



KENTUCKY YOUTH ADVOCATES

Making Kentucky
the best place
in America to be a kid

ISSUE BRIEF

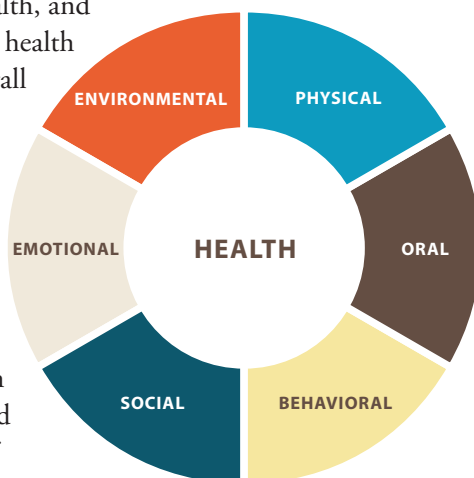
APRIL 2014

Integrated Health Care Benefits Kentucky's Children

Childhood health affects almost every aspect of children's well-being. In Kentucky, too many children struggle with poor health or have special health care needs. Kentucky also has a high rate of child poverty, with 27 percent of children living in poverty – a rate higher than all but four states in the nation.¹ Income level is a leading predictor of health disparities, with children living in poverty experiencing poorer health than their peers in higher-income families.² For these reasons, Kentucky must work to ensure that the comprehensive health needs of children, especially low-income children, are being met through improved access to high-quality care that encompasses physical, behavioral, and oral health.

Kentucky faces great challenges with children's physical health. Kentucky has the seventh-highest rate in the nation of overweight or obese children ages 10-17 and the seventh-highest rate of children ages 0-17 with current asthma.^{3,4} Our state also has the highest rate in the nation (approximately 26 percent) of children ages 0-17 with special health care needs⁵, defined by the National Survey of Children's Health as those with chronic physical, developmental, behavioral, or emotional conditions who require health and related services of a type or extent beyond that usually required by children.

Cognitive development, behavioral health, and oral health are as important as physical health for children to experience optimal overall health and quality of life. Kentucky's children fare poorly in many of these health indicators. For example, almost 10 percent of Kentucky children ages 3-17 have a learning disability,⁶ and nearly 19 percent of Kentucky children ages 1-17 have had one or more oral health problems, such as toothaches, decayed teeth, or unfilled cavities, within the past 12 months.⁷ If unmet, these health needs can have negative lifelong consequences on overall well-being, development, and productivity.



For more information, contact

Katie Carter

kcarter@kyyouth.org

11001 Bluegrass Parkway • Suite 100
Jeffersontown, KY 40299
(502) 895-8167 • www.kyyouth.org



FOUNDATION FOR A
**HEALTHY
KENTUCKY**

This report is funded by the Foundation for a Healthy Kentucky. The contents of this report are the sole responsibility of the authors and do not necessarily reflect the opinions of the foundation.



Efforts to improve the health of Kentucky's children must address all the components of health and its biological, behavioral, social, and economic determinants. This brief examines the advantages of integrated health care, discusses the necessity of school-based care, and explores the ways in which federal and state health care reforms can facilitate the broader implementation of integrated health care. The report concludes by offering recommendations for expanding integrated care to benefit Kentucky's youth.

What Is Integrated Care?

There are various definitions and interpretations of the term “integrated care,” sometimes referred to as coordinated or comprehensive care. A recent study found that patients more or less understand the concept even if they cannot define the term.⁸ A relatively new definition of integrated care that prioritizes the patient describes it as “patient care that is coordinated across professionals, facilities, and support systems; continuous over time and between visits; tailored to the patient's needs and preferences; and based on shared responsibility between patient and caregivers for optimizing health.”⁹ Some of the goals of an integrated care approach include the following:

- Improving access to and continuity of care
- Enhancing the quality of care and quality of life for patients
- Boosting consumer satisfaction
- Increasing efficiencies and cost effectiveness

Two aspects of integrated care are particularly important for children: comprehensive care and co-location of services. Comprehensive care addresses the full continuum of health needs through both preventive care and treatment/therapy, including the use of social support services. Co-located services (i.e., primary care, oral health care, behavioral health, and social services offered at one site) are more convenient, increasing the likelihood that children will receive comprehensive care.

