
Child & Adolescent Health Center

Provider Toolkit

What You Need To Know to Be Successful in School Based and School Linked Health Centers
in Michigan





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Child & Adolescent Health Center Practice

Practicing within reach of your population

PRINCIPLES AND GUIDELINES OF PRACTICE



Child and Adolescent Health Centers Offer Unique Opportunities

On behalf of the Child and Adolescent Health Centers(CAHC) Team, **Welcome to the Team!** We are excited to have you as an integral part of our ever-growing health centers program! Our program currently consists of 82 clinical and alternative clinical centers, 14 School Wellness Programs and 4 Behavioral Health Service models throughout the state. The clinical program is targeted to uninsured, underinsured and Medicaid children ages 5-10 and adolescents ages 10-21 as well as infants and small children of eligible adolescents. Details about our program, as well as a Health Centers Map, can be found at our website:

http://www.michigan.gov/mdch/0,4612,7-132-2942_4911_4912-342503--,00.html

This toolkit is intended to provide to general information about our program, as well as provide general guidance on key parts of working in a Child and Adolescent Health Center in Michigan.

Child and Adolescent Health Center Settings- Principles of Practice

As a new provider to a Child and Adolescent Health Center in Michigan, you will either be providing care in a School-Based or School-Linked Health Center (SB/LHC). School-Based Health Centers (SBHC's) operate on school property, whereas School-Linked Health Centers (SLHC's) operate close to one or several school campuses within a geographical area. In either

setting, you will notice some great opportunities and challenges to your professional practice. The great opportunities come through the ability to design your practice to fit individual and population needs through professional autonomy. This autonomy provides an opportunity to utilize best practices in planning your care and interventions, as well as allows the ability to transform health-related behaviors through personal, long-term relationships with patients and families in your care. The differences from traditional health care settings are also important to highlight here. There is some uniqueness to the practice setting in the areas of patient consent and confidentiality, as the students are usually seeking healthcare independently of parents after the consent process. In addition, there are also legal and legislative limitations to care provision in the State of Michigan that are important for each provider to be aware when practicing in the school-based setting.

CAHC Settings- Opportunities

CAHC's provide practitioners with a unique opportunity to design and implement health care for an elementary or adolescent population guided by the CAHC Minimum Program Requirements (MPR's), professional standards of care and Scope of Practice, and population needs. In most cases, the provider is able to design and implement programming based on the unique needs of students in the school setting, compared with traditional settings where care is often directed by the physician or health care agency. CAHC's provide a unique opportunity to put the personal touches on health care delivery, and tailor the health center to the population it is targeting. These settings often allow greater personal and professional growth and autonomy as a provider than traditional settings, which can lead to greater professional satisfaction.

CAHC Settings and Primary Care

The main purpose of the CAHC is to provide comprehensive primary care services for children and adolescents within the context of their family, social/emotional, cultural, physical and educational environment. Underserved populations are the target of CAHC health services, which are provided regardless of ability to pay, religion, sex, race, sexual orientation or gender identity. Centers are strategically placed in areas of greatest need in an attempt to address social determinants of health including: access to primary care services, insurance status, socio-economic status, and various other demographical determinants that effect health status

of children and adolescents. Many social factors combine to contribute to the fact that children and adolescents (especially) lack regular preventive healthcare. In fact, there are no out-of-pocket expenses for students enrolled in the health centers. Insurance payers are billed for services rendered, as appropriate, with collected fees returned for use in the health center. CAHC's have a unique opportunity and location to increase access to primary care services in these populations thereby reducing risk and preventing chronic disease and injury.

The most basic principle of the CAHC's is to provide essential primary care services, well visits, immunizations, pre-participation exams, and risk assessment and counseling, trauma screening and behavioral health interventions and counseling) in an attempt to prevent chronic disease states and injury. CAHC providers are also uniquely positioned to assist in managing chronic illness and injury, while also keeping students in school, ready to learn. In Michigan, primary health care services include both comprehensive physical and behavioral health services. This includes comprehensive physical and behavioral health assessments, diagnosis of minor acute, and chronic medical conditions, mental health crisis intervention, behavioral health counseling, and referrals for specialty care when needed, including emergency services, community support programs, as well as outpatient care programs. Therefore, CAHC's are uniquely positioned to act as a medical home for students, and or to collaborate with existing primary care providers, other medical providers, social service agencies, behavioral health agencies, outside programs and organizations to ensure continuity of care.

CAHCs and Confidentiality

Students attending CAHC settings are fully consented by a parent or guardian prior to administering services to the student. Due to the nature of the centers, the consent process allows the student to seek needed health care without the presence of the parent or legal guardian, and remain active throughout the student tenure at the school, in the community, or until they become of legal age. Parent(s) and/or legal guardian(s) have the right to limit and/ or revoke the consent in writing at any point in time. Therefore, students are typically seen without the presence of a parent, which imparts a responsibility on the part of the center providers to encourage stewardship of the student to act as a responsible healthcare consumer. This is a critical responsibility of the school health centers. Written and verbal consent of the student, and a detailed review of student Rights and Responsibilities is an essential task in encouraging responsible healthcare consumerism. MDCH requires student consent and provision of Rights

and Responsibilities documents to students seeking care in our health centers. These documents should be student friendly and written in plain, easy to understand language. All members of the health center team play a vital role in ensuring students are well informed of their rights to confidentiality, as well as their Rights and Responsibilities as a health care consumer.

It is important to understand student rights to confidentiality and confidential services. The student should always be informed of the limits to confidentiality with each visit. Students need to be informed that confidentiality may be broken without their consent when: 1) There is a reasonable suspicion that they are being hurt, 2) They are hurting others, and/or 3) They are hurting themselves. Every attempt should be made to notify the student prior to disclosing confidential information in these circumstances. A center's policy on confidentiality must be discussed and reviewed with the student **prior** to collecting any confidential information from them.

Minor Consent Laws in Michigan are summarized in the links under **Minor Consent** in the Resources for Clinicians by Topic Area document.

Michigan Law prohibits the distribution of contraceptive drugs or devices on school property. MDCH requirements prohibit abortion counseling or referrals in State-funded centers. Failure to comply with these requirements could result in termination of a center's contract, and/or ability to practice on school property. Centers must acknowledge adherence to these specific requirements each year of the MDCH Grant cycle. Specifically, each center will be asked to review and sign off on the following assurances:

___ Abortion services, counseling and referrals for abortion services will not be provided as part of the services offered.

___ Services will comply with all federal and state laws and regulations prohibiting discrimination and with all requirements and regulations of MDE and MDCH.

___ Family planning drugs and /or devices will not be prescribed, dispensed or otherwise distributed (if located on school property).

___ All CAHC Minimum Program Requirements will be met through the CAHC proposal.

Please consult with your consultant for specific questions regarding family planning and abortion service restrictions in State-funded centers. School-Linked Health Centers are not required to adhere family planning assurances, as they provide services off school property. They must, however, adhere to the requirements around abortion counseling and referrals.

As we need to be careful stewards of mentoring teens to become good healthcare consumers and protect the confidentiality of each client, it is also important to involve the parent(s)/guardian/caregivers in the healthcare decisions of their children. Often times, clients will be seen without a parent present. The clinician must be astute in recognizing when to call a parent for clarification of the HPI, as well as to communicate care options and care delivered to their child. Careful coordination among the clinician, student, parent/guardian/caregiver, and the primary care provider (when available) can be challenging, especially in the elementary sites. This is explored more thoroughly in the Relationships section below.

CAHC's- Essential Components of Care

Enrollment and Parental Consent Process

A parent or legal guardian must consent to care for their minor child at the respective health center. Exceptions to this requirement are: 1) Minors may consent for confidential services according to Michigan Public Health Code. 2) A student may consent for his/her own care once they meet the age of majority, or 18 years of age.

Parental consent should contain the following information at minimum:

- a) services provided in the health center
- b) services in which the minor may consent on his/her own
- c) explicit explanation that birth control devices and prescriptions, abortions and abortion referrals are restricted services and not provided in school-based health centers (note, school linked health centers can provide family planning services)
- d) how communication between the primary care provider and the health center will occur

Recommended information includes:

- a) Current insurance status with insurance information.
- b) Student or family income for sliding fee schedule
- c) Parent/guardian contact information
- d) Student information, including a method for contacting them for confidential information
- e) Student Health History
- f) Family Health History
- g) Primary Care Provider information for all providers
- h) Date of last dental exam
- i) Date of last well-child exam

Consider the following inclusions at the time of consent to smooth care coordination:

- a) Release of Information for limited communication to the school, school nurse
- b) Immunization Consent
- c) Rights and Responsibilities document that has a signature line for both the student and parent
- d) Consent for dental services, where provided
- e) Hours of operation and information on 24 hour coverage for medical and behavioral health services

Comprehensive Primary Care Services

Primary care services provided must involve must include the use of recognized standards of care including American Academy of Pediatrics (AAP)'s Bright Futures, American Medical Association's (AMA's) Guidelines for Adolescent Preventive Services (GAPS), as well as an annual risk assessment with the Risk Assessment for Adolescent Primary Services (RAAPS), Guidelines for Adolescent Preventive Services (GAPS), or Bright Futures tool. Primary health care needs (i.e. immunizations, etc.) should be assessed at each visit, including minor acute visits. It is expected that preventive health measures are incorporated into every visit. Ideally, clients will be asked to return to the health center to meet primary healthcare and preventive services, when needed, at visits for acute illness or injury. In addition, oral healthcare should be incorporated into the clinicians' assessment. Inquiries regarding the most recent dental exam,

as well as education on dental hygiene, and referral to a dental provider for routine care, are encouraged.

