FQHC 101 & School-Health Center Partnerships
Healthy Students, Promising Futures Learning Collaborative
Ron Yee, MD, MBA, FAAFP
Chief Medical Officer
August 2, 2017

America’s Voice for Community Health Care
Agenda

• NACHC and Health Centers
  (Federally Qualified Health Centers)

• School & Community Partnerships

• Why Partner with Health Centers and NACHC?
National Association of Community Health Centers

• Founded in 1971

• **Mission**: To promote the provision of high quality, comprehensive and affordable health care that is coordinated, culturally and linguistically competent, and community directed for all medically underserved populations.
NACHC Priorities

• Attain capacity to manage the health of 30M people across the country

• Assure that 100% of FQHCs reach Patient Centered Medical Home (PCMH) recognition

• Lead or actively participate in local and/or regional innovative care and integration models

• Advocacy and communications for the 1,400 health center organizations with 10,000 sites serving 25M
NACHC & the Health Center Program

- NACHC – National Association and Voice for Health Centers
  - Research-based advocacy
  - Education about the mission and value of health centers
  - Training/TA to health center staff and boards
  - Clinical Workforce, Innovation, Performance

- Health Center Program
  - 1,400+ Health Centers across the country
  - 10,000+ sites nationally
  - 22,000 Clinicians
  - 25,000,000 patients served in 2016
    - Goal is 30,000,000 patients by 2020
Health Center Controlled Networks (60)

- Data Warehousing
- EHR adoption and upgrade Training
- Workflow
- EHR Optimization
- Regulatory Compliance & Reporting (UDS)
- Clinical quality performance analysis/feedback

NACHC: Research-based advocacy and education about the mission and value of health centers. T/TA to HCCNs, PCAs, health center staff and boards. Develop alliances to increase access to primary care for the safety net.
<table>
<thead>
<tr>
<th>Conference</th>
<th>Month</th>
<th>Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy and Issues Forum (P&amp;I)</td>
<td>March</td>
<td>Administrative, Legislative and Regulatory Policy</td>
</tr>
<tr>
<td>Agricultural Worker Health</td>
<td>May</td>
<td>Policy and Operational Issues</td>
</tr>
<tr>
<td>Community Health Institute (CHI)</td>
<td>August</td>
<td>Clinical and Operations</td>
</tr>
<tr>
<td>Financial Operations Management/IT</td>
<td>October</td>
<td>Health Center: Financial and IT staff</td>
</tr>
<tr>
<td>Primary Care Association /Health Center Controlled Networks</td>
<td>November</td>
<td>State level policy, partners, payers, and data</td>
</tr>
</tbody>
</table>
NACHC Social Media Reach

- Facebook
- Twitter
- YouTube
- LinkedIn Company and Group Page
- Instagram
- Pinterest
- Blog

8,400 Likes
7,600 Followers
79,000 Views
Include:

- Community Health Centers
- Health Care for the Homeless Centers
- Migrant Health Centers
- Primary Care Programs in Public Housing
- School-based Health Centers

Each health center is an independent, 501(c)(3), non-profit
Public Health and Primary Care Integration


CARE CONTINUUM

Individual

Population

Wellness, health promotion, healthy lifestyle
Chronic Disease Management
Patient registries
Care coordination
Transitions of Care
Immunizations
Outbreak and Disaster Preparedness
End of Life/Palliative Care
Preventive Care Screenings
Advocacy
Community Involvement
Social Determinants Identification
Behavioral Health Care
Service Planning and Health Impact studies
Case identification and notification
CARE CONTINUUM

Genetics/Epigenetics

Patient-centered Care delivery
Acute Care
Five Essential Elements

1. Located in *high-need areas* (serve MUA or MUP)

2. Provide *comprehensive* health and related services (especially “enabling services”)

3. *Open to all* residents, regardless of ability to pay, with sliding scale fee charges based on income

4. Governed by *community boards*, to assure responsiveness to local needs

5. *Follow performance and accountability requirements* regarding their administrative, clinical, and financial operations
Governed by: A Board of Directors