The Benefits of Integrated Care

An integrated approach can increase patients' access to care, encourage engagement in the care they receive, reduce the stigma they experience, and improve their adherence to care plans.¹⁰ Physical and behavioral health conditions frequently coexist and interact with each other, making the coordination of care imperative for effective prevention and treatment. For example, a significant proportion of lifelong cases of mental illness begin by age 14 but go undetected during childhood.¹¹ In addition, many pediatric primary care visits are for psychological or social issues.¹² For all of these reasons, behavioral health and primary care services that are co-located and/or include an integrated treatment plan can promote better outcomes.¹³

In addition to its positive impact on patient outcomes, this approach also has the economic benefit of reducing the cost of health care by improving the effectiveness of the care administered and increasing the productivity of medical providers.¹⁴ This is particularly true when primary care and behavioral health services are co-located, since the presence of a behavioral health specialist gives primary care practitioners more time to attend to other patients.

Integrated care can also refer to the expansion of providers' services to include preventive care for health needs traditionally regarded as beyond their scope of practice. For example, primary care providers play an important role in oral health education and prevention for their young patients, most of whom who see primary care providers earlier and more frequently than they see dentists.¹⁵ In Kentucky, primary care physicians with patients under age 6 on Medicaid may be reimbursed up to twice a year for applying fluoride varnish.¹⁶ This example of integrated care allows professionals outside of dentistry, often in primary care settings, to improve the oral health of young children, since fluoride application is one of the most effective, simple, and inexpensive ways to prevent or slow the development of cavities in young children.¹⁷



INTEGRATED HEALTH CARE BENEFITS KENTUCKY'S CHILDREN

INTERPROFESSIONAL TRAINING ON CHILDHOOD HEALTH

For children's health providers to dispense patient education, screenings, and preventive services for other areas of health, they need the appropriate training. Incentives, such as free training and reimbursement for such work, are also important. The national Smiles for Life program is a good example of interprofessional training for children's health providers. This program is designed to promote oral health by engaging and training primary care providers, such as doctors and nurse practitioners. Its free comprehensive curriculum consists of eight topical online courses (including one on children's oral health) that qualify for continuing education (CE) credits.¹⁸ In 2013, 219 Kentucky health professionals received CE credits from Smiles for Life.¹⁹ The Kentucky Oral Health Coalition will be promoting utilization of this resource throughout the state over the next two years.²⁰

The Role of School-Based Health Care

The integrated care approach promotes service provision in a variety of settings in order to reduce barriers to health care access. Offering integrated care in school settings is a win-win proposition for students and educators. Students whose health and social services needs are met can focus better in class and may demonstrate improved academic performance.²¹ Furthermore, since schools often depend on funds tied to average daily attendance figures, providing school-based health care can benefit students and shore up school budgets at the same time.

The concept of school-based health care originated in the 1900s to address the public health challenges of communicable diseases, including measles, tuberculosis,

whooping cough, and scarlet fever.²² Schools experienced high student absenteeism due to those illnesses and lacked an effective way to control the problem, so they brought in school nurses to create treatment protocols, care for sick children, and provide health education to families.²³ Since then, the recognition of the necessity of school-based health care, including school-based health centers (SBHCs), has continued to grow and the types of services provided have expanded.

SBHCs are one model for providing health services in schools. They are often operated through partnerships between a school and a community health organization, such as a community health center, health department, or hospital.²⁴ SBHCs have the potential to implement integrated models of health care that address many of the factors that impact health, including behavioral, social, and economic determinants.²⁵

Studies on the effectiveness of SBHCs demonstrate that they increase access to care, improve student health and education outcomes, and generate high levels of patient satisfaction.²⁶ A 2009 study showed that students with an SBHC at their elementary school had a greater probability of seeing a dentist, medical doctor, counselor, or social worker. These students were less likely than their counterparts (without access to an SBHC) to visit the emergency department for care.²⁷ Studies on SBHCs also indicate a positive impact on student achievement and attendance.²⁸ The most recent data show that in Kentucky, federally qualified health centers operate sites in only 44 of the more than 1,200 public schools in the state.²⁹

Aside from SBHCs, school nurses play a crucial role for students by promoting health and safety, intervening to address students' health issues, and providing case management services. Studies link school nurse interventions with reduced absenteeism and other positive student outcomes.³⁰ Nevertheless, a survey of Kentucky's public school districts in the 2008/09 school year found that Kentucky fell far short of meeting the nationally recommended school nurse-to-student ratio. The statewide average of reporting districts was one full-time equivalent nurse to 1,254 students, while the National Association of School Nurses recommends one nurse for every 750 healthy students.³¹