Diagnosis and Treatment of Medical Conditions

Appropriate triage and care of minor acute injuries and stable chronic illnesses are a significant component of CAHC services. This can include providing prescriptions for needed medications, and co-management of chronic illnesses (i.e. diabetes, asthma, obesity, etc.) with the students' primary care provider and/or specialists. Such services may include comprehensive education of the pathology of the students' condition, provision of mutually developed care plans, and care coordination among providers. Referrals to outside providers and communication back to the primary care provider, with regard to provided services within the CAHC, are expected to occur within the context of treatment. Follow-up of referrals should be clarified in policies and procedures, as well as documented in CAHC logs or the student's medical record/electronic health record (EHR).

Laboratory and Diagnostic Testing Procedures

It is required that all CAHC sites will apply for a Clinical Laboratory Improvement Amendments (CLIA) license for waived testing. Each site should have a laboratory area with adequate space to perform and store routine point of care tests for the course of care in their center, with properly designated clean and dirty areas. CLIA applications and licensing is the responsibility of the site and fiduciary. Centers must comply with CLIA regulations, including appropriate policies and procedures for each waived test, annual competency testing for staff completing testing, quality control measures and appropriate documentation of results and follow-up for test performed. Resources for CLIA waived testing are located in the Resources for Clinicians by Topic Area document, under **CLIA Waived Standards**.

The CAHC Program supports free testing for Sexually Transmitted Diseases- HIV, Gonorrhea and Chlamydia, through the State Lab. Each site is assigned to either the Lansing or Saginaw laboratory for specimen submission. Please consult your Program Director for this information. Michelle Twichell (twitchellm@michigan.gov) coordinates the ordering of the HIV tests and pre-paid order forms every **June**. This is an annual order, therefore, centers must be aware of the anticipated number of HIV tests they expect to conduct, as well as the anticipated number of

pre-paid order forms for chlamydia and gonorrhea testing that they anticipate they will need for **all** testing to be completed in the following fiscal year. Some fiduciaries supply their own HIV tests, and do not participate with the pre-paid testing forms. However, if your center plans to participate, compliance with ordering procedures set by the CAHC team is expected. This includes submitting your requested order on time, as well as completing the mandatory HIV training program mentioned later in this manual. Clinicians are also required to attend a phone conference led by Amy Peterson, STD Program Specialist with MDCH (peterona@michigan.gov), each September on modifications to the testing forms and specimen submission. Notification of the ordering procedures and phone conference will occur through the Clinician and State-Funded Listserves. Resources and links for specimen submission are located in the Resources for Clinicians by Topic Area document, under **Laboratory Submission Guidelines and Forms.**

Behavioral Health Services

Access to onsite behavioral health services for assessment, counseling, crisis intervention, and referral to community resources are required at a minimum of 0.5 FTE Master's level mental health provider. Integration of physical and mental health care is encouraged through a coordinated risk assessment, warm hand-offs, shared charts, and internal referrals between the medical provider and behavioral health therapist.

Behavioral health therapists typically have their own counseling caseload, as well as assist in crisis intervention and referral to outside agencies for more intensive services. Assessment, intervention, and re-evaluation in 90-120 days and termination, when appropriate, are necessary stages of the treatment plan.

Expanded Services

Depending on fiduciary resources, onsite dental care, nutrition counseling by a Registered Dietician, and health educations programs can be included in the scope of provided services.

It is expected that all CACH's will provide health education activities as part of their service delivery plan. This can include individual health counseling in the center, health education

programming in classrooms, as well as education programs for families and the community as a whole.

All centers are also required to assist students and families, when eligible, with onsite enrollment in Medicaid programs. As a significant amount of our funding for the CAHC program is derived from federal matching of State Medicaid funds, Medicaid outreach activities are a necessary component of programming. Medicaid outreach includes onsite enrollment, providing education on Medicaid programs to the school community through health education events, as well as training on Medicaid programs for health center staff. Provision of basic needs (food and hygiene products) and referral to community resources to assist families to meet basic needs is a recognized component of CAHC services. Some centers have also incorporated a clothing closet for students.

Policies and Procedures

CAHC *specific* policies and procedures are required in all centers. This is particularly important in larger organizations (health system, FQHC, health department), as larger fiduciaries tend to have overarching policies and procedures for all areas of care, and may have a more difficult time amending policies and procedures through formal channels. A procedure manual or addendum that specifically addresses care in the CAHC is important in these circumstances, as over-arching policies and procedures may not completely address care differences provided in the health centers. This is especially true for responses to emergencies and crises within the center or school building, and the Continuous Quality Improvement Initiatives. In addition, clear policies and procedures for internal and external referral processes including follow-up of internal and external referrals, communication with the PCP where available, communication with parents/guardians, minor consent of confidential services, the Rights and Responsibilities process, addressing child abuse and neglect, and release of information are areas to which centers need to pay particular attention.

CAHC's in larger fiduciaries are also more vulnerable to inadvertent release of confidential care records with the move to the Electronic Health Records (EHR's). The CAHC should ensure that confidential information is flagged, and/or placed in a "confidential tab" in the chart, and that specific policies for release of adolescent medical records follow a process of review by a clinician prior to release to a parent/guardian. These policies and procedures should be

communicated to the larger fiduciary to ensure that confidentiality of the adolescent is maintained.

Specific policies and procedures for communication with the school and school personnel are especially important for school-based health centers. Student confidentiality should be maintained, while ensuring communication with school partners.

Organizational Structure

A clear organizational structure from the fiduciary through the CAHC should be outlined. The organizational chart should reflect clear lines of authority for the administration of the CAHC, as well as the roles of the sponsoring facility, the CAHC, and the school. Reporting relationships of the Community Advisory Council (CAC) and Student/Teen Advisory Council (S/TAC) should be included. This chart should be reviewed periodically and revised as needed.

Staffing

Care is provided by a multi-disciplinary team that includes, at minimum: the medical provider (often a Nurse Practitioner or Physician's Assistant), a physician as acting Medical Director (not required to be onsite), a behavioral health therapist, as well as one or more assistants. The Nurse Practitioner or Physicians Assistant may also act as the CAHC Coordinator or Director, or the center may have an additional staff person to fulfill this role. Depending on the center, the assistant may be a Registered Nurse, medical assistant, and/or an office clerk/biller. Other potential team members include a Health Educator, Registered Dietician, dental assistant and/or Dentist, and community health workers. Care is provided on-site with 24-hour access to on call services for medical and behavioral health services as arranged by the center. All centers are open year-round, including school and summer breaks. CAHC's are required to be open a minimum of 30 hours (5 days per week) for full-clinical sites, and 24 hours (3 consistent days per week) for alternative clinical sites. Ideally, centers maintain hours prior to and after school in an effort to improve hours of access and encourage school attendance.

Therefore, CAHC services are uniquely positioned to act as a medical home for students, and or to collaborate with existing primary care providers, other medical providers, social service agencies, behavioral health agencies, outside programs and organizations to ensure continuity

of care. As care is provided within a school setting, working with school personnel for the mutual benefit of the student is essential. Mutual collaboration and policy development in a cooperative atmosphere with school personnel are essential to success of the CAHC to accomplish the mission of the provision of comprehensive health education and a healthy school environment. Ultimately, the center fiduciary is responsible for administration, operations and oversight of the center, but centers must meet MPR's outlined by the CAHC Program.

Relationships

CAHC's are organized through family, school, community, and health provider relationships. There should be established relationships with:

The Client's Family: A family-centered care model is ideal to provide care to a student. The family should be informed of care visits to the health center, provided received care is non-confidential. The method of preferred communication would depend upon the nature of the information. Routine care can be communicated through a post-discharge care summary. Coordination of chronic care and clarification of required history might be better communicated via telephone, and/or scheduled appointment. Parental contact is required after emergency services or urgent care needs of the student are met. Involvement of the family in the goals of the health care plan, as well as education about chronic conditions and options for treatment is the gold standard. The plan should be developed in collaboration with the student and family, considering family culture, dynamics, and function. Child and Adolescent Health Centers typically serve families with a high level of need. Though family involvement in the care plan can be a challenge in the health center environment, the clinician should make every effort to include the family in the care planning process. Families should be educated on the use of preventive health care services, and the role of the primary care provider in care management, as well as appropriate use of acute care for urgent health care needs.

