Oregon Health Authority
Health Policy Programs
Responses to Joint Committee on Ways and Means
Human Services Subcommittee
April 6th – 7th, 2015

Representative Nathanson: How do School Based Health Centers and School Based Health Services fit in the Health Care System?

(Updated from 4/7/15 response to include behavioral health services)

School Based Health Centers (SBHC):

1. SBHCs are defined in ORS 413.225. SBHCs are operated by a community health care agency such as a county health department or local clinic. They are "school-based" in that they are located on the school property. Funding comes from state Public Health, and billing Medicaid for children enrolled in OHP, and other sources. Certified SBHCs are required to have a designated SBHC medical director (health care provider with a license to practice independently with the population being served and who has prescriptive authority such as an M.D., D.O., N.D., N.P., and is actively involved in development of clinical policies and procedures, review of records and clinical oversight). Certified SBHCs must be staffed by a Primary care provider (M.D., D.O., N.P., N.D., P.A.) — 10 hours/week, at least two days/week.

   Some SBHCs are primary care homes, sponsored by FQHCs and certified as PCPCHs. There may be clinic days when the RN is in the center alone operating under standing orders.

2. If the child has been assigned to a Primary Care Provider (PCP) in the community, Coordinated Care Organizations (CCOs) may not pay claims to the SBHC if they have already pre-paid the PCP through sub-capitation for that child's primary care. This avoids a duplicate expenditure for the CCO.

3. 90% of all School Based Health Centers now offer behavioral health services on site, in part, due to the legislative investment of 2013. 57% of students who received mental health care in the SBHCs in 2013-14 had OHP. Behavioral health services are more easily accessed when located within a school site and in a non-stigmatizing healthcare setting. Easily accessible service is a primary strategy in reducing youth suicide. SBHC staff work with community behavioral health providers when more

intensive services are needed or if a youth is better served by the community mental health provider.

School Based Health Services (SBHS) services provided under public education rules and regulations for services provided in public education settings leveraging Medicaid:

4. School Based Health Services (SBHS), for health related services mandated by the Individuals with Disabilities Education Act (IDEA), and provided by public education exist to address the educational needs of children with disabilities only, not to address overall healthcare needs. Those other needs are met by Medicaid and the CCO delivery system.
5. SBHS mandated by IDEA for health related services provided to children with disabilities are a carve-out from managed care; it is not in the CCO global budget.
6. CCOs do not contract with School Based Health Services, like school nurses and therapists because those staff are not able to address all of a child's healthcare needs; only those needs that allow a child to access their free and public education.
7. SBHS IDEA health related services are, however, eligible for Federal Financial Participation as part of cost sharing and are billed to Medicaid under School Based Health Services wherein schools pay state share portion for costs to provide these services and DMAP pulls down the federal share portion and combines them to equal 100% payment to schools for the cost to provide these services. They are a leveraged program where the state share does not come from state general fund.
8. 1903(c) of the Social Security Act (SSA) makes Medicaid first payor before education for SBHS IDEA health related services. In this case, if the child is eligible for OHP, OHA is the first payor.
9. Coordination for physician ordered nurse services currently exists and has been in existence as required by the Individuals with Disabilities Education Act (IDEA). The coordination is between public school districts and Education Service Districts that obtain physician orders from primary care physicians and/or specialty physicians for their patient(s). These orders

are for nurse services provided to children with complex medical needs and fragile children attending school for their free and appropriate public education.

10. SBHS IDEA health related services are required to be provided to ALL children found eligible under the IDEA whether they are eligible for Medicaid or not.
11. A School nurse program under public education is defined under public education's rules and regulations for "School" nurses for services addressing ill and injured students, required screenings such as vision,...; school nurse for school health policies and educating public education staff and/or training staff for Epinephrine, CPR, Blood Borne Pathogens....; physician orders for nurse services provided to children with complex medical needs or fragile children eligible under IDEA; (more info available from Oregon Department of Education ODE).

