



**W.K. Kellogg Foundation
School-Based Health Care Policy Project
(SBHCPP)**

Capstone Report

October 15, 2010

Executive Summary

For 25 years in Oregon, passionate partners, dedicated volunteers and staff have steadily increased awareness of and support for the school-based health care model, with the Oregon School-Based Health Care Network (Network) as the “loosely” formed construct to support advocacy. In 2004, however, a significant opportunity emerged and the Network was awarded a 6 year, \$1.4 million grant from the WK Kellogg Foundation within their national initiative: *School-Based Health Care Policy Project*.

The Network is a now key player in ensuring the success and viability of school-based health care centers (SBHCs) as an innovative model of care with in Oregon and at the federal level. The Network's mission is to advance access to quality health care for youth, and it is dedicated to making school-based health care available, accessible and stable for the health, well-being and success of all of Oregon's children and youth. It is the collective voice to build a stable, effective and available health care system in Oregon's schools.

The Network builds capacity to provide quality services to children and youth at school-based health centers, and is the primary source of professional training and resources for center staff. The Network also advances policy to improve and expand health care services to children and youth throughout Oregon, and develops grassroots leaders to strengthen awareness of and support for school-base health care. Presently, SBHCs are in 55 schools across 22 Oregon counties; there are 10 developing centers with state planning grant funds.

This report is the Capstone Report outlining the work over the project period related to Kellogg’s *School-Based Health Care Policy Project*. This report describes the main areas of impact and outcomes of policy advocacy at the federal, state, and local levels. It is intended to provide the goals, strategies and approaches to improving access to quality health care for children and youth through the expansion of school-based health care in the state of Oregon. The report annotates challenges and achievements over the course of the project, which not only addresses policy advocacy, but the underpinning of an organizational approach to sustaining that advocacy.

The Capstone Report contains the following sections; a separate Evaluation Report has been submitted as a part of the process of reporting.

Policy Development: framing an in-depth description of the State, Federal, and Local health and education policy.

Organizational Development: providing a perspective of the process to create and sustain the policy work. This section describes findings from the organizational assessment tool, referred to as the McKinsey

Impact of Our Work: outlining the range of ways our work has had an impact and made a difference in the course of the project

Analysis and Conclusions: describing the progress, the challenges, and learnings at a 30,000 foot level.

The primary writers of the report are Liz Smith Currie, policy director for Network and Paula Hester, executive director. The project evaluator provided analysis of the McKinsey. Secondary contributors to the end product include two primary board members, Jackie Rose and Tammy Alexander. Multiple staff and volunteers have reviewed the document in sections as it was created. Information contained in the Capstone was gathered from the annual progress and evaluation reports to WKKF over the past five years, surveys over time, event evaluations, and documentation of work performed by the Network funded by other grantors and/or donations and earned income.

Additionally, interviews and casual conversations with multiple parties substantially impacted the contents. Specific communication with the field of SBHC providers and advocates, including youth, has emerged in the process of preparing for this report. Venues such as Awareness Day in February 2010 and the 2010 SBHC Conference provided opportunities to learn from a broad group of people. The Capstone Meeting in South Carolina also provided focused, face to face reflection on the project. Kellogg provided funding to bring together all grantees from the initiative, and specifically, the Network had two board members, two community partners, the executive and policy directors, and the project evaluator at the meetings.

Report Overview

Major increases have occurred in the skills and capacities of the Network's staff, particularly the policy director, to conduct advocacy and policy work at the local, state, and federal levels during the SBHC Policy Project. The organization has an increasing ability to form partnerships and alliances with others. There have been major increases in the ability of the

The Network also has significantly increased its involvement in multiple areas of policy, including not only legislative appropriations, but also rules and regulations, professional board issues, task force recommendations, statewide health care reform, and relationships between insurance payors, hospitals, and other funding sources and school-based health care centers.

The impact of the expanded scope has been to improve the effectiveness of Network policy advocacy, and to greatly increase the influence and reputation of the Network as an advocate for health care access for youth. This effectiveness includes a broad group of people, not just the staff, board or consultants for the organization, but specifically, the long-endearing professionals and the youth they support in doing advocacy.

The Network has been highly successful in advocating for increased state appropriations and other funding for school-based health care centers, resulting in additional funding for existing centers, expansion of school-based health care by at least one-third over the past several years, and an increase in the number of schools with planning grants for SBHCs.

The Network has had a major positive impact on the capacities, sustainability, and growth of youth engagement and youth advocacy among SBHCs. This work has resulted in an increase in access to care and quality of care among SBHCs and other organizations in Oregon, and a major increase in overall support for the SBHC movement in Oregon.

The resources provided by the Kellogg Foundation for the Policy Project has been essential to the policy successes of the Network in expanding school-based health care in Oregon. Without the support of the Foundation, the Network would likely still be in its infancy, and not have accomplished the major success outlined above.

Other positive influences on Network policy successes include the expertise of Network staff, alliances and partnerships, participation of Oregon SBHCs, other foundations and funders, youth advocates, and managed care organizations. The political climate, the Network board, and the Oregon Dept. of Human Services SBHC program office also had a positive influence on Network impacts.

SBHCs: The work of the Network in collaboration with its partners and stakeholders, including youth advocates, has resulted in an expansion of the number of school-based health care centers in Oregon, thereby increasing access to care among youth in Oregon, and an expansion of funding for existing new and planned centers. The sustainability of school-based health care in Oregon is significantly greater than before the advent of the SBHC Policy Project. Developing relationships between school-based health care centers and managed care organizations and other insurance payors, and supporting the capacity for SBHCs to advocate for themselves, also contributed to SBHC sustainability.

Network: Over the course of the Kellogg Policy Project, the sustainability of the Network has increased significantly but the decline of Kellogg Foundation support provides concern for the board and staff, as well as partners and advocates. Funding from the Kellogg Foundation has enabled the major policy achievements and growth in capacity of the Network. The Network has sought to increase its own sustainability through individual donations, grants applications, collaborative work with other organizations, and through in-kind donations of space and facilities from partners and collaborators.

SBHC Movement: The sustainability of the SBHC movement is largely predicated on the sustainability of the Oregon Network. Advocacy for SBHCs and for the movement would suffer considerably if the Network no longer existed; most predicted that there would be loss of support for school-based health care at the state and local levels. The lack of a sustained Network presence would severely impair the effectiveness of advocacy efforts for school-based health care centers statewide, and cause a reversion back to the pre-Kellogg state of affairs in which local health centers advocated independently for their own needs.

Policy Development

Liz Smith Currie
Policy Director
OSBHCN

Overview

The primary initial policy targets of the Kellogg grant—written in 2004—were to maintain and expand existing state general fund support for school-based health centers, to establish Medicaid reimbursement policies and practices for all eligible SBHCs, and to increase third-party reimbursements to SBHCs. At the federal level, achieving outcomes that substantially increase financial support to non-FQHC sponsored centers was a must. Adjacent to these overarching goals were mechanisms of community engagement and building a solid grassroots foundation to ensure lasting outcomes. Over the six years of the Kellogg grant, the Network has refined the phrasing of its goals, but the intent has remained basically the same.

The work at each level (state, federal and local) is separated for ease of understanding the targeted work. It should be noted, however, that each of these distinct policy arenas overlap in multiple ways, not the least of which is the complementary nature of each to the other. At times, the advocacy efforts for policy changes or funding support from level of government was supported by the outcomes achieved at another level.

SBHCs and State Policy

State Policy Goal 1: School-based health centers will have adequate funding sources to ensure sustainable operations and will have effective financial systems to collect for billable services.

- Outcome 1: State funding for school-based health centers is distributed more equitably among sites.
- Outcome 2: Legislative support to stabilize and grow state funding for SBHCs has increased and is more secure.
- Outcome 3 (in process—interim outcome): The Network, SBHC systems, insurers and state policy makers have a better understanding of SBHC barriers to billing and reimbursement and have succeeded in improving billing and revenue systems and payment relationships.
- Outcome 4 (in process—interim outcome): State policy supports SBHC billing and reimbursement system.

State Policy Goal 2: More children will have access to quality health care.

- Outcome 1: State planning grants support the establishment of SBHCs.
- Outcome 2: All children in Oregon have access to health insurance.

State Policy Goal 3: The state will ensure high quality care in school-based health centers.

- Outcome 1: The Network participates in the revision process of SBHC state certification.
- Outcome 2: Legislature appropriates funding for implementation of Key Performance Measures

State Policy Goal 1

School-based health centers will have adequate funding sources to ensure sustainable operations and will have effective financial systems to collect for billable services.

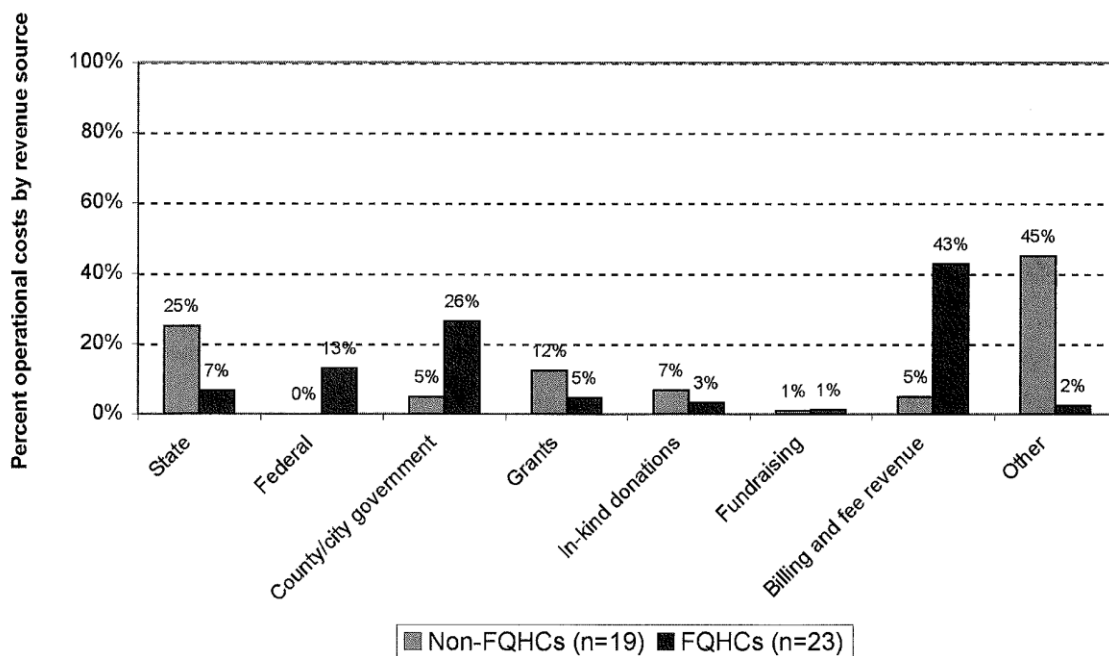
Rationale

SBHCs need stable and more equitable funding sources. Fluctuations in state and local government revenue make SBHCs vulnerable to budget cuts. It is imperative that SBHCs become less dependent on government as a main source of funding. Sites can do a better job capitalizing on available insurance revenue; but because SBHCs are an access model available regardless of insurance status or ability to pay, there will always need to be a public investment in health centers as part of the safety net for children. State dollars that are available should be fairly distributed across the state.

Background and Context

SBHCs in Oregon have multiple funding sources. Medical sponsorship has a major impact on billing revenue for SBHCs (see graph “Sources of Revenue Reported by Oregon SBHCs”). Sites that are sponsored by Federally Qualified Health Centers generate far more revenue than those that are sponsored by other providers (such as an individual physician’s office or hospital). Dependence on state funding also varies by community. From their inception in the 1980s until 2005, only half of Oregon’s SBHCs received any state funding, despite having similar hours and level of care. Today, all communities with SBHCs benefit from the state grant. Still, SBHCs are primarily a locally supported model: for every \$1 in state funds spent on SBHCs, \$3-4 additional dollars are leveraged through local public-private partnerships (source: DHS Public Health Division, 2009).

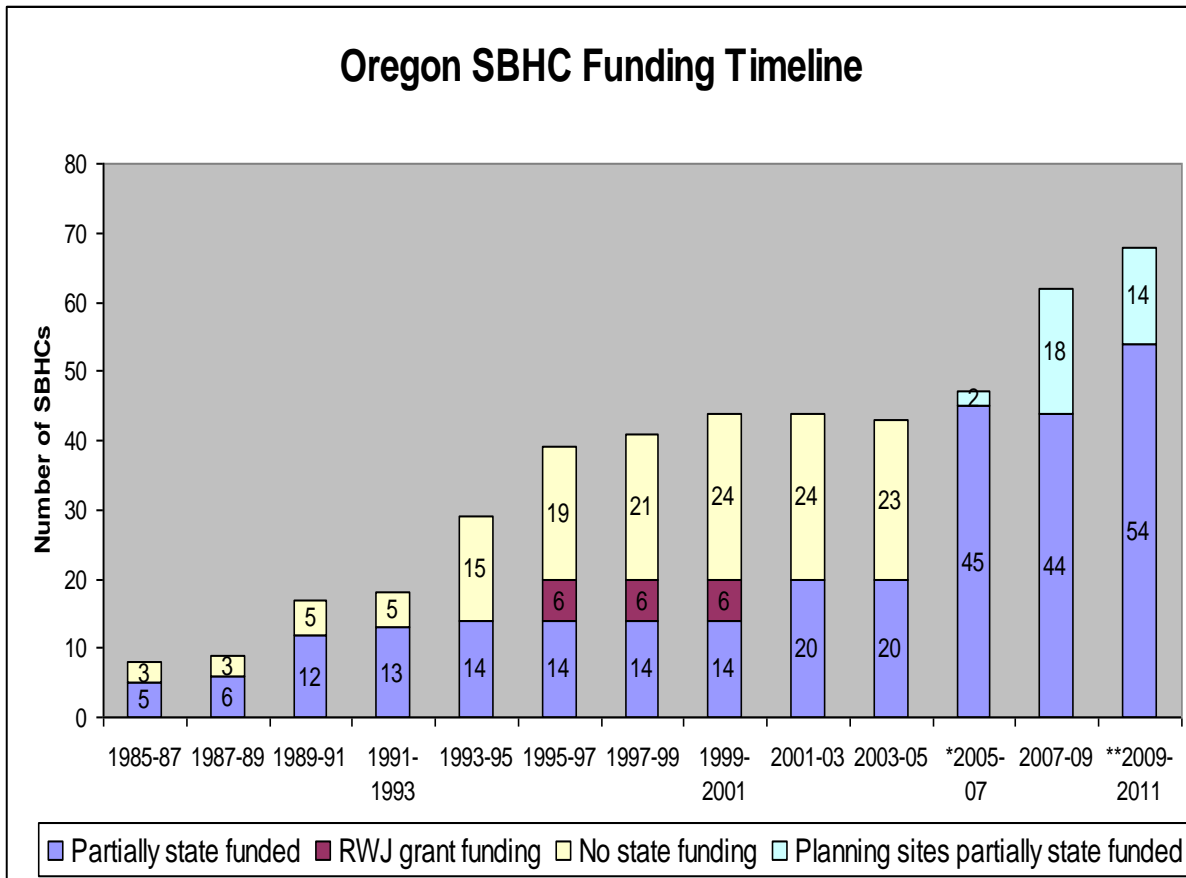
Figure 2. Sources of revenue reported by Oregon SBHCs, by sponsor type (n=42)



A major focus of our state policy work has been to find adequate funding sources to ensure sustainable operations and to build effective financial systems to collect for billable services. At the same time, we

believe that public dollars will always be necessary to support our prevention focused youth access care model. To that end, our first outcomes center on growing and fairly distributing the state budget for SBHCs and ensuring that SBHCs are properly paid for the quality health care that they offer.

Outcome 1: State funding for school-based health centers is distributed more equitably among sites. Today, all SBHCs that are state certified receive state funding, compared with about half in 2005 (see funding timeline graph).



Context

Prior to July 1, 2005, SBHCs were funded through a competitive grant process which resulted in considerable state funding inequity in SBHCs around the state. By 1993, fewer than half of the SBHCs in the state received grant funding for operations. Sites that received state funding were re-funded year after year. The remaining SBHCs received no direct state funds, despite maintaining similar levels of care. The inequity of the state grant program dissipated the effectiveness of advocacy efforts for SBHCs because the “haves” (those SBHC systems with state dollars) had much more incentive to support the state budget at the state level than the “have not” systems.

New funding formula: 2005

During the fiscal crisis of 2003, a ballot measure supporting the state budget failed, eliminating funding for SBHCs in the state closing the state SBHC State Program Office (SPO) in February. The legislature restored funding in August, but not before many state-funded SBHCs closed, reduced hours or had to find

emergency funding. The Network worked with foundations to provide “bridge” funding to keep some centers open. When state funding was restored, the Network and newly reopened SPO used the opportunity to redesign SBHC funding. The Network worked with the SPO and the Conference of Local Health Officials (CLHO) on a new funding formula that aligned SBHCs with the public health delivery system for stability and ongoing support, while leveling some of the inequities. The initial work on the redesign of state funding coincided with the beginning of the Kellogg grant program.

By July 2005, under the new grant program, each county that had a state-certified SBHC was eligible for state dollars through their Local Public Health Authority (LPHA) under a funding range system. The LPHA was provided funds to support SBHCs and SBHC systems based on the number of state-certified SBHCs in the county and the availability of legislatively approved dollars.

Number of State Certified SBHCs	State Grant to LPHA/year
1-2	\$60,000
3-5	\$120,000
6-9	\$180,000
>10	\$240,000

Feedback from the field on this 2005 range funding formula led the Network and state to question the new funding formula impact on SBHC expansion and sustainability. As we worked to grow the number of SBHCs in our state, it became clear that small counties would have a very difficult time building a second center without severely impacting the funding of the first center. On the other end of the scale, the largest SBHC system, with 12 centers, received a disproportionately smaller share of state grant dollars per site. Clearly, while the new system met our goal of ridding our state of the “have and have not” state funding system, the system remained inequitable and discouraged growth.

A second revision of the funding formula in 2007-2009

During the 2007-2009 biennium, the legislature funded the largest expansion in Oregon's SBHC history, funding 18 planning sites. Working within the 2005 range funding formula, many counties began to re-evaluate their ability to develop new centers without harming their existing centers. In response, in January 2009, a funding workgroup (including the Network, the SPO and the CLHO) convened to (1) revisit how State General Fund dollars support the overall mission of SBHCs in Oregon; (2) examine the effectiveness of the current funding formula in the present times; and (3) explore other funding formula models to improve sustainability and expansion efforts with the possibility of recommending a revised formula.

Based on the workgroup discussions, a new funding formula was implemented July 1, 2009 stating:

- Counties with only one certified SBHC receive \$60,000/yr
- Counties with > 1 certified SBHC receive \$41,000/yr for each center.

Strategies employed to achieve Outcome 1

The Network played an integral role in the two major efforts over the last five years that have achieved more equitable distribution of state SBHC grant dollars.

- The Network staff sought input from the field and regularly toured sites to learn about the needs of the communities it represents.
- We met regularly with the state SPO to share information from the field on the impact of the funding formula.
- In 2009, the SPO, CLHO and the Network reconvened the funding formula review committee that had worked on the 2005 funding formula change. SBHC stakeholders agreed to a two part process: (1) an exploratory review of the current funding formula to determine whether there is a need for a new funding formula model and upon decision, (2) develop a revised funding formula recommendation on how state funding would be distributed to the LPHAs.
 - Exploratory Workgroup: In February 2009 an exploratory workgroup held three meetings with the ultimate goal as whether to maintain the current SBHC funding formula or convene a funding workgroup to explore other funding formula scenarios. The workgroup unanimously voted to explore other funding scenarios and therefore assembled a funding workgroup that would do so.
 - Funding Formula Workgroup: In March 2009, the funding workgroup convened to explore other funding formula scenarios. Three voting representative groups—the SBHC State Program Office, the Oregon School-Based Health Care Network, and the Conference of Local Health Officials—as well as five additional partners—Maternal and Child Health, the Oregon Primary Care Association, the Rural and Urban Health Departments, and the Washington County Commission on Children and Families—were involved in the decision making process. The Funding Principles were updated to reflect current funding expectations. Nine different scenarios were explored with one proposed recommendation sent out for comments to all SBHC partners and local county health departments.
 - A final recommendation on how to change the formula was made to the Maternal Child Health Committee of CLHO of on May 20, 2009.
- We kept open the lines of communication with the field throughout the funding formula review process, forwarding on information through webinars and teleconferences hosted with the state.

Analysis, conclusions and recommendations

The 2005 and 2009 funding formula review processes created positive outcomes:

- More equitable funding across the state
- Statewide support for the funding formula revision
- No loss of funds to counties transitioning from the current to the new formula
- Nine out of 22 counties gained funds transitioning from the current to the new formula
- A monetary value placed on every certified center, maximizing the potential for local community advocacy to maintain existing funds
- The expectation of shared funding such as local investment and ongoing work towards sustainability
- Clear guidelines for distribution of future additional state funds if the state budget for SBHC funding is reduced

The success of this process was very much due to the collaboration of various partners in analyzing the current system, establishing clear goals for change, seeking input from the field and agreeing on solutions. One challenge related to this outcome was ensuring that legislators understood that changes to the funding formula had been made. While the model can change quickly, people’s perceptions are slower to change. On two occasions, legislators met constituents who disliked the old funding formula. It took a concerted

effort, including multiple communications from the Network staff, before the legislators understood that a change in the funding formula had been made. In both cases, the earlier communication from the constituent was remembered more easily than the later communication from Network staff. Legislators are busy, and are visited by a number of people every day. When they hear of a problem in the community they want to help. When that problem is “solved” then it is best to have the communication come from both the local stakeholders and the Network.

Outcome 2: Legislative support to stabilize and grow state funding for SBHCs has increased and is more secure.

As the Network and state improved their communications about SBHCs, more communities understood and expressed interest in developing the model. Communities with SBHCs saw the advantages of providing care in school and wanted to expand their services to new schools. All SBHC communities struggle to find and sustain local resources for SBHCs. Because SBHCs are patient centered and prevention focused, they are unable to sustain their services on billing and reimbursement alone. The tendency to spend more time on non-reimbursable preventive care, along with the adolescent’s desire for maintaining privacy in the SBHC setting, often precludes sites from submitting a bill for services. State and local dollars are critical to maintaining the unique model of care on SBHCs. The Network supported expanding the state grant and providing new dollars to help communities build sites.

Context

For 25 years, the state has made funding available for SBHCs. What began in the mid-1980s with an initial commitment of \$212,000 to partially fund five SBHCs grew to a commitment of \$7,005,000 to support 55 certified SBHCs and 14 planning sites, and to staff the state program office of SBHCs, in the 2009-2011 biennium.

State funding for SBHCs had mixed legislative support in the early 2000s. Some Republicans were vocally oppositional to the model because of perceived services that they did not see as appropriate in a school setting. Legislative Democrats were supportive, but advocacy and political support was concentrated in those communities with SBHCs that benefited from state funding. Other communities did not have state funding, so it was harder to inspire state advocacy. In 2003, the state had a major revenue shortfall and the Governor did not include SBHC funding in his proposed budget. The Network worked with Children First for Oregon, the Oregon School-Nurses Association and the Oregon Nurses Association to educate the legislature about the model, and funding was eventually put into place, but not before the state program office closed and many sites were forced to close, reduce hours, or scramble for local funding. As described in Outcome 1, the pause in funding created an opportunity to revise how state dollars were allocated to sites. Working with our partners, a new grant system was created to be more equitable and stable by designating grant funding based on the number of certified centers in each county.

The redesign of the state funding system meant that by the 2007 legislative session, public health authorities in 17 counties in rural, suburban and urban parts of the state shared the \$2.1 million in state grant funding. This meant that SBHC advocates could show more legislators that their communities were benefiting from state funding. The Network saw this as a critical time to build a strong advocacy network and to educate state policy makers about the model of care.

From 2004-2006, the Network formalized a relationship with Children First for Oregon through the Kellogg grant. Children First’s policy expertise helped inform the Network’s advocacy. In 2006, the

Network hired their own policy director who continued to develop state level policy work and grassroots support for the program. During this time, the Network and Children First worked closely with the Governor's office to lay the groundwork for an expansion in funding for school-based health care. In late 2006, the Governor unveiled his Healthy Kids Plan at a school-based health center. The Healthy Kids Plan was a major effort to provide access to health insurance for all children in Oregon through an increase in the tobacco tax. The plan included \$2.5 million in new funding for SBHCs.

In the 2007 session, the legislature moved the SBHC expansion funding out of the Healthy Kids Plan and into the general fund (which was fortunate, as the Healthy Kids Plan was referred to voters and ultimately failed to pass). As a result, 18 communities were given planning grants and the number of state certified SBHCs grew from 44 to 54 by 2009.

The 2007 legislative session was remarkable in the show of broad bi-partisan support for school health centers. Republican leaders, who were vehemently opposed to the Healthy Kids Plan, introduced an alternative plan that they argued would provide true access to health care by expanding access to SBHCs across the state.

There are several likely factors that can account for the change in the Republican position on SBHCs.