The Primary Care Provider (when available): Care coordination is an essential piece of child and adolescent health services. Communication regarding health needs outside the scope of the health center, as well as care provided that pertains to chronic health conditions of the student should be communicated to the Primary Care Provider. Certainly, the PCP should be made aware of ongoing, acute health care needs or services rendered in the health center,

especially if the clinician is treating a chronic health condition that is poorly controlled or impacts care that may be provided by the PCP. Every effort should be made to coordinate care to provide seamless care between the PCP office and the health center, while avoiding duplication of services.

The Medical Director: Relationship with the health center Medical Director should be outlined in the Collaborative Practice Agreement for NP's (Reference see **Collaborative Practice Agreement** in the Professional Standards and Development document) and the **Supervisory Agreement** for a PA (Reference see Supervisory Agreement in the Professional Standards document). There is no prescribed amount of time or frequency of visits to the health center that the Medical Director is required to fulfill. The involvement of the Medical Director should be coordinated according to the needs of the individual provider, with newer providers including the Medical Director in a more active role in health center operations and clinician guidance. At minimum, the Medical Director must review policies and procedures according to policy (annually, biannually), and needs to review care guidelines and resources with the provider on an annual basis. This should be done with the annual review of the Collaborative Practice Agreement and/or Supervisory Agreement with health center providers.

The School, School Board and School District: Relationship with the school is an essential tool for a successful health center. Often times, schools provide in-kind space and other services for the health center, when on campus. This can include janitorial services, as well as technology support. Schools can also be essential for marketing services of the health center to students and their families. A cooperative arrangement with the school assists the health center in obtaining essential information on students, including class schedules and health needs, assisting in parental consent process, as well as collaborating in the Community Advisory Council, and outreach services to the school and local community through school events. Annual to bi-annual review of the Interagency Agreement is also required. Confidentiality of student information is of great concern in both the school and healthcare environments. CAHC's operate under the Healthcare Information and Portability & Accountability Act (HIPAA), whereas the school operates under Family Education Rights and Privacy Act (FERPA). These are distinctive Federal privacy acts that govern student information. It is important to have a mutual understanding of the requirements of each Act, so that a good working relationship can ensue on behalf of the student client. For more information on HIPAA and FERPA requirements, see **Confidentiality** under the Resources for Clinicians by Topic Area document, as well as the

Laws and Regulations in the CAHC Program, in the Professional Standards and Development document.

The Community. The health centers should receive input from the larger community regarding perceived needs of the students served by the center. The formal mechanism for this is the Community Advisory Council. Just as the community helps the health center fulfill the centers needs, the center should also assist in meeting the greater needs of the community. This can be achieved through varied means, including provision of health screenings at school events, educational events on the Medicaid enrollment process, or a chronic health issue. These are excellent ways to market the services of the health center and act as a means of student recruitment.

The Sponsoring Fiduciary. The sponsoring fiduciary must be involved in the administration and operation of the health center program. At minimum, fiduciaries provide budgetary support, technology support and program support through assistance in planning and implementing budgets, record storage, 24 hour service coverage, as well as support for center-specific CQI activities that include support for regular team meetings and required DCH trainings for program participants. Fiduciaries are also responsible to ensure that confidential services remain confidential, regardless of service provision location. Specific policies and procedures must include assurances for maintaining confidentiality of student records.

Local Health Department (LHD): Required communications between the health center and the LHD should occur with regard to communicable diseases and provision of immunizations through the Michigan Disease Surveillance System (MDSS) and the Michigan Care Improvement Registry (MCIR) systems, respectively. Each clinician may register through the Michigan Single Sign On (SSO) page, and subscribe to needed systems with the approval of your Program Director or Fiduciary. Please see the Professional Standards and Development document, under **MCIR and MDSS**. The LHD can also act as a source for referrals for services such as family planning needs and substance abuse treatment, depending on available services. The health centers should work closely with the LHD to coordinate a full spectrum of care services for clients, while avoiding duplication.

Local Community Mental Health Community: The local mental health authority and or community behavioral therapists can fulfill behavioral health needs of students and families that are beyond the scope of the health center, including the care of severe mental health conditions.

Local Department of Human Services: Referrals to DHS are frequently required for students and families accessing care at the health centers. In fact, local DHS offices are sometimes incorporated into the school building in high need areas, including programs such as Safe and Secure Schools and Pathways to Potential. A collaborative relationship with the health center and DHS is beneficial to students and their families.

Community and Youth Advisory Councils

Youth and family input into the services provided at the CAHC are an important component of the program. Youth Advisory Councils (YAC's) and Community Advisory Councils (CAC's) act in an advisory capacity to the CAHC. CAC's must approve center policies with regard to confidential care, reporting child abuse and neglect, parental consent and release of medical records on an annual basis and be documented in council meeting minutes. Councils may provide feedback to the CAHC on programming, service provision, and needed services. Formal youth input is also a requirement of the CAC. This input may be obtained through student representation, and/or other mechanisms, such as focus groups. CAHC's share information with the councils on center services, outcomes of services outreach activities, and information gathered in needs assessment and patient satisfaction surveys. Councils can also provide outreach activities to encourage use of center services.

http://www.michigan.gov/mdch/0,4612,7-132-2942_4911_4912-342474--,00.html

Fiscal Operations and Reporting Requirements

The annual budget includes sources of funds (State grant dollars versus 30% minimum match), receipts, expenditures, equipment inventories, budget analysis, and total service calculations, and requires administrative support. A designated individual should be responsible for Quarterly reporting required by MDCH. Reports are due 30 days after the end of each Quarter:

Quarter 1	October 1-December 31	Report Due	January 30
Quarter 2	January 1-March31	Report Due	April 30
Quarter 3	April 1- June 30	Report Due	July 30
Quarter 4	July 1-September 30	Report Due	October 30

Clinicians should familiarize themselves with the reporting templates. This allows the clinician to be aware of the required data that is reported to the CAHC team.

Links to reporting templates can be found on the CAHC website under Program Resources:

http://www.michigan.gov/mdch/0,4612,7-132-2942_4911_4912-342519--,00.html

Systems should be in place for determining Medicaid eligibility for each student at each visit. CHAMPS or webDENIS may be used by the CAHC to determine eligibility. Links to determine eligibility for Medicaid can be found at:

<http://www.michigan.gov/mdch/0,4612,7-132-2945-57088--,00.html>

In addition, the CAHC program is enacting a sub-recipient monitoring process that includes a financial review of all centers that receive grant funds. Sub-recipient monitoring is a Federal requirement for all programs receiving grant funds. Each center will be assessed on a risk scale to determine order of review, with higher risk agencies being reviewed sooner than lower risk agencies. Please consult with your assigned consultant for any concerns or question.

Billing

The health center shall establish and implement a sliding fee scale that is not a barrier to the health care for adolescents. Adolescents must not be denied services because of inability to pay or insurance status (public or private). CAHC grant funding should be utilized to offset any outstanding balances, including co-pays, to avoid collection notices and/ or referrals to collection agencies.

A process for billing Medicaid, Medicaid Health Plans and other third party payers should be established. The process established should not breach the confidentiality of the client (i.e.: STI Testing Services). Policies and procedures should delineate how each health center protects client confidentiality in the billing process.

All revenue generated from the health center must be used to support health center operations and programming.

Clinicians should obtain a National Provider Identification Number (NPI) and be credentialed to bill Medicaid. Your fiduciary should be able to assist you with this process. For assistance, please see the Provider Enrollment page on the MDCH website:

http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546-104293--,00.html

Resources for obtaining an NPI can be found at the National Plan and Provider Enrollment System (NPPES) found here:

<https://nppes.cms.hhs.gov/NPPES/Welcome.do>

with instructions for enrollment found here:

<https://nppes.cms.hhs.gov/NPPES/StaticForward.do?forward=static.instructions>

To bill Medicaid in Michigan, you must be registered in the Community Health Automated Medicaid Processing System (CHAMPS). Information on CHAMPS can be found here:

http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-145006--,00.html

Medicaid Outreach

Five areas of Medicaid Outreach are required for the CAHC Program.

Area 1- Public Awareness

Activities include 1) Informing eligible or potentially eligible individuals about Medicaid and how to access Medicaid services; or 2) describing the services covered under a Medicaid program as part of a broader presentation e.g., within the context of a health education program.

Examples include Medicaid literature distribution; using print or electronic media, school announcements to promote Medicaid covered services; and participating in health fairs where such literature is distributed. DCH requires health centers to keep a log of the Public Awareness Medicaid Outreach activities, including location of the event, approximate number of people served, and amount of literature distributed.