• Reflect community served
• 51% or more must be health center patients
• Other 49% or less are community leaders, teachers, business & health care professionals, attorney’s, bankers, etc.
• Balance patient perspectives with local business insight
• Health Services related to:
  – Family Medicine
  – Internal Medicine
  – Pediatrics
  – Obstetrics
• Diagnostic Laboratory and Radiologic Services
• Dental Screenings
• Pharmaceutical Services

• Referrals to Other Providers
• Patient Case Management
• Enabling Services: Translation, Transportation, Outreach, and Health Education
# Health Center Program Growth

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2015</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of Grantees</strong></td>
<td>1,124</td>
<td>1,375</td>
<td>+22.3</td>
</tr>
<tr>
<td><strong>Total Patients</strong></td>
<td>19,469,467</td>
<td>24,295,946</td>
<td>+24.8</td>
</tr>
<tr>
<td><strong>Total Visits</strong></td>
<td>77,069,234</td>
<td>96,951,585</td>
<td>+25.8</td>
</tr>
</tbody>
</table>

Source: 2015 UDS Data, BPHC/HRSA, 2016 not yet available
## Patient Characteristics

### Age and Gender

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 18</td>
<td>3,786,434</td>
<td>3,803,015</td>
<td>7,589,449</td>
<td>+23.2</td>
</tr>
<tr>
<td>18-64</td>
<td>5,637,199</td>
<td>9,148,357</td>
<td>14,785,556</td>
<td>+12.2</td>
</tr>
<tr>
<td>65 and Over</td>
<td>770,520</td>
<td>1,150,421</td>
<td>1,920,941</td>
<td>+16.7</td>
</tr>
<tr>
<td>Total</td>
<td>10,194,153</td>
<td>14,101,793</td>
<td>24,295,946</td>
<td>+12.2</td>
</tr>
<tr>
<td>Percent</td>
<td>42.0</td>
<td>58.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: 2015 UDS Data, BPHC/HRSA, 2016 not yet available
Patient Characteristics

Race/Ethnicity

- Non-Hispanic White: 36.8%
- Racial and/or Ethnic Minority: 63.2%
- Hispanic/Latino Ethnicity: 35.2%
- Black/African-American: 23.0%
- Asian: 3.9%
- American Indian/Alaska Native: 1.3%
- Native Hawaiian/Other Pacific Islander: 1.2%
- More than one race: 3.5%

Source: 2015 UDS Data, BPHC/HRSA, 2016 not yet available
Income as a Percent of Federal Poverty Level

- **100% & Below**: 70.9%
- **101 - 200%**: 21.3%
- **100% & Below**: 7.8%
- **Over 200%**: 70.9%

Source: 2015 UDS Data, BPHC/HRSA, 2016 not yet available
Insurance Status

- 23.6% Uninsured
- 53.1% Medicaid/CHIP
- 13.2% Other Third Party
- 10.1% Medicare

Source: 2015 UDS Data, BPHC/HRSA, 2016 not yet available
School & Community Partnerships
Rapid Assessment for Adolescent Preventive Services (RAAPS)

- 2014 JAMA Pediatrics – 1/3 adolescents not asked about sexual health during P.E. visits; if did, average of 36 seconds per interview

- Sexual Health Online Counseling (SHOC) module that transforms adolescent risk reduction counseling

- Standardized, electronic, evidence-based, confidential

- Ongoing support and text communication

- Currently over 250 agencies serving 80,000 adolescents

- 98% of providers indicated they would recommend

- Our study involved 42 trained and 91 youth screened
Rapid Assessment for Adolescent Preventive Services (RAAPS)

- **Youth**
  - Sexually Active Teen Identified by:
    - RAAPS system
    - STI/pregnancy testing
    - Face to face interview

- **Health Professional**
  - Login
  - Health Center

**RAAPS SHOC Module**

- **Youth Responses**
  - Sexual health assessment and health education tailored to individual