1. State funding now included sites from outside of the urban metro centers. In fact, many SBHCs are now located in districts represented by Republicans. Rural Oregon has a lot of medical deserts—there are several areas of the state where people have to drive for four hours to the nearest provider. SBHCs were a new and important way to deliver care in rural Oregon.
2. The model is adaptable to community mores. The rural and suburban communities can choose not to provide family planning services on site—one of the major concerns of opponents.
3. Communities in the planning stages were given guidance by the Network and state in reaching out to faith communities. This was critical in dispelling myths about services offered on site.
4. A legislator who was the most vehement opponent of SBHCs left her office.
5. Our Republican US Senator was from a rural part of the state. That community had two SBHCs, which his son used, and he became a major advocate at the federal level for SBHCs. His support helped lead other Republicans to support SBHCs and probably made it difficult for other Republicans voice their criticism.

Given the mixed support in previous sessions from both parties, the legislative support in the 2007 session was remarkable. As one longtime health care lobbyist commented, “since 2003 SBHCs have gone from the easiest program in the budget to cut to the program everyone wants to support.”

In 2009, the Governor once again introduced his Healthy Kids plan—this time funded through a provider tax on hospitals and insurers. SBHCs were once again allocated funding for expansion, and this funding was not part of the general fund pot and is therefore less vulnerable to budget cuts. Legislators had to grapple with state revenue shortfalls of \$3.8 billion, and SBHCs were one of the only programs to receive an increase in funding, receiving \$1.38 million for 14 planning grants and additional state dollars for the grant program.

The growth in funding for SBHCs is a direct result of the Network's policy and communication strategies. Building our advocacy network meant developing our capacity to communicate with our membership and to policy makers about the SBHC system and to develop the youth voice of our movement.

Strategies employed to achieve Outcome 2

- **We improved our messages about SBHCs.**

- **We educated ourselves about how to communicate effectively.** A critical first step in advancing both state and local level policy maker support for SBHCs was to change how we talked about the model. Prior to the Kellogg funding, there was little capacity to build a strong communications plan. Most of our messages centered on “Myths/Facts” about SBHCs, which in retrospect may have reinforced “bad” messages about the model. In 2006, the Network policy director attended communications training in Detroit which helped us to rethink and reframe our communications. As a result, the Network changed our fact sheets, web site and communications tools to reflect polling on “best messages” for SBHCs.
- **We targeted our communications to our appropriate audiences.** The work of Dr. Juanita Richardson and the Kellogg Resource team also helped us to think more about how to target messages to fit our audiences. Directly focusing on how SBHCs help educators and administrators was very helpful in advancing our movement through support from the education community.
- **We built our youth voice.** Beginning with our 2006 Day at the Capitol, the Network began a concerted effort to have youth tell their stories about why SBHC was important to them. Using a youth voice and engaging youth in our messaging helped show the person behind the data. The Network sought to deliver messages, images and stories from a culturally diverse group of youth and advocates. Over the last several years, the Network has created a “story bank” of videos and written stories from youth, parents and providers who can speak about the importance of SBHCs. We sought input from the youth in the Multnomah Youth Commission and with the Oregon Health Action Campaign to develop a story form which included permission to use their stories and images in a variety of ways (testimony to share with reporters, to put in our web communications, etc).
- **We included a multicultural perspective in our messaging**—helping our field think through culturally competent messages for their individual communities and sub-communities. For example, some frontier and rural parts of Oregon have very high poverty rates, but have a stigma against public programs. In these communities, sites might focus their messages on how SBHCs help individuals succeed. Also, we learned that it is important not to talk about “free” services with policy makers, because the services are not free, but are paid for by someone other than the client (in some cases). It is better to talk about how the community has created this model to help their children succeed.

- **We disseminated “best messages” to the field and community.**

The Network used the Detroit training to create a communications workshop for SBHC sites. Communities from across the state attended our workshop and, in turn, recreated their own local level messages for SBHCs. The Network continued to work with sites and youth groups on how to engage in social marketing that was culturally competent and fit the needs of the populations they were trying to get to act on their behalf. We also created the School-Health Bulletin, which updates our field on important developments in SBHC policy.

- **We delivered our messages to policy makers.**

Over the last 5 years, the Network has continued to “beat the drum” at the state capitol for SBHCs at every opportunity. Oregon has undergone a major health care reform effort, the “triple aim” of which has been to expand access to quality health care, improve health outcomes and lower or contain the cost of care. The Network has made it a priority to be a part of the health care reform

conversations and to show policy makers that SBHCs are in fact already ahead of the curve in both the delivery and quality of health care services. To achieve this, the Network has:

- worked closely with the Governor, legislators and their staff by
 - meeting regularly with the Governor’s staff and key legislators and their staff,
 - participating in public input sessions on Governor’s budget and policy committees,
 - having Network members attend town halls,
 - disseminating highlights of state led community surveys indicating the high level of desire in communities to open new SBHCs,
 - disseminating state annual reports on the status of SBHCs;
- Sought feedback from legislators and participants to improve our annual SBHC Awareness day;
- Trained youth and other advocates on how to talk about SBHCs with people in their communities and at the state and expanded our youth voice at the capitol (we now hold yearly SBHC Awareness Days and train more youth. In 2010 we trained 145 youth at SBHC Day, compared with 50 in 2005);
- Recruited our membership and have staff attend health care forums and town halls to continue to build awareness of the model;
- Organized tours of SBHCs for legislators both during and after legislative session;
- Asked local policy makers to express their support of SBHCs to state policy makers;
- Asked state policy makers to express their support of SBHCs to federal policy makers;
- Had the Governor sign a proclamation to make February 2010 SBHC Awareness month;
- created a tool kit to help sites with their local awareness-building activities for SBHC Awareness Month;
Created an Action Alert system to instigate and track calls to legislators when necessary;
- Had staff, board members and membership hold direct meetings with legislators, the Governor and their staffs to keep them informed about SBHC policy priorities;
- Worked with the Oregon School-Nurses Association to help legislators to understand our complementary roles in the health of our children (Our organizations have held joint briefings for legislators and staff and have testified together before the Senate Education committee on the roles and differences between SBHCs and school nurses and how together we impact educational outcomes.);
- Held meetings prior to the legislative session with legislative leaders from both parties to improve their understanding of the benefits and challenges of providing health care in school.

- **We grew partnerships to support SBHCs.**

For many years, the Networks advocacy was primary done through Network volunteers, most of whom were SBHC providers, with the support of a few partner organizations. During the Kellogg grant, the Network focused on growing strategic partnerships and worked in collaboration with other groups to build understanding of the SBHC model of care and to bring more voices to the capitol in support of SBHCs. As a result, the Network has a large number of partnerships.

- Health care policy partners who advocate for expansion of SBHC services:
 - Children First for Oregon policy and advocacy for SBHC continues, despite the end of our fiduciary relationship with them.
 - The Oregon Primary Care Association works closely with us on various committees and we meet regularly.
 - The Oregon School Nurses Association works with us to coordinate our messages and work together to educate legislators.

- The Oregon Nurses Association includes questions about SBHCs in their candidate endorsement interviews.
 - Stand for Children includes questions about SBHCs in their candidate forums.
 - Coalitions where the Network plays an active role, helps to advance our policy goal:
 - The Health Allies advocates for health care reform and the provider tax.
 - The Human Services Coalition is a human services group who works with us to send the message about the need for budget stability.
 - The Reformers include business associations, insurers and providers advocating for the “triple aim” of improved access, outcomes and affordability, particularly through a primary care home and payment reform. The Network successfully pushed to include SBHCs in a medical home bill and worked with the Reformers on a legislative concept to define an` integrated health care home include: “cultural competence that is accepting and respectful of diversity and difference while engaged in a continuous process of self assessment and reflection on one’s personal (and organizational) perceptions of the dynamics of culture.”
 - Healthy Kids Learn Better includes advocates from education, public health, the environment, transportation and other groups; they promote SBHCs as part the coordinated school health model.
 - Health Allies includes the Network and 40 other organizations to build support for state health care reform.
 - The Safety Net Advisory Council is a team of experts charged with assessing the stability of Oregon’s health care safety net and providing the Governor and the Oregon Health Authority with specific policy recommendations for the provision of safety net services for vulnerable populations who experience barriers to accessing care. The Network is represented on this council which is critical in delivering our issues to policy makers by a former SBHC practitioner and board member.
 - The Pediatric Primary Care Home Committee is a new subcommittee that was created to inform policy makers during the transitions around health care delivery as a result of state and federal health care reform. The Network successfully nominated a retired SBHC practitioner and past Network board president to this committee.
 - The Healthy Kids Steering Committee is a new committee that oversees the roll out of the expansion of children’s health coverage to cover all Oregon kids. Two Network board members were appointed to this committee.
 - Unions and businesses that support the Network:
 - Oregon Business Association (OBA). The Network has presented to their health policy board and they have supported SBHCs in their policy work).
 - Associated Oregon Industries (AOI). The Network has worked to educate them on the value of SBHCs and they have advocated for them through their monthly association magazine and by introducing the Network to their business partners. The Network has connected AOI to local sites in order to help them develop “Beyond the Check” ways that businesses can help sites. The Network is planning to co-host a teleconference on this issue.
 - The American Federation of Teachers. This union has included SBHCs as part of their legislative agenda.
 - The Oregon Nurses Association. They continue to work with the Network to support SBHCs.

- State and local offices that work with the Network:
 - The SBHC State Program Office. The Network has multiple weekly contacts with staff at the state on budget and policy issues affecting SBHCs. We have a monthly standing meeting and inform each other on message strategy and developments in the field.
 - SBHC Coordinators. The Network presents and often helps facilitate the quarterly SBHC Coordinator’s meetings hosted by the state.
 - County Commissions on Children and Family. The Network has established relationships with two local Commissions on Children and Families and is working to establish a relationship with the state Commission.
- Education community (including principals, teachers, administrators, outreach workers, school nurses, superintendents, Department of Education staff, universities):
 - Educators are engaged through open houses and tours of school-based health centers. When legislators tour a school-based health center, the legislator is accompanied by the policy director as well as a school principal who can speak about the value of SBHCs to education.
 - The Network’s Board of Directors includes a staff person from the Oregon Department of Education and a high school vice-principal.
 - The Network has contracted with an education specialist since 2007 to further the school and SBHC partnership.
- Youth:
 - The network has established strong partnerships with SBHC youth councils across the state. Youth are primarily engaged in the Network through Awareness Day at the Capitol and the leadership development and training that takes place there. Over the 6 years of the Kellogg grant, youth play an increasingly vital role in both developing and delivering messages about the value of SBHCs both at the state and local level. Our youth are also our most diverse partners, both economically and culturally.
 - The Network staff have conducted messaging and leadership training with My Future, My Choice teen advocacy group at both local and statewide conferences.
 - We hold a youth focused track at our yearly conference (where youth are often the presenters) and seek their input in developing our policy agenda.
 - The Network policy director has brought a lead youth advocate to the capitol to discuss SBHCs and the need for health insurance expansion with legislators.
 - Most recently, advocates have approached the Network about forming a state-wide youth council.
- Communities of color:
 - The Network staff attended Urban League functions and an Urban League staffer presented at our Board meeting.
 - We participated in a Community Collaborative meeting focused on decreasing health disparities.
 - Staff attended a Latino Health Coalition conference.
 - Cultural competence training for the SBHCs has been facilitated by minorities.

Analysis, conclusions and recommendations

By improving our messages and engaging strategic partnerships in advancing our policy agenda, the Network has successfully grown and diversified state funding for SBHCs from \$2.5 million in state general fund dollars to \$7.005 million in a mixture of general fund and provider tax dollars.

Having bi-partisan support has been important to the success of SBHCs. Showing legislators that SBHCs fit the needs of their community (urban/rural/suburban) involves applying a multicultural lens when developing messages to those audiences. SBHCs are one of the few human service budget items that businesses are eager to support in Oregon. Educating the two largest business associations—Associate Oregon Industries and the Oregon Business Association has been vital to our success in developing business support.

In many ways, SBHCs have been fortunate to have support from the Governor for the last 8 years. But this governor is leaving office. We can no longer count on this level of support and, with a projected \$3.5 billion revenue shortfall for the next biennium and the 10 year outlook continuing to have shortfalls, it is highly likely that state funding will be reduced. However, because we have built a strong Network that can respond quickly to budget cut lists and that has strong bi-partisan support in the legislature, it is unlikely that SBHCs will experience complete elimination from the budget that happened a decade ago.

Outcome 3 (in process—interim outcome): The Network, SBHC systems, insurers and state policy makers have a better understanding of SBHC barriers to billing and reimbursement and have succeeded in improving billing and revenue systems and payment relationships.

Rationale

SBHCs in Oregon are part of our state’s health care safety net and must see children regardless of their family’s ability to pay for services. In 2008-2009 school year, 47 percent of clients of Oregon’s SBHCs reported no insurance at their first visit. When children are insured it is important that sites have the capacity and policies in place to be reimbursed for those services. Community and state funding for dollars are subject to cuts in a poor economy. Under the new Healthy Kids program, all children in Oregon have access to health insurance in Oregon. SBHCs should bill insurance and reduce their amount of uncompensated care.

Context

During the 1980’s and early 1990’s, few SBHCs billed for their services and sites had some difficulty establishing contracts with managed care organizations. In 1991, Oregon enacted Senate Bill 760 which created a “carve out”—a requirement that prepaid Medicaid managed care organizations (MCOs) contract and pay public health providers (including SBHCs) for immunizations, diagnosis and treatment of sexually transmitted diseases, and testing and treatment of communicable diseases. The law also allowed SBHCs to bill Medicaid directly on a fee-for-service basis for HIV counseling and family planning services.

Despite achieving mandated contracts for the services indicated in SB 760, in the mid 1990’s, many school-based health centers still did not receive reimbursement for services they provide that were not specifically covered by the legislation. Large SBHC systems, like that in Multnomah County, used SB

760 as the platform to begin conversations with managed care plans to agree to terms so they may establish common billing protocols, procedures and communications. Smaller systems had more difficulty than the larger systems in establishing systems to collect revenue and a number of sites struggled to achieve the capacity to adequately bill for services.

Although nearly every site bills for some services, there is huge disparity between SBHCs in their reimbursement revenue. As describe in Outcome 1 above, 43 percent of operating costs are covered through billing on average at an FQHC sponsored SBHC, compared to only 5 percent at non-FQHC sponsored sites. Because FQHC's administrative resources make it easier to generate bills, the Network and the state have encouraged FQHCs to sponsor SBHC systems. FQHCs make up 65 percent of the medical sponsors in our state. But even within FQHC systems, reimbursements can generate anywhere from 7 percent of their overall revenue to over 80 percent. Clearly, being sponsored by an FQHC does not ensure better billing practices.

Over the years, SBHC advocates have expressed to the Network and policy makers that they experienced various barriers that kept them from having robust billing systems in place to generate operating revenue. Those barriers included not being able to contract with some Medicaid Managed Care and Mental Health Organizations, not having the staff to adequately follow a bill through the reimbursement process and not having the training to adequately bill for reimbursable services.

At the beginning of the Kellogg grant we knew that we needed more information and data to inform our policy work in this area. The Network began to identify strategies that would help SBHC systems (both FQHC and non-FQHC sponsored sites) expand their revenue and improve their billing and systems. Whereas before the Kellogg grant the Network had only anecdotal information about barriers to insurance reimbursement, the grant gave us the funds to conduct in depth analysis of and to seek solutions to these barriers.

Strategies and important developments:

- **We developed the Network's understanding of the revenue cycle and identify policies that positively and negatively impact billing and reimbursement.**
 - **Meetings with insurers:** In September 2005, the Network convened seven of Oregon's largest private insurers. The State Program Office and Kellogg's program manager, Terri Wright presented and the Oregon Consensus Program facilitated discussion. The Oregon Consensus Program submitted a written summary to the Policy Leadership Team (the Network's policy committee) at a debriefing meeting in October. This outlined significant work toward next steps:
 - gathering more detailed information on the current status of private insurance billing and reimbursements for SBHCs;
 - strengthening the state Medicaid program's support for SBHCs;
 - clarifying the long-term vision for SBHCs in Oregon; and,
 - clarifying the role that private insurers can and should play to support SBHCs.
 - **2006 Funding Mix Study** In 2006, a funding mix study of community partners conducted by the Network's evaluator captured for the first time the differences and complexities of funding for school-based health centers. The funding mix report was a pivotal turn in clarifying how the Network might look at systemic issues of sustainability. The funding mix has been used by

other states and by NASBHC. One community partner used the study to focus her board on the funding needs of the organization. Information from the study has also been used in providing technical assistance to new start-up centers.

Prior to this study, the obvious solution to financial sustainability seemed to be for centers to bill for the services they provide. Yet most centers were billing and still not achieving sustainability. The “funding mix study revealed the complexity and challenges of a traditional revenue cycle applied in school-based health care.” The study led to the realization that the Network needed to learn more about the existing billing and reimbursement that was happening at sites and so set the objective to identify the positive and negative aspects of billing and reimbursement in a sample of school-based health centers.

- **2007: State cost study and Healthy Kids Plan reimbursement mandate** A key to developing our understanding of the insurance system and SBHCs was the release of the state report, *An overview of costs and revenues of Oregon’s School Based Health Centers*, published in 2007. This report gave us the first clear insight into the true cost of running an SBHC in Oregon and the sources of operating revenue. The report came out at the same time as the Healthy Kids Plan, which included a mandate that all safety net clinics be reimbursed for Medicaid services. This legislative interest came from policy maker’s experiences talking with local communities about their particular billing issues. A complicated series of events eventually led to the mandate being cut from the Healthy Kids Bill. The Network knew that more information was needed to understand whether a mandate would help centers achieve financial stability.
- **2008—Billing and Reimbursement Report and Survey on MCO relationships** For years, SBHC sites had reported difficulty in billing Medicaid and private insurance systems. The Network entered into a consulting relationship an experienced FQHC manager to research this issue and to make policy recommendations to the organization. Using the cost analysis study and interviews from the field, the Oregon School-Based Health Center Sustainability Report (which we call the Billing and Reimbursement Report) outlined major obstacles to reimbursements. In addition, during the summer of 2008, the Network surveyed SBHC systems about their relationship with Managed Care Organizations (MCOs), Division of Medical Assistance Programs (DMAP) and Mental Health Organizations (MHOs). Relative to Medicaid Managed Care, the Billing and Reimbursement Report and the survey revealed that the majority of SBHC systems were not being intentionally kept off of MCO provider panels. In fact, the majority of sites were already contracted and billing MCOs in their communities and/or DMAP. The report and survey indicate that a legislative mandate, which would have essentially required MCOs to contract with SBHCs, would not have impacted SBHC billing materially because these relationships already exist. The survey and study do indicate a need to improve operations within the billing system, a need for improved relationships and communication between SBHC staff and MCOs and improved technical assistance for staff.
- **Meetings with insurers:** In September 2008, the Network board and staff met with representatives from FamilyCare, CareOregon, OPCA, Multnomah County and Washington County to discuss ways to support operations of SBHCs to improve reimbursement. As a result, the Network and these organizations agreed on a set of ideas for improving billing systems at SBHCs. By establishing closer relationships with insurance payors, the Network was able to help SBHCs cut through some of the red tape they were experiencing at the local level and to help sites to establish conversations with MCOs. This directly resulted in several new contracts between MCOs and SBHC systems.

- **We developed insurance companies’ understanding of the value of SBHC**
 - **Building relationships with MCOs.** In addition to the above meetings with insurers and MCOs, the Network has made an effort to build better relationships between top level staff at MCOs and with our staff and administrative staff at SBHCs. Network staff are members of two organizations, the Reformers and the Community Site Development Team, which bring us face to face with other safety net clinics, MCO lobbyists and government affairs staff to discuss health care reform issues. These relationships allow us to be more responsive when the field has a contract problem with a Medicaid payor. We are often able to cut through the red tape at local level by going to the director or government affairs staff of the MCO. These payors understand that if they don’t pay for SBHC care, they are likely to be subject to a legislative mandate. They would prefer to make these payments happen without legislative interference.

As MCOs have learned more about SBHCs, they have begun to sponsor our annual conference. Five years ago, the Network had no MCO sponsorship. This year we have \$13,500 in conference support from MCO sponsors, and participation by MCOs in conference sessions.
- **We disseminated information on billing and reimbursement to state policy makers.** The Network distributed copies of the billing and reimbursement report and the MCO contracting survey to all state legislators and the governor. The Network sent memos to the members of the House and Senate Health Care Committees to discuss reimbursement issues. The Network held meetings with the Chairs of both Health Care Committees and the Governor’s health policy staff prior to the 2009 and during legislative session to discuss policy possibilities related to SBHC reimbursement.
- **We provided technical assistance on collecting insurance information, privacy laws and coding:** Our research led us to understand that while some SBHCs effectively bill for services, others do not. The Network worked with the state to provide technical assistance and training on coding to help improve these services.
 - The Network began to provide coding training at our annual conference beginning in 2009 and also brought Laura Brey from NASBHC to provide additional assistance.
 - The Network and state joined together to provide webinars on coding and privacy laws.
 - The Network created space on our website to permanently house technical assistance (webinars, reports, MCO contact and other information) on improving billing and reimbursements for SBHCs.
 - The Network brought together site billing administrators and mental health organizations to discuss barriers to adequate reimbursement for mental health services.
- **We worked on finding funding and support to develop a central billing system for sites that do not have the capacity to maximize their reimbursements.** Because of our research, the Network understands that operational issues within SBHC systems, such as few staff relative to billing complexities, working with a youth population and the complexity of enrolling with multiple providers are the major barriers to effective and efficient billing and reimbursement. To address concerns, the Network has:
 - Examined the work School-Community Health Alliance of Michigan by to see where comparable opportunities lay.
 - Submitted a grant request to Providence Partners in Policy Making to expand on these opportunities; the grantor did not support this or any other SBHC grants submitted.

- Have ongoing discussions (since late 2008) with OCHIN (an HIT organization focused on software and services to clientele like SBHCs) to examine potential to increase both Practice Management and Electronic Medical Records for SBHC.
- Increased staff knowledge of the system of billing for services.
- Have hosted conference calls regarding billing and reimbursement with SBHCs.
- Committed OCHIN to a webinar for sites re PM and EHR, as well as helping to create language for HRSA’s SBHCC grant in 2010.
- Held conference sessions with SBHC staff to outline strategies for maximizing EHR components and the timeline for rolling out such services at sites with little capacity.
- Anticipate engaging with SCHA-MI and other states in the Kresge Foundation to expand state associations’ ability to raise the capacity of SBHCs to bill and be reimbursed.

Analysis, conclusions and recommendations:

Perhaps the best part of this outcome was improved data and information about existing issues related to billing and reimbursement. For many years, the Network had heard of problems with SBHC contracts, but once we had the billing and information report and survey, we understood that those issues were not as big a determinant of successful billing. Rather, it is the resources at the local level to support a thriving billing system that drive revenue collection. The Network highly recommends conducting a site by site survey of billing systems and barriers. This can help inform all levels of policy work.

Outcome 4 (interim): State policy supports SBHC billing and reimbursement system

Background:

As described in the background for Outcome 3 above, since 1991, SBHCs have had a carve-out for a few services. SBHCs can also bill Medicaid directly on a fee-for-service basis for HIV counseling and family planning services. State policy also specifically “encourages” the establishment of payment relationships between SBHCs and MCOs. Most SBHCs in Oregon already bill for Medicaid services (only two sites do not bill). Some communities have historically found establishing these relationships difficult and can be frustrated by the time it takes to get on provider panels and establish contracts.

Because of their small staff size and the population they serve, building a robust billing and reimbursement system can be challenging for SBHCs. The Network has explored various policies to support SBHC reimbursements as well as alternative funding models to the traditional revenue cycle system to help sites achieve sustainability.

Strategies and important developments:

- **We worked on establishing a mandate that SBHCs be paid for services by Medicaid** As described in the background section above, SBHCs have a carve-out for a few services. SBHCs can also bill Medicaid directly on a fee-for-service basis for HIV counseling and family planning services. State policy also specifically “encourages” the establishment of payment relationships between SBHCs and MCOs. Many sites have found these relationships possible, but can be frustrated by the time it takes to get on provider panels and establish contracts. The Network has struggled with whether to try to establish a mandate that MCOs and other Medicaid providers pay for or contract with SBHCs.

- In 2007, the Network supported language in the Healthy Kids bill which would have required reimbursements to SBHCs by contractors of this public insurance plan. The Network worked with a large coalition of MCOs and advocates who supported the overall Healthy Kids plan. The MCOs threatened to pull their support if the mandate language stayed in the bill, but ensuring the Network that contract issues could be worked out at the community level. The Network felt that the overall success of the Healthy Kids bill was more important than the reimbursement language and so we agreed to have that language removed from the bill.
- In 2009, the language was again in the Healthy Kids plan. This time, the Network worked with members of the Safety Net Advisory Council and the Oregon Primary Care Association on legislation requiring that all Fully Capitated Health Plans (FCHPS—which are all Medicaid payors) contract with safety net clinics, including SBHCs. We negotiated with the insurance companies and successfully and unanimously passed a contract mandate out of the House and Senate health care committees with the support of all MCOs but one. Unfortunately, the language was stripped from the final version of the bill because a revised fiscal impact statement had it costing the state millions of dollars in “wrap” payments to FQHCs. We count this as a partial success, however, given that we had established that FCHPS were mostly willing to be subject to the mandate.