Area 2- Facilitating Medicaid Eligibility Determination

Activities that demonstrate facilitating Medicaid eligibility are those where the CAHC staff assists in the Medicaid enrollment process by enrolling uninsured clients onsite at the health center. As of October 1, 2014, report the following: 1) the unduplicated number of uninsured clients who access the center during the year, broken down by quarter; 2) the unduplicated number of uninsured clients assisted onsite with completion of the Medicaid application; and 3) the unduplicated number of uninsured clients that your health center assisted onsite with enrollment that were successfully enrolled. (Note: The number of uninsured clients assisted onsite with completion of the Medicaid application, should not be greater than the number of uninsured clients who access the center during the year. The number of clients that your health center assisted onsite with enrollment that were successfully enrolled, should not be greater than the number of clients that were assisted onsite with completion of the Medicaid application). Assisting children and families in Medicaid enrollment is a major initiative of our program. All centers are required to have onsite Medicaid enrollment for students and their families. Training programs are available for staff to become certified enrollees.

Michigan Benefits Access (MBA) In-Person Training

<http://mibenefitsaccess.org/partners/training/>

MBA Toolkits for Training Curriculum and Tools and Outreach

<http://mibenefitsaccess.org/partners/toolkit/>

Area 3- Program Planning, Policy Development and Interagency Coordination related to Medical Services

This area focuses on the collaborative development of programs with other agencies that assure the delivery of Medicaid-covered physical, mental, and oral health services to children and adolescents. Centers should develop systems and methods for referral to ensure care delivery to those that have Medicaid. Oftentimes, Medicaid providers are scarce to nonexistent in the community. Therefore, the CAHC coordinates referral and care sources for the local offices in the community in order to ensure appropriate care for these clients. Contracts may be required between the CAHC and these other agencies in order to ensure that local offices will agree to care for Medicaid clients of the CAHC if no other options exist in the community.

Area 4- Referral, Coordination and Monitoring of Medicaid Services

Activities in this area include targeting the Medicaid population in the CAHC by: developing appropriate referral sources for program-specific services; coordinating programs and services at the school or community level; monitoring the delivery and quality of Medicaid-covered services provided by the CAHC; and/or providing medically necessary administrative activities for which skilled professional medical knowledge is required in this population.

Additional resources for Medicaid Outreach can be found on our website under Program Resources:

http://www.michigan.gov/mdch/0,4612,7-132-2942_4911_4912-342519--,00.html

Data Management

Health Centers are required to report quarterly and year-end data to DCH. The data is primarily the responsibility of the health center coordinator, however, physical and mental health clinicians need to be aware of data that is collected in reporting in order to determine the best and most consistent methods for data collection. Upon hire, clinicians should be oriented to the site specific Goal Attainment Scaling (GAS) Tool, as well as the Year -End Report template. A thorough review of how data is mined from the EHR is essential to accurate reporting. Collaboration with IT personnel is usually necessary, though most small centers are able to ensure accurate data through team collaboration.

Accurate data is critical to the health center model. Michigan is the only State that has federal matching of state Medicaid funds contributing to program funding. Year-End CAHC Program data is compiled into several usable formats for all community partners:

Dashboard: Program data is compiled in a Dashboard, similar to those used in most health centers for reporting quality measures, and illustrates how the program is meeting thresholds for various care measures including, for example, immunization rates, and on-site treatment of Chlamydia. The Dashboard is shared with legislators to demonstrate program outcomes on an annual basis. The current Dashboard can be found on the main page of the CAHC website at:

http://www.michigan.gov/mdch/0,4612,7-132-2942_4911_4912-342503--,00.html

Report Card: A Report Card is provided to each center at the end of the year to allow sites to examine progress in specific measures from year-to-year. This Report Card illustrates how a particular health center in our program is meeting thresholds for established program criteria. The ultimate goal is to publicize these Report Cards to community partners, as well as use them as a gauge for continued funding.

Condition Specific Promotion Pages: These pages highlight health center work in specific areas such as Asthma Management and Primary Care objectives. These infographic pages summarize key successes in our program and are distributed to community partners to promote health center successes.

It is also imperative that patient data and information are protected following HIPPA guidelines. Health Center policies should specifically describe how protected health information is being maintained confidentially, with specifics on disclosures and how medical and mental health release of information is conducted within the center.

Links to our specific Program Data can be found on our website at:

http://www.michigan.gov/mdch/0,4612,7-132-2942_4911_4912-342533--,00.html

Facility Requirements

All health centers are required to have at minimum: 2 private exam rooms, a lab space, a waiting room, a private office for counseling, and an accessible bathroom. Ideally, school-based health centers should have an outside entrance to allow client access year-round.

Continuous Quality and Improvement (CQI)

Health Centers must implement a **health center specific** quality improvement plan, and involve all members in regular meetings and discussions. Both physical and mental health care should demonstrate evidence of CQI. Components of the plan shall include at a minimum:

- Practice and record review, shall be conducted at least twice annually by an appropriate peer and/or other staff of the sponsoring agency, to determine that conformity exists with current standards of physical and mental health care.
- Evidence of a continuous quality improvement plan and results of recent quality improvement review.

- Review criteria
- Thresholds are identified and evaluated.
- A system shall also be in place to implement corrective actions when deficiencies are noted.
- A CQI Coordinator shall be identified.
- CQI meetings, that include staff of all disciplines working in the health center, shall be held at least quarterly. These meetings shall include discussion of reviews, client satisfaction survey and any identified clinical issues.
- The plan incorporates the completion or access to a needs assessment process every three years to determine health needs of the target population; and implementation of a client satisfaction survey at least annually.

There are two primary needs assessment surveys that centers use in Michigan. These are the Michigan Profile for Healthy Youth (MiPHY) and the Youth Risk Behavior Survey (YRBS). The surveys are conducted by the Michigan Department of Education (MDE) every other year, with the YRBS conducted on odd years, and the MiPHY on even years. The MiPHY provides student results on health risk behaviors including substance use, violence, physical activity, nutrition, sexual behavior, and emotional health in grades 7, 9, and 11. The survey also measures risk and protective factors most predictive of alcohol, tobacco, and other drug use and violence. This survey offers school and county level data. Information on the MiPHY can be found here:

http://www.michigan.gov/mde/0,4615,7-140-28753_64839_38684_29233_44681---,00.html

The YRBS is part of a nationwide surveying effort led by the Centers for Disease Control and Prevention (CDC) to monitor students' health risks and behaviors in six categories: unintentional injury and violence, tobacco use, alcohol and other drug use, sexual behaviors that contribute to unintended pregnancy or disease, dietary behaviors, and physical inactivity. The YRBS provides national, state, and large city data. Information on the YRBS can be found here:

http://www.michigan.gov/mde/0,4615,7-140-28753_64839_38684_29233_41316---,00.html

Most health centers are part of a larger fiduciary that conducts Continuous Quality Improvement activities. However, it is required that the health centers examine their **own data** and implement a plan based on the **specific** needs of the health center population. Many times, measures that the larger fiduciary is monitoring, may also fit with the health center population. It is a requirement that the measures be specific to the health center population as well. For instance, if the larger fiduciary is examining tobacco cessation counseling as one of its meaningful use measures, the health center can also examine this as part of their CQI. The objectives would have to be specific to the health center population. Most centers use the PDCA format (Plan, Do, Check and Act/Assess). See **CQI** under the Professional Standards and Development document, as well as the CAHC Website, under Program Data at:

http://www.michigan.gov/mdch/0,4612,7-132-2942_4911_4912-342533--,00.html

Plan

Measure: Improve tobacco cessation counseling, using the Five A's method (ask, advise, assess, assist, arrange) from the current threshold of 30% to 75% by end of the fiscal year.

- Clinicians will assess tobacco use with every visit.
- Each client will be advised to quit.
- Each client will be assessed for their readiness to change using the Prochaska Stage of Change Model (SOC).
- Each client will be offered a menu of options to reduce or quit smoking.
- Each client will have a follow-up visit within 2 weeks of their initial visit to reassess readiness to change, and/or evaluate the success of their plan, and/or follow-up with the mental health therapist to assist in behavior change, as appropriate.

Do

- Chart audits will be done quarterly to determine adherence to the Five A Method.
- All charts with code 305.1 will be assessed for codes 99406-8 for completed counseling and “dummy” SOC codes.
- All charts with code 305.1 will be assessed for follow-up visit for cessation within 2 weeks of initial visit (dummy code: 305.FV- Tobacco cessation follow-up visit).

- All charts with code 305.1 will be assessed for referral to MH provider.

Check/Study

Quarterly data will be assessed at each staff meeting to assess the adherence to use of the Five A Method, as well as data on change in counseling thresholds from baseline to level of SOC at the end of the fiscal year, or successful cessation. We will assess the impact of MH counseling on success in achieving cessation and/or use of the Five A method in moving the Stage of Change closer to Readiness to Quit.

Act/Assess

We will assess whether or not the Five A Method was successful in achieving cessation and/or moving clients closer to the Readiness to Quit on the Stages of Change Model. We will also examine the effect MH counseling, in addition to clinician counseling, impacts the rate of cessation through Case Management discussions at staff meetings.