The Affordable Care Act

In 2010, major federal health care reform legislation, the Patient Protection and Affordable Care Act (ACA), was enacted. Among many other things, the ACA promotes better coordination of health care delivery, such as integrated care models.³² The ACA also appropriated funds for SBHCs – the first national recognition of their significant contributions to the health and well-being of children and adolescents.³³ The \$200 million in funding is being used to create new SBHCs, modernize current sites, and expand the range of preventive and primary care services they offer.³⁴

Other provisions in the law that can enhance integrated care include the following:

- Easier access to preventive care for children covered under private plans³⁵
- The creation of an essential benefits package that helps ensure all children and families have access to preventive care, chronic care management, behavioral health services, and substance use disorder services
- Equality in the type of coverage provided for physical health, behavioral health, and substance use services by a plan³⁶

The ACA also provides support for states to build facilities that promote integrated care.³⁷ Health homes are one such model for improving coordination of care among Medicaid beneficiaries with chronic conditions by having one provider, or one team of providers, “integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person.”³⁸ In January 2014, Kentucky received a planning grant to draft an amendment to its state Medicaid plan in order to establish health homes.³⁹ Depending on how the program is designed, health homes can be targeted to address the chronic health needs of specific groups within Kentucky’s Medicaid population. Children in the child welfare system, for example, often have complex health care needs. Better coordination of services can pay off by providing better health care in general and for people with specific chronic problems.⁴⁰ Improved continuity of care could greatly benefit children, particularly those in the child welfare system, as they move between settings.⁴¹

Medicaid Managed Care

Managed care is a cost-saving approach to health care delivery that aims to improve quality and coordination of care and increase access to care. It does so by ensuring that those enrolled in the program have a primary care provider and that beneficiaries rely mainly on preventive and primary care, rather than emergency services.⁴² In late 2011, Kentucky implemented the use of Managed Care Organizations (MCOs) for the Medicaid program statewide. MCOs provide a package of specified health care benefits with a list of designated providers. The Kentucky Department for Medicaid Services pays the MCOs up front, based on the number of members enrolled. An October 2013 press release from the governor’s office identified improvements brought about by the implementation of Medicaid managed care, with its emphasis on wellness and preventive care. For example, flu vaccinations in children increased 33 percent.⁴³

Another key component of MCOs in Kentucky is the use of case management for some participants. This service can promote more cohesive care by designating someone to manage health care delivery for members with chronic or serious health risks. Case managers ensure that patients are connected to necessary services to address their health care needs, promote continuity of care, and avoid duplication of services. In Kentucky, case management is available to select patient populations in Medicaid managed care:

- Children under age 3 who have developmental disabilities and are enrolled in the state’s early intervention program
- Young children in the state’s home visitation program for families at risk of child abuse or neglect
- Children deemed by their respective state commissions to be disabled or to have special health care needs
- Children with severe emotional disability or mental illness who are at risk of out-of-home or institutional placement.⁴⁴

One goal of case management, and of managed care in general, is to reduce reliance on emergency room visits and specialty services. It’s better for a parent to take his or her child to the doctor for a cold, for example, than to forgo treatment, only to have the child hospitalized later for pneumonia. However,



INTEGRATED HEALTH CARE BENEFITS KENTUCKY'S CHILDREN

prioritizing savings above all else can have the unintended effect of reducing access to services and increasing impediments to high-quality care. Seeking to address this issue, in 2013 the Foundation for a Healthy Kentucky worked with researchers to conduct focus groups across the state with adults and parents of children in Medicaid managed care. While the majority of participants reported good experiences receiving specialty care (such as obtaining therapy or being referred to a specialist), initially accessing that care was the most common difficulty participants faced. Another identified need was improvement in the level of integration of behavioral and physical health services. The report identified barriers to integrated care, such as the subcontracting of behavioral health services to external companies by some MCOs. Another barrier was a state Medicaid reimbursement policy requiring that behavioral health and physical health services be delivered on different days.⁴⁵ Shortly after the focus groups were conducted, the state changed this policy to allow for same-day billing of services by different providers as long as the services being billed for are not identical.⁴⁶

Ways to Enhance Integrated Care in Kentucky

Because of Kentucky's high poverty rates, the state relies heavily on Medicaid to meet its citizens' health care needs. The Kaiser Commission on Medicaid and the Uninsured recently released a brief outlining five promising approaches used by some state Medicaid plans to better integrate health care. These approaches fall along a continuum of strategies, from taking modest steps to fully integrating patient care. This continuum can help stakeholders assess their progress

and decide what further steps they can take to integrate patient care, even if full integration cannot be achieved.⁴⁷