- **We sought state support for funding pilots of alternative funding models for SBHCs.** In 2009, the Oregon legislature took on major health care reform. The legislative vehicle for reform was HB 2009 and it included the creation of a subcommittee of the new Oregon Health Authority called the Payment Reform Council.

In an effort to address some of the payment issues for SBHCs, the Network tried to have HB 2009 include a provision that “the Payment Reform Council to investigate opportunities in both public and private sector programs to develop and implement new methodologies of reimbursing health care providers to reward comprehensive management of diseases, provision of prevention services, quality outcomes and the efficient use of resources. To assure access to vulnerable Oregonians, the Council will investigate and fund pilot projects on alternative reimbursement models for safety net clinics, including school-based health centers.”

We believed that alternative payments could include sharing of resources between payers for population based preventative care, capitated, non-risk based reimbursement, continued payment relationships based on retrospective reporting of utilization or outcomes. This strategy was met with opposition from the members of the health care committee, who were leery of paying for pilot projects. Ultimately, the strategy did not get beyond some initial conversations with legislators and staff.

- **We poised SBHCs as leaders in the health care reform movement.** For many years, the Network has argued that SBHCs are “unique” and need special consideration. In 2010, as Oregon’s major health care reform effort began to take shape, the Network decided that it was time to reframe our message of SBHCs as unique to one where we are leaders. A new staff person at the SBHC State Program Office put it this way, “the health care reform train has started to leave the station and we need to make sure we aren’t left behind.” We decided that our “unique” message meant that we were conveying that we weren’t part of the system. Instead, we are reframing our messages to show that SBHCs are leaders in creating a system that meets the three goals (called the Triple Aim) of Oregon’s health care reform efforts: a healthy population, extraordinary patient care for everyone, and reasonable costs shared equitably. As part of our strategy, the Network:
 - Recruits attendees and staff to attend public input events related to health care reform. The Network provides talking points to attendees emphasizing the importance of SBHCs.

- Attends weekly meetings of the Health Allies during the legislative session. This is a group of health care advocates working to pass reform.
- Attends regular meeting of the Reformers group, which develops legislation to require the state to report to lawmakers on the feasibility of implementing a reimbursement system for health care delivered through primary care homes. The legislation includes language about the need for SBHCs to get reimbursed for their services and works on a legislative concept that the definition of a health care home include "Cultural competence that is accepting and respectful of diversity and difference while engaged in a continuous process of self assessment and reflection on one's personal (and organizational) perceptions of the dynamics of culture."
- Nominates and successfully places a former SBHC practitioner and board member on the Pediatric Primary Care Home Committee of the Oregon Health Authority's health reform implementation board to guide the state on developing guidelines for primary care homes (and to include SBHCs in their definition).
- Continues to serve on the Safety Net Advisory Council to provide expert information on the needs of SBHCs to the state.
- Policy director sits on the Healthy Kids Outreach and Enrollment Advisory Committee to improve the communications and outreach of the state's new insurance plan.
- Serve on the Healthy Kids Steering Committee
- Meets with top level state policy staffers and committee staffers who are working on implementation of health care reform to point to all of the ways that SBHCs are out front in serving the needs of their populations and are hitting many of the goals in the "triple aim."

Recommendations:

We highly recommend keeping all parties informed about SBHC policy initiatives, even those who may take an opposing view. When we worked on mandating SBHC contracts in 2007 and 2009, we did not keep our partners informed until late in the process. Although it worked out well in the end, one policy person for a managed care organization told the Network that bringing them in earlier would have been a better strategy.

A new development for the Network is working within Oregon's new Health Care Reform movement. We only recently realized how important it is to position SBHCs as already achieving some of the results that health care reform wants to achieve. We recommend that SBHC advocates take the same step that we are taking: repositioning from SBHC care as being "unique" to being "leaders" in health care delivery.

State Policy Goal 2

More children have access to quality health care.

Background: SBHCs have grown significantly in recent years.

2005 School Year	2009 School Year
45 Centers in 17 Counties 2 planning grants awarded Oregon SBHCs served 17,702 clients in 56,633 visits	55 Centers in 20 counties 10 planning grants awarded (will add 2 counties) Oregon SBHCs served 24,995 clients in 72,080 visits

At the same time, Oregon transformed its public insurance program to make health insurance available at no cost, low cost or affordable cost to all uninsured children in Oregon and provided safety net clinics with grants to provide support for the care of undocumented children. Since the Healthy Kids insurance program was implemented in 2009, more than 54,000 of Oregon’s estimated 117,000 uninsured children have enrolled.

Between 2005 and 2010, the Network committed a significant amount of energy to support both the expansion of SBHCs and the adoption of the Healthy Kids plan. We see the success of these efforts as two of our major accomplishments. Insurance alone does not equal access--finding a provider who takes public insurance can be difficult in some areas of our state—but being insured does have a significant impact on children’s well being. By expanding SBHCs and insurance, Oregon has made an investment that ensures access to health care for thousands of children while increasing the revenue from insurance that SBHCs need to be sustainable.

Outcome 1: State planning grants support the establishment of SBHCs.

Since 2005, the Governor has supported and legislature has allocated funding for 34 planning grants to communities to develop SBHCs. In 2005, the state offered two planning grants. The Governor, state agency and legislators worked with the Network to develop a vision for expanding access to health insurance and school based health care and in 2007, 18 planning grants were awarded by the state. In 2009, despite massive cuts to the state budget, 14 SBHCs were awarded planning grants.

The process of determining which sites will receive planning grants begins with a Department of Human Services survey of health departments, school districts and others to gauge their interest in establishing new SBHCs. The Network provides input to SBHC State Program Office (SPO) to about the political climate for moving forward with asking for new dollars to expand the program. Ultimately, it is the Governor’s decision whether to recommend expansion to the legislature. Once the Governor asks for funding in his recommended budget, it is up to legislative leadership whether to provide that funding. It has therefore been crucial that the Network develop relationships with the SPO, the Governor and the legislature to support expansion of SBHCs. Since 2005, the majority in the legislature and Governorship have been Democrats, which has made finding support for expansion a bit easier.

From the beginning of this grant, the Network has worked to support the establishment of SBHCs in any community that wants one. We also believe that it is important that interested communities fully plan for and understand the realities of establishing and maintaining an SBHC and establishing strong business plans to ensure their sustainability.

Strategies:

- **We built support from and relationships with the Governor’s office:** As described in Goal 1 above, the Network established an early and ongoing relationship with the Governor and his staff to support SBHCs. In 2002, the Network and Children First for Oregon worked with the Governor’s transition team to help him understand the importance of providing healthcare in schools. Since the inception of this grant, building a successful relationship with the governor has included:
 - Meeting yearly with the Governor’s staff to go over the SBHC state funding package and regular staff communications with the governor’s staff as needed throughout the budget process.
 - Youth and advocates invite the Governor and his staff to meet with students at our annual SBHC Awareness Day
 - Working with the governor’s team when he wants to do a press event at an SBHC.
 - Helping the Governor’s staff find families willing to talk to the media about the need for health care.

- **We created a defined and close working relationship with the Department of Human Services SBHC staff.**

The Network has a unique and close relationship with our state program office. This relationship includes:

- Monthly meetings with SBHC Program Office staff and management.
 - Participation in state run SBHC coordinators meetings
 - Development of a “roles and responsibilities” matrix to help define the differences between the state program office and the Network for the field.
 - Working together to build the agency state policy package for SBHCs: In Oregon, state agencies submit budget requests to the Governor, who then uses those requests to build his recommended budget. In 2005-2006, Network staff worked closely with the state program office staff to develop a policy option package with included planning grants for SBHCs. The Network held regular meetings with the Governor’s staff and state agencies to develop our request.
 - Jointly holding training for SBHC staff.
 - Reviewing publications for each other for accuracy and information.
 - Working together to create a vision for SBHCs and to define the model of care.
 - The Network reviews applications for SBHC grants for the state.
 - The state certification requirements include a recommendation that sites become members of the Network.
 - The Network participates in regular planning grant technical assistance calls conducted by the state.
- **We developed both a grass-tops and grassroots advocacy campaign to build legislative understanding of and support for SBHCs.**

Grass-tops Advocacy: Network staff, board and advocates regularly meet with state legislators.

- Staff is being present in the capitol to answer questions and engage lawmakers and other health policy organizations about the importance of SBHCs and the need to grow the model. Staff communicate best messages about SBHC services and policies to state policy makers
- Staff distributes policy papers, data and information on a regular basis to lawmakers.

- Network holds SBHC Awareness Day in the capitol—this has been an annual Network event and is a major opportunity to engage state legislators in understanding our model. This is where the grassroots and grass-tops come together: youth and other advocates are trained on best messages, how to talk to legislators, and how to continue to build the SBHC movement in their local communities. Each year, we meet with about 1/3 of the state legislature in person. Youth use “elevator speeches” training to go office to office to talk to available staff about the SBHC model and to drop off information. We promote the event with the media and encourage schools to bring their student newspapers and to reach out to their community papers about the visits. We capture our experience in stories, photographs and in video and put that information in our story bank and on line.
- Staff, board, practitioners and youth testify about the need for SBHCs before health and education subcommittees.

Grassroots: Building a knowledgeable and effective advocacy base has been crucial to building state level support for all of our goals. Since 2005, the Network has developed its capacity to communicate its messages and its community of support for SBHCs statewide. The Network has built its grassroots support by helping our members and supporters to tell their stories and build the case for SBHCs:

- Applying a multicultural lens to our messaging.
 - Providing training to Network membership and other advocates on SBHC best messages
 - Redesigning our web and email communications to more effectively communicate our messages
 - Building an action alert system to allow us to immediately respond to pressing concerns.
 - Bringing supporters to the capitol every year and providing them with messaging tools and training to allow them to communicate with legislators.
 - Local communities (advisory councils, youth groups) write letters in support of SBHC and SBHC expansion.
 - Staff communicates to local SBHC leaders to get them to attend legislator’s town halls.
- **We more carefully involved youth in our advocacy which has also been a key part of building our advocacy base.**
 - Since 2005, then network has brought more than 500 youth to the capitol to build SBHC awareness. The youth are extremely effective at telling their stories. We worked on helping them to build their messages, not just for the meetings with their legislators but also to be able to tell their stories in 30 second “elevator speeches”—so that they can quickly get to the point of why SBHCs are important to them.
 - Asking youth to join our email lists.
 - Exploring communications options that appeal to youth and creating a Facebook account for the Network
 - Capturing the youth voice through oral and written stories and developing a story bank.
 - Involving the youth in the planning process for our SBHC Awareness Day
 - Planning meetings held during our 2008, 2009, 2010 conferences
 - Youth participate in our conference calls for planning our Awareness Days in 2008, 2009, 2010

- Youth lead a training session during our 2010 Awareness Day.
 - Staff regularly visits youth advisory councils to train and listen to youth.
- **We purposefully involved communities without SBHCs in conveying why they want to develop SBHCs**
 - Bringing communities without SBHCs to our statewide trainings
 - Involving youth from planning grant sites and communities that are interested in planning grants to the state capitol to make sure their legislators understood why they wanted SBHCs.
 - As a follow up to our Awareness Day, Woodburn High School students decided to advocate for opening an SBHC at their school. The Network has trained them on targeting their messages to various audiences and provided some guidance on how to begin planning for an SBHC.
- **We developed SBHC awareness among partner organizations, including organizations focused on communities of color.** We collaborate with a number of organizational partners (for details, see Growing Partnerships under goal 1 above).
- **We created an Awareness tool kit and SBHC Awareness Month.**
 - Obtain a gubernatorial proclamation for SBHC Awareness Month (held in February).
 - Creating an Awareness Tool kit and housing it on our web site. The tool kit includes ideas for marketing and building awareness of SBHCs to targeted audiences: Students, Schools, Parent, sponsors, media, businesses, community organizers, faith community, elected officials and others.
 - Promote tool kit in our e-newsletter and at coordinator’s meetings and youth advocacy council meetings.
 - Working with sites to hold open houses.
- **We engaged the media:**
 - The Network has written press releases, op-eds and letters to the editor about SBHCs.
 - The Network serves as a primary media contact when SBHC stories are written.
 - The Network has provided media training to SBHC advocates, including youth.

Results:

The expansion of the SBHC program has had multiple positive impacts between 2004 and 2009:

- 26 percent growth in the number of SBHCs
- 4 new counties have established SBHCs that didn’t have one before
- 32 percent growth in the number of visits with a total of 325,714 visits
- 41 percent growth in clients—with 104,676 clients served
- 36 percent growth in Hispanic clients served
- 38 percent increase in Medicaid coverage

In addition, 10 communities are on track to open new SBHCs by spring 2011. If they are all successful, there will be 65 SBHCs in 2011—up from 44 in 2005.

Outcome 2: All children in Oregon have access to health insurance.

As described above, a key health care reform policy change during the last 6 years in Oregon has been the implementation of the Healthy Kids plan, which was enacted by the 2009 legislature. This plan provides access to no cost, low cost or affordable health insurance to all uninsured, Oregon children either documented or citizen. The Network played an important role in the legislative success and implementation of this plan.

Passage of the Healthy Kids Plan was a major focus of our advocacy efforts for three reasons.

1. Healthy Kids was the vehicle for the increase in state funding for SBHCs and also included a second grant program to support all safety net clinics, including SBHCs, serving undocumented populations ineligible for the Medicaid program.
2. Forty-seven percent of SBHC clients report no insurance, making it impossible for sites to be reimbursed for their care. The goal of Healthy Kids is that 95 percent of all uninsured children will enroll in the new health insurance plan. Indeed, as of September 2010, more than 54,000 of uninsured Oregonian children have enrolled. All SBHCs and safety net clinics will reap benefits from having fewer uninsured clients.
3. As described above, during negotiations on the Healthy Kids bill, the Network worked, unsuccessfully, to include language mandating that safety net clinics be reimbursed for services to Medicaid clients. (See reimbursement section under Goal 1).

The Healthy Kids plan took on three different forms. First, the Governor tried to pass it in the 2007 legislature with funding through a tobacco tax. The legislature then referred that measure to voters as a ballot measure, which was defeated with major opposition funding coming from the tobacco lobby.

Finally, the Governor reintroduced the bill in 2009 with funding coming from a tax on hospitals and insurers (a provider tax). That measure passed after considerable negotiations and debate with the providers. As a result, every child who is a US citizen in Oregon has guaranteed access to affordable or no cost health insurance.

Strategies:

The Network worked with many groups to help pass the Healthy Kids Plan and continues to support the implementation of the program. The Network:

- Helped the Governor's staff kick off his Healthy Kids campaign in 2006 at an SBHC.
- Provide ongoing communications to the field about developments in the Healthy Kids campaign and sought grassroots involvement in advocacy for the program.
- Played an active role in statewide Healthy Kids advocacy coalition and Health Allies throughout the 2007 and 2009 legislative sessions
- Work in coalition with other organizations on the Healthy Kids Ballot Measure campaign, including recruiting advocates for canvassing, phone banking and other campaign activities.
- Met with members of the legislature to express support for the bill and emphasize the positive impact it would have on SBHCs.
- Worked with MCOs to compromise language related to reimbursements for SBHCs (see Goal 1).
- Brought youth to the bill signing ceremony

- Serve on the statewide advisory committee on outreach and enrollment strategies for the Healthy Kids insurance plan.
- Has received a statewide grant to conduct outreach and enrollment through SBHC in several counties and is developing enrollment strategy tools for SBHCs.

Result:

Since implementation of the Healthy Kids bill, 54,000 uninsured children have gained access to health insurance. SBHCs are beginning to report a reduction in uninsured youth. (Multnomah County has seen a 10 percent increase in insured children). The Network continues to work with sites to build their billing capacity.

State Policy Goal 3

The state will ensure high quality care in school-based health centers.

Background:

Until 2000, there was no baseline standard to define a school-based health center. State funding was determined through application. Oregon's certification process was implemented on July 1, 2000. Part of the purpose of the state certification process was to establish demonstrate and ensure that SBHCs provide quality care. The standards are a baseline that all sites that receive funding must meet. These standards allow the Network and sites to show insurance companies and policy makers that they are more than “a nurse handing out band aids” at school. The certification standards are routinely evaluated for needed changes, and the Network plays a role in that process.

Once the state established certification standards, the Network and state saw a need to gather data to demonstrate the impact of the SBHCs on the health care of the children they serve. The state developed a new requirement that sites begin to implement Key Performance Measures which now help the state to gather information about the quality of care provided.

Outcome 1: The Network participates in the revision process of SBHC state certification.

Oregon's SBHC certification standards are the drivers in the quality of care in SBHCs in our state. The standards are voluntary process (rather than licensing), but all SBHCs receiving state funds are required to be certified. The SBHC certification standards were developed in partnership with the Network, Conference of Local Health Officials, and the SBHC State Program Office.

A major revision of state certification took place in 2009 and a Network board member took an active role in the review process and served as the “voice of the provider” at the table. As a result of this effort, SBHCs not only have updated certification standards, but the Network was able to get new language into the standards which created an official role in the review process and encouraged membership in the Network:

“Oregon School–Based Health Care Network (OSBHCN) will be consulted for recommendations and will review changes to the certification standards document. All certified SBHCs are encouraged to maintain active membership in the OSBHCN”.

Strategies:

- Regularly meet with the state program office to review certification
- Ensuring that all SBHC communities are represented, thereby representing the cultural diversity (geographic, ethnic and economic) of the SBHC field.
- Participate with CLHO and SPO in formal adoption of the standards
- Disseminate information to the field about new certification standards
- Provide feedback to the state when sites have difficulty meeting standards

Results:

Oregon’s certification standards allow the Network to demonstrate to policy makers that there is a baseline of services, hours, and staffing at all 55 state funded SBHC programs. It is not always easy for sties to meet the standards—which are voluntary, but a prerequisite for state funding. The Network can

use the review process to make the case for changes in the standards which can help communities that have difficulty adapting to the model. The standards have greatly aided the Network's advocacy allowing us to define the model consistently.

Outcome 2: Legislature appropriates funding for implementation of Key Performance Measures

SBHCs are committed to high-quality, age appropriate, accessible health care for school-age children. To ensure this goal, the state began implementing Key Performance Measures (KPMs) for state certified SBHCs in 2006. Sites must demonstrate yearly progress and meet statewide targeted goals, otherwise funding may be reduced. Under KPMs, sites must conduct a risk assessment, a comprehensive physical exam and a BMI for any student with at least 3 visits to the SBHC. Sites must conduct chart audits and report their data to the state.

Implementation of the KPMs was met with some resistance and confusion from sites, for though most SBHCs were meeting the goals of KPMs, some found the reporting burdensome. The Network was able to site implementation of KPMs as a reason why the legislature should increase its support for the state grant. The 2007 legislature allocated an additional \$648,000 to state certified SBHCs to support the implementation of these new prevention requirements.

Strategies:

- Meet regularly with SPO to discuss KPMs
- Add funding for KPMs to our legislative agenda
- Meet with legislators, explain importance of KPMs and need for dollars to support implementation

Results:

- \$648,000 in new dollars to support certified SBHCs in adopting KPMs
- 2008 full implementation and compliance.
- State continues to work with sites in helping them to report their KPMs.

SBHCs and Federal Policy

Federal Policy Goals:

- Pass Federal Authorization of a School Based Health Center Program
 - Fund appropriations for SBHCs
 - Mandate reimbursement/payment for SBHCs through SCHIP (letter to Baccus)
 - Include SBHCs in relevant education policy
-

The Network is proud to have played a substantial role in developing the SBHC movement at the federal level. The Network has ensured our congress peoples' support of our goals through consistent messaging and communications from their constituencies. The Network takes NASBHC's lead on all federal policy goals, and works to make certain that our legislators understand the impact of those policies on SBHCs.

Outcomes:

Authorization and appropriations: In 2010, congress passed federal health care reform which included both the authorization of a school-based health care program and \$200 million in emergency appropriations for the equipment and construction of SBHCs. The Oregon delegation consistently provided legislative leadership on SBHC Authorization.

In 2007-2008, Representative Darlene Hooley (D) and Senator Gordon Smith (R) were two chief sponsors of the School-Based Health Clinic Establishment Act, which was the precursor to federal Authorization that passed in the 2010 health care reform bill. Four out of five of our congressional representatives co-sponsored the House version of the bill. The fifth, a Republican, told us that he supported SBHCs, but didn't want to be "out front" on the issue when he was no longer in the majority party.

In the Senate, Gordon Smith was one of the only Republicans to support the School-Based Health Clinic Act of 2007. Senator Wyden did not co-sponsor the bill because he had his own SBHC bill, the Healthy Americans Act, which included both the reimbursement of SBHC providers and grants to SBHCs. Although the Healthy American's Act did not become the vehicle for federal health care reform, many Republican senators supported the legislation (including Senator Smith) and are now on record for supporting a bill that includes SBHC funding and reimbursement.

Ultimately, federal authorization was achieved as part of health care reform, but without funding for operations. Senators Wyden and our new senator, Jeff Merkley (who beat Smith in his reelection bid in 2008) were two of seven senators to sign a Dear Colleague letter to the chairs of the Senate appropriations committee to request that SBHC receive operational dollars as part of the appropriations bill. All five our House members told us that they supported SBHC operations funding.

Reimbursements: Oregon's Senator Ron Wyden and Congressmen Wu and Blumenauer were co-sponsors of the Healthy Schools Act which would mandate reimbursement for SBHCs who provide covered services under SCHIP and Medicaid, to patients included in the programs. This bill has not yet made it out of committee.

In February, 2009, Federal SCHIP reauthorization passed and included the first explicit recognition of SBHCs as a potential provider of CHIP services. The provision clarifies that a state may “...provide child health assistance for covered items and services that are furnished through school-based health centers.”

The provision also establishes a NASBHC-crafted definition of “school-based health center” for purposes of the SCHIP program. As a result, SBHCs can seek provider status in their states’ CHIP programs, and to argue for reimbursement by CHIP managed care plans. In Oregon, where the CHIP program is part of the Medicaid program, it should be helpful in getting Medicaid provider status as well. The language is a first step toward establishment of federal laws and regulations to ensure that SBHCs are reimbursed by government programs.

Education Policy: Our goal around education policy is that SBHCs are recognized as partners in ensuring student achievement. NASBHC led this effort and we supported their work by talking about the connection between student health and academic achievement whenever we met with our congressional delegation. The Network provided feedback to NASBHC on the Innovation Fund guidance that was issued by the Department of Education in relation to the American Recovery and Investment Act.

Our goal was to ensure that the guidance included SBHC services in the community school movement. In 2010, the Diploma Act was introduced to incentivize partnerships between schools, parents, business leaders, higher education institutions, and community- based organizations in order to ensure children’s success. We see the DIPLOMA act as a building block for the inclusion of SBHCs in Elementary and Secondary Education Act (ESEA) Reauthorization. At this point, we are supporting NASBHC by planning to respond to any calls for action on the DIPLOMA act and by continuing to reiterate the connections between health and education with our communications and policy work.

Because there is so much overlap in our advocacy for each of these goals, we have combined our list of federal strategies for each of these goals.

Strategies:

- **We regularly engage and educate Oregon’s federal legislators and their staff about SBHCs.**
 - **Organizing Tours and Open Houses:** Network staff brought local partners together with congress people and their staff to tour SBHCs. During the grant, the Network has organized SBHC tours with all seven congress people and/or their health care staff at local SBHCs. Tours usually included youth, providers and school administrators.
 - **Meetings:** Network staff and field have held regular meetings in person in the district offices and Washington DC offices of all seven congress people. Building strong relationships with Oregon’s legislative staff on the Hill. Between 2007 and 2010, the Network brought more than 40 Oregon Network members to Washington DC for NASBHC Advocacy Day. As follow up, many legislative staff requested tours of SBHC sites.
 - **Grassroots engagement:** the Network activated its Action Alert system when asking legislators to co-sponsor legislation. NASBHC reported that Oregon had the most tracked calls to legislators from the field. Outreach included: action alerts, information emails, presentations at Human Services Coalition and other healthcare advocate meetings to keep people informed on the Network’s position.
 - **Positioning our Congress people to become SBHC Movement Leadership:** We worked closely with Senator Smith and Representative Hooley when they were the lead sponsors of federal SBHC

legislation. We took them on tours of sites and regularly responded to questions from their staff. When they both left office in 2009, the Network actively engaged their replacements as possible new leaders in the movement. Senator Jeff Merkley and Representative Kurt Schrader had both been SBHC supporters when they were in the state legislature (Senator Merkley had been Oregon's Speaker of the House and had spoken at two of our SBHC Awareness Day rallies). Rep. Schrader had a long relationship with SBHCs as a state legislator and participated in the original Kellogg site visit in spring of 2004, supporting Oregon's application. We met with Merkley's congressional office several times and got NASBHC's permission to have him be a speaker at the NASBHC Rally in 2010. Senator Wyden continues to be a leader for SBHCs and Congressman Wu, as member of the Education Committee has used SBHC stories sent to him by the Network in his District communications. The Oregon congressional delegation is unanimously supportive of SBHCs, have all visited SBHCs in their districts and can very often be counted on to co-sponsor or engage their colleagues in support of SBHC legislation.