    See Brochure at below link for further information:
    https://public.health.oregon.gov/HealthyPeopleFamilies/Youth/HealthSchool/SchoolBasedHealthCenters/Documents/SBHC_Pubs/SHS_flyer_FINAL.pdf

Rep. Nathanson: With recent bills that have been introduced, why is Oregon Health Information Technology disassociated from other state agencies and state process, and appearing to be acting autonomously?

HB2294A is our update for OHA's HIT work under OHIT, and includes a procurement exemption in Section 1(8) of the bill for participation in a partnership or collaborative like the Emergency Department Information Exchange (EDIE). The rationale for this exemption has been that these types of externally-driven collaboratives are very unusual and don't meet our typical procurement situations.

Upon further meetings this week with DAS and the State CIO's office, OHA has assurances that these unusual situations can fit within the procurement code and do not require an exemption to statute. We will seek an amendment that will remove this provision (Section 1(8)) from HB2294A completely.

By removing this provision, HB2294 will not conflict with DAS or State CIO statute, policies, and impending legislation under SB7 and HB3099. All OHA/OHIT projects will be subject to the standard procurement and IT oversight required under DAS and State CIO's office.

OHIT like other offices within OHA will continue to work through our OHA/DHS Office of Information Services (OIS) to engage with the State CIO office for IT project oversight, including complying with the stage-gate processes.

Sen. Steiner-Hayward: Concerned about the 60-days for DHS assessments for children newly placed into foster care, this seems too long. What was reason for this benchmark?

The 60 day window for assessments in the DHS Custody measure is based on OAR 413.015.0465: Medical assessment, dental assessment, and mental health assessment for all children in substitute care. Under this OAR, children must receive:

- A medical assessment within 30 days of entering care;
- A dental assessment within 30 days of entering care;
- A mental health assessment within 60 days of entering care.

In 2012, the Metrics & Scoring Committee originally considered only adopting mental health assessments within a 30 day window as the CCO incentive measure, but ultimately adopted the composite measure with a 60 day window standardized across all three assessments.

Note the CCO incentive measure starts the 60 day window on the date that the child in foster care was enrolled in the CCO; however, DHS and caseworkers are still responsible for children receiving assessments within the 30 or 60 days listed

above based on the date the child entered foster care.[1]

Rep. Nathanson: Would like a comparison of the outcomes with mental health status patients released from the hospital and those that received treatment elsewhere, such as residential care, as it relates to the 7-day follow-up metric. Is there any correlation between the two? Would like some information on the AMH dashboard.

OHA will potentially be able to supply this information after working on the methodology for comparison, and should be able to supply it by late May / early June.

OHA is working on developing additional analytic tools to provide staff with better ways to monitor cost, utilization, and metrics. The AMH dashboard is a new product in development to provide quarterly utilization data for mental health and substance use services, and in the future will include metrics such as follow up after hospitalization for mental illness.

Rep. Keny-Guyer: Can OHA supply a comparison of the APAC readmitted patients with the 7-day mental health follow up metric?

OHA can provide a comparison of Medicaid and Commercial rates for the Follow Up after Hospitalization for Mental Illness measure from the all-payer all-claims database but not until the end of May / early June.

OHA notes that any mental health / substance use measures calculated in APAC will be an under-calculation as substance abuse diagnoses are excluded.

[1] For additional information on the differences between the OARs / federal requirements for DHS and the CCO incentive measure, please see the guidance document online at: http://www.oregon.gov/oha/analytics/CCOData/Assessments%20for%20Children%20in%20DHS%20Custody%20Guidance%20Document%20-%20revised%20Dec%202014.pdf

Sen. Bates: How does Oregon compare on immunization rate? Is there a lag in immunizations up to age 2 and then a jump at school year age?
The national average for 2-year old (19-35 months) up-to-date immunization rates is 70.4% based on data from the 2013 National Immunization Survey.[2] Oregon's rate is 66.6% and falls between the low of 57.1% for Arkansas and a high of 82.1% for Rhode Island.