UNIVERSAL SCREENING

Recognition that an individual's health is complex is the foundation upon which the concept of integrated health care rests. As such, providers must screen patients for conditions in addition to those for which they seek care. For example, primary care providers can screen patients for behavioral health and oral health needs. A number of evidence-based tools are available to accomplish this, and screenings are typically designed to take very little time. Screening for behavioral health problems is especially important for children and adolescents, since such issues frequently remain undetected and untreated, leading to a multitude of negative outcomes, such as school failure, underemployment, and poverty in adulthood.⁴⁸

Recognizing the importance of early identification in prevention and treatment, the Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities is working on a culturally competent, community-based approach to screen students in schools for behavioral health issues.⁴⁹ The department is looking at ways to implement the Global Appraisal of Individual Needs Short Screen (GAIN SS) screening system, which is currently being used by the Kentucky Administrative Office of the Courts to help determine the need for referral to behavioral health services/resources.⁵⁰ The results of this pilot project will need to be examined before it is implemented in each school district.

Continuum of Health Care Integration

COORDINATED CARE

CO-LOCATED CARE

INTEGRATED CARE



Source: Kaiser Commission on Medicaid and the Uninsured (2014). *Integrating Physical and Behavioral Health Care: Promising Medicaid Models*.

NAVIGATORS

If a screening indicates the need for referral to another provider, the individual often needs help obtaining those services. Recognizing the difficulties of navigating the health care system, many Medicaid programs are now using “navigators” as informed companions to help beneficiaries. Navigators may be nurses, social workers, or trained paraprofessionals, and their roles can range from helping a beneficiary find and secure needed care, to interacting with their health care providers on their behalf. The relationships they develop with beneficiaries and their providers can foster a culture of more coordinated and integrated care.⁵¹

Peer specialists are one type of navigator used in state Medicaid programs. These navigators have personal experience with behavioral health needs and have completed training to help other behavioral health clients navigate the system.⁵² These individuals can provide the support and information necessary for patients to recover. Kentucky’s Division of Behavioral Health has provided training opportunities for consumers to become peer specialists and has assembled a committee to evaluate the program’s effectiveness.⁵³ As of January 1, 2014, peer specialists working under the supervision of a psychiatrist, licensed clinical social worker, or other certified provider can be reimbursed by Kentucky’s Medicaid program.⁵⁴ Research has found that use of peer navigators increases the likelihood that individuals with serious mental illness will use primary care services.⁵⁵ Time will tell whether the recent change allowing Medicaid reimbursement will improve access to and utilization of this service in Kentucky.

CO-LOCATION

Sometimes the biggest barrier for patients to get all their health needs met is distance to and from the doctor’s office. A lack of transportation, difficulty taking time off from work, and the necessity of making trips to multiple locations can be prohibitive. Patients may decide to seek help only for their most pressing health care needs. Community health centers have been leaders in the co-location of physical and behavioral health care. Medicaid’s managed care system of providing up-front payment, rather than fee-for-service, supports this model because community health centers can factor in the costs of including licensed behavioral health practitioners when calculating prepayment rates.⁵⁶

Several non-profit organizations in Kentucky use the integrated care approach of co-location to better serve patients. Below are three examples of organizations that address a variety of children’s health needs using this model.

FAMILY HEALTH CENTERS

When established in 1976, Louisville’s Family Health Centers (FHC) had a vision to provide



Family Health Centers

Care for your Health & Wellness

quality care to all residents. FHC now has seven locations throughout the city designated as federally qualified health centers. They provide care to patients who may not otherwise have access to quality care because of their health insurance status or lack of sufficient income. FHC providers include medical doctors, osteopathic doctors, advanced-practice registered nurses, psychiatric mental health nurse practitioners, dentists, pharmacists, and licensed clinical social workers.⁵⁷ The range of services includes the following:

- Primary care (adult and pediatric care, OB/GYN care, and laboratory and X-ray services)
- Oral health care
- Behavioral health services
- Pharmacy
- Family and parenting resources
- Health education classes
- Support services (e.g., interpretation, applying for health coverage)

HOME OF THE INNOCENTS

For more than a century, Home of the Innocents has provided programs and services to thousands



of underserved children in the Louisville area, including those who have experienced abuse, abandonment, or neglect; children who are medically fragile; and children with autism.