- **Staff to staff engagement:**

- The Network worked directly with Senator Smith's staff on language related to SBHC authorization bill. We were often called upon to answer questions about SBHCs to inform the writing on the bill.
- The Network worked with Senator Wyden's staff on his own health care reform bill which included SBHC funding. The Network pointed out a flaw in the proposed legislation which would have conflicted with Oregon's privacy laws.
- Conference calls and meetings with congressional staff to brief on impact of SCHIP and a CMS rule change which could have affected SBHCs. Staff got information from SBHC systems on the impact of CMS rules and shared that information with federal legislators in conference calls.

- **Secure co-sponsors for SBHC related bills:**

- In 2008, Senator Smith and Rep. Darlene Hooley were two lead sponsors of federal legislation authorizing SBHCs. The Network requested the field to contact legislators to support SCHIP and Reauthorization bills and staff made contact with all federal legislators' offices. Out of the 10 co-sponsors of SCHIP reimbursement amendment, 2—Reps Wu and Blumenauer--were from Oregon and 4 out of 5 Oregon delegates co-sponsored HR4230 (Authorization bill)
- Our congress people consistently signed on to the authorization language. Senators Wyden and Merkley were two of seven senators to sign on to a letter to the Senate Appropriations Committee asking them to fund SBHC operations.
- Sen. Smith co-sponsored Senator Wyden's SBHC bill at the request of the Network

- **Media outreach:**

- Coordinated SCHIP press conference for Senator Smith at a SBHC so the Senator could press President to sign SCHIP; Had 40+ advocacy people there as well as press.
- Co-wrote Senator Smith's press release on SBHC Authorization bill.
- Found provider and community quotes for press releases.

- **Engaging Partners:**

- The Network signed a letter with 39 other state organizations as part of our advocacy work against onerous CMS rules. We also signed a national letter led by the National Alliance on Children and Families to oppose this legislation. In addition, we participated in conference calls to federal legislators to explain the impact on sites.
- The Network secured Children First for Oregon's signature on a federal letter related to Authorization.

- The Network engages health and educational organizations in our advocacy work by including members of the Healthy Kids Learn Better Coalition and the Human Services Coalition in our federal action alerts.
- **Actively participate in NASBHC’s federal policy work**
 - The Network coordinates NASBHC conference attendees from Oregon when they visit Capitol Hill.
 - A school nurse who works in an SBHC on the southern coast sits on NASBHCs Government Affairs committee and attends the NASBHC conference. This is a focused opportunity to broaden the engagement of potential leaders for the field in Oregon.
 - The Network ED has taken a more functional role in federal policy, specifically meeting with state leaders, and the Government Affairs Committee at the NASBHC convention to identify work for the upcoming session.
 - The ED and policy director are joining the nearly weekly Government Affairs conference calls and monitor their list serve to ensure that all federal action requests from NASBHC are relayed to the field and responded to by board and staff.

Results:

The passage of federal health care reform and emergency appropriations are big first step for the national SBHC movement. The Network can now use the passage of federal authorization as evidence that Oregon’s SBHCs are part of a national movement and that they are part of the solution for implementing the goals of health care reform. The emergency appropriations will be helpful in developing new sites and allowing sites to update or purchase equipment, but fall short of the original intent—to help sites with operational costs during the recession. Still, the funding will help sites buy licenses for electronic medical records which will help them comply with some of the technology mandates of health care reform.

SBHCs still have work to do on finding solutions for reimbursement issues. We can work at the federal level to ensure that SBHCs both have the capacity to generate bills and to get on to insurers panels.

Bringing federal legislators to our SBHCs, showing them the connections between health and educational outcomes and sharing the stories of the impact of SBHCs on the lives of the children they serve has been instrumental in building unanimous support for the SBHC model with our federal delegation.

SBHCs and Local Policy

Local Policy Goal:

Local SBHC communities, planning sites and other partners, including youth, are strong advocates for SBHCs and are building the SBHC movement.

Our local level policy plan has changed substantially during the six years of this grant. Originally, the grant included five community partners—Eugene’s 4J SBHCs, Clackamas County, Kids Health Connection in Medford, Lincoln County, and St. Helen’s in Columbia County. The Network officially ended its formalized community partnership program by the end of year 4 and so we have no changes to our original year 4 community partnership reports and have included them below. However, we continue to work with local communities across the state in developing their policy work.

SBHC Community Advocacy is Culturally Competent

One of the strengths of the SBHC model in Oregon is that it is community driven. Strong community planning and engagement has been crucial to SBHC success, both in developing and sustaining sites. Indeed, for every state General Fund dollar supporting an SBHC, 3-4 additional dollars are leveraged through local public-private partnerships. Sustaining that level of support requires consistent, powerful community engagement in support of the model. To be successful, that engagement must be culturally competent—both in reflecting the “faces” and adapting to the values of the community members.

Oregon’s multiculturalism reflected in its economic and geographic diversity, and in its growing non-White population. Oregon has great economic disparity—it is home to some big-name corporations, yet is also one of the hungriest states. In 2009-2010 school year, there were over 19,000 homeless children who attended public schools. According to the US Census, in 2009, 79.6 percent of the population is White, non-Hispanic, 11.2 percent Hispanic or Latino, 2 percent black, 1.6 percent Native American and 3.7 percent Asian).

Oregon’s Hispanic population is growing quickly, and many of the communities with SBHCs have higher than the state average Hispanic population, particularly in the public school system. We note that many of the youth groups involved in teen advocacy for SBHCs have large Hispanic populations (Woodburn and Forest Grove, especially). The Network has hired a staff person who is fluent in Spanish to do outreach at SBHCs to involve the population in the new Healthy Kids insurance program.

Oregonians often speak of an “urban/rural” divide. Outside its urban centers, Oregon is a very conservative state. To grow SBHCs in rural and frontier communities, planning sites must be clear about the value of the services to the community, and tailor services and communications to reflect those values. SBHCs have long been the target of a few vocal conservative groups who oppose reproductive health services, referrals for family planning and see SBHCs as interfering with parental rights.

Key to SBHC’s growth in Oregon has been the work of both the Network and the State Program Office (SPO) in helping sites develop key messages that are tailored to the community mores, are consistent with the best SBHC model of care, and demonstrate the positive value of the services on the health and

educational outcomes of the youth they serve. The Network has worked with the state program office to help guide new sites through the community engagement process, and communities are doing a better job than in the past in building plans that anticipate possible opposition and crafting messages and strategies that can help dispel this opposition. For example, in 2005, an SBHC planning community was unsuccessful because a church community came out strongly in opposition at community meetings. In 2007 and 2009, the state hosted, and the Network participated in, monthly planning calls with sites and in webinars that included training on how to engage reduce the impact of opposition and to engage supporters to help refocus the conversation to better outcomes for kids.

Another major difference we have seen between urban and rural areas is the general acceptance of public programs. In Falls City, which is one of the poorest cities in our state, one of our youth advocates worked on a health needs assessment of her city to determine the need to build an SBHC there. She tried to assess how many of her neighbors were on the Oregon Health Plan. Very few wanted to admit they received public assistance, though state data showed that a large percentage did. Working with rural communities requires sensitivity to both the community's values and the real need for services.

The Network has found that working with the faith community, particularly in rural Oregon has been key to helping overcome opposition to SBHCs. The Network has hosted trainings on working with the faith community. Building our youth voice has also helped to personalize the need for services. As a result of these efforts, sites are more able to respond to opposition and be ready to counter it with best messages and community support that reframe the conversation.

The growing role and importance of youth in local policy work:

Youth have played an important role in developing new centers and improving services at existing sites. They can be involved in everything from testifying about the critical services to school boards to helping choose the colors on the waiting room walls. In Multnomah County, members of the Multnomah Youth Commission conducted focus groups and sent “secret shoppers” to sites so that they could make recommendations to improve services to youth. In Eugene, students fundraised \$60,000 to support their SBHCs. In Forest Grove, students were involved in all phases of the development of the new center.

The Network has helped to foster these youth connections—both through our communications and leadership trainings and by bringing youth together at our annual conference and SBHC Awareness events to learn from each other's experiences. Youth engagement has been purposeful and has evolved during our Kellogg funding. In the beginning, we brought youth to our SBHC Awareness Day, taught them what to say and then had them meet with legislators.

Today, we try to engage youth early on in the planning process—from deciding what dates are most “youth friendly” to having them take over parts of the training at the events. A key piece of our Awareness Day is developing an action plan with youth—brainstorming and talking about work that they want to accomplish in their community. SBHC youth advocates have developed an expertise that they share with their “colleagues” —other youth— across the state and the nation.

In 2008, students from Eugene 4J attended the NASBHC conference and led a session. Multnomah Youth Commission members now routinely participate as presenters at our annual conference. Forest Grove student's were integral in the development of their health center, and even won the Governor's Advocacy Award for their achievements. The Kellogg Foundation featured them in their publication: *Diverse voices*,

one vision build new school-based health center in Forest Grove, Oregon. One local television station captured the story and one child is quoted, “I’ve learned how to start from a small seed to grow to a big plant. I’ve learned multiple things, working with groups and committees, things like that” (to view the entire interview, visit <http://www.osbhcn.org/what+we+do/action> and scroll down to “Every Day Heroes.”

Awareness Day could be considered a “contagion” for local advocacy. Youth and adults get excited and feel empowered when they talk to their state legislators. It makes them feel like they can do more in their community. In 2010, a group of students from Woodburn, a rural, low income community with a large Hispanic and migrant population attended SBHC Day. Woodburn does not have an SBHC, but students heard about the program through a Department of Human Services AmeriCorps worker who was working with them. Some of the students who attended SBHC Day were so excited about the model that they became determined to bring an SBHC to their community. They formed the Woodburn Health Advocates Movement (WHAM). From the local newspaper:

WHAM started after the Oregon School-Based Health Care Network’s (OSBHCN) kick-off at the Capitol Building in February. While most schools were there to thank legislators for providing them with a school-based health center, Woodburn students were there to ask for one. While there, they were given support from State Rep. Betty Komp and Sen. Peter Courtney.

“That gave us adrenaline and inspiration,” said Montes. “They said keep going with this and we will fully support you.”

<http://www.woodburnindependent.com/news/2010/July/21/Education/woodburn.students.participate.in.national.health.study/news.aspx>

The Network staff has continued to communicate with their AmeriCorps worker to help them plan community and policy engagement activities. The WHAM students were awarded the first NASBHC “You Name It” pilot project to investigate how health information is presented for youth in the community.

Local Policy Strategies (additional strategies from community partners follow this section):

- Provide training and materials on advocacy and communications.
 - Local training examples included:
 - Raising awareness through earned media
 - Talking to the media
 - Social Marketing
 - SBHC Messaging
 - Building relationships with legislators
 - Sharing your story
 - Working with the faith community
 - Youth engagement
 - Holding an Awareness Day event
 - How to host a tour
 - (MORE)
 - Responding to opposition
 - How to engage your local and state officials

- Tool kits and technical support provided:
 - The Network is providing technical support to some communities in establishing billing contracts and in overcoming billing issues.
 - The Network has reviewed and helped edit press releases for Woodburn and St. Helens communities
 - Network staff travels to sites to help them develop their messaging and prepare for Awareness Day.
 - Awareness Tool Kit
 - CORE resources: this online tool kit provides communities, providers and youth with hundreds of resources that can help them build the case for SBHCs.
- Bring partners together to discuss pressing community needs and share solutions: examples include:
 - Bringing community partners to our Visions training to develop our multicultural lens.
 - The Network brought together county mental health billing specialists from Multnomah, Washington and Clackamas counties to discuss problems with mental health billing and to explore possible solutions
 - The Network posted contact information on our web site of people within our largest managed care organizations who can help local communities to overcome barriers they may encounter with contracts.
 - The Network hosted a conference call for sites to share efficiencies they have built into their operations.
- Advocacy for local policy:
 - The Network helps generate turn out for local public meetings and support for local causes. For example, in 2006, the Network worked with the Oregon Nurses Association to bring advocates to public hearings in opposition to a proposal to close five SBHCs. Students, teachers, principals and businesses wrote letters in support of the SBHCs and testified in front of the budget hearing. No SBHCs were closed.
 - The Network attended a Clackamas County meeting about SBHCs and discussed why billing was such an important aspect of sustainability. The county had nearly closed its SBHC, now has two full time SBHCs open.

Local Community Partnership reports from Year 4 Report:

St. Helens community partner

Demographics

St Helens is the largest city in Columbia County and is the county seat. Its population is majority white, about 98%, with a growing Hispanic population. Unemployment and jobs loss is high, and with that is a large number of uninsured. Almost 36% of the county's kids are uninsured.

Unmet Medical Needs

Access to health care services is extremely limited. There are only 10 medical providers in the county. The Sacagawea Health Center's medical sponsor, Legacy Health System, is facing chronic staffing shortages. The local Public Health agency does not provide primary care. Of those that do have insurance, many have plans with Kaiser, however there is no Kaiser provider in the county (and Kaiser does not contract with SBHCs in Oregon). Access to dental care providers is also limited, and a St. Helens school-nurse arranges for a dental van to provide pro-bono services to its uninsured youth.

Update: Columbia county now hosts two certified SBHCs.

Political Climate/Community Support

School-based health care is well supported politically by local representatives and has a champion in state Sen. Johnson. The school district in St. Helens is very concerned with finances, particularly since the recent opening of a charter school is directing students (and therefore money) away from the schools.

Policy Target

The SHC wants to conduct outreach to and engage the school district and other educators in the work of the center, and to support of Medicaid Administrative Claiming (MAC). Interwoven in this work is building awareness about the importance of healthcare access for the wellbeing of the community.

This policy target was selected because the school-based health center realized it needed to better engage the school district, a source of both in-kind and tangible resources. This was a key to their sustainability. In addition, these educators can be influential with colleagues around the state and help make the case for school-based health care.

Progress and Accomplishments

The center is now more sustainable and its success can be used to leverage talks with legislators and colleagues across the state. Out of this process the center also identified new champions, including the chair of school board.

Despite economic constraints, the center was successful in securing 60% of its budget from the school district to cover costs of space and utilities; 8% of its budget in cash to fund a half-time licensed clinical social worker for the center to provide mental health services; and the additional space the center needed to house the social worker. In addition, the school designated its Medicaid Administrative Claiming funding to the center.

Strategic Approaches

Community Engagement

St Helens successfully engaged the business community, the school district, the teacher's union, Legacy Health System, the Commission on Children and Families, public health officials, parents through the center's advisory board and local artists, who donated art to the center's fundraiser. Youth have also been engaged in support of the policy work, attending the Network's Education Day at the Capitol, and performing at the center's fundraiser.

The center held focus groups with youth and community members about the value of their services. These generated information that was used in grant applications and when talking to school boards. In addition, older youth have also been supporting younger children in the community through a fitness program.

Leaders within these groups include one youth member who sold CDs of his piano music at the fundraiser and donated all proceeds to the center, the center's charismatic school nurse and a father who accompanied his two daughters to Education Day at the Capitol and voiced his support of school-based health care.

Missing in this list of engaged audiences is the faith community.

Communication

Sacagawea focused its communication with the school district on the value that centers bring to schools. The center already had the support of educators, but needed to bring the “number crunchers” on board. It had to make the case for school-based health care to the school district through data. For mental health services, for example they were able to demonstrate that behavioral citations of students receiving therapy decreased by 66%.

Sacagawea credited the workshop hosted by Dr. Richardson of the W.K. Kellogg Foundation Resource Team at the 2006 NASBHC conference as sparking some of their thinking around the policy target. They applied information prepared by Dr. Richardson to develop customized talking points relevant to the education community and attended a session held by the Oregon Network and Dr. Richardson. They were also able to network with school-board members from around the county during regional trainings, which proved helpful in the planning process. They used messages shared by the Oregon Network in a communication and messaging training for community partners and others in the field. In addition, the center also relied on background information and online resources provided by NASBHC on subjects including advocacy (“how to contact a legislator”) and Medicaid.

It engaged parents to tell their stories and a well-known school nurse to carry its message. This individual has become known as “the face of school-based health care” in the community. Barriers to the work included a lack of hard data that points to what school-based health centers are helping schools achieve. The biggest need for information is to be able to make a connection for health services that can demonstrate increased ‘seat time’ and a correlation to increased educational outcomes for students (similar to what they were able to do for mental health services and the decrease in behavioral citations).

Communication strategies used by the center included limited media outreach. The center drafted a press release when the center secured a \$10,000 grant. The grant was received at the same time as their fundraiser that included the donation of the sales of the CD produced by one of the youth served by the center. The story was picked up by Margie Boulé, a columnist with the Oregonian. The story angle was about the young man that had chosen to donate \$600 in CD sales to the center rather than spend the money on I-Tunes.

OSBHCN connected the Oregonian to the Health Center so the state paper could interview local families for a story on how working Oregonians face enormous expense and difficulty accessing health care. The associate editor writing the yearlong series sought compelling stories to help convince the Legislature to better fund and expand health care services. Communications tools include a creating a website, brochure and letterhead using “best messages” from the communications training by the Network.

Lesson Learned

A key lesson learned of this initiative was the importance getting hard data as well as compelling stories. Figuring out an audience’s self-interest and targeting it was also an effective strategy that St Helens used. For teachers, this was classroom time and for legislators it was the support of the business community.

Impact

The center’s work with the education community has modeled the way to make the connections between education and health; however, it has found it difficult to deeply engage teachers because they are so busy. Impacts of the center’s policy work include sustained political will, strengthened alliances as a

result of focus groups, relationships with members of the health and education community, diversified resources, and improved communication skills.

Evaluation

Evaluation of this work conducted by the center included looking at why kids with insurance were using school-based centers. They discovered that it was a matter of access, since travel time and a difficulty in getting a timely appointment were barriers. The center also looked at why some youth were not using the center. This was predominantly because they had insurance and didn't need to use the center.

Former Lincoln County community partner

Demographics

Lincoln County has a high per capita income due to millionaires and second homeowners in the area that skews the data that includes pockets of poverty and medically underserved communities. A logging and fishing community, Lincoln County has suffered huge losses over the past 15 years with a decrease in the number of sawmills from 60 to just 1. The County has a high tourism industry that brings with it service jobs and no insurance. The largest employers in the County are Georgia Pacific, the school district, the Coast Guard and the hotel industry.

Lincoln County is a predominantly white population (96%). There are a high number of mostly Hispanic immigrants that are employed in the tourism industry in low-income jobs with no or inadequate benefits. While many are established in the community, there are also many recent arrivals. The Siletz tribe is present in the County and has a tribal clinic. Of the total 5500 kids in the school system, 400 are identified as homeless.

Unmet Medical Needs

There are provider shortages in some areas of the county. There is a high Medicaid eligibility rate but few Medicaid providers in the area. The Coast Guard provides TriCare but few providers take that insurance. There is only one Medicaid dentist who is often closed to new patients. The teen pregnancy rate in the County is on an increase. There is a methamphetamine problem in the County.

Specific medical needs seen by the school-based health centers include parenting teen programs, chronic medical conditions, mental health and oral health. School-based health centers are operated by the Lincoln County Health and Human Services. The centers often provide health services for those that can't be served by the tribal clinic but is not able to bill for them.

Policy Target

The former Lincoln County community partner has focused policy efforts for the past three years on diversifying funding streams. Specifically, they have looking at missed opportunities in billing and reimbursement in an effort to stabilize school-based health centers by diversifying revenue streams. A major focus has been looking at the options for billing services provided by registered nurses, including risk assessments and casework.

This policy was selected out of a concern for sustainability. The billing and coding session offered at a NASBHC convention in Rhode Island a few years back was the impetus for this work. By increasing revenues from billing, the center hoped to add more staff that could in turn increase the provision of services as well as to create a model that could be replicated by other centers ("model the way").

Additionally, Lincoln County's work focused on positive youth engagement. By the end of the second year of the grant, they had robust youth engagement, which has continued throughout all last four years. The youth participated in county-level policy development focused on adolescent health issues. They have also participated in all the youth leadership trainings and SBHC Education Days at the Capitol.

Progress and Accomplishments

As an FQHC, Lincoln County benefits from a higher reimbursement rate. It is also set up for billing TriCare. Lincoln County provided coding training to its staff through the State Program Office. It streamlined billing sheets and forms and engaged the County in doing its data entry for billing.

As a result, regular billings have increased from zero in 2003 to \$200,000 in 2007. It implemented billing for RNs in May 2007 and is retroactively billing for these services. It also made practice management improvements to manage productivity. In two months, Lincoln County will move to electronic medical records in partnership with Oregon Community Health Information Network, which will create an even more productive and efficient system and will increase their ability to generate data.

Barriers to this policy work included: the mindset of staff that simply wanted to provide services and not ask for payment; learning how to ask for payment; limited capacity of the provider to bill; lack of understanding of how to code and bill; lack of compatibility between the center's billing system and the county's billing system; and students that needed to understand that the role of the center was changing ("no longer could they come in for just an aspirin"). To overcome this barrier, extensive education efforts with staff took place, involving them in all steps in the process.

In addition, family planning rule changes lowered the ability to bill for family planning services and cut reimbursement rates in half. The changes also increased documentation requirements. To overcome this challenge of required documentation needed before treatment, it uncovered a way to for youth to obtain their birth certificates and social security numbers without involving parents.

Strategic Approaches

Community Engagement

Audiences the centers engaged included the center staff, State Program Office, other school-based health care coordinators, other states with school-based health centers (to learn from their experiences), Oregon Department of Medical Assistance Program, County billing experts, the Health Council Advisory Board and parents. Outreach was made to educators but there was a realization that they have limited time and so it is a challenge to get them involved in school activities beyond what they already do.

Leadership came from the Advisory Board that encouraged Lincoln County to bill for what it could. The clinic assistant also emerged as a champion and a leader, sharing with peers her best practices to ask patients for billing information and testing new approaches to support the billing and reimbursement program.

Communication

The core communication strategy for this policy work to was to engage staff and get their buy-in for billing. This was a significant shift in organizational culture, moving away from a culture of "leading with the heart." The message frame used focused on: the difference between willing to pay versus being able to pay; the fact that people that could not pay would not be turned away; and that a sustainable center would mean that more people would be served. An overt effort was made to not use the word 'free' in

communication but to talk about shared costs and affordable health care. Messengers included upper management and the center's billing staffer. Staff was engaged through ongoing encouragement and an overt request from management.

Impacts

Key to messaging and achieving results was the center's ability to generate good financial numbers from the County to track its billing. This required strong collaboration and relationship building.

The policy work changed attitudes and beliefs of school-based health care staff, school personnel and students about the role of the center. It also increased and diversified resources and exceeded target revenue goals.

Key Learnings

- Staff participation is essential to this policy work and getting staff involved first and bringing them along in the process is vital.
- Billing is a constant learning and adjusting process.
- RN billing is possible.
- Even the most hard-nosed bleeding heart can be turned around to do billing.

Evaluation

Major measures of the success of this policy work are the revenues generated and the exceeding of revenue target goals. In addition, the centers have undergone several chart reviews and coding compliance sessions and feedback on services is then provided to each practitioner.

Community partner	Communities Served	Significant health issues or areas of unmet need	Major areas of local policy work
<p>St Helens (Columbia County) Sacagawea Health Center Elementary School</p>	<p>With about 12,000 residents, St Helens is the largest city in mostly rural Columbia County and is the county seat.</p> <p>92.74% White, 0.34% African American, 1.68% Native American, 0.63% Asian, 0.15% Pacific Islander, 1.35% from other races, and 3.11% from two or more races.</p> <p>Hispanic or Latino of any race is 4.05% of the population.</p> <p>Unemployment and jobs loss is high, and with that is a large number of uninsured. Almost 36% of the county's kids are uninsured.</p>	<p>There are only 10 medical providers in the county.</p> <p>The Sacagawea Health Center's medical sponsor, Legacy Health System, is facing chronic staffing shortages.</p> <p>Kaiser insures 13% of their patients, but there is no Kaiser provider in the county.</p> <p>Access to dental care providers is also limited.</p>	<ul style="list-style-type: none"> • Defining and Marketing Connections between Education and SBHCs: Using messages informed by Dr. Richardson, created a document and conducted outreach to the school district which resulted in increased funding from school district and more sustainability • Focus groups with youth and community members to identify value of centers and for use in communications informed by Lake Partnership polling • Built advisory board to engage the business community, the school district, the teacher's union, Legacy Health System, the Commission on Children and Families, public health officials and parents • Sent OSBHCN Thanksgiving postcards to Columbia County Commissioners, Columbia Commission on Children and Families, St. Helens School Board and Superintendent, and state legislators

Community Partner	Communities Served	Significant health issues or areas of unmet need	Major areas of local policy work
<p>Eugene 4 J (Lane County)</p> <p>Four high school health centers</p>	<p>Population: 140,000 approximately; 5,000</p> <p>Latinos, this population increasing by 1,000 yearly</p> <p>30% of Lane County's total family households (25,617 out of 84,969) had incomes under \$35,000 (200% of the 2008 federal poverty level for a family of 3)</p> <p>There are many working poor who do not qualify for the Oregon Health Plan, or who move on and off insured status.</p> <p>The 2006 Oregon Population Survey found that approximately 17% of residents in this region report being uninsured, compared with 15.4% of residents across Oregon.</p> <p>This estimate translates into one in five residents, or more than 57,000 uninsured.</p>	<p>5 safety net clinics, which include the Eugene School Health Centers, serve 18,000 clients.</p> <p>A study commissioned by Lane County's 100% Access coalition for 2005-06 found that the charges incurred by the uninsured to the Emergency departments at the hospitals were approximately \$59 million.</p> <p>Preliminary results from the 2007 data suggest that Emergency department visits are increasing at a rate of 3% per year, with 15% increase in costs.</p> <p>93% of uninsured visits to the Emergency departments do not result in hospitalizations but account for only 38% of the cost incurred by the uninsured, suggesting that the uninsured are visiting the emergency departments for non-emergent, routine health care needs.</p>	<ul style="list-style-type: none"> Major focus is on building and developing the TAC (Teen Advocacy Council). The TAC has participated in many local health care events, advocated for health centers at the local and state level, participated in the NASBHC conference, done outreach to the media, raised \$14,000 for the health center in one year and is helping to develop the OSBHCN Education Day at the capitol. The SBHC team is highly involved in community wide initiative under the 100% access coalition to start a pilot program for 1,500 uninsured individuals to access health care services. An SBHC TAC student participates in presentation to 100% coalition. Conducted outreach to the education community through school district outreach event, including participation of TAC members and TAC members present to the school board on their community engagement activities Created new branding “My School’s Health Center” through focus groups that included youth and community members and work with communications experts.