The vaccinations included in the 2-year old rate calculation differ from those required for school. Therefore, it is not possible to make a direct comparison between the 2-year old up-to-date rate and the school-required immunization rate. In 2014, however, 92.1% of Oregon kindergarteners were up-to-date on their school-required immunizations.[3]

Sen. Bates: Is there any way of calculating the costs and outcomes with the alcohol and drug recidivism?
Please see the attached report (Appendix A- p. 10-12) showing whether or not individuals discharged from residential services return to residential treatment services, methadone treatment services, and/or detox within one to three years, for 2009 – 2014.

OHA would potentially be able to provide some cost estimates, but will require additional time to develop a methodology.

[2] http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6334a1.htm#Tab3
[3] http://public.health.oregon.gov/PreventionWellness/VaccinesImmunization/GettingImmunized/Documents/SchImmExmpData.pdf

It should be noted that alcohol and drug issues are a chronic, lifelong issue for individuals. Readmissions to services should not be evaluated as a poor outcome without fully understanding the circumstances involved.

Rep. Nathanson: How believable are survey data based on self-report? How useful is it to self-report when there is really no incentive to be honest?
See Survey Table (Appendix B – P. 13-15) below for additional information on Oregon's Student Wellness Survey and Oregon Healthy Teens Survey.

Rep. Stark: Are you experiencing calls from upset parents because of topics being asked on the survey that have not yet been introduced to their children? Do students have the option to opt out of the survey? How do we ensure anonymity of the students?
See Survey Table (Appendix B – p. 13-15) for additional information on Oregon's Student Wellness Survey and Oregon Healthy Teens Survey.

Sen Bates: What is the definition of illicit drugs in the 30-day illicit drug use metric?
The illicit drug use question on the Oregon Student Wellness Survey asks about marijuana, cocaine, ecstasy, heroin, hallucinogens, and methamphetamines and the data can be reported with or without marijuana. The data reported in the presentation was inclusive of all products.

2014 Student Wellness Survey[4]

Illicit drug use:	6th grade	8th grade	11th grade
Including marijuana	1.4%	8.1%	19.1%
Excluding marijuana	0.5%	1.5%	2.3%

[4] See page 40:
https://oregon.pridesurveys.com/dl.php?pdf=Oregon_SWS_Statewide_Report_2014.pdf&type=region

Sen. Winters: What are some strategies that are working to help decrease the obesity rate? Are there any plans to address this issue? The issue is not for lack of programs or information; it is getting people more involved in these programs. Are we tracking results?

OHA will provide an informational presentation on state and CCOs efforts to reduce tobacco use and obesity on scheduled on Thursday, April 30th.

Sen. Bates: What does the Medicaid tobacco use rate look like since the ACA expansion?

Unknown. Our most recent information on tobacco use for the Medicaid population came from the 2013 CAHPS survey, which does not include any of the ACA expansion members.

OHA is currently wrapping up the 2014 CAHPS survey, which will include ACA expansion members. Updated tobacco use prevalence for Medicaid will be available in June.

Rep. Keny-Guyer: Which CCOs have better / lower tobacco utilization rates? What are these CCOs doing that decreases this rate?

Tobacco use prevalence in the Medicaid population ranges from 28% (Fee For Service) to 47% (Columbia Pacific).[5]

A summary of each CCOs' cessation benefits and activities related to promoting their cessation benefits is available in the 2014 Tobacco Cessation Services report.[6] See below link for specific activities.

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[5] Tobacco prevalence data from 2013 CAHPS survey for each CCO; does not reflect any ACA expansion members. http://www.oregon.gov/oha/metrics/pages/measure-tobacco-use.aspx

[6] http://public.health.oregon.gov/PreventionWellness/TobaccoPrevention/Documents/tob_cessation_services_2014_survey_report.pdf

Sen. Bates: Request for a short presentation from OHA of how CCOs are decreasing obesity and tobacco use rates. Interested in outcomes as well as programs.

OHA will provide an informational presentation on state and CCOs efforts to reduce tobacco use and obesity tentatively scheduled for Thursday, April 30th.

Sen. Bates: What states are we behind in bending the cost curve?