Another possibility is to evaluate risk assessment data for risk disparities among populations that the health center serves. The **Risk Disparities Assessment Tool** is a tool developed by the CAHC team to assist centers in evaluating risk data for actual risk disparities. The center data is entered into the tool in order to identify potential health disparities. The health disparities identified, may then be formally addressed by the center staff through corrective action. A link to the Risk Disparities Tool can be found on the CAHC Website under Program Resources at:

http://www.michigan.gov/mdch/0,4612,7-132-2942_4911_4912-342519--,00.html

For example, you enter your risk assessment data into the tool and discover that the African American male population is significantly more at risk for STI, as they report a lower rate of use of condoms with sexual activity. The previous year, you note that your G/C and HIV testing for your teen population (15-21 yrs. of age) was 3/120 clients or about 3%. You elect to address the

use of condoms in your health center with all sexually active African American students, and offer HIV and G/C testing to all sexually active African American students.

Plan

Measure: Improve the percent of African American students who agree to HIV, G/C counseling to at least 90% of the eligible population (100 students) by the end of the fiscal year.

Measurement: African American students with high sexual risk factors (>4 sex partners, lack of condom use, MSM, poor school performance) will be referred for MH counseling.

Do

- AA students with a positive RAAPS for the sexual health question will be assessed for completion of HIV(86701) and G/C testing (87491/87591)
- AA students with high sexual health risk factors will have 2 visits with a MH provider.

Check

- We will do quarterly chart audits to examine thresholds for G/C and HIV testing.
- We will perform quarterly chart audits for v code v69.1- High-risk sexual activity and African American race to obtain a registry of patients, in order to ensure they have been referred to MH. All patients with code v69.1 and AA race will be scheduled for 2 visits with the MH provider. If patients refuse MH referral, they will be scheduled with the provider for 2 follow-up visits for risk reduction plans. Case management will occur with the MH provider by the clinician.
- Clients with high-risk sexual activity will complete the RAAPS sexual health risk survey at baseline and post 2 visits with the physical or mental health clinician.

Act/Assess

In evaluating our thresholds:

- 1) We will attempt to identify barriers to completing testing, and
- 2) Adapt our program to remove testing barriers.

We will examine the impact of MH therapy and/or risk reduction plans on risky sexual behaviors.

The CAHC Program also uses Continuous Quality Improvement to monitor and improve programming. This endeavor is called Quality and Evaluation Support Team (QuEST). An example of Continuous Quality Improvement at the program level can be reviewed in our Spotlight section of our website at:

http://www.michigan.gov/mdch/0,4612,7-132-2942_4911_4912-342559--,00.html

Mandatory Training from CAHC

As a new provider in the CAHC program, we offer a variety of programming to assist clinicians in meeting their personal and professional goals, as well as the Minimum Program Requirements (MPR's) for the program. The CAHC team offers a variety of **required** educational programming throughout the year. The programming consists of the following events:

Clinical Training Days- Clinical Training Days are an in-person educational event that occurs every summer, typically in June. This event is a 1-2 day event that explores hands-on training (i.e. Ortho Assessment) and or explores a clinical topic in depth (Asthma- Assessment, Diagnosis, Treatment, Tricks of the Trade, etc.). This is mandatory for the site provider, but may also include the Medical Assistant and office support staff as appropriate.

Coordinator's Meeting- The Coordinator's Meeting is also an in-person educational event that occurs every fall, typically in October. This is a 1-2 day event that explores a particular topic in-depth that has relevance to Adolescent Healthcare (i.e. Health Risks and Disparities) and

breaks it down into relevant topics for application to care in your health centers (i.e. Using the Risk Disparities Tool to assess Health Disparities and how they may be addressed in your center). This is mandatory for the Program Director and the site provider, but again may include the Medical Assistant, Medical Director, and office support staff, as appropriate.

Grand Rounds with Dr. Barone, CAHC Medical Director- Grand Rounds is a webinar/live stream educational event that occurs typically in the fall and spring of each fiscal year. Grand Rounds typically highlights a clinical topic that is seen in everyday care in the health centers.

HIV Counseling and Testing- HIV Counseling is a one hour online module, followed by a 2 day in-person risk training specifically on HIV counseling and testing in the adolescent population. All providers are required to take the course. The first step is to complete the online module at: <http://breeze.mdch.train.org/hivmodule1>. The second step is to complete the required test with a passing grade. The link to the test can be found under **HIV Training** in the Clinician Resources By Topic Area document.

Risk Assessment Training- Risk Assessment Training is a 6-hour self-study module, followed by a full day of in-person risk training directed at overall assessment of risk behavior in the adolescent population. This program is also mandatory for all physical and mental health providers and Program Directors. Risk Assessment Training is typically held once to twice per year, depending on need, typically late summer to early fall.

All upcoming and past training events can be viewed on the MPHI website at the following link:
https://mph-web.ungerboeck.com/wri/wri_p1_display.aspx?oc=10&cc=CAHC

CAHC Minimum Program Requirements (MPR's)

CAHC Program Requirements

STATE-FUNDED CONTINUOUS QUALITY IMPROVEMENT



Quality Outcomes Are the Goal of the CAHC Program

Minimum Program Requirements (MPR's)

The aforementioned principles and guidelines for practice set the stage for the CAHC MPR's. Each State-funded CAHC site in Michigan is required to follow the minimum set of standards put in place by the CAHC program, in order to be compliant with grant funding requirements. These requirements are outlined in the MPR Narratives and the Site Review Tools specific to each program (See Below under Specific CAHC Type), which are divided into four main categories: Clinical, Administrative, Mental Health and Medicaid Outreach. CAHC staff needs to become familiar with the MPR's upon hire to their individual center. The MPR's also act as a Continuous Quality Improvement Tool for the CAHC Team and the individual CAHC site. The MPR's and Site Review Tool allow the CAHC team to provide consistent feedback to the individual CAHC sites on grant requirements in a structured and consistent manner, as well as guide and monitor the CAHC program as a whole.

Adolescent Sites

Services provided through the adolescent CAHC program are designed specifically for teens 10 through 21 years of age, and are aimed at achieving the best possible physical, intellectual, and emotional health status. Included in this element are adolescent health centers designed to provide comprehensive primary care, psychosocial and mental health services, health promotion/disease prevention, and outreach services. The infants and young children of the target age group can be served through this program.

See the **Adolescent MPR Document**

http://www.michigan.gov/documents/mdch/Minimum_Program_Requirements_1014_FINAL_475622_7.pdf

See the **Adolescent Site Review Tool**

http://www.michigan.gov/documents/mdch/Adolescent_SiteReview_Tool_475640_7.pdf

Elementary Sites

Services provided through elementary CAHC's are designed specifically for school-aged children ages 5-10 aimed at achieving the best possible physical, intellectual, and emotional status. Included in this element are elementary, school-based health centers designed to provide comprehensive primary care, psychosocial and mental health services, health promotion/disease prevention, and outreach services.

See the **Elementary MPR Document**

http://www.michigan.gov/documents/mdch/Minimum_Program_Requirements_1014_FINAL_475622_7.pdf

See the **Elementary Site Review Tool**

http://www.michigan.gov/documents/mdch/Elementary_Site_Review_Tool- FY15_483804_7.pdf

School Wellness Program Sites (SWP)

Services provided through the SWP program are nursing and Mental Health Services.

See the **SWP MPR Document**

http://www.michigan.gov/documents/mdch/Minimum_Program_Requirements_1014_FINAL_475622_7.pdf

See the **SWP Site Review Tool**

http://www.michigan.gov/documents/mdch/SWP_Site_Review_Tool- FY15_483818_7.pdf

Understanding the Site Review Process

CAHC MPR's and the Assessment and Mentoring Process

MINIMUM PROGRAM REQUIREMENTS AND SITE REVIEWS



Site Reviews Ensure Program Adherence to CAHC MPR's

The MPR's also guide the site review process, and have been incorporated into a Site Review Tool that is used during the formal site review process. [See **Adolescent, Elementary, or SWP Site Review Tool links, pages 29 and 29**]. During the site review process, each center is evaluated on the adherence to the MPR's using the appropriate Site Review tool. The site review process allows the CAHC team to perform an in-person assessment of the strengths and areas for improvement of each CAHC site. The CAHC team also utilizes the site review process to problem-solve solutions to issues that each CAHC site team may encounter in the course of their work, and act as advocates on behalf of the CAHC staff. Site reviews occur at a minimum of every 5 years, after funding has been established. Some centers may be evaluated more frequently, depending on the findings of initial and subsequent site reviews. Each site review team has a minimum of one Administrative, Clinical and Mental Health Consultant that participate in the formal process. This team utilizes the CAHC Site Review Tool to evaluate adherence to the MPR's. Each clinical site is notified of their upcoming review 3-6 months in advance. The reviews typically begin and conclude with a meeting of the site review team, CAHC health center staff, its' administrators and Medical Director. During the review, the site review team will observe normal clinic operations, and may make suggestions for immediate improvement during this observation period. Reviewers attempt to notify CAHC site staff, at the

time of the review, of any discrepancies found in meeting the MPR's that may result in a formal citation. Also at the time of the review, clinical staff is encouraged to use the time to consult with the members of the review team to assist in problem solving any issues in healthcare delivery by asking questions to help clarify requirements with the CAHC team.