INTEGRATED HEALTH CARE BENEFITS KENTUCKY'S CHILDREN

The care given at Home of the Innocents is integrated to deliver a wide range of programs and services, ensuring that children receive effective treatment at low cost. With the recent creation of Open Arms Children's Health, Home of the Innocents is now a one-stop shop for many different health services. Children can receive all of the following health care services during one appointment: medical, oral health, hearing, vision, radiology, behavioral health, and pharmacy services. Home of the Innocents also provides autism intervention services, pediatric respite care, pediatric outpatient rehabilitation for speech and occupational therapy, and aquatic therapy.⁵⁸

PENNYROYAL COMMUNITY MENTAL HEALTH CENTER

Serving eight counties in Western Kentucky, the Pennyroyal Center was founded in 1967 to address the gap in behavioral health services available to children and families. In

addition to providing comprehensive programs and services in the areas of community behavioral health, intellectual and developmental disabilities, and substance abuse, the center recently began offering primary care services at its Hopkinsville location. All of the center's services (behavioral health and primary care) are available to every client, although a sliding fee scale based on income is not offered for primary care services.⁵⁹



HEALTH HOMES

As discussed previously, health homes are an option authorized by the ACA that allows state Medicaid plans to advance the integration of care for beneficiaries with complex health issues. Health homes offer “comprehensive care management; care coordination and health promotion; comprehensive transitional care; patient and family support; referral to community and social support services; and the use of health information technology to support these services.”⁶⁰

The Kentucky Department for Medicaid Services has received from the federal Center for Medicaid Services an 18-month planning grant to develop a state amendment

creating a health home program to coordinate care for Medicaid patients with chronic conditions. The core planning workgroup is responsible for identifying experts and organizations that can provide consulting services and technical assistance. It is also tasked with identifying organizations and stakeholders to take part in the planning process.⁶¹ Kentucky officials will be studying which populations to include in the health home program. Children in the child welfare system would greatly benefit from being identified as an eligible population.

SYSTEM-LEVEL INTEGRATION OF CARE

Fully integrated care requires a patient's health providers to function as a team “in a shared practice and with a shared vision, [in which] both providers and patients experience the operation as a single system treating the whole person.”⁶² This system-level integration represents the most advanced model on the integration continuum.

The Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities has a 4-year, \$4 million agreement with the federal Substance Abuse and Mental Health Services Administration to improve support for children with behavioral health needs and their families.⁶³ The goals of this project, known as the Kentucky Initiative for Collaborative Change (KICC), align with the Kaiser Commission's description of system-level integration of care. KICC's goals and planned activities include improving financing strategies, increasing wraparound training for care coordinators, exploring options for improving case management, and strengthening interagency collaboration.⁶⁴ If accomplished, this initiative could be a step toward achieving a high level of integrated care for the children of Kentucky.

Conclusion

Integrated care leads to better health outcomes for Kentucky's children and their families. It addresses health care needs using a range of strategies and resources in a variety of settings, promoting increased access to care and to higher-quality care. It has been modeled by pilot programs in Kentucky and in other states. Enhancing the integration of care is especially important in order to reduce the burden of poverty for Kentucky's low-income children.



