increased clinical supervision."
- "Marketing of SBHC services to schools, community, and PCPs."

In addition to these provider remarks, students and parents also offered suggestions for improvement during the focus group interviews, such as:

- “More or better hours,” such as being open daily, during afternoons and early evenings, and over lunch.
- “More providers, including specialists.”
- “Larger, more comfortable facilities.”
- “Increased collaboration with school staff,” such as school nurses and coaches.
- “Increased information and awareness campaigns.”
- “Assistance for families in crisis.”

### MCOs Described Value of Partnerships with SBHCs

At the close of the project, representatives from the three *Salud!* MCOs were interviewed on a wide spectrum of issues. They described the pilot project as a unique partnership between unlikely, and even competitive, entities that forged new networks and professional relationships. Working with and getting to know SBHCs was an important highlight of the project, since SBHCs had been outside of the MCOs’ traditional marketplace. Respondents said they had learned a great deal about SBHCs and their value in increasing access to care for children and adolescents. Other specific highlights included credentialing the SBHCs; collaboration among the three *Salud!* MCOs; developing the clinical guidelines; planning and conducting the health education trainings; increasing access to behavioral health services through the SBHC pilot sites; and developing the customer orientation to work toward the health needs of children and adolescents.

Quoting the MCOs’ responses, some of the most challenging aspects of the pilot project were:

- “Getting the SBHC sites up and running so they could bill and be paid.”
- “Addressing system issues, such as billing, credentialing, efficiency (e.g., EPSDT), referrals, and coordination of services with PCPs, specialists and case management/care coordination.”
- “Developing mutual understanding of the organizational culture of MCOs and SBHCs and diverse personnel and resources of the SBHC sites.”
- “Getting the word out about the project and promoting its successes frequently and regularly (e.g., to policymakers).”
- “Building PCP awareness and involvement.”
- “Creating/finding meaningful [CPT] codes that work for schools, students, and families.”
- “Protecting adolescents’ confidentiality.”
- “Encouraging SBHCs to rely on the MCOs for more support, e.g., case management.”
- “Coordinating the different approaches of the three MCOs (challenging for both MCOs and SBHCs).”
- “Understanding the challenges SBHCs face each day when providing health care.”

The MCOs also described many lessons learned, such as:

- “Building new systems of care between MCOs, SBHCs, and state agencies.”
- “Coordinating efforts and sharing an agreed-upon common goal.”

- “Shifting competition to cooperation, networking, and getting to know people personally.”
- “Integrating SBHCs into a larger health care system.”
- “Broadening the concept of care when serving students at SBHCs.”
- “The reality of rural health care with its limited resources, providers, and problems in maintaining confidentiality.”

In addition, the MCOs stressed the importance of selecting new pilot sites carefully when expanding the project so that they are prepared to meet all of the project requirements. They agreed that it would be critical to have a strong, patient, articulate, competent, and committed champion or leader who can pull each of the various partners together to keep the project moving forward, as well as an experienced and influential representative Advisory Board that is not too large. They recommended ongoing meetings to ensure that project partners have a locus for decision-making, problem-solving, and networking. Interestingly, the MCOs also commented that the project had increased collaboration among themselves and had facilitated their shared cooperation on other projects as well.

The MCOs agreed that communication between SBHC providers and PCPs continues to be critically important, and requires a combination of targeted outreach, communication, education, personal contacts, and system adjustments. Several representatives suggested that presentations or poster sessions showing the PCP communication process and highlighting project success and data be made to various provider groups in New Mexico, such as the New Mexico Academy of Pediatrics, the New Mexico Academy of Family Practice, the New Mexico Medical Society, and the New Mexico Primary Care Association. To engage a wider audience, it was suggested that these presentations be focused on Medicaid first and SBHCs second.