Subsequent to the review, a formal report is communicated to the center that contains formal citations or areas requiring change, as well as suggestions for improvement based upon the on site review conducted by the site review team. The center will receive the report no later than 45 days after the onsite review, and will have a **maximum** of 45 days to respond to the report, once the report is received by the clinical site. On occasion, some citations, called sentinel citations, will require immediate action (typically 10-15 days) on the part of the sponsoring agency and/or health center staff.

Once the site review is completed, each CAHC will be assigned an accreditation status. Accreditation statuses include: full accreditation, provisional status and probationary status. Each status is based on a formula representing the percentage of requirements the center has met. Accreditation status determines the timing of subsequent site reviews, financial penalties and time frames for corrections. A full description of the accreditation process is available in the **Site Review Tiers** link here:

http://www.michigan.gov/mdch/0,4612,7-132-2942_4911_4912-342519--,00.html

The formal site review process is one part of the ongoing collaboration between the CAHC Team and the CAHC sites. The CAHC team consists of Administrative, Clinical and Mental Health Consultants that also provide ongoing monitoring and technical assistance to the CAHC sites. Each consultant on the CAHC team is assigned to several centers throughout the state to assist CAHC sites in meeting not only grant requirements, but state, federal, and professional requirements for health care delivery.

The assigned consultant works with the CAHC site team to ensure that health centers are also demonstrating fiscal responsibility of grant funds. The site review process affords both the CAHC site staff and the CAHC team the abilities to: learn and grow through the auditing process, continue to direct educational and general programming, as well as identify opportunities to highlight “Best Practices” occurring at the CAHC sites. The assigned consultant also acts as a liaison for the CAHC site by bringing site specific issues, in the areas of planning, implementing and evaluating, to the larger team for discussion and resolution.

Team contact information may be obtained by visiting the MDCH website at:

http://www.michigan.gov/mdch/0,4612,7-132-2942_4911_4912-342537--,00.html

CAHC Goal Attainment Scaling

Clinical Quality Improvement, Educational Programming and Medicaid Outreach



Goal Attainment Scale (GAS) is a method of tracking individual CAHC and Program accomplishments in Quality Initiatives. The GAS was developed in order to document the successes and reach of the CAHC program, specifically to demonstrate return on investment to the Michigan legislature. Eventually, the GAS will be utilized to determine funding for CAHC programs. All staff are encouraged to complete the following PowerPoint training program to assist in learning about the GAS and mandatory reporting elements:

<http://breeze.mdch.train.org/CAHCreportingrequirementsupdate>

Additional assistance with GAS completion and CAHC reporting can be provided by direct communication with your assigned consultant. Please refer to your Program Director for the name and contact information for your site's consultant, or visit the CAHC website:

http://www.michigan.gov/mdch/0,4612,7-132-2942_4911_4912-342537--,00.html
http://www.michigan.gov/mdch/0,4612,7-132-2942_4911_4912-342440--,00.html

Educational and Clinical Programming

Center programming must adhere to 5 general principles:

1. Be based on evidence-based programs
2. Go "above and beyond" a typical intervention
3. Be based on needs assessment or health disparities data for the targeted school population
4. Be acceptable to the community, and

5. Staff must be have the capacity to deliver the program

Evidence-based programs are those that are recognized as a standard of care for the physical and mental health community. For example, in developing an asthma program for the healthcare setting, use of the NHLBI Asthma Guidelines would be considered evidence-based. Going “above and beyond” routine care might include adding spirometry testing within 4 weeks of presentation to the health center for asthma symptoms. This is considered “above and beyond,” as it is generally not seen as routine for a primary care office to perform spirometry, or to do so within a set timeframe from symptom presentation. Another example would include using CDC STI guidelines for screening adolescents for STI’s. The CDC STI guidelines are a recognized standard of care for assessing and screening adolescents for STI’s. Going “above and beyond” in this case may include: use of a risk reduction plan with the adolescent to change high-risk sexual behaviors that led to testing for STI’s, and reassessing and modifying the plan with a follow-up visit in 2-4 weeks to assess the adolescent’s follow-through with their risk reduction goal, and/or modification of the goal.

Evidence-Based Programming (EBP’s)

MDCH requires EBP’s in at least one of five Focus Areas. The focus areas include:

1. Alcohol, Tobacco and Other Drugs
2. Chronic Illness (Asthma, Diabetes, etc.)
3. Nutrition and Physical Activity
4. HIV/AIDS/STI Prevention
5. Teen Pregnancy Prevention.

EBP’s are programs that have been shown, through meticulous evaluation, to be effective in significantly impacting specific health outcomes or risk behaviors among the population to which the program was delivered. These programs generally have been replicated in multiple populations or settings with similar effects. The results of the evaluation that details the effectiveness are typically published in peer-reviewed journals, reviewed by independent scientific review panels, and are recognized by nationally respected organizations and/or government agencies. Evidence-based clinical services and guidelines are also widely available. For example, The Cochrane Collaboration is a resource that reviews clinical studies and publishes recommended standards of care that your center can incorporate into clinical

practice and measure through chart reviews and other methodology. Numerous entities publish compendia of evidence-based interventions, including clinical interventions. Some compendia may use research or evidence-based and promising or best practice terminology interchangeably. The following are a starting point for your search for an appropriate program based on the specific needs of your population:

<http://nahic.ucsf.edu/wp-content/uploads/2014/08/Evidence-Based-Guide.pdf>

<http://www.nrepp.samhsa.gov/ViewAll.aspx>

With the approval of the site consultant, EBP's may also be designed by the provider using current established clinical guidelines.

Common challenges to implementing EBP's with suggested solutions are as follows:

1) Getting Access to Students for Programs:

- a) The best advice is to plan early and *with* school administrators and staff.
- b) This means planning your programming using your needs assessment data to address issues of urgency and importance to the school staff and administrators.

For example, if there is a high level of teen pregnancy in the school – the school administration most likely wants that addressed. If you come to the table with a tried-and-true teen pregnancy prevention curriculum, and mental health counseling to help prevent the traumatic contributors to teen pregnancy, the school administration is going to see to it that you have the access you need to students. Take every opportunity you can to communicate with the school staff about what problems they see, and what you can do to help address those concerns. That helps the school to become a safe and healthy environment for learning

- c) Show how your health-focused curriculum aligns with academic curriculum expectations.

For example, writing across the curriculum is a very commonplace practice to help students achieve academic standards in English Language Arts and to increase performance on standardized testing. Does your classroom intervention include writing activities? If so, the topic(s) that the students write on for your curriculum can be used as a graded writing

assignment in class...so in this essence you aren't taking away from class time but rather you are contributing to and becoming integrated into the curriculum.

- d) Use a combination of classroom interventions with after-school and clinical interventions. Plan some interventions that can be delivered in classrooms, but also plan other interventions that reach targeted youth (e.g., those with highest risk) over the lunch hour, after school and/or in a clinical setting during clinical visits.

For example, it may be appropriate to provide a classroom-based substance use or tobacco prevention curriculum if smoking is really prevalent in the school, and you want all kids to hear the information and know how to respond to the peer pressure to smoke. But, if there are students who are smoking, you might need to have individual or group therapy to more completely address those concerns. Target the high risk students and require a more intensive or one-to-one interventions with that subset of students, and there you have two evidence-based interventions in the alcohol, tobacco and other drug area!

- e) Share evaluation results from programming/established evidence-based interventions to show the positive effects that your intervention is expected to have on students.

For example, share the MESH evaluation results that clearly show that our CAHC's impact the health status (and, by extension – the readiness to learn and academic behaviors/outcomes) for students. Or, share the results of a program you have implemented with the school staff and administrators and school board. Use this data to your advantage to demonstrate the benefit of health center programming in the school.

A link to the study can be found here:

http://www.michigan.gov/documents/mdch/MESH_Project_Brief_Final_375932_7.pdf

A summary of the study can be found in the **Working With Schools Section**, page 41.

2) Implementing sexual health education in the classroom

During the school day, a certified or qualified teacher must either teach or be present in the classroom while the curriculum is being taught. In order to teach sexual health education, teachers must be “qualified to teach health” by possessing an MA (health), MS (health, physical education, recreation and dance combined), or KH (family and consumer science) endorsement. These endorsements qualify teachers to teach health education in Michigan, thus qualifying them to teach sexual health education. It applies to all middle school and high school teachers who teach sexual health education under a secondary teaching certificate. Many CAHC staff go into the classroom and teach sexual health education, but the main (certified) teacher must stay in the classroom, as they are the one that is "qualified to teach it" under the law. This is how you can work with the requirement. While Sexual health education does require a certified teacher, HIV education does not. CAHC staff can provide HIV education without the presence of the certified teacher . When teaching HIV education only, the presenter can utilize a licensed health care professional who has training in HIV/AIDS to provide the instruction - which includes your CAHC Provider. More information on the difference is available here:

http://www.michigan.gov/documents/mde/Qualifications_of_Sex_Ed_Tchr_3.07_Districts_191454_7.pdf

If you are not able to provide sexual health education in the classroom working within these requirements, then you should concentrate on other methods of providing intervention (e.g., in the clinical setting) or focus on other areas of need.