Community Partner	Communities Served	Significant health issues or areas of unmet need	Major areas of local policy work
<p>Medford (Jackson County)</p> <p>Kids Health Connection</p> <p>Four elementary school health centers</p>	<p>Medford’s population is about 71,000 people.</p> <p>The racial makeup of the city was 89.99% White, 0.50% African American, 1.07% Native American, 1.14% Asian, 0.26% Pacific Islander, 3.87% from other races, and 3.17% from two or more races.</p> <p>Hispanic or Latino of any race was 9.25% of the population.</p> <p>31.7% of households have children under the age of 18 living with them,</p> <p>About 10.3% of families and 13.9% of the population were below the poverty line, including 19.8% of those under age 18.</p> <p>About 10 percent of children are uninsured in Jackson County</p>	<p>Four priority needs for Jackson County were listed in order as:</p> <p>a) substance abuse treatment</p> <p>b) basic health care, including mental and dental care, particularly lacking in this county.</p> <p>c) education about health which is difficult with the schools struggling with lack of funding.</p> <p>d) coordinated services provided either by teams of social workers visiting homes, schools, etc. or site-based integrated service centers, offering “one-stop shopping” for health care.</p> <p>There are “hidden” communities with great needs in Jackson County, especially seniors, Hispanics and the young disabled.</p> <p>Chronic poverty is often an unpleasant fact for people with physical disabilities and/or mental impairment, lessening their ability to get adequate care.</p>	<ul style="list-style-type: none"> Major focus has been on working with the United Way, local foundations and other community partners to map medical, dental and mental health services in school-based and school-related health care clinics for elementary, middle and high school students resulting in new funding sources. Participation in this process has helped funders focus on gaps and understand differences in proposed funding projects. Kids Health connection has focused on redesigning their staffing model in order to increase efficiencies and opportunities to enhance billable revenue. They have shared their results with the Network in a technical assistance conference call. They have improved community relations through working on messages.

Local policy section recommendations:

Local advocates know their communities far better than our statewide organization. The Network has been most effective when we provide training which gives advocates the ability to think through how to engage their community in support of the model in a way that best fits the values of that community and that demonstrates the need for services in the community. Youth have been powerful partners in our community advocacy, and have made a real difference in both the expansion of services and in tailoring those services to meet their needs.

By providing opportunities for communities to share their experiences with each other the Network is truly living up to its name—it is connecting individuals from across our state so they can share and learn from each other. Our conferences, webinars and local trainings have helped to bridge the urban/rural divide and unite us in our movement.

One of the difficulties and disappointments of this grant was that our original community partnership plan did not work out. Local staff changes and tight community budgets made it difficult for sites to fulfill all of the reporting requirements of this grant. We consistently heard from our community partners that they loved having youth engagement, but that it took a lot of time and resources from their budget. Long term sustainability of SBHC youth councils is an issue that continues to worry our communities. The Network shares information about grants that are available to support youth engagement, but some sites don't feel they have the capacity to even submit the proposals. Still, in some communities, youth engagement has resulted in the concrete results of bringing dollars in the door for their services.

Building a Social Movement

Oregon's Contribution

SBHC supporters have been growing the SBHC movement across our state for more than 20 years, with profound results. In the last few years, the state has expanded the number of certified sites, increased state funding and helped expand access to care to thousands of children across our Oregon. We want to keep this momentum going. In a letter to the Network dated October 8, 2010, Governor Ted Kulongoski said:

“Despite unprecedented revenue shortfalls, and with the Network’s great help, Oregon has made significant progress toward achieving the goals set forth in the Children’s Charter. Just over a year ago, the state enacted the Healthy Kids Plan and since then, over 57,000 children who were previously uninsured have enrolled in no cost, low cost, or affordable health insurance.

As you well know, insurance alone does not equal access. There needs to be places children can walk in the door and get the treatment and prevention services they need to stay healthy. That is why I have made the expansion of school-based health centers the cornerstone of my plan to expand access to care for children. For these reasons, and for all the tremendous work you do for our children, families and our schools and communities, I am proud to announce today that I have proclaimed January 2011 as School-based Health Care Awareness Month.

The Network has my sincere appreciation for all of its passionate work on behalf of our children. All the best to you today and as together we pursue a better and healthier future for our children and all of our communities. You have my sincere thanks on behalf of a grateful state.”

The Network has spent the last six years of this grant helping individuals, businesses, communities and policymakers to understand the value of placing health care in school and to become advocates for school-based health care. The school-based health care movement continues to build bridges between health and education communities, to bring the stories of the children who deserve to be healthy to the forefront and to demand better health outcomes for our state and nation.

It is our hope that SBHCs from across the state will use Awareness Month as a platform for building community support for access to quality health care in schools. The Network will continue to lead this effort by working to build increased public support and policy maker understanding of School Based Health Centers.

We are part of a national social movement. The Network shares and uses resources of other state associations. We reduce “reinventing the wheel” and learn much from our colleagues.

From our Year 4 report:

Demand for better access to affordable healthcare places SBHC in an advantageous position in health care reform discussions. “In Oregon, this model is a growing and breathing product that gives kids access

where they truly do not have it.” “Gives people even most likely to vote down social health care an icon for how to care for the most vulnerable children.”

Interview participants believe it is better not to conceptualize the work as a social movement, since Oregonians are suspicious of this term. Instead, the preference is to refer to the work as ‘collaboration’. The word “social” is a loaded label that raises perceptions of socialist and social justice. The term raises connotations of “taking over the administrative building”. In fact, the movement is unfolding very differently—“as a groundswell of support for a great idea.” The bottle bill (in Oregon) was a mandated social movement. The preference is to bring people alongside the Network and to get them to understand the need.

Since 1993, the board has felt that it was involved in a movement and now it has evolved to a point where foundations and others are getting involved and investing in the work. The SBHC movement is gaining in support both in terms of growing the number of sites and in building awareness of the model.

The movement is building and gaining visibility. “As the old guard of superintendents retires and the new generation is moving from being teachers to principals...they have lived with the concept during their formative years... and leadership moving in is already enlightened.” This is evident in the 18 sites that applied for planning grants in 2007 and the proposed additional expansion of the program by another 12 sites.

We have seen intentional planning in Washington County that is serving as a model for how to open a new site. This planning grantee was able to leverage 19 dollars for every state dollar spent on their planning grant and are open and seeing students nearly a year before becoming state certified.

In the 1980s, fear of losing the limited state funding that was available led to a concerted effort to stay under the radar and not be a part of anything. In the 1990s, with RWJ funding and NASBHC starting, then things started to change. The first NASBHC convention was “a religious experience.” Many people involved in SBHCs now see themselves as part of a movement and that expansion and growth require risk taking and action.

Organizational Development

Paula Hester
Executive Director
OSBHCN

Organizational Development Goal:

Serve as the statewide voice for school-based health care, engaging all key constituents, including diverse allies, and build long-term organizational stability.

To achieve success in policy development, consistency must be created within a system or structure that supports the fundamentals of monitoring, evaluating and pursuing opportunities. Creating that system requires determination and expertise.

Looked to as a guiding star, this goal was purposeful, grounded in what makes an advocacy group functional and productive. The journey, however, was not that simple. Several strategies lay strewn along the path as the Network moves through difficult developmental stages. Highlights and lowlights helped shape each turn on the path, and redirect efforts. The greatest challenges for organizational development were early in the grant period and the impacts of these challenges did two things: 1) they tore at relationships, and 2) they forged progress.

Getting Started and Stalling

Since the Network was not a standing non-profit, the grant proposal was developed with a working partnership. However, the executive director (ED) at Children First for Oregon (CFFO; the Networks' fiscal agent), left her position just after the grant was awarded; the new director brought a different personality and relationship to the table. The impact of this was unanticipated. The new ED added negativity and competition to the table, which played a harmful role in the growth of this young and tender organization. The intended nurturing partnership became grueling, controlled, and ineffective. Neither the new staff for the Network nor its board members could clear the air, move the organization out of the situation, nor could they find support or guidance to make that happen.

An early focus on strategic planning and development was overshadowed by infighting between the project director and board members, disagreeable leadership within CFFO, and a lack of sound organization-building expertise, compounded the challenges exponentially. After nearly two years the tide was still unabated. Long-time advocates found themselves on opposite sides regarding board leadership and next steps for organizational development. Finally, what some refer to as a *coup*, there were changes in the board leadership. These changes came with a cost; there were injuries to long-time friendships and working relationships. This kind of impact within a small organization touches all its stakeholders.

Parallel to the board changes, the Network project manager was frustrated with her working relationship with the ED. She reasoned that she was not the person to move the work along and set a plan in motion to have the Network hire a seasoned executive director. This transition took place, but it was not a fix to the problems with the CFFO director, who was the only member of the hiring team to vote against the selected candidate.

The triangulated relationship between CFFO, the Network and Kellogg was an additional problem for organizational development. Conversations between CFFO and Kellogg were about the Network, not with the Network. For example, the initial conversation with Kellogg and CFFO and new the Network ED was plagued with tension, which was surprising, given the newness of this relationship.

To address the situation, the board and new ED decided that separation from CFFO would be the appropriate step. This was hindered for months with a list of problems relative to the history, the lack of trust, and powerful personalities at every level. CFFO proposed a Memorandum of Understanding, but it took nearly five months to reach agreement, at which time the Network moved to a separate location.

Moving Out and Testing Potential

The Network now had to create its own corporate culture and to combat some damaged staffing relationships cultivated within the previous setting. The relationship with CFFO was still demanding and oppositional. During the final months leading up to the grant transferring to the Network in March 2008, CFFO's ED tried to hire key staff out from under the Network in order to keep the Kellogg grant. Those two staff refused the offer, and informed the Network ED. The final separation from CFFO marked another opportunity for the Network to advance.

The Network began to find success on its own and the work became strategic and more flexible in nature, matching the nature of policy advocacy. The new ED engaged the project evaluator to help bring focus to the work of the organization, which substantially increased the development of staff. The process of evaluation became a side-by-side function with the evaluator and executive director, and included the board. The ED had the evaluator attend board meetings as an observer, allowing the team to assess the process of developing the organization. This was more than a little helpful, as insights were gained during, and contributed to the progression of the organization.

With new determination, energy was directed to planning, answering the question, "Where do we go from here?" Staff, evaluator, community partner representatives and key stakeholder participated. The strategic plan was rewritten in collaboration of all these partners and stakeholders. A business plan was developed under an imposed deadline from Kellogg and the process felt rote in nature. Over time, however, the business planning process was useful in stretching the capacity of the ED to think about the work in a more substantive way.

In 2008, one board connection led to a partner who helped the Network bridge a gap with funding needs by making a one year commitment of \$500 a month; they also helped secure donated office space, which initially was a two year commitment that has recently renewed for two more years. However, there was the price paid for loss of privacy and the energy taken just sixty days prior to the legislative session.

In addition to the move and the culture change, a key staff for the Network resigned in February 2009, mid-session. Hiring a replacement, getting them oriented to new work (whose first day was SBHC Day at the Capitol), all on the heels of developing the cultural competency training and launching new web developments, added to the stress of completing the planned work.

Other staffing changes have impacted the organization over the six years of the grant, but each change has brought new opportunities. Resource development is one area of growth to be discussed later in this report; however, the most difficult staff change will come in late October 2010, when the policy director leaves the Network for a new position with a county commissioner.

Community and Partners

With the grant came the opportunity to support local organizational growth, while building the grassroots for policy work. The specific aim here was to build close relationships with local SBHC systems deemed community partners to help shape and meet the demands of policy work. The Network and its' community partners were challenged with frustrations and disappointments, as well as accomplishments:

Frustrations and strategies to address them

- **Organizational development and leadership were not sufficient to allow the project to thrive in the first two years of the grant. The first year of the grant was also the legislative session in Oregon, which is a biennial session; focus on that session was imperative.**
 - **Changes in leadership were implemented, hiring the right staff and focusing the project work with the evaluator**
- **Grant expectations were specifically difficult for community partners given the scope of work, reporting and involvement, while attempting to create local-level outcomes based on where each partner was on the continuum of experience.**
 - **While some CPs dropped out, the remaining partners were more involved in the process and plan development in years 3 and 4.**
- **Transparency and “safety” did not seem to exist in a variety of relationships in the earliest timeframes: Network to community partners, grantor to Network and community partners, fiduciary to Network board and community partners.**
 - **Moving the Network offices away from the fiduciary, building the relationship (and trust) with the grantor over time, and including CPs in the planning and development processes improved these issues dramatically**
 - **Being intentional in the scope of work addressed some of this problem**
 - **Securing other funding sources to work in partnership with a variety of other SBHC systems diffused some concerns, including the Networks feeling of autonomy**

Disappointments:

- **Engagement between the Network and the community partners was not managed well early on in the project, it was time consuming and less helpful to the partners than they anticipated.**
- **Two community partners dropped out of the project; one in the first year and one in the third year.**
- **The Network did not tell the story of its body of work, including community partners, to the SBHC community during the first three years of the grant.**
- **Sustainable funding was not available to maintain staffing and project focus.**

Accomplishments:

- **The Network is *the* SBHC advocacy organization in Oregon**
- **The Network learned the needs of the local SBHC communities, enabling them to respond in a meaningful way to local issues**
- **The Network understands the impact of its work on diverse populations: urban/rural, insured/uninsured, poor/middle class, racial diversity and age**
- **The Network enjoys positive relationships, increased capacity building, successful policy work at the local, state and national levels**
- **SBHC systems demonstrate confidence in the Network through participation in activities**

and events, making requests of the Network for assistance, following through on advocacy requests

- **Community Partners are engaged in the goals of the Network and both learn from one another**

Relationship Management

In addition to community partner relationships within the constraints of the grant, the organization learned that the community is the partner... and, depending on what the Network was working to achieve, that those communities had specific needs, wants, abilities, and capacities. Mining the community for the right relationship at the right time is an artful process, and securing them as partners takes time.

In some ways, the Network had a head start because of the policy success of advocates in the late 1990s and 2001; some board members provided leadership in building assets within the legislative community. With the hiring of the right staff and connecting with like-minded organizations, the Networked forged ahead a little bit each year, building on connections where ever they could be found.

There was pressure from the grantor to broaden relationships. In certain areas, the relationships were neither ready-made (organizations representing diverse cultures that were naturally interested in the mission) nor appropriate for the particular stage of organizational development (like youth as board leadership). The Network felt it was being pushed to move faster than capacity indicated; therefore, some relationships were targeted because it was imposed as a measure of success.

There are areas where the Network found success and difficulties in developing/sustaining relationships:

- In 2007, an **Advisory Council** was formed to help Network staff implement another grant (EC Brown Foundation). The members include a broad range of educators and champions for students who come from a variety of backgrounds. The Council helps in developing guidelines and selecting sites for the mini-grant project of this program, which is similar to the Community Partner program of the SBHCPP. In connection with the learnings from the first three years of the SBHCPP, all grantees must include youth engagement in order to be a successful applicant. This Council has assisted the Network in administering \$236,000 in mini-grants since 2007, and in broadening its perspective of educational outcomes for children and adolescents.
- Oregon Department of Health **State SBHC Program Office**: The relationship with the SPO developed over time, with specific difficulties, however, the lasting impact of working through those problems have helped equalize the balance of authorities between the regulatory side of providing services and the training and advocacy side of supporting the model. The SPO and the Network meet monthly as a team, covering essentials from rumors in the field to planning and coordinating work. The SPO manager and the Network ED will lead a strategy/planning session at the Network Conference in 2010.
- Regional trainings: Between fall 2008 and spring 2010, the Network had provided regional trainings on School-**SBHC partnerships** in 7 locations. The training was developed and delivered with an Oregon education consultant who has partnered with the Network since 2007; Kellogg's education consultant, assisted in the initial development and the first training, which helped build the capacity of the organization on the ground. An online Partnership Toolkit was also created to help support centers in finding creative ways to approach and partner with their school community in meaningful ways. A new training was developed with consultants on cultural competency for SBHC and school staff; the initial regional training was held in Portland in spring 2009 and in Medford November 2009.

- **Healthy Kids Learn Better Coalition:** Founded by the Network’s policy director in a previous role, the coalition was chaired by one of the Network’s staff from 2008-2009. In connection with another organization, the Network secured \$10,000 grassroots advocacy grant from Northwest Health Foundation to underwrite policy work inter-related to health and education during the legislative session. The Network staff led the planning for HKLB Advocacy Month, supported the Coalition’s health/education legislative agenda, and attended HKLB Advocacy Day.
- The Network began collaboration with **OCHIN** (a health information technology group) to develop capacity for electronic health records, practiced management and billing; other avenues, including the newly announced Kresge Foundation grant may provide a broader opportunity to partner with the Michigan SBHC program that has created a successful billing program.
- **Oregon Department of Education:** Met with Susan Castillo, Oregon Superintendent of Schools to advocate for increased partnership between DHS and ODE around coordinated school health program delivery. Superintendent Castillo’s chief aide participated in an HKLB meeting at the Network’s invitation to discuss how the department was supporting healthy students. ODE staffer serves on Network Board.
- **Oregon School Nurses Association:** Co-presented to legislators about policy impacts. But have not convinced them to co-conference with us.
- **Stand for Children** (state’s largest education advocacy organization): Began collaboration, working through an SBHC advocate who is a high school vice-principal; Stand co-presented with a Network board member at the 2010 Network conference about family/parent engagement.
- **Oregon Alliance for Health, Physical Education, Recreation and Dance** (teacher coalition): Worked to plan joint annual conferences, bringing together education and SBHC staff, and partners in October 2009. The working relationship was disastrous.
- **Interns:** As part of the learning from engaging interns for policy advocacy, the Network began looking for interns to expand staff capacity. The interns have helped with collateral materials production, website updating, and communication projects. In 2010, the Network was awarded a VISTA employee to support the executive director in resource development by providing structures for tracking grants, identifying donors and aligning the plans for development with earned income opportunities. Interns take a lot of staff support, and learning has occurred, including intern orientation. For the 25 Year celebration of SBHC in Oregon, two interns helped developed the 20-page magazine telling the story of this history. More than 300 volunteer hours were invested here.

Youth Engagement

One area where the Network built success was in youth engagement. However, this process was difficult for several reasons: in the early part of the grant, the Network lacked understanding of its scope and purpose; authentic relationships with youth did not naturally exist at most sites, let alone with the newly formed state association; several people were skeptical of the goal of youth engagement; while training by the grantor was helpful in gaining a birds’ eye view of engagement, there were few applicable methods shared, leaving the Network to learn by trial and error.

In the third year of the grant, the Network hired a consultant to create advocacy training for youth. It was expensive, but did help the staff learn more about what it might do with youth. The staff developed and delivered the training for the youth in the last three years. In addition to this, the grantors resource team, specifically Maria Elena Campisteguy, helped the staff think about ways to increase youth participation in the planning and delivery of the trainings.

The Network increased its capacity to build relationships with youth, including bringing young interns on for policy advocacy, and mentoring one high school senior during the 2009 legislative session. This

experience opened the door for a clearer understanding of what youth were getting from their relationship with the Network: the value of contemplating what their voice means in their world.

Building on this success, and having supported the capacity of local SBHCs increase in supporting local youth advisors, the Network engaged local youth in identifying what the trainings would be for Awareness Day, as well as having them present. In years five and six of the grant, this relationship has grown to the inclusion of youth in identifying annual training conference agenda, presenting to the adults, and creating a track that is youth-focused.

For example, in the 2009 conference, a session was dedicated to youth building ideas for Awareness Month in 2010 and committing youth to lead these projects and to expand our Awareness Month toolkit for local communities. The payout for this was beneficial, as youth who participated, including youth who have yet to have an SBHC in their school, use the materials in their advocacy efforts. Additionally, the Network created a youth and parent friendly SBHC story sheet which includes a media consent form. These stories are endlessly helpful in telling the stories of SBHC to a broad audience.

At the 2010 SBHC conference, 27 youth presented and participated in a variety of ways. The outcomes were excellent learning group and for all the youth, the adults working with them, and the Network. After the conference, one recent high school graduate (now a university student), who still works with the Forest Grove SBHC Advisory Council, contacted the Network to see how she can help formulate a statewide youth advisory council. Excellent outcomes are sure to follow.

Communicating Thoughts

Kellogg provided a substantial grounding through Lake Associates' data and communication training in the latter part of grant year two. The Network, like others in the initiative really had to "try on" this language to convey its mission. The Networks' new policy director replicated the training for the Oregon SBHC field; after all, if she were going to get a message out for policy advocacy, everyone had to know what that message was and how to best convey it. This engagement with the field was the first of its kind since the grant began. It was the basis for building a reputation for technical assistance, even though the Network did not fully recognize it as such as the time.

In year four and five of the grant, with the assistance of a consultant, the board developed a case statement. As with other projects to this point (including resource development planning), day-to-day operation was where the real learning took place. Applying our new language included redevelopment of communication tools like brochures, website and newsletter. It took time, like other things, for this language to be a natural part of our work. We have used it to write grants, donation requests and other products, and it is the act of repetition that has underscored its relevance, which might make an organization think about how it can convince the world about a message: by simply saying it again and again and again.

Recently, communication and messaging was reviewed with new employees and the experience was like looking back into the tunnel of time and realizing just how far the organization had come. Staff knows how to convey the message of SBHC to multiple audiences and they can help interpret policy impacts at levels of education, health, and community life. It is imperative to recognize the process that took place, including the continuity of staff who gives the work meaning.

Currently, the Network uses web-based programs for most communication and cultivation of information including surveys, action alerts and weekly e-news: *School Health Bulletin*. The bulletin was started in

2007 as a way to communicate with SBHC Coordinators, cutting down on the multiple messages from staff to the field and to help create a brand for the organization. The bulletin grew from the 50 on the coordinators list to nearly 800 people in the last three years. This does not imply a huge following, however, and the Network needs to consider realignment with a weekly note to coordinators, and a monthly newsletter to its mailing list, with a targeted message.

The website has undergone two major re-workings, building the capacity for the Community Online Resource Exchange (CORE) developed by the Network. The expansion of the website has increased users and access, although not to the extent envisioned, and it is highly regarded by the community of SBHCs, local funders, and many other organizations.

The breath of information found on the site has expanded greatly, specifically with the increase of staffing to support updating, creating pages that are specific in focus. All the staff have increased in their capacity to add information and drive people to the pages that contain materials, for example, to advance awareness, build the board capacity, and commit to donating to support the cause.

Resource Development

A variety of approaches helped broaden the Network's capacity for policy success. The most prominent changes were built upon the Resource Development Plan (mid-2008) and the Case Statement (February 2009), developed by the board of directors, staff and consultants. The production of these documents helped frame not only the beliefs about who the Network is, but how that story gets told.

Staffing Mechanics

Until 2009, the Network had only used consultants, select board members, and current staff to do any development work. Finally, the Network hired a part-time development staff to help implement the RD plan, with the intention of building structure around the RD plan; however, the new staff was bombarded with more than they could possibly complete in the context of the position. This led to frustration and less-than-optimal outcomes. The staff left after 10 months, and given the budget, the position was not refilled.

What was achieved during the tenure of this staff was rolling out the initial Case in a more thoughtful way than could have been achieved without her. Additionally, the staff focused on board development and engagement included developing elevator speeches with the board for the "personal ask" and an online board toolkit, to support the board in its activities and reaching purposeful outcomes. The hiring, working with and losing this staff, was a significant learning process within the organization, at all levels of staff and board. Ideally, the Network would have a full-time resource development staff focusing on grants, corporate sponsorships and developing earned income opportunities for the organization.