INTEGRATED HEALTH CARE BENEFITS KENTUCKY CHILDREN

Endnotes

- 1 Annie E. Casey Foundation (2013). *KIDS COUNT Data Center*. Available at <http://datacenter.kidscount.org/data/tables/43-children-in-poverty?loc=19&loc2=2#ranking/2/any/true/868/any/322>. Accessed March 2014.
- 2 Seith, D. and Isakson, E. (2011). *Who Are America's Poor Children? Examining Health Disparities among Children in the United States*. National Center for Children in Poverty. Available at http://www.nccp.org/publications/pub_995.html. Accessed March 2014.
- 3 Data Resource Center for Child and Adolescent Health (2012). *2011 National Survey of Children's Health*. Available at <http://childhealthdata.org/browse/allstates?q=2416>. Accessed March 2014.
- 4 Data Resource Center for Child and Adolescent Health (2012). *2011 National Survey of Children's Health*. Available at <http://childhealthdata.org/browse/allstates?q=2401#>. Accessed March 2014.
- 5 Data Resource Center for Child and Adolescent Health (2012). *2011 National Survey of Children's Health*. Available at <http://childhealthdata.org/browse/allstates?q=2546#>. Accessed March 2014.
- 6 Data Resource Center for Child and Adolescent Health (2012). *2011 National Survey of Children's Health*. Available at <http://childhealthdata.org/browse/survey/results?q=2539&cr=19>. Accessed March 2014.
- 7 Data Resource Center for Child and Adolescent Health (2012). *2011/12 National Survey of Children's Health*. Available at <http://childhealthdata.org/browse/survey/results?q=2587&cr=19>. Accessed March 2014.
- 8 Walker, K., Labat, A., Choi, J., Schmittl, J., Stewart, A. and Grumbach, K. (2013). "Patient Perceptions of Integrated Care: Confused by the Term, Clear on the Concept." *International Journal of Integrated Care*, vol. 13, Jan.-Mar. Available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3653280/>. Accessed March 2014.
- 9 Ibid.
- 10 Foundation for a Healthy Kentucky (2012). *Integrating Care for Better Health: Charting a Course Together for Better Health for All Kentuckians*. Available at <http://www.healthky.org/sites/default/files/Final%20PDF-IC%20White%20Paper.pdf>. Accessed March 2014.
- 11 National Institute of Mental Health (2009). *Treatment of Children with Mental Illness*. Available at <http://www.nimh.nih.gov/health/publications/treatment-of-children-with-mental-illness-fact-sheet/index.shtml>. Accessed March 2014.
- 12 Foundation for a Healthy Kentucky (2012). *Integrating Care for Better Health: Charting a Course Together for Better Health for All Kentuckians*. Available at <http://www.healthky.org/sites/default/files/Final%20PDF-IC%20White%20Paper.pdf>. Accessed March 2014.
- 13 Collins, C., Hewson, D. L., Munger, R. and Wade, T. (2010). *Evolving Models of Behavioral Health Integration in Primary Care*. Available at <http://www.milbank.org/uploads/documents/10430EvolvingCare/10430EvolvingCare.html#intro>. Accessed March 2014.
- 14 Foundation for a Healthy Kentucky (2012). *Integrating Care for Better Health: Charting a Course for Kentucky*. Available at <http://www.healthky.org/sites/default/files/Integrated%20Care%20Issue%20Brief%202012.pdf>. Accessed March 2014.
- 15 Pew Charitable Trusts (2011). *Reimbursing Physicians for Fluoride Varnish*. Available at <http://www.pewstates.org/research/analysis/reimbursing-physicians-for-fluoride-varnish-85899377335>. Accessed March 2014.
- 16 Cantrell, C. (2009). *Engaging Primary Care Medical Providers in Children's Oral Health*. National Academy for State Health Policy. Available at <http://www.nashp.org/sites/default/files/EngagingPrimaryCareMedicalProvidersCOH.pdf>. Accessed March 2014.
- 17 Pew Charitable Trusts (2011). *Reimbursing Physicians for Fluoride Varnish*. Available at <http://www.pewstates.org/research/analysis/reimbursing-physicians-for-fluoride-varnish-85899377335>. Accessed March 2014.
- 18 Smiles for Life: A National Oral Health Curriculum (2014). Available at www.smilesforlifeoralhealth.org. Accessed March 2014.
- 19 Smiles for Life National Oral Health Curriculum (2013). *Report on Trends, User Profile, and Satisfaction: January 1 – December 31, 2013*.
- 20 Kentucky Youth Advocates (2014). *Smiles for Life in Kentucky: A National Oral Health Curriculum*. Available at <http://kyyouth.org/smiles-for-life-in-kentucky-a-national-oral-health-curriculum/>. Accessed March 2014.
- 21 Basch, C. (2010). "Healthier Students Are Better Learners: A Missing Link in School Reforms to Close the Achievement Gap." *Equity Matters*, Research Review no. 6. Available at http://www.equitycampaign.org/ia/document/12557_equitymattersvol6web03082010.pdf. Accessed March 2014.