Information about Sexuality Education Standards in Michigan can be found at the following page:

http://www.michigan.gov/mde/0,4615,7-140-28753_64839_38684_29233---,00.html

3) Ideas for clinical staff to meet these requirements and yet deliver well and acute health care in the health center:

The main clinical provider does not have to be the person implementing the interventions; a social worker, health educator or other qualified staff that support your health center (like an RD) could implement focus area programming, appropriate

to the selected program and staff credentials. The main clinical provider can implement one classroom curriculum-type intervention along with a clinical intervention, so that at least one intervention is being incorporated into the hours of clinical care.

4) Using an outside facilitator to conduct focus area programming on behalf of our student health center:

The state is providing funds to your health center to provide the expected services/educational programming. The health center contract with your sponsoring agency assumes a level of accountability that what is written in your GAS plan will occur (e.g., delivery of an evidence-based intervention with fidelity and evaluation of that intervention). The best way to ensure this accountability is for your health center staff to deliver (and evaluate) the intervention. Plus, when your health center staff delivers an intervention, it is a fantastic opportunity for staff and students to get to know each other outside of the clinical setting; making the students familiar with providers, and more open to coming in and communicating health concerns with the staff. At times, a health center might want to contract out with another agency to deliver programming to meet the focus area requirements. If this is done, the health center needs to be certain that a formal agreement is in place that assures some level of “control” (accountability) that the intervention will be evidence-based, delivered with fidelity, and evaluation will occur. The health center will need to have complete access to those evaluation results. This holds true for any contractual arrangements, you have to remember that these services are being provided under the auspices of the health center, and some level of accountability and quality assurance for the services must be assured. Contractual agreements should include specifics on service delivery and evaluation, quality improvement measures/processes, client satisfaction and staff supervision. Any programming that is already delivered in the community/school and that would occur without the involvement of the health center cannot be counted as focus area programming. Any programming used to fulfill another state grant requirement cannot be counted as focus area programming.

5) Using the same focus area programming and interventions at multiple sites under the same fiduciary:

If a fiduciary/sponsoring agency has more than one health center, they can address the same focus areas at more than one health center provided the needs assessment results clearly show that the same needs or issues exist at each location. The health centers can use the same

interventions to meet focus area requirements at different health centers provided the selected interventions are appropriate for the populations at both locations. Your intervention has to make sense based on your population's unique characteristics, like culture, literacy level, risk and protective factors, and other considerations important to successful health education. Even if you determine that you can use the same interventions at different sites, the GAS may not look exactly the same for those health centers. For example, you might implement an intervention four times per year at a high school vs. twice per year at a middle school, so that you can reach more youth at the high school (which probably has a bigger population). Or, you might have greater risk behaviors among the population at the high school, so you might want to include interventions above and beyond the minimum two in order to address those risk behaviors.

6) Shortening a Program to Accommodate Clinical Schedules, etc.

In order to be effective, an intervention has to be implemented with fidelity. If you shorten a program, the material you take out may be critical to the intervention's effectiveness. If you feel like you, as the provider, can not implement the full program then you should look for support in implementing the program e.g., team-teaching with other qualified health center staff or tapping into resources from your sponsoring agency to assist in its implementation.

7) One Time Lecture vs. Series of Classes/Groups

A one-hour classroom lecture is not an evidence-based intervention and it will not count toward fulfilling the Focus Area requirements. In fact, most evidence-based programs are typically, at a minimum, six hours in length. Programs with the greatest impact, those that have been shown to truly change behavior over the long-term, are more comprehensive and last several hours over the course of weeks or months of intervention. So, you must select two evidence-based interventions that are recognized as effective through publication of evaluated results in peer-reviewed journals or websites; which have been reviewed by scientific review panels; and/or are recognized by nationally respected organizations and/or government agencies. You can of course arrange for others, like MSU Cooperative Extension, to provide a onetime presentation to supplement the evidence-based interventions you are offering. You can put these types of supplemental programming on the work plan, if you like, to show the full range of what you are providing to your population, but it is not necessary.

8) More Than Required Focus Areas:

Health centers should review their needs assessment data to determine at least one priority health issue that is of such significance to their target population to warrant an enhanced “focus” for the upcoming year. The increased attention to the issue, through multiple evidence-based approaches, is what makes it an area of focus (a focus area) for the health center. Many of the health centers offer programming above and beyond our minimal requirements; and choose to create and submit additional objectives on the GAS that don’t necessarily have evidence-based approaches in each area. However, it does demonstrate the additional work that the health center is doing to meet the needs of their target population. To sum up, we require two evidence-based programs in one focus area, or one evidence-based program in 2 focus areas. However, you may offer more interventions in additional focus areas, as desired. Please remember that whatever is included in your GAS, you are expected to implement, evaluate, and report these to MDCH.

See the following page for an example of EBP’s using the Physical Activity and Nutrition Focus Area.

Focus Area: Physical Activity and Nutrition

Your examination of your data (RAAPS, teacher surveys, student surveys, stratifying BMI’s in your health center, etc.) have revealed that obesity prevention is a priority need of your population.

Evidence-Based Programming:

Intervention 1: Curriculum Based: Use of an evidence-based nutrition curriculum that involves a 6 week nutrition program in the classroom setting. You elect to present this to all 6th graders in your target population. You provide the group education to 2 classrooms the first semester and 2 classrooms the second semester.

Intervention 2- Clinically-Based: You identify a group of students with a BMI >85% and focus your interventions beyond “routine” primary care. You decide to utilize the HEAT guidelines from NAPNAP to do a complete nutrition assessment of the student and his/her family physical activity and eating habits. You provide the student with a pre-intervention survey of his/her eating and physical activity habits. You then have the client return to set up healthy eating and activity goals using motivational interviewing a prescribed number of times. You then measure behavior change with a post-survey following the prescribed intervention, and report on any changes.

Working with Schools

Building Relationships with School Partners is Essential for Successful CAHC's



Top 10 Tips: Working Effectively with Schools

1. Express Empathy

Collaboration is the key to empathy. Working together to solve a problem you both understand personally, can be very helpful in paving the way to a successful relationship with the school. An example of this can be compliance with privacy guidelines- the health center must comply with HIPAA, while the school must comply with FERPA. In the course of the working relationship, situations will emerge that may present roadblocks on the path to collaboration. First and foremost, understand that these issues are mutually frustrating. Prevention can often be the key to a smooth working relationship. For example, develop a plan with the school administration to develop a consent to share limited information to ease the working relationship and collaboration. Within the health center parent consent, request access to school schedules as well as limited sharing of information with the school nurse on a “need only” basis. This type of agreement is mutually beneficial to the school, health center and the consenting adult, as it improves the flow of communication between the health center and the school, while maintaining the privacy of the student.

2. Sell Yourself as Support

Answer the call! Oftentimes, administrators are busy trying to meet student demand for services. So are we. They may call on you to assist them in their efforts. Take them up on it! A seemingly less than ideal situation, can lead to an opportunity to demonstrate your willingness

to go the extra mile. One clinic had school administration ask them to allow a local Cardiologist to use their health center space to perform cardiac screenings for sports physicals. This request led to a collaborative effort on the part of the health center's Provider and the Cardiologist to identify athletes at risk. They were both able to work together to assess the athletes and make appropriate referrals. The value of the clinic was clearly demonstrated to administration.

3. Small Acts of Kindness

All of us need to be recognized for the work we do on a day-to-day basis. The staff and teachers at the school are no exception. Sending flowers to the school secretaries or school nurse, sponsoring a faculty luncheon during parent-teacher conferences are small acts of kindness that go a long way toward building a relationship with school staff. These small acts of kindness demonstrate your appreciation for the work that the school staff do, and provide an avenue for the center to show that they respect the staff and can garner support for center operations.

4. Integrate Yourself Into the Culture of the School

Use your Student or Teen Advisory Council (SAC/TAC) to guide you in this process. Involve yourself in school activities as much as possible, through the use of the students. Students often have great ideas for activities that integrate the center into the school environment. One health center, at the suggestion of students, was able to start an Open House for Halloween. The health center serves cookies and punch, and the students are present to answer questions about the health center when other students visit to find out information.

S/TAC's can also be an effective recruitment tool. Older student planning activities for younger students, or at other schools in the district, is a good way to showcase the work of the health center and the S/TAC for future clients and or members of the health center advisory groups.