The MCO respondents had other specific recommendations to address the PCP/SBHC communication issue, including:

- Displaying posters at SBHCs (potentially via a school poster contest).
- Developing attractive posters for PCP offices.
- Creating and sending visually attractive and quick-to-read SBHC postcards to PCPs.
- Increasing marketing with PCPs and in the community at-large, including the development of a distinguishable logo.
- Redesigning the PCP Notification Form to make it more recognizable to PCPs, perhaps by making it a brighter color or adding a logo.
- Conducting small SBHC/PCP meetings, lunches, or conferences to facilitate the development of personal relationships.
- Including a regular column on SBHCs in the MCO provider newsletters.
- Building an SBHC web site with links to the MCO web sites and, conversely, including SBHC resource links on the MCO web sites.
- Utilizing care coordination more to help students establish relationships with their PCPs.

## Project Sustainability and Diffusion

Several months before the end of the pilot project, the Advisory Board convened to discuss sustainability of the project beyond the grant funding and potential expansion of the project to other SBHC sites. The Board unanimously agreed that the project should not only continue beyond the pilot phase, but expand to include new SBHCs. Recognizing that there are tradeoffs resulting from participation, the participating SBHC sites expressed their appreciation and understanding of the importance of being part of the mainstream health care delivery system. The MCOs recognized that SBHCs could help them increase access to comprehensive and preventive care services for their younger members, especially hard-to-reach adolescents and those who might not otherwise be seeking care.

The MCOs will continue to contract with the six original SBHC pilot sites and have agreed to add three new sites through the remaining MCO contract period, which ends on June 30, 2005. Beyond that, project staff plan to include SBHCs in the requests for proposals (RFPs) that are developed for the Medicaid physical and behavioral health contracts slated to go into effect for fiscal year 2006. The three new pilot sites will be provided with ongoing technical assistance from all of the project partners, including mentoring from the six original sites, to ensure their successful integration. In addition, as mentioned in the preceding section, the Advisory Board has expressed its interest in increasing PCP participation using a number of targeted strategies. The role of SBHCs will be included on the agenda of a conference for PCPs in September of 2004.

The work of the project also will continue through a research project that is underway at the University of New Mexico (UNM) to study the screening tool used in the project's practice guidelines for management of depression. Another research project, which was conducted recently by Dr. Alberta Kong, concluded that SBHCs are vital partners in identifying students at-risk for obesity, heart disease, and diabetes.<sup>32</sup> Additionally, components of the project's practice guidelines for the management of asthma have been incorporated into the New Mexico School Health Manual, so that other DOH-funded SBHC sites can benefit from the work of the project and incorporate the project guidelines into their operations.

Information about the project has been disseminated through presentations at the National Assembly on School-Based Health Care (NASBHC) national conventions in 2002, 2003, and 2004; at the CHCS Quality Summit in 2004; at the 2001 conference, "Reaching Today's Adolescents through Public Programs," sponsored by the American Public Human Services Association (APHSA); during a national teleconference titled, "Best Practices Employed by School-Based Health Centers for Maximizing Reimbursement," sponsored by the US Health Resources and Services Administration (HRSA); at New Mexico's Head-to-Toe annual school health conference in 2002; and at the New Mexico School Nurses Association conference in 2001. In addition, an article on the project appeared in the November/December 2001 issue of *Healthplan*; in a publication titled, "Partners in Access: School-Based Health Centers and

---

<sup>32</sup> Kong, M.D., A. Division of Adolescent Medicine, Principal Investigator, University of New Mexico School-Based Health Diabetes Prevention Program. 2003-2004.

Medicaid,” issued by NASBHC in October 2001; and in the winter 2001 newsletter of the New Mexico Chapter of the American Academy of Family Physicians.

As noted at the beginning of this report, the pilot project was borne out of a School Health Summit that was held in the winter of 1999. As project staff worked to conclude the grant-funded portion of the project, it seemed fitting to hold another summit to address the status of school health programs in New Mexico, including the role of SBHCs in the overall health care arena, and to strategize further about next steps. On June 14, 2004, a second School Health Summit was held, attended by the Cabinet Secretaries of all four state agencies that partnered on the project; legislative leaders; advocates; providers; and others to obtain a broad overview of school health in New Mexico, to develop a shared aim for school health, and to commit to sustaining and expanding school health programs by more effectively managing resources.