- **Patient Dashboard**
  - Summary of responses
  - Behavior change plan
  - Health messages
  - Customized referral sources

- **Provider Dashboard**
  - Youth risk summary
  - Behavior change plan
  - Health messages
  - Customized referral sources
  - Alerts for screening
  - Alerts for STI/HIV screening

- **Text Messages**
  - Reminders of steps to achieve behavior change plan
  - Tailored health messages related to identified behaviors

- **Health Professional**
  - Supports behavior plan
  - Facilitates referrals
  - Offers to email/print health messages and behavior change plan for youth
  - Provides recommended STI/HIV screenings

- **Provider and Youth discuss risks and behavior change plan developed by RAAPS SHOC as part of the healthcare visit**
Rapid Assessment for Adolescent Preventive Services (RAAPS) Outcomes – Clinical Staff

1. Self-rating of skill in effectively counseling

2. Self-rating of confidence in talking about RSBs

3. Self-rating ability to gather comprehensive Sexual Hx and create safer sex action plans

4. Self-rating effectiveness in counseling Teens on reducing risky sexual behaviors

Source: A Primary Care Response to Adolescent Sexual Health Risks, P4C, August, 2016
Youth care about their health and were interested in receiving sexual health information
- 85% opted in to receiving health education using RAAPS
- 55% opted in to receive text message follow up after their healthcare visit
- 98% liked the model and preferred the use of technology for sexual history & f/u

This population participates in more high-risk sexual behaviors than “average, with multiple partners & failure to use protection
- 79% reported having sex within the past 3 months
- 47% did not use a condom with last sex, 11% report never using condoms
- 38% had 4 or more sexual partners
- 16% report alcohol or drug use the last time they had sex

Despite high-risk status <\(\frac{1}{2}\) reported appropriate STI screening
- 66% had not had a chlamydia test within the last 6 months
- 35% had never had an HIV test

Source: A Primary Care Response to Adolescent Sexual Health Risks, P4C, August, 2016
Focus: Children aged 7–13 years, Dx obesity, overweight or at risk for obesity

Evidence-based MEND Program (Mind, Exercise, Nutrition, Do It!) Collaboration with the CDC, 4 states, 4 health centers each

In design phase, looking at community linkages, including elementary and junior high schools

http://www.mendcentral.org
Community Engagement

- Public school health education
  - Nutrition, physical activity, risk reduction, safety
- Health Fairs
- Legal assistance forums
- Town Hall needs assessments and feedback
Improving Population Health

- Comprehensive approach to social factors
- Medical care and social services integration
- ESL, vocational training, legal services, housing, community gardens, microcredit loans for women entrepreneurs, substance abuse recovery
- Close community ties
- 28 culturally diverse populations served

La Maestra Circle of Care

http://www.lamaestra.org/circle-of-care/default.html
Many health center clinicians serve as team physicians

Gain continuity with primary and secondary school students through providing sports physicals at schools or on-site at health center
Prom Treasures

- Low income families served
- Can’t afford prom dresses
- Community service
- Provide funds for guy tuxes
- Annual event
Why Partner with Health Centers & NACHC?

- **Collaborative Partnership** in a complex environment of Health System Transformation

- Leverage existing infrastructure with state & local partners, payers, providers & patients in primary care

- **Reach to the field** of 25M patients, 22,000 clinicians and 10,000 sites

- **Architects of the new models** of health care to improve population health

- **Act:** Contact health centers, PCAs, HCCNs or NACHC
FQHC 101 & School-Health Center Partnerships
Healthy Students, Promising Futures Learning Collaborative
Ron Yee, MD, MBA, FAAFP
Chief Medical Officer
August 2, 2017
FQHCs and School Health Services: A Chicago Case Study

Megan Erskine
Director, School & Oral Health Services, Heartland Health Centers

Aug. 2, 2017
Chicago’s Student Population

- Close to 400,000 students
- Close to 700 schools
- 80.22% Free and Reduced Lunch
Chicago Health Services & Schools