The most recent state-by-state comparative health care expenditure data available is from 2009.

Based on these data, Oregon is about 12th in terms of average annual per capita cost growth by state of residence, and 19th by state of provider. http://kff.org/other/state-indicator/avg-annual-growth-per-capita/.

OHA may be able to provide additional detail based on the available data, but cautions against relying on this data, given the extent of health reform in Oregon since 2009.

Table 1. Admissions to Residential, Detox or Methadone Treatment for *Persons Discharged From Drug Residential Treatment Programs*, by Year of Discharge[1]

Age Category	Time from discharge date[2]	Discharge Year									
		2009		2010		2011		2012*		2013*	
		Counts	Percent	Counts	Percent	Counts	Percent	Counts	Percent	Counts	Percent
Youth	Within one year	69	16.6%	58	15.0%	86	18.3%	64	14.6%	66	15.0%
	One to two years	10	2.4%	13	3.4%	14	3.0%	10	2.3%	*	*
	Two to three years	10	2.4%	8	2.1%	10	2.1%	*	*	*	*
	Transfer	5	1.2%	8	2.1%	13	2.8%	6	1.4%	8	2.1%
	No readmission	321	77.3%	300	77.5%	348	73.9%	357	81.3%	298	79.9%
	Total	415	100.0%	387	100.0%	471	100.0%	439	100.0%	373	100.0%
Adult	Within one year	560	17.8%	664	19.8%	638	20.0%	548	19.1%	504	17.5%
	One to two years	190	6.0%	242	7.2%	205	6.4%	142	4.9%	*	*
	Two to three years	128	4.1%	150	4.5%	110	*	*	*		*
	Transfer	121	3.8%	72	2.1%	77	2.4%	79	2.7%	87	2.8%
	No readmission	2150	68.3%	2233	66.4%	2153	67.6%	2094	72.8%	2477	80.1%
	Total	3149	100.0%	3361	100.0%	3183	100.0%	2875	100.0%	3091	100.0%
Total	Within one year	629	17.6%	722	19.3%	724	19.8%	612	18.5%	570	16.5%
	One to two years	200	5.6%	255	6.8%	219	6.0%	152	*	*	*
	Two to three years	138	3.9%	158	4.2%	120	3.3%	*	*	*	*
	Transfer	126	3.5%	80	2.1%	90	2.5%	85	2.6%	95	2.7%
	No readmission	2471	69.3%	2533	67.6%	2501	68.4%	2451	74.0%	2775	80.1%
	Total	3564	100.0%	3748	100.0%	3654	100.0%	3314	100.0%	3464	100.0%

1. Excludes those with a termination type of 1 (initital appointment not kept within 14 days of enrollment), 12 (client deceased), and 15 (administratively closed).

2. Transfer indicates the person was moved from residential treatment to detox, methadone treatment or another residential treatment program within one day of residential discharge date.
No readmission indicates the person was not admitted to detox, methadone treatment or residential treatment within three years of the residential treatment discharge date.

**Data for discharge years 2012 and 2013 is incomplete as not enough time has elapsed to conduct a final analysis.*

Table 2. Type of Programs that Persons Were Admitted to Within One Year of Discharge from Residential Drug Treatment

Age Category	Program Admission Within One Year[2]	Discharge Year									
		2009		2010		2011		2012*		2013*	
		Counts	Percent	Counts	Percent	Counts	Percent	Counts	Percent	Counts	Percent
Youth	Residential	69	100.0%	58	100.0%	85	98.8%	64	100.0%	64	97.0%
	Detox	0	0.0%	0	0.0%	1	1.2%	0	0.0%	2	3.0%
	Total admits within one year[3]	69	100.0%	58	100.0%	86	100.0%	64	100.0%	66	100.0%
Adult	Residential	422	75.4%	458	69.0%	406	63.6%	351	64.1%	318	63.1%
	Detox	95	17.0%	167	25.2%	181	28.4%	160	29.2%	151	30.0%
	Methadone	43	7.7%	39	5.9%	51	8.0%	37	6.8%	35	6.9%
	Total admits within one year[3]	560	100.0%	664	100.0%	638	100.0%	548	100.0%	504	100.0%
Total	Residential	491	78.1%	516	71.5%	491	67.8%	415	67.8%	382	67.0%
	Detox	95	15.1%	167	26.6%	182	28.9%	160	25.4%	153	26.8%
	Methadone	43	6.8%	39	6.2%	51	8.1%	37	5.9%	35	6.1%
	Total admits within one year[3]	629	100.0%	722	100.0%	724	100.0%	612	100.0%	570	100.0%