In mid-2010, the Network was awarded a VISTA staff, who began working in late August. This position is organizing the RD processes, calendaring of grants, and working with donors for conference sponsorship. This is a fulltime position through next July. The VISTA will provide grant research and draft grant applications. The experience of having a VISTA staff is enlightening. There is much training for such a new worker, but the process has helped formulate staff orientation to a much higher standard, thereby impacting board orientation and materials used for communicating the organizations purpose.

The Network more regularly uses interns for expanding its work, particularly around marketing and events, which, as a resource, help expand resources. Communications, marketing and web development, as well as policy interns are a more regular component of the organizations' staffing. The concept of internships grew from the process of working with youth to develop SBHC Day 2009; realizing how important the 2009 session would be, an opportunity emerged to secure youth interns to assist the policy director.

Most recently, the Network engaged two interns (one for writing, the other for graphic arts) to develop a record of the 25 years of SBHC in Oregon. However, managing interns has been a learning process as it pertains to the organizations development, including how to create a clear project outline to ensure the best use of intern and staff time, and measuring the output based on the inputs.

The Board's Role

The board has made great strides in development over the life of the grant. As noted previously, the initial board during the grant had struggled to be cohesive; not in drive or desire, but in generating outcomes it wanted. After the re-alignment of the board in 2006 and the hiring of a policy director and executive director, the work of the board took on deeper meaning.

With the resource development planning, and the writing of the Case, the board found some specific success organizational success... success that was internalized. Under a short-term contract with Metropolitan Group in Portland, the Network examined the current and upcoming need for board member expansion and development. Updating a tool created to collect information about the areas of expertise of current board members, and filtering this information through the lens of map that identifies areas of strength and weakness, the board is focused on enriching the leadership diversity. This remains a process, however, with a majority of the board coming to the end of a term this fall, much is to be gained.

In June 2010, the board set out to determine a more productive schedule and committee structure, with the full board meeting less often, modeled after the California and NASBHC partners' boards. The coming year will be the testing ground for success and learning.

In the meantime, the board is building its capacity to develop resources for the organization by tackling specific projects like the annual conference, where they develop corporate sponsorships, donations for the auction and raffle, and provide a face to the organizations members and associates.

Members

Membership is not a significant source of income for the Network. Ideally, those most passionate about the work would make sure it is well funded, but in reality, those most passionate people are focused on the daily work of providing care. The process of collecting dues from individuals, as anticipated in the business plan, has been flat, at best. Even gaining ground on collecting SBHC-system memberships has been uneventful. In response to the lack of grant funding available (in general), the Network is focusing on developing a plan for greater buy-in of support at the systems level. This will include a membership fee that builds in more substantial support, especially to support legislative policy work.

To better manage information about members, stakeholders and donors, the Network explored web-based database. In year four of the grant, a contract with eTapestry (web-based database) was initiated, but after two years, the investment has not been fruitful. Examinations of product usability, ease of use, and cost analysis lead the organization to find a different tool or tools for relationship management. While an ideal product has yet to be found, the Network still has online giving, conference registration, and membership options available via the web.

Earned Income

Over the course of the Kellogg grant, the Network has initiated and built earned income by way of training/conference fees and membership drives. This has been a slow process, but since 2007, the annual conference fee structure grew from a \$30 charge to \$110 per adult attendee in 2010.

Two opportunities have been earned by the Network to provide fee-for-service under contracts. The state program office for SBHC has contracted with the Network to investigate and outline solutions to resolve problems identified within one county in conjunction with Medicaid reimbursements to SBHCs. Oregon Oral Health Coalition contracted for support of its board in planning and development of their policy work. These combined efforts have increased earned income by \$11,000.

Sponsors and Donors

Expansion of personal and corporate giving to support activities, like Awareness Day and conference was increased by \$17,000 or nearly 33 percent between 2008 and 2009. This built a lot of hope, but with the loss of resource development staff in late 2009, and without the concentrated efforts, the Network has fallen short, in fact, bringing in \$9,000 less as of October 2010.

Another significant shortfall in 2010 is corporate and individual contributions. In 2008 and 2009, an oral health organization helped underwrite some administrative staff for the Network, and the loss of this income is the major source of this decrease. Glaringly, the individual contribution has dropped in 2010. This is a difficult area to ensure success, but the drop over the last two years has been 50% each year. More information is needed to assess the reason behind the drop.

The most significant developments in sponsorships are focused on aligning sponsors for multiple years, and to the broad work of the Network, so the corporate donor is a contributor across all organizational work. Data still needs to be gathered to outline the number of hours services rendered and what numbers of people were served.

One significant contribution that is not cash is that of donated office space, which includes desks, chairs, conference rooms, and telephone, fax and internet services. While the donor records this contribution around \$8,000 per year (since October 2008), the actual cash savings has been closer to \$20,000 per year, or a total of \$40,000 in savings. This is not included in the table below.

Unrestricted Income-Booked					
Year	Contributions	Event Sponsors	Registration Fees	Membership	Totals
2007	6650	8875		3715	19240
2008	6006	17100	4340	2840	30286
2009	6400	39482	7474	2980	56336
10/2010	1575	30435	9150	5020	46180

Grants

The Kellogg Foundations’ grant has been a substantial support, particularly during the recession. Aside from it, the primary funding for the organization has been the EC Brown Foundation over the last four years. Additional support has been isolated funding, with little support for real policy advocacy.

Funding is lean from foundations, particularly in the last few years given the losses that many foundations have suffered. Making the case for policy work over direct services is profoundly difficult. Just since August 2009, the Network has written 16 new grant requests totaling \$1,098,000. Of that, nine have been denied and one has been funded at 50% of the request (\$819,000) and seven have been fully or partially funded (\$279,000) and two of three that were in-kind submissions have been awarded. One of these awards actually costs the Network a match of \$8,500 for the VISTA position.

One of the grants received was written in collaboration with the advocates for SBHC in Washington State, to support the investigation and development of an SBHC association in that state. Funded through Group Health Foundation, the Network executive director has worked with a planning group to form the Washington Alliance for School Health Care. The stakeholders in WA were surveyed about school health care and the desire for an SBHC association, after which the planning group worked through a variety of activities to formulate the mission, vision, goals and objectives to move the organization forward.

McKinsey Capacity Grid Ratings 2004 - 2010

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MCHD

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Executive Director
OSBHCN

Introduction

The McKinsey Capacity Assessment Grid was a tool used in the WK Kellogg Foundation's School-Based Health Care Policy Project (SBHCPP) to monitor annual progress in the 'organizational capacities' of the Oregon School-Based Health Care Network (Network). Improving the Network's organizational capacities and capabilities was a key component of the SBHCPP's strategy for improving youth access to health care and increasing the sustainability of the school-based health care model. The following evaluation report summarizes the changes in the Network's organizational capacities over the 2004-2010 project period, and identifies key strategies that contributed to or impeded the desired changes.

McKinsey Methods of Administration: 2004 - 2009

Because the methods of administration of the McKinsey Organizational Capacity Assessment Grid tool differed in successive years of the SBHCPP, the methods for each year are listed separately.

2004: On November 16, 2004, W. S. and Associates completed an initial organizational capacity assessment for Year One of the grant. Using the McKinsey capacity assessment grid, of critical baseline data were collected as an integral part of the cluster level evaluation. The Network staff and consultants that provided the data for the completion of the McKinsey capacity assessment grid were Debbie Kaufman, project director; Maxine Proskurowski, SBHC program manager; Jackie Rose, SBHC consultant; and Tammy Alexander, SBHC consultant. Also attending the assessment portion of the meeting was Bethanne Fox, a consultant from Burness Communications.

2006: In April, May and June 2006, John Dougherty (the new WKKF evaluator for Oregon) re-administered the McKinsey Capacity Assessment (individually) to Debbie Kaufman, Tammy Alexander, Dana Brown (consultant), Jackie Rose, and Maxine Proskurowski, by John Dougherty, the WKKF project evaluator. The ratings for each individual were averaged together to arrive at an overall rating for each item in the grid.

2007 - 2009: On April 6, 2007, June 10, 2008, and May 8, 2009, the McKinsey was administered to Tammy Alexander, Jackie Rose, and Paula Hester (Project Director and Network ED), as a group. The group developed a consensus numerical rating for each item.

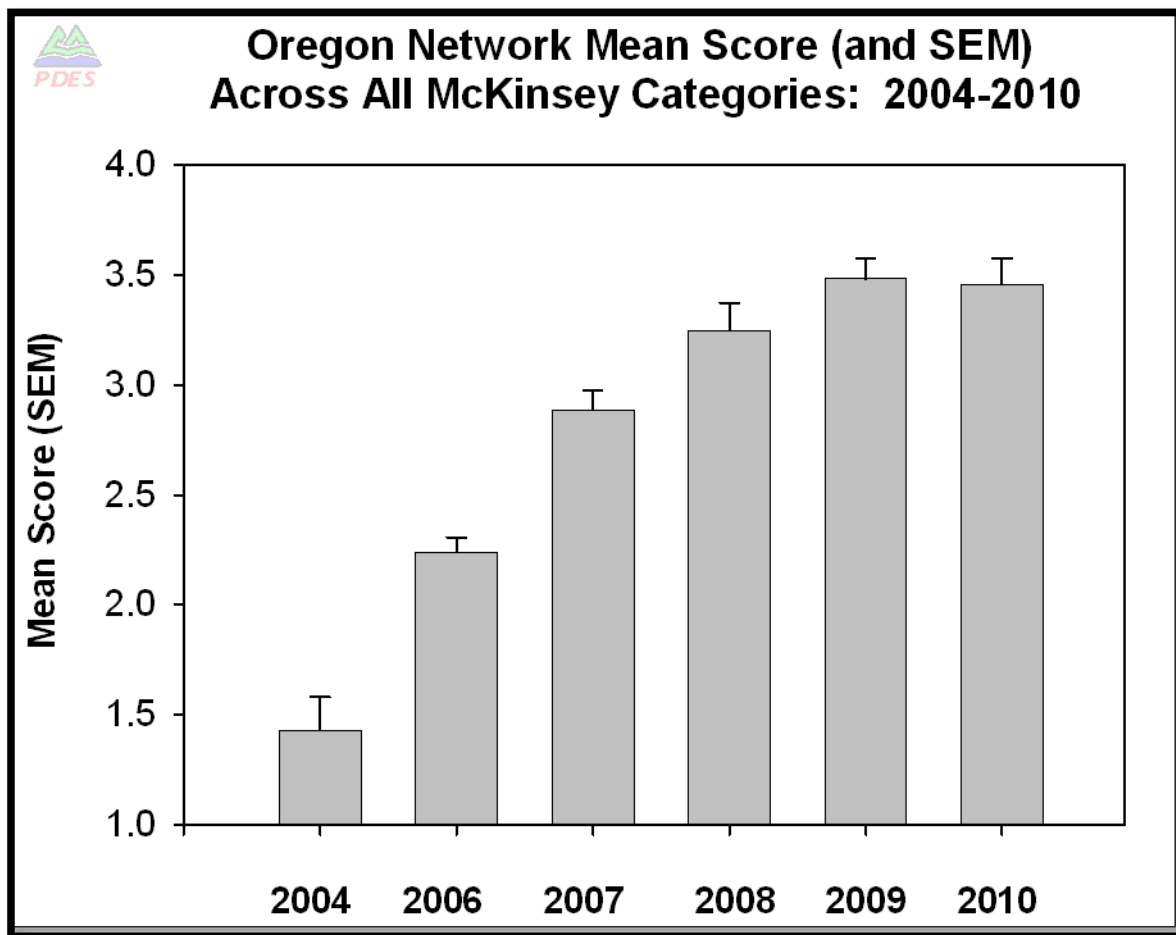
2010 Capstone: The McKinsey was again administered to Tammy Alexander, Jackie Rose, and Paula Hester, as a group, and the group developed a consensus numerical rating for each item. The procedure in 2010 differed from 2007-09 in that the ratings from 2004-2009 were shown as a graph next to each McKinsey item, allowing the group to not only to give a 2010 rating, but also to comment on changes over the course of the project and the reasons for these changes.

Change in Averaged McKinsey Score: 2004 - 2010

Figure 1 shows the average rating (plus the standard error of the mean) across all 58 McKinsey items for each year of the project. The Figure shows increased Network organizational capacity during the SBHC Policy Project, with relatively larger increases occurring between 2006 and 2008. [The differences between adjacent years are statistically significant, except for 2004-2006.] Increases after 2008 were smaller, and are likely to reflect a ‘ceiling effect’ – where the range of the McKinsey scale limits increases at the higher end. [On the McKinsey Capacity Assessment, the lowest rating is 1 and the highest is 4.] The mean score in 2010 was 3.65.

In the 2010 assessment, participants noted that with an increased understanding of the potential growth of the organization, the scoring became more reserved over time, even backsliding in some cases, acknowledging the possibilities for maturation.

Figure 1



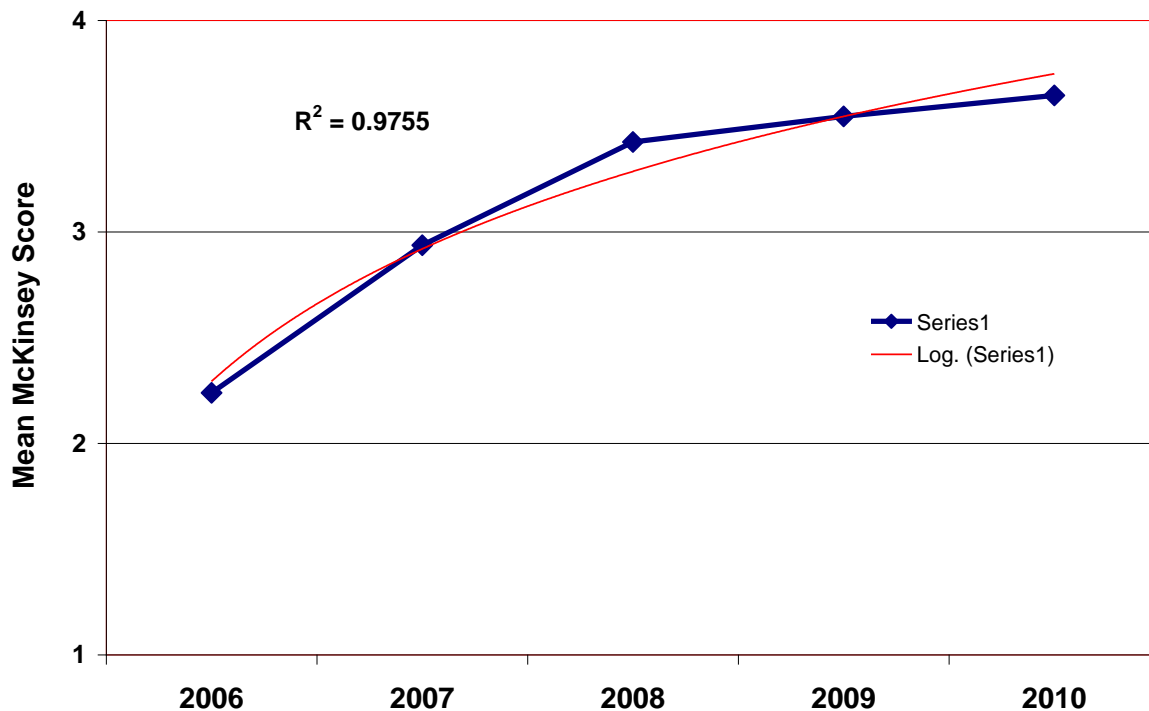
To further examine the changes in McKinsey scores during the SBHC Policy Project, the average scores obtained from the group interviews conducted in consecutive years by the SBHCPP evaluator (2006-2010) are shown in **Figure 2**.

About 95% of the variance in mean scores over time can be accounted for by a simple logarithmic function (narrow smooth trend line without data points). Given the significant changes that occurred in the resources available to the Network over the course of the SBHC Policy Project, this regularity is somewhat surprising, perhaps suggesting that the changes in the overall mean McKinsey score may not accurately inform the reader about increases and decreases in critical organizational capacities.

Figure 2



Mean McKinsey Score 2006 - 2010 (with Log Trendline)



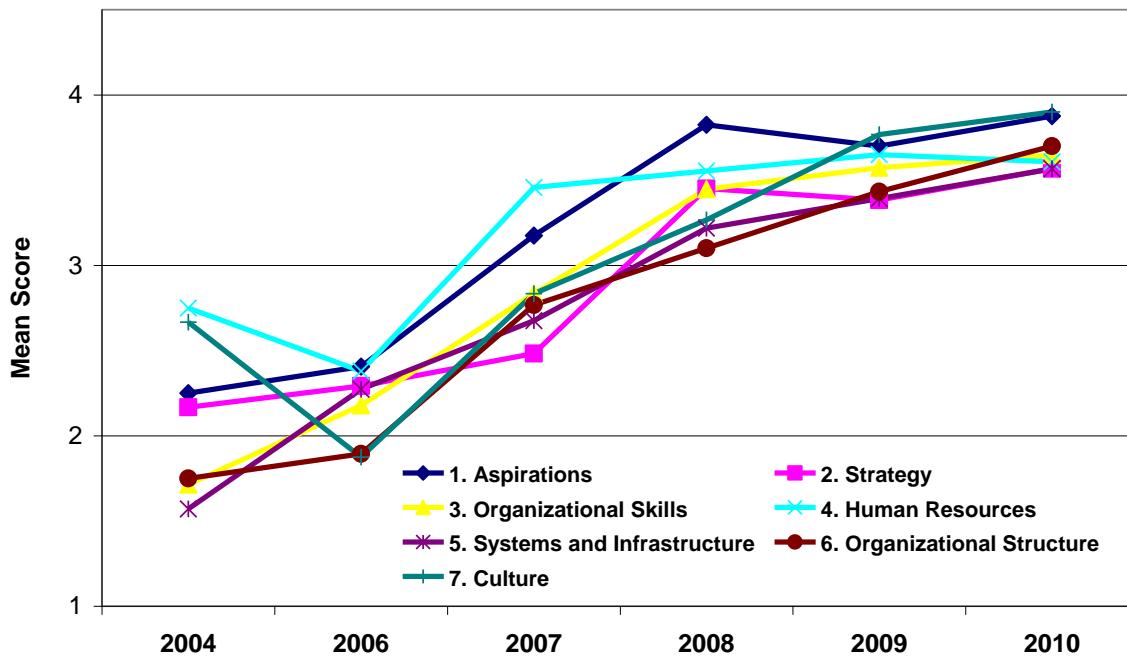
The 58 items on the McKinsey are grouped into 7 categories. **Figure 3** (below) shows the average rating for each of the 7 categories of the McKinsey for each year of administration. Increases among the categories over the six-year SBHC Policy Project period are about the same regardless of the category of organizational capacity.

Except for two decreases in capacity seen 2006 (possibly from a change in method of survey administration – see Methods, above), most categories of capacity appear increase steadily over the duration of the project, and there is relatively little difference (variability) between categories. There are no declines in any organizational capacity category except for Aspirations in 2008-2009 as the mean scores approached the highest score of 4. Averaging individual McKinsey items within the 7 categories may yield an overall sense of change that also may obscure important differences evident in the 58 individual items.

Figure 3



Mean Scores in the 7 Major McKinsey Categories
Oregon Network: 2004 - 2010



The overall McKinsey mean and the averages for each of the 7 categories show a steady increase in organizational capacity beginning with the second year of the project, topping out in Project Years 5 and 6 as the highest possible score on the scale is approached (highest score for each item is 4; the lowest is 1).

However, variability among McKinsey categories does not change over successive years and the time-course of increase is similar for all McKinsey categories, suggesting that the averaged scores provide only a very gross indicator of increased capacities, or may be misleading. Also, the consensus self-assessment method of estimating McKinsey ratings, and the requirement that ratings be reported yearly to the Kellogg Foundation may be partly responsible for the apparently uniformly increasing capacities.

It may be misleading to interpret McKinsey scores without considering the method of administration, the rating procedure, whether item scores are averaged or not, and narrative data. The McKinsey averages therefore may have limited value in informing the organization accurately about areas in which successes have been achieved and areas in which further attention may be desired. Therefore, change in ratings of each of the 58 McKinsey items was graphed and they are presented below along with the narrative comments of the raters.

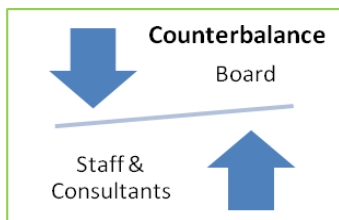
General Comment on McKinsey changes 2004-2009 Provided by the Group:

The major variable precipitating change in 2007 (and later) was the hiring of a part time policy director and new executive director in late 2006. Subsequent to that hiring, key change in staff, board, volunteers, consultants, and fundamental Network operations were a necessary prerequisite for the general improvements in organizational capacity on all areas assessed by the McKinsey during the remainder of the SBHCPP.

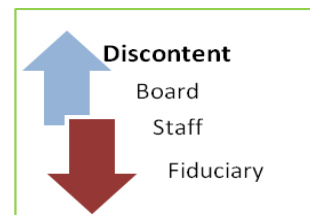
Analysis and Discussion of Assessment Results

Mean scores in **Figure 3** illustrate growth over time, even with dynamic structural changes within the organization like board and staffing events. But discontent between the primary parties delayed action on many items that would sustain the organization in time. It was not a creative stress, and delayed productive outcomes.

Elemental to organizational growth is leadership that conveys a vision at every level of operation: staff, board, membership, core and developing



partners, and in this particular case, policy makers and funders. The McKinsey reflects the maturing of the Network, where eventually, the combined matrix of staff, board and consultants moved past the conflict, and focused its energy in making something of the potential.



Policy advocacy is what the organization does; however, funding such work can be a troubling matter. As a product, advocacy does not lend itself to deliverables or direct services, much loved by donors and foundations. The cost of developing a case statement and a resource development plan were expensive and not oriented to the type of operations of this quasi- advocacy, technical assistance, grassroots, grassstops, professional association really needed.

The process to get to that understanding is still emerging as of the writing of this report and will likely emerge with a business plan that targets earned income opportunities and sponsorship from organizations that find the work most meaningful. It is hard to say, based on the McKinsey assessment when this would have been an organizational learning, but the recommendation to funders for projects like this would be to focus on organizational grounding before moving to the policy work.

The strengths of the Network may be too heavily reliant on the staff. The policy director is leaving her employ after four and a half years, and the upcoming state legislative session shows signs of being the worst for SBHCs in eight years. The executive director has significant public policy background, and has developed many insights with the guidance of the outgoing policy director. There are several practices in place that support consistency, even in the face of this change like communication systems, advocacy day, awareness tools, and a large grassroots network. This opportunity, however, presents a challenge to the leadership to realign responsibilities so appropriate focus will be continued in the policy work.

The following pages outline the 58 specific functional assessment areas of the McKinsey. The comments consist of those recorded by the evaluator during the administration of the McKinsey. In some instances, additional comments have been provided by the executive director to provide specific information relative to what organizational strategies and/or external factors may have contributed to changes, either in facilitating or obstructing progress; and what the findings suggest about strengths and ongoing needs for the organization's capacities for policy advocacy.

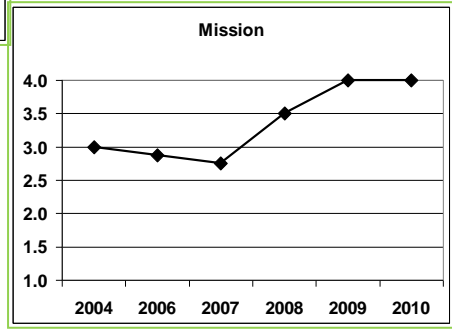
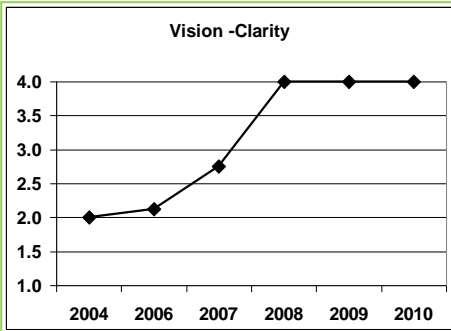
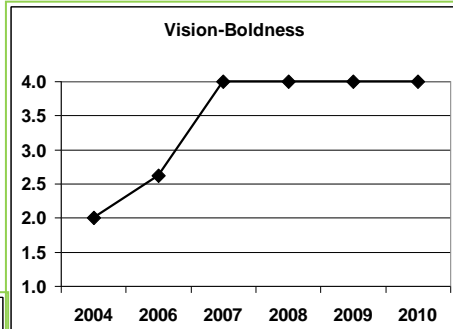
Notes:

- If an individual graph shows a missing data point, the group assigning the ratings decided not to provide a rating for that item in that year (e.g., Senior Management Team in 2008 and 2010, where the group declined to rate themselves).
- Not all graphs of individual McKinsey items have accompanying Capstone comments from the evaluator – the group did not provide comments on all items.
- Occasionally, two items were discussed together, so comments for those items are combined.