The summit culminated with a solid commitment to build on the work of the project by bringing together representatives from all school health programs, including those representing Medicaid managed care; the Medicaid School-Based Services program for special education students; the Indian Health Service; primary care and behavioral health providers working in schools; school nurses; SBHCs and others. Together, this group will consider how to improve the coordination of school health services; utilize resources more effectively; estimate the costs associated with establishing and operating SBHCs; establish standards for the delivery of all school health to ensure the quality of care provided; and track health outcomes.

## Conclusion

The “*Salud!* Comes to Your School” project, and the visible successes evidenced in the project’s evaluation, is reflective of extensive collaboration between multiple state agencies; SBHCs; MCOs; community primary and behavioral health providers; advocates; and students and families. It is the product of numerous discussions over how best to build the partnership among all of these entities to increase access to care among New Mexico’s children and adolescents – especially the neediest and most at-risk. The collaborative approach of the pilot project has proven essential, not only as a means of strengthening these relationships, but also for informing and guiding decision-making about the project’s optimal organizational structure, needed programmatic and business practice revisions, areas in need of clarity, and overall problem-solving capacity.

While there is more work to be done in all of these areas, affirmation of the project’s success can be found in its original goals and objectives, which were largely met and in many cases exceeded. The next measure of the project’s success lies in the future inclusion of SBHCs as full participants in the Medicaid behavioral and primary health care delivery systems that are slated for implementation in fiscal year 2006. In the end, the project’s strong record makes the ultimate case for inclusion, having demonstrated that SBHCs, while still in their infancy as a provider group, are positioned to be leaders in implementing clinical best practices; in improving the quality of care; in integrating primary and behavioral health services; and in providing a holistic approach to the health of New Mexico’s children and adolescents.

## Bibliography

Adams, E.K. and Johnson, V. "An Elementary School-Based Health Clinic: Can It Reduce Medicaid Costs?" *Pediatrics*. April 2000.

American Academy of Pediatrics Committee on School Health. "School Health Centers and Other Integrated School Health Services." *Pediatrics*. February 2000.

Barnet, B., Arroyo, C., Devoe, M., and Duggan, A.K. "Reduced School Dropout Rates Among Adolescent Mothers Receiving School-Based Prenatal Care." *Archives of Pediatrics & Adolescent Medicine*. 2004; 158: 262-268.

Brindis, C.D. and Ott, M.A. "Adolescents, Health Policy, and the American Political Process." *Journal of Adolescent Health*. 2002; 30: 9-16.

Brindis, C.D. and Sanghvi, R.V. "School-Based Health Clinics: Remaining Viable in a Changing Health Care Delivery System." *Annual Review of Public Health*. 1997; 18: 567-587.

*CMS Guidelines on Administrative Claiming*. Centers for Medicare and Medicaid Services, May 2003.

Critical Issues in Financing School-Based Health Care. National Assembly on School-Based Health Care. September 1999.

English, A. and Kenney, K.E. *State Minor Consent Laws: A Summary, 2<sup>nd</sup> Edition*. Center for Adolescent Health & the Law, 2003.

Friedrich, M.J., "25 Years of School-Based Health Centers." *The Journal of the American Medical Association*, March 3, 1999, Volume 281, No. 9.

"Guidelines for Contracting with Managed Care." *Making the Grade*. 1998

Hacker, K. "Integrating School-Based Health Centers into Managed Care in Massachusetts." *Journal of School Health*, November 1996; 12 (9): 317-321.

Hacker, K., Weintraub, T.A., Fried, L.E., and Ashba, J. "Role of School-Based Health Centers in Referral Completion." *Journal of Adolescent Health*, 1997; 21: 328-334.

Harvey, J., Vaquerano, L., Nolan, L., and Sonosky, C. *School-Based Health Centers and Managed Care Arrangements: A Review of State Models and Implementation Issues*. Center for Health Services Research and Policy, School of Public Health, The George Washington University, July 2002.