3. Totals in this row equal the counts in the "Within one year" row on Table 1 above.

Table 3. Admissions to Residential, Detox or Methadone Treatment for *Persons Discharged From Methadone Treatment*, by Year of Discharge[1]

Age Category	Time from discharge date[2]	Discharge Year									
		2009		2010		2011		2012*		2013*	
		Counts	Percent	Counts	Percent	Counts	Percent	Counts	Percent	Counts	Percent
Adult	Within one year	371	27.2%	292	26.2%	356	28.6%	241	22.0%	67	5.7%
	One to two years	88	6.4%	70	6.3%	76	6.1%	7	0.6%	*	*
	Two to three years	65	4.8%	34	3.1%	1	0.1%	*	*	*	*
	Transfer	158	11.6%	120	10.8%	140	11.3%	121	11.0%	53	4.5%
	No readmission	684	50.1%	597	53.6%	671	53.9%	728	66.4%	1046	89.7%
	Total	1366	100.0%	1113	100.0%	1244	100.0%	1097	100.0%	1166	100.0%

1. Excludes those with a termination type of 1 (initital appointment not kept within 14 days of enrollment), 12 (client deceased), and 15 (administratively closed). No youth to report.

2. Transfer indicates the person was moved from methadone treatment to detox, residential treatment or another methadone treatment program within one day of methadone discharge date.
No readmission indicates the person was not admitted to detox, methadone treatment or residential treatment within three years of the methadone treatment discharge date.
**Data for discharge years 2012 and 2013 is incomplete as not enough time has elapsed to conduct a final analysis.*

Table 4. Type of Programs that Persons Were Admitted to Within One Year of Discharge from Methadone Treatment

Age Category	Program Admission Within One Year	Discharge Year									
		2009		2010		2011*		2012*		2013*	
		Counts	Percent	Counts	Percent	Counts	Percent	Counts	Percent	Counts	Percent
Adult	Residential	29	7.8%	19	6.5%	29	8.1%	10	4.1%	0	0.0%
	Detox	123	33.2%	86	29.5%	106	29.8%	73	30.3%	0	0.0%
	Methadone	219	59.0%	187	64.0%	221	62.1%	158	65.6%	67	100.0%
	Total admits within one year[3]	371	100.0%	292	100.0%	356	100.0%	241	100.0%	67	100.0%

3. Totals in this row equal the counts in the "Within one year" row on Table 3 above.

Survey Table

	Student Wellness Survey[1]	Oregon Healthy Teens[2]
How believable are survey data based on self-report? How useful is it to self-report when there is no incentive to be honest?	In 2012, OHA asked its survey vendor to conduct a pilot study prior to implementation of the Student Wellness Survey. The purpose was to see if results would be different for online versus paper and pencil surveys. A number of validity checks to identify respondents who did not complete the survey seriously were conducted. The pilot study found that 1.1% of the 8th and 11th grade surveys needed to be removed using these tests; none of the 6th grade surveys were removed. The validity tests included: • Surveys identified as potentially invalid because a respondent marks all 30 day illicit drug use with maximum value (e.g., use in all previous 30 days). • Surveys identified as potentially invalid if respondent marks a 30 day illicit drug use but not the same lifetime use (e.g., reporting having used twice in the past month but never in lifetime). • Surveys identified as potentially invalid if a respondent does not respond to any of the 30 day illicit drug use or lifetime illicit drug use. • Surveys identified as potentially invalid if a respondent marks an age that is more than one year younger or three years older than expected age for grade.	Protecting student *confidentiality and anonymity* is paramount. Studies have shown that most young people are truthful in answering anonymous surveys such as OHT and give more accurate results than those where students believe their answers can be traced (and so are more likely to say what they think we want to here). Survey data from adolescents is as reliable as data collected from adults. While a small number of participants do misrepresent their true behavior, internal reliability checks are conducted to help identify the small percentage of students who falsify answers. The OHT survey is a key part of a state-wide effort to help local schools and communities ensure that all Oregon youth are healthy and successful learners who contribute positively to their communities. Our goal is to reduce those behaviors among high school and middle school students that adversely affect their health and ability to learn. The only way to determine if adolescents are at risk in key health risk areas is to ask questions about their behaviors.