- 220 community health center sites within 25 miles of Chicago’s city center
- 31 school based health centers
- Hospital – based mobile vans
- STI testing program
- Dental sealant program
- Vision exam program
FQHC School Health Service Spectrum

- Who is your population?
- What is your purpose?
- What is your need?
- What are your resources (inputs)?
Heartland Health Centers & Schools

• 16 sites (community, integrated, and schools)
• 22,000 unique patients total and 4,000 unique patients at 6 school sites
• Schools included in scope; schools IDPH certified
School Based Health Center Model

- SMART Clinic at Sullivan (Collaboration between CVS, SMART SBHC model, Heartland Health Centers)
- Population 626 students; Impact is very high
- Purpose is to address graduation disrupting health risks and behaviors; 100% of the building was seen SY 2016-2017
- FQHC Scope change, Illinois Department of Public Health certified
- Operating costs of $330,000. Over 3,000 surplus in year one with HHC, which is a success. **Goal is to be sustainable and affect graduation rates.**
School Based Health Center Satellite Model

- SMART Clinic at Kilmer Elementary (across from street of Sullivan)
- SY 2012-2015 (hospital): Started as a single room in a school and provided services as needed
- SY 2016-2017 (FQHC) open 3 days a week to meet IDPH standards; certification allows SBHCs to bill all Medicaid MCOs regardless of PCP
- SY 2017-2018 – expanding days, so model will be more similar to Sullivan
- Big Idea: You don’t need to start with a million dollar school based health center to provide services to students in a school
Hub and Spoke Model

UIC Office of Community Engagement and Neighborhood Health Partnerships

Dr. Cynthia Boyd

**Population:** How do you define population in an area where severe health shortages exist? How do you expand services to more students in more schools without building a SBHC in every single school?

- UIC OCEAN flagship sites at a school in Brighton Park (HRSA grant) and Auburn – Gresham neighborhoods (took over SBHC from another FQHC)

- **Phase 1:** Open SBHCs that are also open to the community with a focus on students with chronic conditions, high absenteeism, and their families

- **Phase 2:** Develop relationship with community organizations that work with neighborhood schools, so that students may access “hub” sites
Hub and Spoke Model

• **Phase 3:** Provide portable services at schools with very high health needs and refer back to the hub as needed
  - Realization that services are still better accessed at school (even if a community health center or SBHC is nearby)
  - FQHCs do have to change their scope if providing services regularly at a site
  - UIC billed through hub site

• **Phase 4:** Telehealth- provide telehealth to schools near the hub sites
  - SY 2016-2017 pilot year at two sites
  - Grant funded to start
  - Provider on one side (can bill) and the nurse on the other side (cannot bill)
  - Nurse works with school to identify difficult cases
  - Challenges with equipment in year one

• **Community health workers key to the all phases of the model**
More Examples

• Health educators or Americorps members provide health education to schools near FQHCs or FQHC–operated SBHCs nearby (Erie Family Health Centers, Chicago)

• Following a dental screening or sealant program work with FQHC to schedule students with restorative needs for dental services (HHC, Chicago)

• Invite FQHC to provide physicals/immunizations at school (portable service allowed through HRSA).

• Work with a mobile van (hospital–based) that refers back to FQHC for follow-up or medical home referral. FQHC mobile van (Alivio, Chicago)
What Works?

**Schools**

- Principal buy-in – most important
- Community organization that has existing relationship with schools
- School district buy-in
- School or neighborhood organization designee
- High Medicaid insurance enrollment
What Works?

**FQHCs**

- Champion
  - Does not have to be someone who deals with schools
  - FQHCs want to expand unique numbers and market share; maybe it’s a marketing or community relations person
- FQHC that is financially stable
- Designated staff to community relations (community health worker)
- State regulations that support open access billing for schools
- “Yes, but” operational culture
- Keep it local
Questions?

Thank you!

Megan Erskine
merskine@heartlandhealthcenters.org