- 22 Keeton, V., Soleimanpour, S. and Brindis, C. (2012). "School-Based Health Centers in an Era of Health Care Reform: Building on History." *Current Problems in Pediatric and Adolescent Health Care*, vol. 42, no. 6. Available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3770486/>. Accessed March 2014.
- 23 Ibid.
- 24 U.S. Department of Health and Human Services, Health Resources and Services Administration (2014). *School-Based Health Centers*. Available at <http://www.hrsa.gov/ourstories/schoolhealthcenters/>. Accessed March 2014.
- 25 Clayton, S., Chin, T., Blackburn, S. and Echeverria, C. (2010). "Different Setting, Different Care: Integrating Prevention and Clinical Care in School-Based Health Centers." *American Journal of Public Health*, vol. 100, no. 9. Available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2920951/>. Accessed March 2014.
- 26 Keeton, V., Soleimanpour, S. and Brindis, C. (2012). "School-Based Health Centers in an Era of Health Care Reform: Building on History." *Current Problems in Pediatric and Adolescent Health Care*, vol. 42, no. 6. Available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3770486/>. Accessed March 2014.
- 27 Larsen, C.D., Larsen, M.D., Handwerker, L.B., Kim, M.S. and Rosenthal, M. (2009). "A Comparison of Urban School- and Community-Based Dental Clinics." *Journal of School Health*, vol. 79, no. 3. Available at <http://onlinelibrary.wiley.com/doi/10.1111/j.1746-1561.2008.00395.x/abstract>. Accessed March 2014.
- 28 Dilley, J. (2009). *Research Review: School-Based Health Interventions and Academic Achievement*. Washington State Department of Health. Available at http://here.doh.wa.gov/materials/research-review-school-based-health-interventions-and-academic-achievement/12/HealthAcademic_E09L.pdf. Accessed September 2010.
- 29 List of Kentucky School Based Health Centers provided by the Kentucky Primary Health Care Association, March 14, 2014.
- 30 Maughan, E. (2003). "The Impact of School Nursing on School Performance: A Research Synthesis." *The Journal of School Nursing*, vol. 19, no. 3. Available at <http://www.rmc.org/wpde/wp-content/uploads/2012/12/The-impact-of-school-2.pdf>. Accessed March 2014.
- 31 Kentucky Youth Advocates and the University of Louisville Urban Studies Institute (2011). *A Picture of Health: A Report of Kentucky School Districts' Health Services*. Available at http://kyyouth.org/wp-content/uploads/2012/11/A-Picture-of-Health_A-Report-of-Kentucky-School-Districts-Health-Services.pdf. Accessed March 2014.
- 32 Golden, O. and Emam, D. (2013). *How Health Care Reform Can Help Children and Families in the Child Welfare System: Options for Action*. The Urban Institute. Available at <http://www.urban.org/UploadedPDF/412842-how-health-care-reform-can-help.pdf>. Accessed March 2014.
- 33 Keeton, V., Soleimanpour, S. and Brindis, C. (2012). "School-Based Health Centers in an Era of Health Care Reform: Building on History." *Current Problems in Pediatric and Adolescent Health Care*, vol. 42, no. 6. Available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3770486/>. Accessed March 2014.
- 34 U.S. Department of Health & Human Services (2011). *The Affordable Care Act and the School-Based Health Center Capital Program*. Available at <http://www.hhs.gov/healthcare/facts/factsheets/2011/12/sbhc.html>. Accessed March 2014.
- 35 Center for Children and Families (2012). *ACA Protects and Improves Access to Preventive Care for Children*. Georgetown University Health Policy Institute. Available at <http://ccf.georgetown.edu/wp-content/uploads/2012/03/ACA-Protects-and-improves-access-to-preventive-care-for-children-3-24-2012.pdf>. Accessed March 2014.
- 36 Foundation for a Healthy Kentucky (2012). *Integrating Care for Better Health: Charting a Course for Kentucky*. Available at <http://www.healthky.org/sites/default/files/Integrated%20Care%20Issue%20Brief%202012.pdf>. Accessed March 2014.
- 37 Golden, O. and Emam, D. (2013). *How Health Care Reform Can Help Children and Families in the Child Welfare System: Options for Action*. The Urban Institute. Available at <http://www.urban.org/UploadedPDF/412842-how-health-care-reform-can-help.pdf>. Accessed March 2014.
- 38 U.S. Centers for Medicare & Medicaid Services (2014). *Health Homes*. Available at <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Integrating-Care/Health-Homes/Health-Homes.html>. Accessed March 2014.
- 39 Personal correspondence with Andrea Adams, Project Director, Office of Health Policy, Kentucky Cabinet for Health and Family Services, March 20, 2014.