[1] 2014 Student Wellness Survey FAQs https://oregon.pridesurveys.com/documents/2013/2013-14%20SWS-FAQs%20FINAL.pdf
[2] Oregon Healthy Teen Survey background information https://public.health.oregon.gov/BirthDeathCertificates/Surveys/OregonHealthyTeens/Pages/background.aspx

	Student Wellness Survey[1]	Oregon Healthy Teens[2]
Does OHA receive calls from upset parents because of topics being asked on the survey that have not yet been introduced to their children?	Yes, although not very many. OHA receives less than 20 in a survey year. In all cases, parents were told how to opt their student out of the survey. The majority of calls received fell into the following categories (from most to least # of calls): 1) Parents of children with disabilities that felt the student would be confused by the questions or unable to complete the survey without assistance. 2) Parents of 6th graders who did not want the topic of drugs brought up through the survey. 3) Parents of children with mental health issues that felt the questions could trigger depression or suicide ideation. 4) Parents who were concerned the student could be identified and there would be negative repercussions for the student or family. 5) Parents who felt the survey was a waste of classroom time and wanted the student to use the class period for school work.	Over the past 10 years, there have been a couple of calls from upset parents regarding specific questions. The Centers for Disease Control and Prevention (CDC) states that there is no evidence that simply asking students about health risk behaviors will encourage them to try that behavior.
Do students have the option to opt out of the survey?	Yes, the Student Wellness Survey is completely voluntary at all levels. Superintendents can opt the entire district out of participation. Principals can opt their school out, and teachers within a school can opt their class out. Parents / guardians are provided advance notice about the survey and given a form to return if they do not want their child to participate in the survey.[3]	Yes. Parents / guardians are provided advance notice about the survey and given a form to return if they do not want their child to participate in the survey.[4] Students who are taking the survey are also free to decline the survey, or to skip any question they don't want to answer.

[3] Parental consent forms and questionnaires can be viewed online at: https://oregon.pridesurveys.com/

[4] Parental consent forms and questionnaires can be viewed online at: https://public.health.oregon.gov/BirthDeathCertificates/Surveys/OregonHealthyTeens/Pages/index.aspx

	Student Wellness Survey[1]	Oregon Healthy Teens[2]
	Students who are taking the survey are also free to skip questions or stop filling out the survey at any time.	
How do we ensure student anonymity?	Individual survey responses are completely anonymous. Students are not asked to write their name on the survey and no identifying information is collected in the survey Survey administration procedures are designed to protect student privacy and allow for anonymous participation. The survey is proctored by classroom teachers, who are given short training sessions on the survey protocol. Students complete an online survey or submit a completed scannable questionnaire, containing no personal identifiers which the student places in the class envelope upon completion. We ask that the last student to complete the survey within a classroom close and seal the envelope and write the school name across the seal. OHA publishes reports at the state and county level. Aggregated reports sent to schools are based on the numbers of students participating so anonymity of students is preserved. Some rural counties receive only combined reports across a number of districts to preserve anonymity.	The OHT survey is anonymous; students are not asked for their names. Once the surveys have been completed and collected, there is no identifying information linking a questionnaire to an individual student or parent. In addition, the information reported to the school district is aggregated – that is, grouped by grade level and gender. No individual set of information is identified in these reports.