5. Know Names

You will have many opportunities to get to know members of the school staff. Take the opportunity to get to know them by name. A friendly "hello" in the hallway, a thank you to the janitor go much farther when someone is addressed by name. In my own experience, two of our best advocates were "Kevin" and "Gary" the school janitors. We knew their names, and the

activities they did for the students on their own, like cooking “soul food” for the students and families in the poor, rural area our center was located, for Black History month. We were always first on their list for any concern we had in the clinic. We knew them by name, as well as their spirit and contributions to the wellbeing of the students. We shared that goal. Knowing teachers and counselors at the school by name, also helps in building shared purpose; being acquainted can bring interest in participation for both health center and school staff. Having teachers and counselors serving on the CAC, can bridge needed gaps in communication when the need arises.

6. Realize the Power of Gratitude and Appreciation

As providers, we are privy to hearing information from students that can assist us in building our relationships with the school. Many times, students will repeatedly identify a teacher or staff member that they feel is a good listener, or a trusted person. Use this information to your advantage! It’s very easy to give positive feedback to a teacher or staff person while maintaining confidentiality of the student. Everyone likes to hear positive feedback! Letting a teacher know that students appreciate them is a great way to give this positive feedback, and allows the school staff to get to know you.

7. Be Present in the Hallways and Lunchroom

A majority of our work takes place in the center. Difficult as it may be to “be present “ in the school, it is really important to the success of your center. There are numerous ways to “be present” in the school that do not necessarily take “extra time.”

- Be in the hallway during class exchange to say “hi” to students during down time.
- Eat lunch in the cafeteria.
- Ask to meet teachers briefly during their planning time to connect your face to the center.
- Adjust your hours to be available before and after school in the center.
- Provide evidence-based programming in the classroom.
- Show school spirit by wearing school gear

Ideas that may take “extra time” include:

- Attend sporting events for the school

- Attend Open House, Parent-Teacher Conference Nights
- Attend Board Meetings
- Attend school staff meetings periodically
- Compose a health center newsletter that gets distributed to the students
- Write articles for the school paper on clinically relevant topics (immunizations, sports injuries)
- Appear on school media channel
- Do a quarterly radio program within the community to publicize services
- Use social media- health center website, Facebook page, Twitter accounts
- Incorporate social media accounts in the school website
- Attend a school pep rally
- Attend or chaperone a school dance or event
- Work the concession stand at sporting event

8. Express a Shared Purpose

Finding a common project is always a good idea! Sport's physicals and concussions in youth sports are a perfect example of how you can work with the school to accomplish a shared goal. Offer your services to perform sports physicals and required concussion screening to the school's Athletic Department. The Athletic Director and coaches want their athletes to be able to play, as well as keep them safe. Providing educational events to the coaches for the Athletic Director on concussions in sports is a great way to start. Coaching staff can be great referral sources for sports physicals. Going a step further, one center was able to present their concussion screening program to the school board, and at team parent meetings. This eventually led to school board members touring the health center upon their election to the board.

9. Communicate Frequently and Clearly

Frequent communication is often needed to remind staff of the services provided in the CAHC, and the limits to how much "sharing" can occur. Annual refreshers at staff meetings on confidentiality and the rationale for limiting services to students only, go a long way to encourage mutual understanding. When planning events, always remind the school secretary

of your previously planned event, or any changes that are happening with the clinic. This can often prevent issues before they start.

A health center (located in the middle school) held an immunization clinic in the high school on a monthly basis. This agreement was reached with the high school as students would often “get lost” on the way to the clinic for immunizations. The high school staff allowed use of the sick room once per month to administer immunizations, as it had a sink and a bathroom. A schedule was set to do the clinic on the 2nd Tuesday of every month, rotating am and pm to allow getting students that left for vocational education at least every other month. Reminding the high school secretary the morning of the clinic was helpful to assist her in planning her day. Unexpected events occur in the course of both roles, so keeping each other abreast of changes does a lot to minimize stress.

Another center has had success with providing teachers with a “welcome back gift” every Fall. The gift is a first aid kit that contains Tylenol and aspirin, hallway passes, and a card listing the services that the health center provides. This is a great way to welcome teachers back to school, as well as remind them of your services, your name and your shared purpose.

10. Express Patience

Learning to work together, takes understanding and patience. Remember to be patient with school staff, and they will learn to be patient with you.

Other suggestions for CAHC’s include:

Attend Board Meetings

Board meetings are a great way to get involved with community partners. Your school board members usually have a vested interest in the students, school and community. Attending meetings and sharing information are great ways to demonstrate that you share a common interest- student and school well-being. Parents that attend meetings, and/or are Board members, may also be interested in serving on the required Community Advisory Committee for the health center. Providing regular updates in services at meetings are a great way to show the community the ways you are working to improve the health, prevent injury and deter risk, of the students that attend schools in your community. Through your presence at the

meetings, it demonstrates that you have a vested interest in the school and community as a whole, as well as a desire to be known by the parents and staff. Visibility of health center staff assists in integrating the health center as a vital part of the school community.

Have a Health Center Liaison in Each School

Each health center should have an identified liaison in the school, or multiple schools if a SLHC, to assist with any problem solving that may occur throughout the course of operating the CAHC. A strong relationship with a school liaison that is invested in the purpose of the CAHC will be key to overcoming problem issues. It may be easy to identify this person through initial planning grant activities, or through a relationship with an individual that is developed over time. The liaison should be knowledgeable in school operations, and have a good relationship with other school staff.

Know Your Principal(s)

Inherent in the success of CAHC's is to ensure that the principal of the school(s) understand(s) the importance of the services your staff provides. There are several ways to accomplish this:

1) Present the value of the school-based health center to your Principal is an important first step in the process. The main goal of the educator is to educate the student. Concrete evidence that health centers are a vital part of that process is critical in establishing the center's worth to the school.

- The MeSH Study- The Michigan Evaluation of School-based Health was a study conducted by Michigan State University in conjunction with MDCH and MDE. The study was published in 2011, and was the first study in Michigan on the benefits of school-based health centers to student performance and health.
 - The presence of CAHCs in schools was associated with health benefits for the entire student population, such as:
 - less physical discomfort,
 - less emotional discomfort,
 - higher self-esteem,
 - engaging in fewer individual risks,
 - fewer threats to achievement, and
 - fewer negative peer influences.

- In addition, the use of CAHC services was associated with health benefits such as:
 - greater satisfaction with health,
 - greater self-esteem,
 - less physical discomfort,
 - engaging in more physical activity,
 - eating healthier foods,
 - greater family involvement, and
 - more active social problem-solving skills.

http://www.michigan.gov/documents/mdch/MESH_Project_Brief_Final_375932_7.pdf

Healthier students make better learners. Less risk-taking and greater family involvement usually means less behavioral issues. Less physical and emotional discomfort means fewer missed school days. These are all benefits of school-based health care.

- 2) Define a mutually agreed upon interagency agreement or Memorandum of Understanding (MOU) with the school.

Involving the school Principal in your required interagency/MOU agreement assists each of you in delineating the responsibilities of the health center staff compared with any existing school staff. The CAHC Team highly recommends that school personnel remain accountable for daily medications, and responding to emergencies within the school. The CAHC is primarily in the school to serve student needs and health concerns. Legal responsibility for school emergencies and daily medications fall upon the school. If a school desires assistance with physical or mental health emergencies, the center should have a clear policy on what types of situations and when a health center employee should respond. However, consider how and when this may interfere with health center operations.

Administer School Staff Satisfaction Surveys Bi-annually

Providing school staff with a way to provide feedback to the health center is another strategy to help integrate the health center into the school community. This is a way that teachers and staff can provide input to the health center in a confidential manner, as well as assist the health center in identifying areas of strength, as well as potential areas for change upfront. In fact, summarizing the information you received, showing appreciation for the positive feedback and steps you are taking to address the issues at a school staff meeting is a great way to demonstrate that the information provided was valuable. In addition, informing school staff of the rationale for not taking suggested changes is just as important. School staff is not always aware of HIPAA and health center regulations and operations, so any chance to offer information will go a long way to promote positive relationships with them. Be Partners with Office Staff , School Nurses and the School Champion.

Attend Rotary Club and/ or Business Roundtable Meetings

Business leaders in the community are a great source of support. These meetings may also be a recruitment ground for members of the CAHC CAC. Updating the business community members of the services provided at the center, as well as the outcomes you have achieved with your population have the potential to secure community support for your clinic, as well as possible financial assistance for special health center projects.

Establish Community Events on Health Education

Successful centers can enlist the support of their CAC and YAC to provide community events to market services to the larger community. Holding a teen health fair can assist school-linked centers in patient recruitment, YAC recruitment, and visibility in the community.

Use Sources of Media to Promote Your CAHC

Information targeted to attract youth is a great way to get your health center noticed:

- Twitter
- Facebook
- Newsletter distributed to local schools and businesses
- Radio spots on local radio shows highlighting CAHC services
- School district media channel commercials or health-information shows