- 40 Golden, O. and Emam, D. (2013). *How Health Care Reform Can Help Children and Families in the Child Welfare System: Options for Action*. The Urban Institute. Available at <http://www.urban.org/UploadedPDF/412842-how-health-care-reform-can-help.pdf>. Accessed March 2014.
- 41 Ibid.
- 42 Henry J. Kaiser Family Foundation (2012). *Medicaid and Managed Care: Key Data, Trends, and Issues*. Available at <http://www.kff.org/medicaid/upload/8046.pdf>. Accessed March 2014.
- 43 Governor Steve Beshear's Communications Office (2013). *Gov. Beshear: Aggressive Action Plan for Managed Care Paying Off*. Available at <http://migration.kentucky.gov/Newsroom/governor/20131024managedcare.htm>. Accessed March 2014.
- 44 Personal correspondence with Erin Hoben, Chief Policy Advisor, Kentucky Department of Medicaid Services, March 21, 2014.
- 45 Palmer, A., Howell, E., Kenney, G.M., Abraham, P. and Costich, J. (2013). *Risk-Based Managed Care in Kentucky: A Second Year Implementation Report and Assessment of Beneficiary Perceptions*. Urban Institute and University of Kentucky. Available at http://www.healthky.org/sites/default/files/Year%202020Qualitative%20Evaluation%20Paper_FINAL.PDF. Accessed March 2014.
- 46 Kentucky Legislative Research Commission. Kentucky Administrative Regulations 907 KAR 15:010E and 907 KAR 1:044E. Available at <http://www.lrc.ky.gov/kar/frntpage.htm>. Accessed March 2014.
- 47 Henry J. Kaiser Family Foundation (2014). *Integrating Physical and Behavioral Health Care: Promising Medicaid Models*. Available at <http://kaiserfamilyfoundation.files.wordpress.com/2014/02/8553-integrating-physical-and-behavioral-health-care-promising-medicaid-models.pdf>. Accessed March 2014.
- 48 Ibid.
- 49 Personal correspondence with Mary Begley, Commissioner of the Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities, March 12, 2014.
- 50 Collins, K. et al (2011). *Reclaiming Futures in Kentucky*. Available at <http://kyyouth.org/wp-content/uploads/2012/11/Reclaiming-Futures-in-Kentucky.pdf>. Accessed March 2014.
- 51 Henry J. Kaiser Family Foundation (2014). *Integrating Physical and Behavioral Health Care: Promising Medicaid Models*. Available at <http://kaiserfamilyfoundation.files.wordpress.com/2014/02/8553-integrating-physical-and-behavioral-health-care-promising-medicaid-models.pdf>. Accessed March 2014.
- 52 Ibid.
- 53 Kentucky Cabinet for Health and Family Services (2013). *Recovery and Peer Support*. Available at <https://dbhdid.ky.gov/dbh/ebpi-recovery.aspx>. Accessed March 2014.
- 54 U.S. Centers for Medicare and Medicaid Services (2014). *Kentucky State Plan Amendment*. Available at <http://www.medicare.gov/State-resource-center/Medicare-State-Plan-Amendments/Downloads/KY/KY-13-022.pdf>. Accessed March 2014.
- 55 Henry J. Kaiser Family Foundation (2014). *Integrating Physical and Behavioral Health Care: Promising Medicaid Models*. Available at <http://kaiserfamilyfoundation.files.wordpress.com/2014/02/8553-integrating-physical-and-behavioral-health-care-promising-medicaid-models.pdf>. Accessed March 2014.
- 56 Ibid.
- 57 Family Health Centers (2014). *About Us*. Available at <http://www.fhclouisville.org>. Accessed March 2014.
- 58 Home of the Innocents (2014). *Overview*. Available at <http://www.homeoftheinnocents.org/overview>. Accessed March 2014.
- 59 Pennyroyal Center (2013). *Primary Care Services*. Available at <http://www.pennyroyalcenter.org/index.html>. Accessed March 2014.
- 60 Henry J. Kaiser Family Foundation (2014). *Integrating Physical and Behavioral Health Care: Promising Medicaid Models*. Available at <http://kaiserfamilyfoundation.files.wordpress.com/2014/02/8553-integrating-physical-and-behavioral-health-care-promising-medicaid-models.pdf>. Accessed March 2014.
- 61 Personal correspondence with Dr. John Langefeld, Chief Medical Officer, Kentucky Department of Medicaid Services, March 21, 2014.
- 62 Henry J. Kaiser Family Foundation (2014). *Integrating Physical and Behavioral Health Care: Promising Medicaid Models*. Available at <http://kaiserfamilyfoundation.files.wordpress.com/2014/02/8553-integrating-physical-and-behavioral-health-care-promising-medicaid-models.pdf>. Accessed March 2014.
- 63 Kentucky Cabinet for Health and Family Services (2013). *Behavioral Health Receives \$4 Million for System of Care Expansion*. Available at <http://chfs.ky.gov/news/SAMSHA+Cooperative+Agreement.htm>. Accessed March 2014.
- 64 Presentation to the State Interagency Council for Services to Children with an Emotional Disability, September 25, 2013. Available at <http://dbhdid.ky.gov/dbh/documents/siac/KICC-Presentation.pdf>. Accessed March 2014.