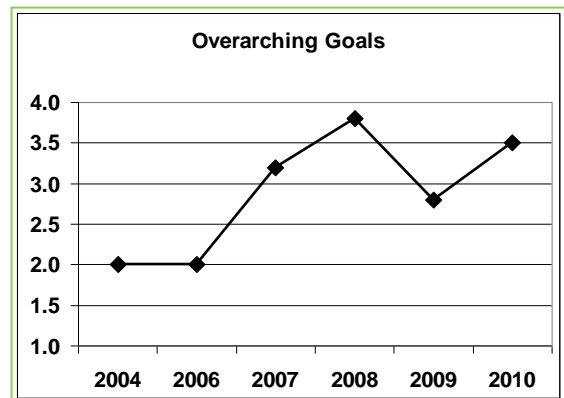
McKinsey Functional Areas

I. ASPIRATIONS

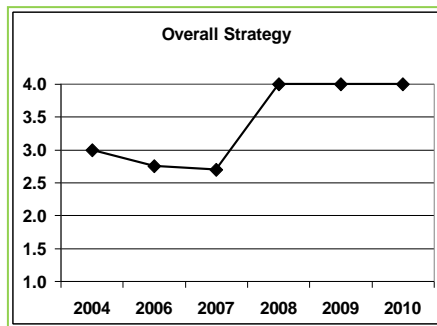
Over the life of the SBHCPP, mission, vision, and overarching goals steadily increased, especially after the hiring of a new executive director in late 2006. When compared with the consistent elevations in the mission, vision, clarity and boldness categories, the decrease in overarching goals seen in 2009 seems at first incongruous.



Overarching goals: In 2009 the overarching goal rating decreased because of the increase in awareness of the political climate in landscape. In other words, there was a more mature view of the situation with a higher level of expectations. There was an increase in the ratings in 2010 because of training provided, including the annual conference. The Network newsletter is widely known within the school-based health care centers in Oregon and used to direct actions and set priorities.



II Strategy

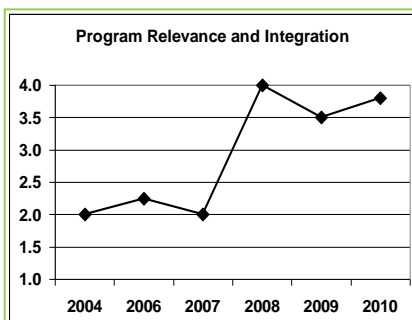


Overall Strategy: The overall strategy rating increased after 2007. This rating increased again in 2008 as a result of the strategic planning sessions held during 2007 (after a change in network leadership). The strategic plan will be revised in 2010.

Goals and performance targets: This rating remains relatively high, especially given that the strategic plan revisions will be

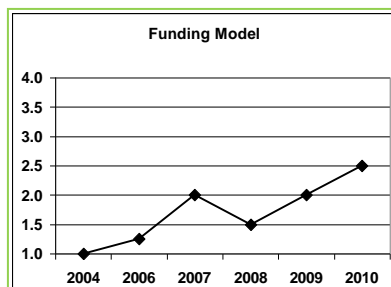
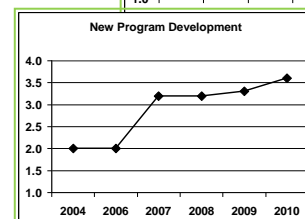
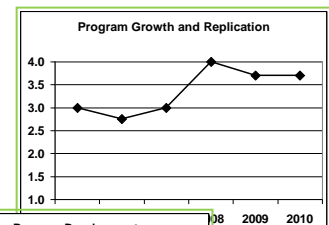


decided upon relatively soon. This may be reflective of the consistency of staff meeting with engaged board members to realign goals, objectives and strategies annually. Measuring the goals to the over arching strategic plan allow the work plans to reflect the learnings and create next steps in performance targets.



Program relevance and integration: This rating has increased this year and steadily over the past year as the various programs within the network became integrated. The evaluator provided questions to help align the various programs; as a result, the “healthy youth relationship” project funded by the EC Brown Foundation is becoming integrated within the programs of the Network and its website. Tying all of the functions of policy advocacy to developing new advocates is now “unconscious consciousness” within the Network, particularly around youth integration.

Program growth and replication & New program development: As a consequence of more effective communications and solicitation of information from the field, inputs into program growth and replication and new program development are coming from the field, from evaluation studies and feedback loops, and staff. Creation of new programs is still a difficulty when measured against staffing patterns and available funding.

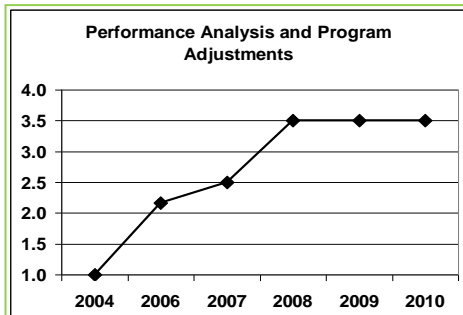
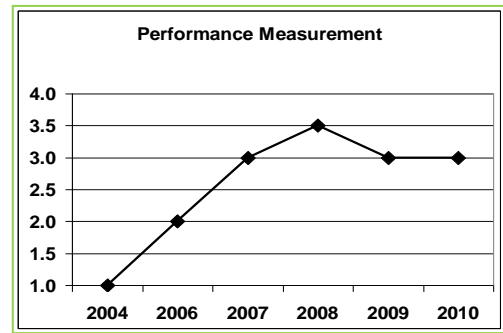


Funding Model: In some ways, the Network has found success in diversifying its funding strategies. The income, both earned and donated, has grown every year since the new ED arrived. Foundation funding has been piecemeal and difficult, particularly around creating deliverables in a declining economy. Funders have cut staff, budgets, funding cycles, and projects. The Network has engaged in capacity building grants, but has only seen about one quarter or less of requests filled.

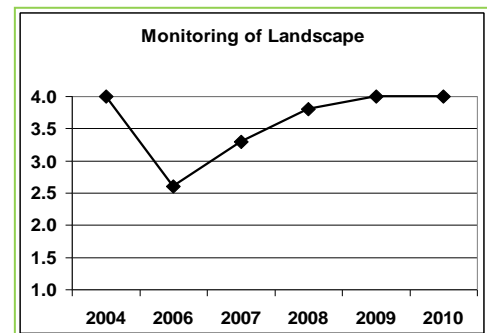
III Organizational Skills

Performance management: Organizational capacity steadily increased throughout the duration of the policy project. No specific strategies or comments were provided by the raters.

These two areas were ones where the raters learned what the possibilities were over time and adjusted the scoring based on this. Even with third party evaluation, there are no control groups per se, but the staff are integrating lessons from the process of evaluation across programs and services.

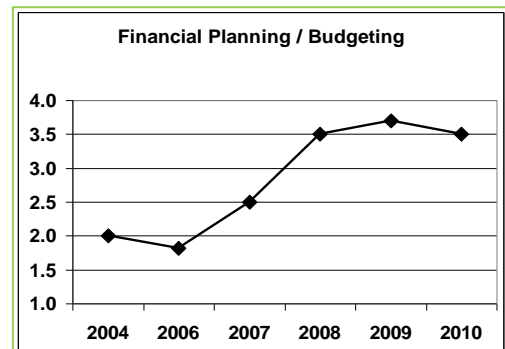


Monitoring of landscape: The rating remains a four and has been consistently high for the past 3 years, reflecting the excellent monitoring of the landscape by the Executive Director, policy director, board members, and consultants.



Strategic planning: This again is rated a 4.0 as the strategic plan is under review and has grown to include visioning work with the state program office. A session was held with 20 advocates and providers at the state conference to identify needs around specific topics like ERH and primary care home.

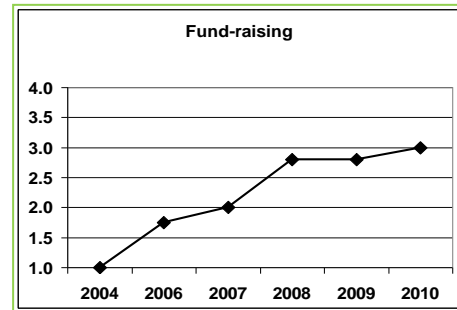
Financial planning and budgeting: There has been a significant improvement over the past five years, but there is also some room for continued improvement as the network continues to work on improving their planning and budgeting systems.



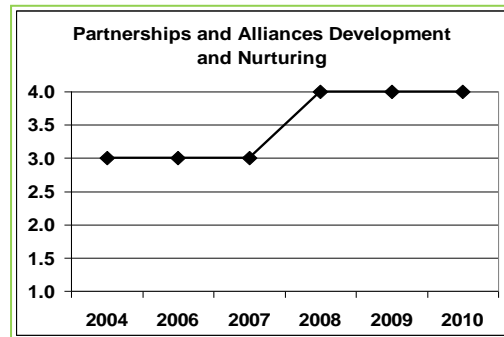
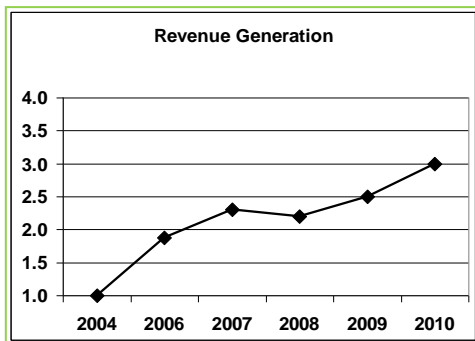


Operational and Human resource planning: Operational planning steadily increased over the past five years. The Network - both internal and external expertise - continues to be involved in operational planning, despite limited funds and the economic downturn. Establishing the right human resources has been a highlight of the organization, with specific decisions around hiring seasoned executive and policy directors, followed by the steady establishment of staff suited to their roles.

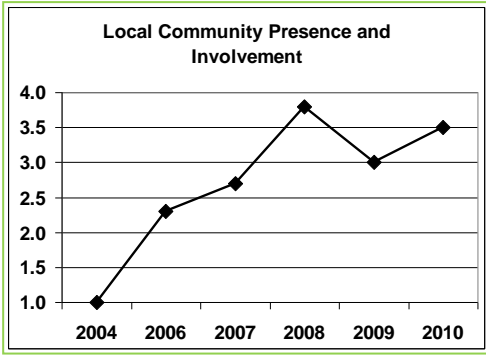
Fundraising skills: Fundraising skills continue to increase among staff and other members of the organization over the past year or two. A resource development director was hired, Kellogg Action Laboratory assistance was received, and there was a systematic approach to resource development that increasingly utilized internal staff, reflecting an increase in capacity.



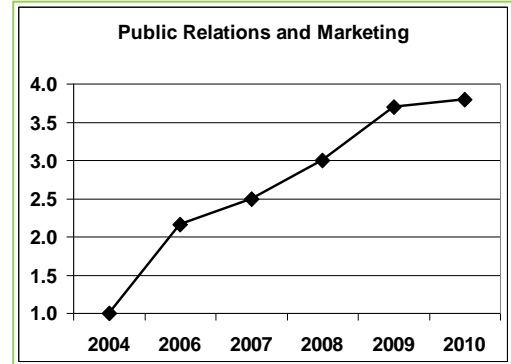
Revenue generation: Over the past year, revenue generation activities have increased, especially with the hiring of the resource development director and the leveraging of positions and some successes with grant applications, although because of the economic downturn, overall grant funding is not meeting expectations.



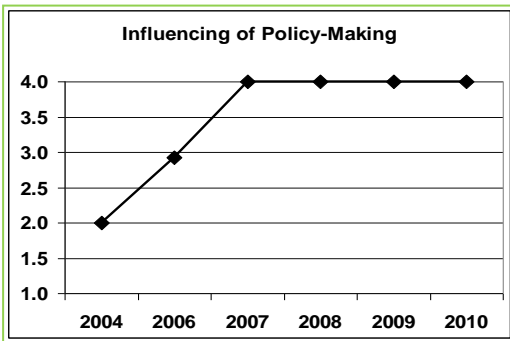
Partnerships and alliances development and nurturing: The network remains well-connected with partners and stakeholders; there has even been an increase in partnerships at the state legislative level over the past year.



Local community presence and involvement: Increases over the past five years are being maintained and involvement of the local community has increased somewhat over past year, especially with respect to the new SBHCs and relationships with the state program office.



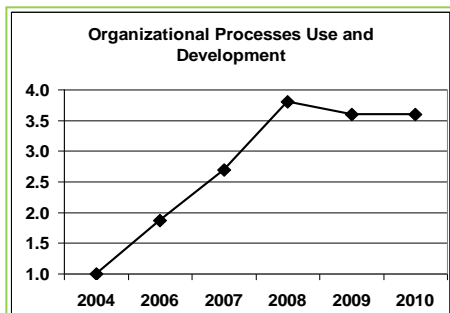
Public relations and marketing: The organizational capacity in this area has increased over the past year. Especially effective have been the weekly newsletters that are broadcast via e-mail by the Network.



Influence of policymaking: This capacity remains highly effective, and in combination with partnerships has been effective in maintaining funding for SBHCs in Oregon despite the economic downturn. The SBHC Day in Salem with Youth Advocates has been a particularly successful approach.

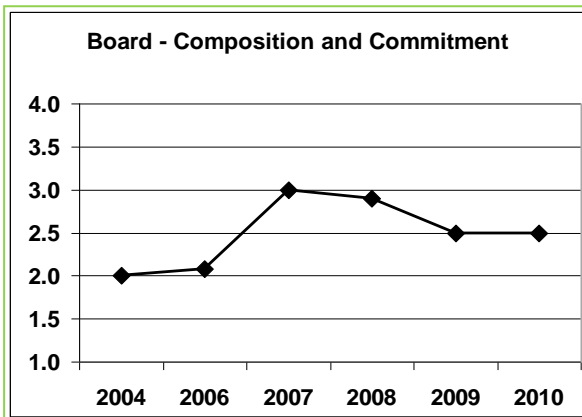
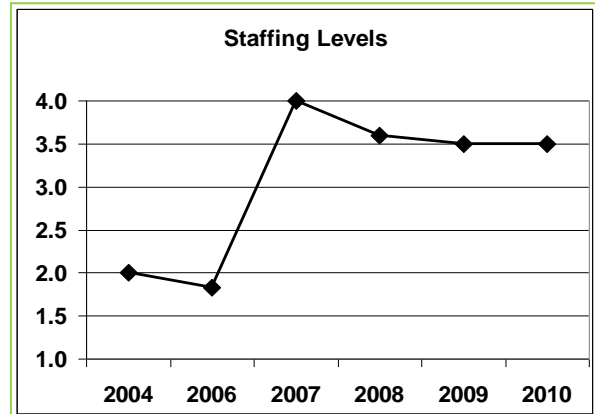


Management of legal and liability matters: A steady improvements over the past five years is being maintained by the Network. The organizational processes use and development category shows a similar improvement.

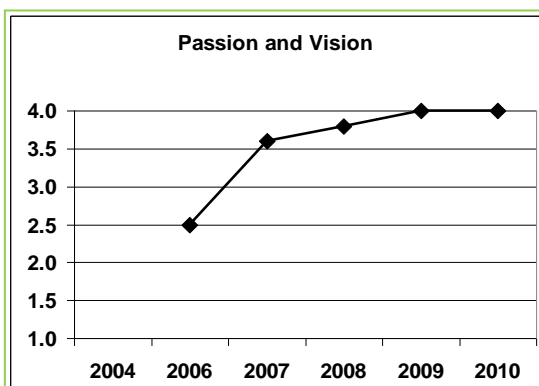
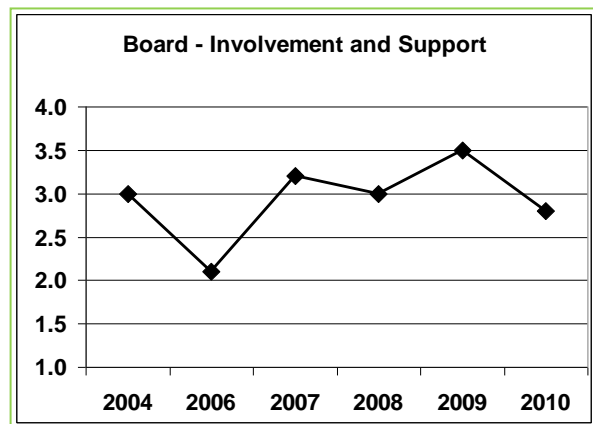


IV Human Resources

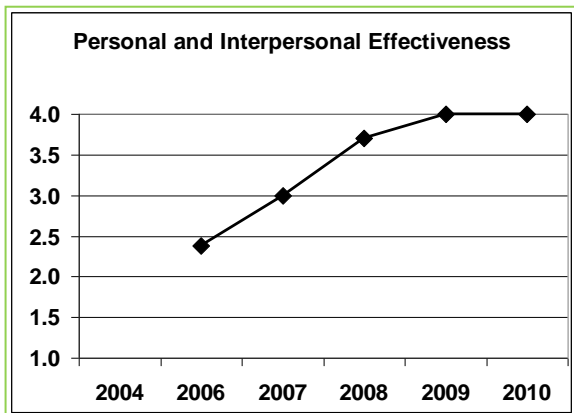
Staffing levels: With the advent of the new leadership in 2007, staffing levels have consistently been adequate. However there are some concerns about board turnover and attendance problems. The multicultural composition of the board could be more diverse, and although there are amazing and individuals committed to the vision of the Network, the board needs additional members who show that commitment and an adequate number of energetic individuals committed to the vision of the network.



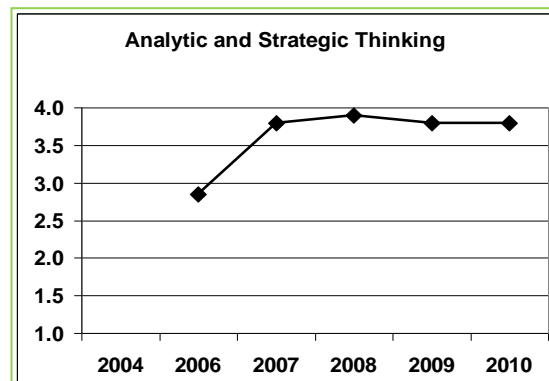
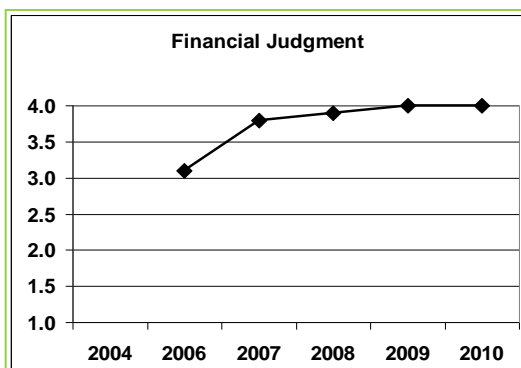
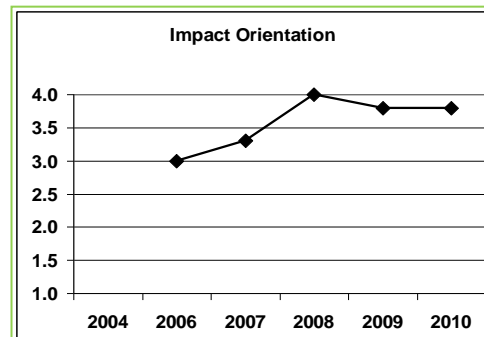
Board composition and commitment: The ratings have remained at relatively moderate levels over the past several years, suggesting that this is an ongoing opportunity for improvement by the Network. These comments also are relevant to board involvement and support, and there has been some attrition among board members. Also several board members have indicated a desire to rotate off the board.



Passion and vision: The Executive Director and the Policy Director are highly motivated and passionate individuals with expertise in their areas of function. Upper-level management maintained and increased the capacity of the Network, while adapting to economic challenges at the same time there have been family challenges.

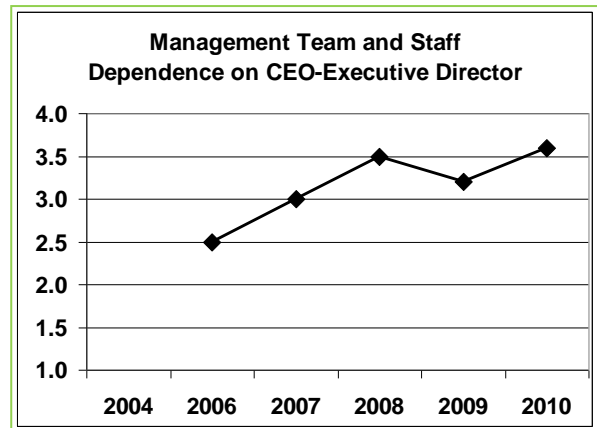


Personal and interpersonal effectiveness: There has been a steady increase in growth among the senior management team in the effectiveness of their interpersonal relations.

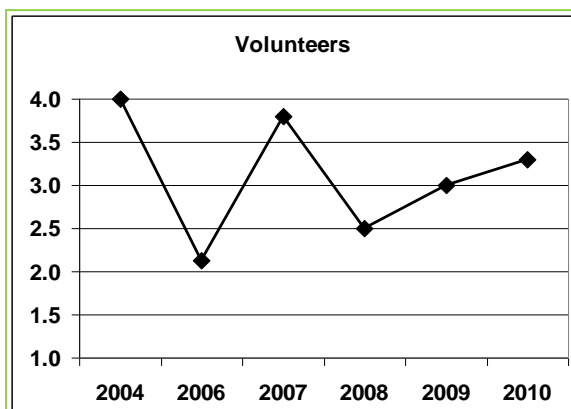
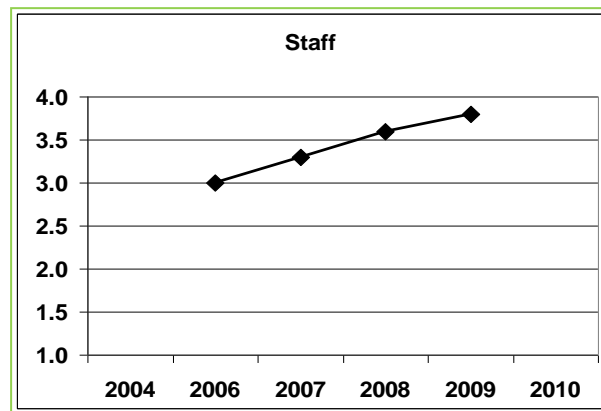
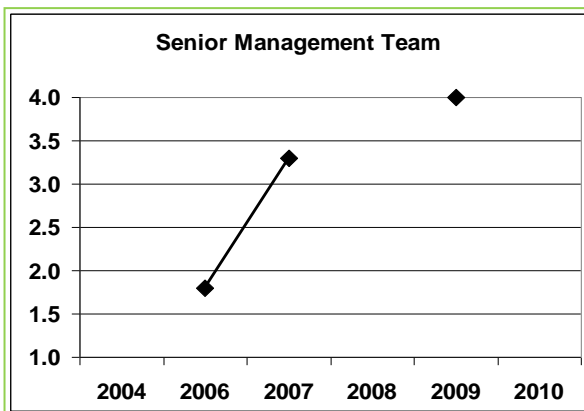


Financial Judgment and Strategic Thinking: The vision of the early founders of the Network, even before the Kellogg grant emerged, set the tone for the thoughtful ways in which fiscal responsibility and analytical processing happens. It is especially helpful when long-term funders extend grants, especially during these times.

Staffing Categories: Assessment of the staffing patterns, resourcefulness and skills indicate a strong team. Experience is abundant in many areas and the staff work as learners, indulging in practices that keep their knowledge on the upcoming targets, not just what lies before them in the moment.



Dependence on the CEO: The staff specifically targeted this issue for improvement. With the absence of the ED during the early part of 2010, the staff was able to maintain interdependence within the team, supporting the ratings on this issue.

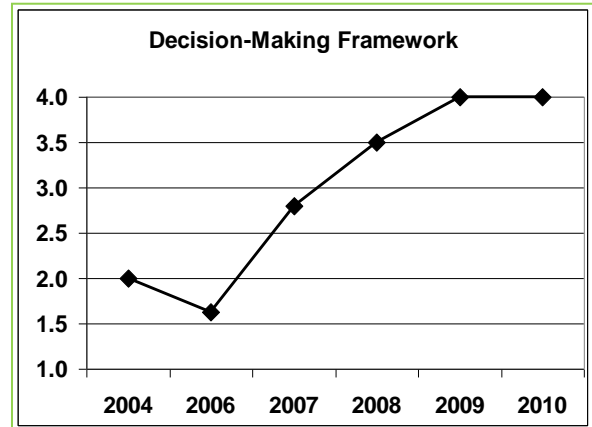


Volunteers: Over the past five years there have been significant challenges in the utilization of volunteers by the Network resulting in inconsistent ratings over the life of the project. However, there have been many outstanding contributions from individuals, especially in the past two years.