HCFA-416: Annual EPSDT Participation Report, New Mexico. FFY 2002.

Honig, M.H. *School-Based Health Centers and Managed Care: Contracting Issues and Options*. Center for Health Care Strategies, Inc., July 2000.

Improving Access and the Quality of Health Care for Adolescents. American Public Human Services Association. June 2003.

Kaplan, D.W., Calonge, B.N., Guernsey, B.P., and Hanrahan, M.B. "Managed Care and School-Based Health Centers." *Archives of Pediatric and Adolescent Medicine*. January 1998; 15: 25-33.

Kong, M.D., A. Division of Adolescent Medicine, Principal Investigator, University of New Mexico School-Based Health Diabetes Prevention Program. 2003-2004.

Koppelman, J., Ferebee, A., and Eichner, N. "School-Based Health Centers: Surviving A Difficult Economy." *The Center for Health and Health Care in Schools*. 2004.

Koppelman, J. and Lear, J.G. "Partnering with School-Based Health Centers: Connecticut's Medicaid Managed Care Experience." *Managed Medicare & Medicaid*, July 11, 1999.

Lear, J.G., "School-Based Health Centers: A Long Road to Travel." *Archives of Pediatric and Adolescent Medicine*. Volume 157, February 2003.

Lear, J.G., Montgomery, L.L., Schlitt, J.J., and Richett, K.D. "Key Issues Affecting School-Based Health Centers and Medicaid." *Journal of School Health*, March 1996; 66 (3): 83-88.

McManus, M.A., Shejavali, K.I., and Fox, H.B. "Is the Health Care System Working For Adolescents?" Maternal & Child Health Policy Research Center. October 2003.

*Medicaid and School Health: A Technical Assistance Guide*. Health Care Financing Administration. August 1997.

"Medicaid Reimbursement in School-Based Health Centers: State Association and Provider Perspectives." *National Assembly on School-Based Health Centers*. June 2000.

Morone, J.A., Kilbreth, E.H., and Langwell, K.M. "Back To School: A Health Care Strategy For Youth." *Health Affairs*, January/February 2001; 20.

New Mexico Managed Care Policies, Section 606. 1997.

New Mexico Medicaid Managed Care Contract, 1997.

Nine State Strategies to Support School-Based Health Centers: A Making the Grade Monograph. Occasional Papers on Policies Affecting School-Based Health Centers. 1998.

Partners in Access: School-Based Health Centers and Medicaid. National Assembly on School-Based Health Care. October 2001.

Rosenbach, M.L. and Young, C.G., *Care Coordination in Medicaid Managed Care: A Primer for States, Managed Care Organizations, Providers, and Advocates*. Mathematica Policy Research, Inc., July 2000.

Rosenbach, M.L. and Young, C.G., *Care Coordination and Managed Care: Emerging Issues for States and Managed Care Organizations*. Mathematica Policy Research, Inc., June 2000.

Santelli, J., Kouzis, A., and Newcomer, S. "School-Based Health Centers and Adolescent Use of Primary and Hospital Care." *Journal of Adolescent Health*, October 1996; 19: 267-275.

Santelli, J., Vernon, M., Lowry, R., Osorio, J., DuShaw, M., Lancaster, N.P., Song, E., Ginn, E., and Kolbe, L.J., "Managed Care, School Health Programs, and Adolescent Health Services: Opportunities for Health Promotion." *Journal of School Health*. December 1998; 68 (10): 434-439.

Taras, H.L., "Managed Health Care and School Health." *Pediatric Annals*. December 1997; 26 (12): 733-736.

Webber, M.P., Carpinello, K.E., Oruwariye, T., Lo, Y., Burton, W.B., and Appel, D.K., "Burden of Asthma in Inner-City Elementary Schoolchildren." *Archives of Pediatrics & Adolescent Medicine*. 2003; 157: 125-129.

Wehr, E., *Basic Elements of Care Coordination for People with Special Health Care Needs in Medicaid Managed Care*. Center for Health Care Strategies, Inc. Issue Brief, February 2000.