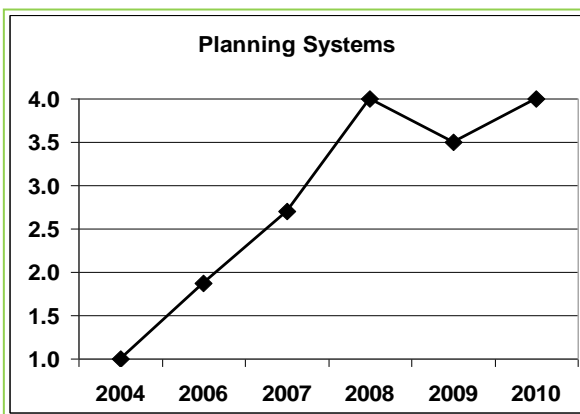
V. Systems and Infrastructure

Decision-making framework: There has been a steady increase in the organizational capacity, especially among staff and board and growth in knowledge.

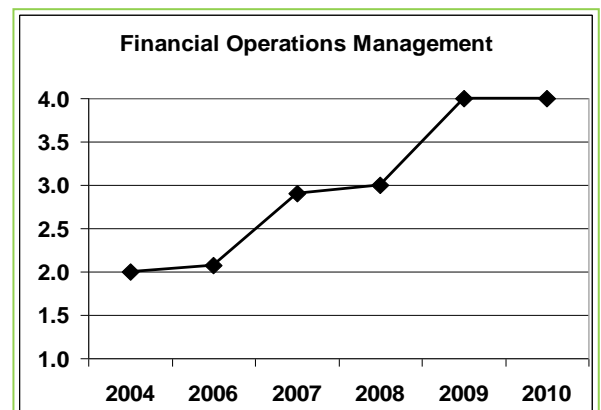
The feedback from the annual McKinsey organizational capacity assessment is a factor in this growth. In addition it has been generalization of knowledge and skills across program elements. The board is involved in managing the budget.



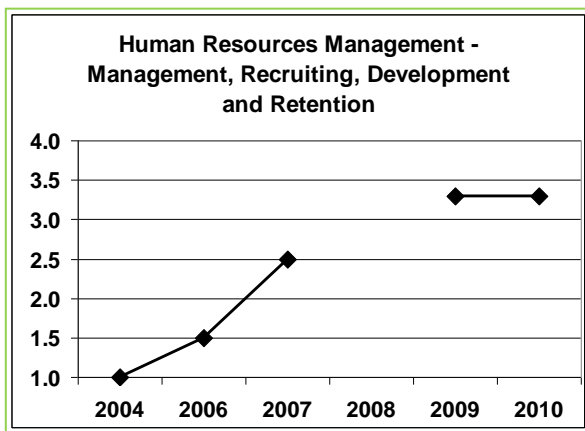
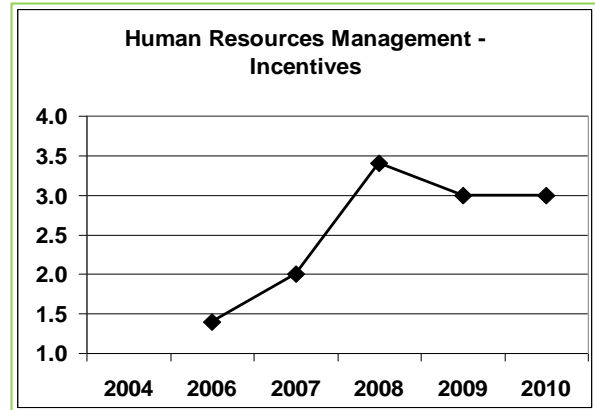
Planning systems: Staff and board were isolated from the planning process in the first years of the grant. In year three of the grant, the work plan was developed with the staff and key board members. Strategic planning, business planning, resource planning were also developed in year three and four. Strategic planning included stakeholders; as a new development, the Network is working alongside the state program office in developing a strategic plan for SBHCs in a statewide process.



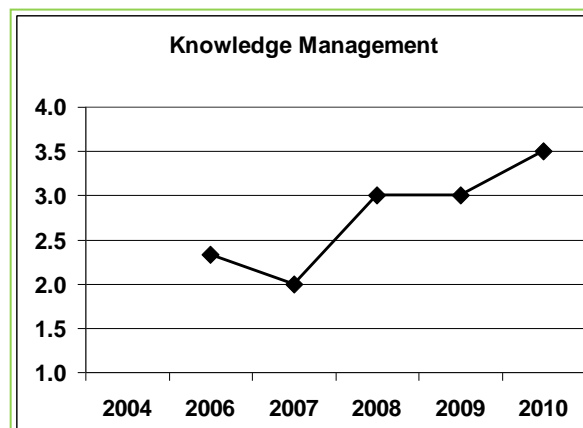
Financial Operations: In this area, the Network grew from being financially managed by a fiduciary, to taking on the breadth of fiscal management. Annual reviews by an external auditor have supported the fiscal management, including operating systems, policies and procedures.

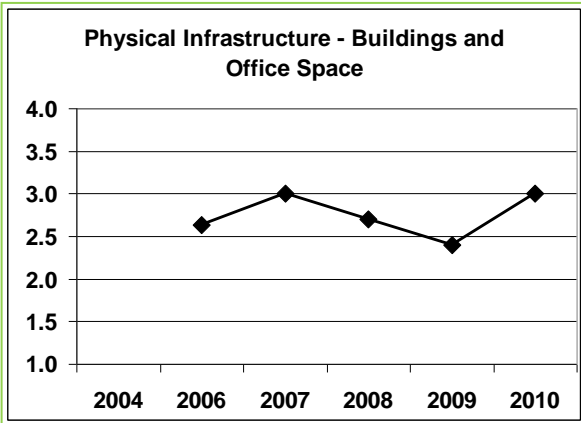


Human resources management and incentives: The capacity increase made through 2007 remains steady, yet incentives have declined because of the economic downturn. At the end of the grant project, the two initial staff left their positions and the policy director is leaving at the end of October 2010. Over all, pay for staff has increased and is commensurate with like organizations.



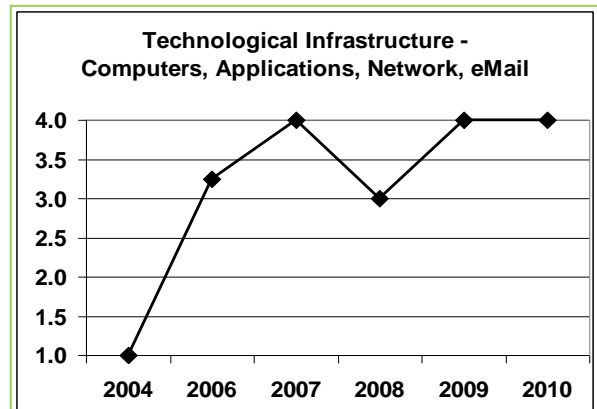
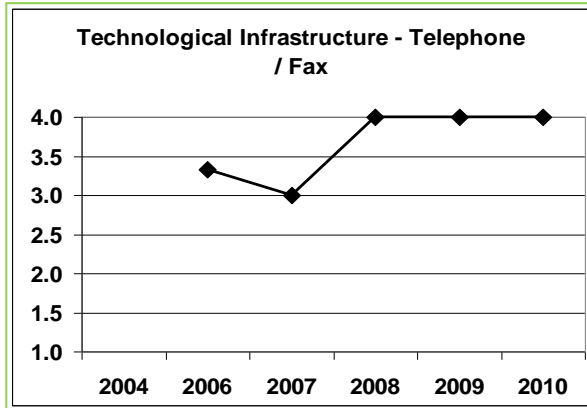
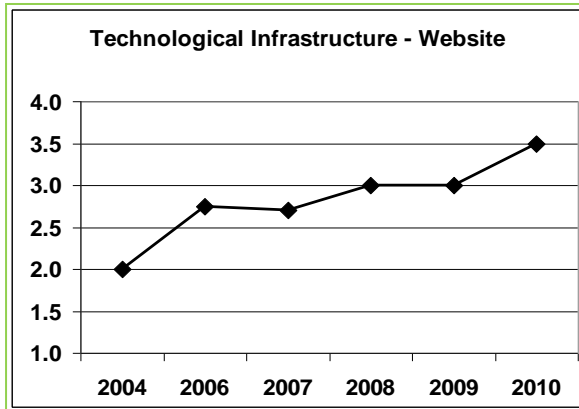
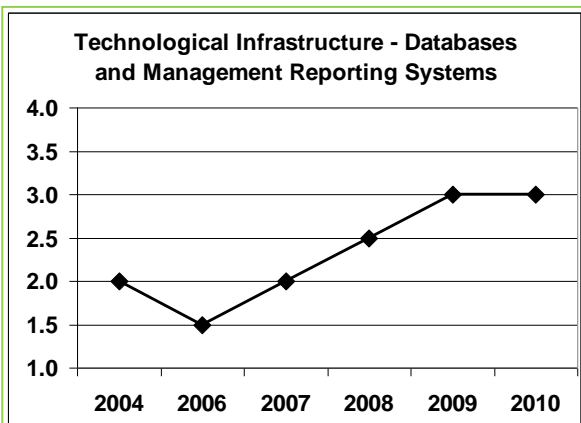
Knowledge management: This has increased of late because of more effective internal networking resources and online resources, including the CORE resources provided by the EC Brown Foundation Project on the web. Timely management of information occurs in weekly staff meetings and one-to-one meetings with supervisors.





Physical infrastructure buildings and office space: Acquiring donated office space within the past two years has had mixed effects on the organizational capacity. On the positive side, the limited and open space facilitates informal communications, conference room facilities are much better than before, and the Network is a closer physical proximity to the state program office. On the negative side, quotation of network offices within a secure building, limit informal contacts with networks and the accessibility of network staff that in the open to configuration limits privacy of staff.

Technological infrastructure - computers: The organizational capacity remains quite high with a recently revised website and excellent core resources available to school-based health care centers throughout the state. These comments also applied to a website which is better maintain more up to date and has a friendlier user-friendly look and feel.

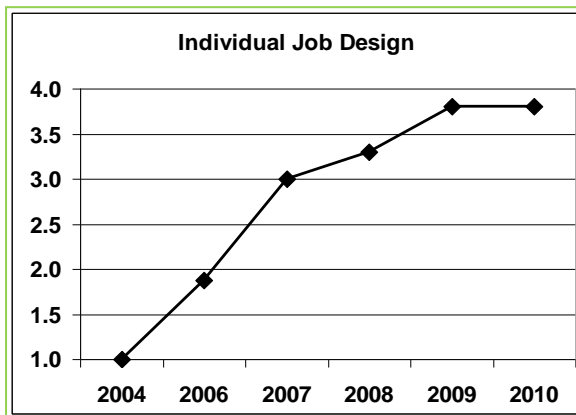
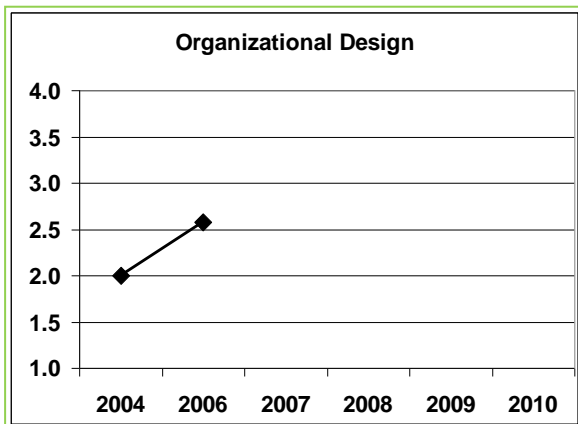
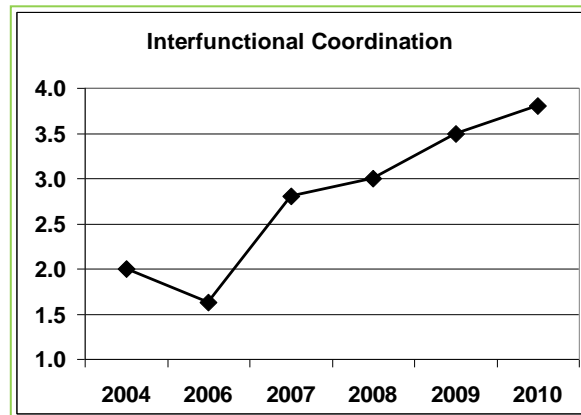


VI Organizational Structure



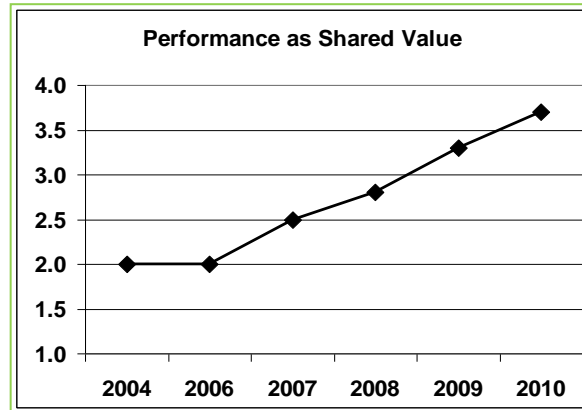
Board governance: There is active support of board members, yet some members are relatively uninvolved. If going just on the capacity of the involved board members, it would be a rating of 4.00, but because of inconsistent attendance the rating is somewhat lower.

Interfunctional coordination: Increases in capacity over the past four years have been maintained, especially the increased communications capacity of the network.

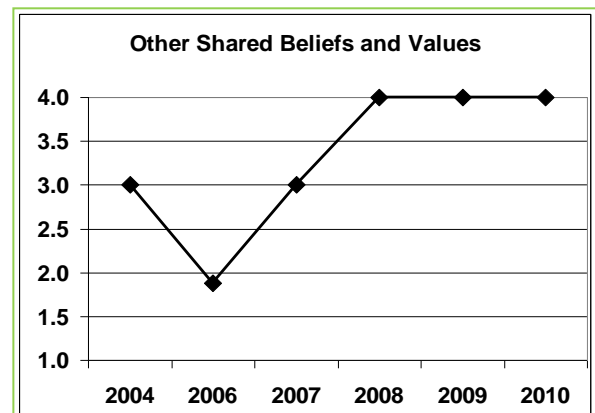
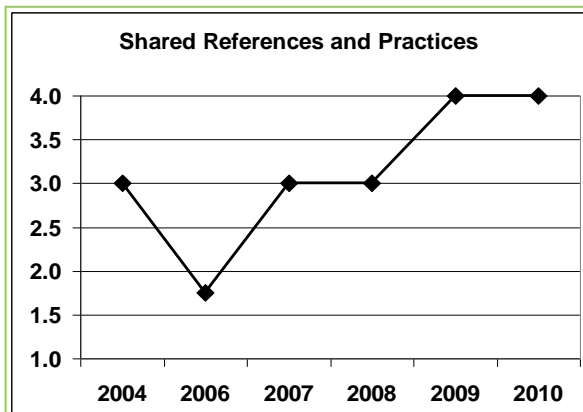


VII Culture

Performance as shared value: the Network's capacity is steadily increasing, with staff and board changes have been prompted improved alignment with within staff, and between staff and board members.



Shared references and practices: there is a rabid belief in a common set of references and practices within the organization and within a year. The upcoming 25th anniversary celebration is designed to honor the stories and the successes of school based health care in Oregon. In literal and symbolic ways, the touchstone—the story that make advocacy what it is will be gathered and shared, open for discussion, and published to the field.



The Impact of Our Work

Impact 1: Local communities, including youth, are shaping the content, quality, delivery, and financing of health care in their communities.

Since the inception of the Kellogg funding, the Network has grown from a few dedicated practitioners to a true state-wide movement. The Network has built a solid, statewide foundation of training, technical assistance, partnerships and policy support that has helped to expand access and improve the quality of health care for youth in Oregon. Local communities have played an important role in guiding this work.

We hold yearly statewide conferences that have brought providers and youth from across the state to learn best practices, improve communications and help inform their youth and community engagement processes. At our conference this year, 170 youth, providers, payers and supporters attended a full day of training, networking and discussions. Through our weekly communications e-bulletin, nearly 800 people around the state have the most current information on funding opportunities, policy developments and training available.

In our communities, SBHC supporters educate legislators, school board members and other policy makers through conducting tours of their sites, open houses, local fundraising events and youth focused outreach. Our communities deliver quality messages to their policy makers and engage the media. (We have captured some of the impressive communications and video work of youth and other supporters at <http://www.osbhc.org/what+we+do/action>).

Community members attended health care reform meetings to provide public comments related to the need for SBHC services. They come to the capitol to testify when SBHCs issues come to committees. They attend meetings with insurance companies to help inform reimbursement discussions. 145 people registered for our SBHC Day at the Capitol in 2010 alone and we confirmed 25 percent of the legislature met directly with youth advocates at this year's event.

Communities have played a particularly strong roll in recent years in the development of sites. All federal legislators have been inside an SBHC, in addition to their staffers. Community engagement is now an official part of the state's planning grant and we have seen much more organized community engagement within newer sites than in past years.

Impact 2: State and national health care policy supports school-based health centers as appropriate models of consumer-centered health care.

Martin Taylor, the former legislative director for the Oregon Nurses Association said: "school-based health centers went from easiest thing to cut to something that everyone wants to support." The Network has developed increased awareness of the issue of access to health care and of school-based health care and gained visibility for this model of care.

Without the Network, this support and awareness would not have happened in this short time frame. The increased awareness and the results of the billing study have also resulted in more success securing meetings with managed care organizations and health insurance companies. SBHCs are consistently being addressed in issues of health care reform by legislators.

There have been clear impacts in state and national health care policy:

- Despite continuing revenue shortfalls and billions of dollars cut out of our budget, the state SBHC program grew by \$4.38 million between 2005 and 2009 legislative sessions.
- State revenue sources were diversified. SBHCs now receive funding from both the general fund and a tax on hospitals and insurers.
- The funding formula review processes created positive outcomes:
 - More equitable funding across the state
 - Statewide support for the funding formula revision
 - No loss of funds to counties transitioning from the current to the new formula
 - Nine out of 22 counties gained funds transitioning from the current to the new formula
 - A monetary value placed on every certified center, maximizing the potential for local community advocacy to maintain existing funds
 - The expectation of shared funding such as local investment and ongoing work towards sustainability
 - Clear guidelines for distribution of future additional state funds if the state budget for SBHC funding is reduced
- State funding recognizes SBHCs as a prevention and access model and helps support services and populations—such as undocumented children—that are not readily reimbursable under our insurance system. State grants (separate from the state SBHC grant) are available to support SBHCs as the safety net for all children.
- The Network is regularly asked to sit on oversight, review and advisory panels to be the voice of SBHCs.

The passage of federal health care reform and emergency appropriations are big first step for the national SBHC movement. The Network can now use the passage of federal authorization as evidence that Oregon's SBHCs are part of a national movement and that they are part of the solution for implementing the goals of health care reform. The emergency appropriations will be helpful in developing new sites and allowing sites to update or purchase equipment, but fall short of the original intent—to help sites with operational costs during the recession.

Still, the funding will help sites buy licenses for electronic medical records which will help them comply with some of the technology mandates of health care reform. Sites continue to struggle to have the capacity to write grants, and the federal grant program is no exception. The Network is working with NASBHC to provide technical assistance to sites interested in applying for the federal grant.

Impact 3: Improved and sustained access to quality services for children and adolescents and in some cases, the broader community

Oregon school-based health centers over the last five years experienced tremendous growth and change. According to the Oregon Department of Human Services, between 2004 to 2009:

- SBHCs provided 325,714 visits to 104,676 clients;
- The number of sites grew from 45 to 55 and there are plans for 10 new sites in the coming year;
- 4 counties have established SBHCs that didn't have one before
- Client growth of 41 percent outpaced the growth in sites and a 32 percent increase in visits;
- Client demographic characteristics changed over time. Sites primarily served clients aged 5 to 19 years old, but doubled the amount of visits to clients over 19 years old by 2009.
- While most of the clients were female, some sites provided a majority of their visits to males.
- SBHCs served an increasingly racial and ethnically diverse clientele. Although most of the clients served are White, that declined 6 percent by 2009. Hispanic clients served grew 36 percent and in four sites comprised more than half of the clients.
- More than half of the clients lacked insurance while Medicaid coverage grew 38 percent and private insurance held steady at about a quarter of the clients.

Impact 4: Strengthened school-based health centers with stable and diverse funding streams that more appropriately support his model of health care delivery.

SBHCs get state dollars from the General Fund and, since 2009, a separate provider tax through the Healthy Kids plan. This is the first time that Oregon's SBHCs receive state funding outside of the general fund. This is a positive because the general fund is very vulnerable to budget cuts. The Network also helped to pass the Healthy Kids insurance plan, which helped enroll 57,000 previously uninsured children in health insurance and which is helping to reduce the amount of uncompensated care in SBHCs across the state. The Network has helped develop relationships between communities and MCOs, hosting several conversations and bridging the gap between payers and providers by helping develop MCO's understanding of the model.

The billing and reimbursement study, together with two other studies form a baseline of information and provide the Network with credible, documented information to take to policy makers and other stakeholders like insurance companies. The Network has begun to use the data in its efforts to drive policy change. The Network is working with one county to investigate particular billing barriers and will inform the field on the outcome of that study. The billing and reimbursement data is moving the conversations with insurance carriers in the state in looking at potential policy changes on their part for financial sustainability for school-based health care centers.

The Network hosts conference calls for the field to share how centers are dealing with issues of sustainability. We get that systems are different, they each have own individual issues and successes and we understand that one solution doesn't fit all.

The study also created the opportunity for the Network to think about its role in working with non-FQHC school-based health centers. These centers are micro-staffed and have neither the capacity nor expertise to effectively bill and generate large amounts of revenue. The Network is considering building, creating or borrowing a billing system where the Network would be the conveyor (like the Michigan School Health Alliance model).

Impact 5: Efficient and high quality delivery of health care by school-based health centers

Oregon’s certification standards allow the Network to demonstrate to policy makers that there is a baseline of services, hours, and staffing at all 55 state funded SBHC programs. It is not always easy for sites to meet the standards—which are voluntary, but a prerequisite for state funding. The Network can use the review process to make the case for changes in the standards which can help communities that have difficulty adapting to the model. The standards have greatly aided the Network’s advocacy allowing us to define the model consistently.

The Network’s advocacy led to funding to sites to implement Key Performance Measures (KPMs). Under KPMs, sites must conduct a risk assessment, a comprehensive physical exam and a BMI for any student with at least 3 visits to the SBHC. Sites must conduct chart audits and report their data to the state.

- \$648,000 in new dollars to support certified SBHCs in adopting KPMs
 - 2008 full implementation and compliance.
 - State continues to work with sites in helping them to report their KPMs.
-

Impact 6: Strong, sustained national and state visibility of the issues affecting school-based health centers

The Network has built our visibility and communications by vastly improving our web site and weekly newsletter. The Network responded to input from our field and streamlined our communications into a weekly e-newsletter. Today, nearly 800 people receive regular updates on policy, share stories and information from across the state, get up to date training information and funding opportunities.

Our web site includes hundreds of resources and tool kits to improve both practice and advocacy. We also post youth video campaigns and media coverage of sites and have an online registration tool for our conference. When necessary, we ask sites to launch campaigns to write letters to the editors or op-eds, and the Network regularly works with sites and youth groups to refine their press releases. The Network has worked with federal and legislators to provide stories for the constituent newsletters and press releases.

Impact 7: State and national school-based health care associations are strengthened in their ability to promote quality health care, inform policy, share best practices nationally, and serve the operational and programming needs of their members.

The Network is now truly recognized as the “go to” body in Oregon for information, technical assistance, policy and communications on SBHCs. This year, was our largest conference ever, with 170 attendees attending 13 different sessions. Youth played a large role, both in presenting and participating in sessions. From conference attendees:

“I am so pleased that the variety of sessions gave us the option to focus in on big issues- sustainability, outreach, and partnerships. I have received so many effective tools!”

“It showed me how wonderful our state-wide community of SBHCs truly is. The result was a fantastic day full of great sessions and sharing. And it succeeded as an adult-youth partnership in a number of ways.”

The Network has had increased attendance at its conference and trainings. Trainings have also helped move new SBHC sites toward opening. Through conference trainings, attendees can get continuing education units.

Analysis and Conclusions

Meeting the demands of a growing organization is not a job for the faint of heart. Typically those who enter the world of nonprofit work are passionate about the outcomes of a mission, whether it is about people or communities, animals or environment. Regardless of the reason for coming, a common concern is sustaining the mission over time. To sustain it, reasonable expectations have to be met around the core ‘business of doing business’ and subsequently focus on the goals related to mission, where passion is realized.

Learnings:

- Develop the mission, vision and clear goals for the organization.
- Hire the right people. Support the right staff with the right mentors (who may or may not serve as board members).
- Develop staff capacity.
- Identify the “Case” clearly and early
- Identify how and *when* to develop the many messages and messengers; train the messengers. That quote about “wisdom and order in all things” establishes ‘calm’ instead of chaos.
- Elicit diverse funding support in a meaningful and targeted way... *before* trying to advance the organization’s mission.
- Work closely with other like-minded organizations and build on their expertise and experience.
- Copy what works: Borrow and adapt whenever possible
- Build friends and alliances, as well as understanding
- Develop meaningful engagement instead of telling community partners what is meaningful... this applies to all levels of engagement.
- Create opportunities to learn from the end-user of your services—then apply the learnings
- Maintain a focus forward, letting the past go—don’t lose the lessons.
- Be careful what you ask for...