BEYOND MAKING THE GRADE

AN ISSUES FORUM ON SCHOOL-BASED HEALTH CENTERS

Presented by

The Oregon Health Division

in association with

The Robert Wood Johnson Foundation

October 25, 2000

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INTRODUCTION

> *"You all know about Willie Sutton, who was asked, "Why do you rob banks?" He said, "I rob banks, because that's where the money is." School-based health centers are where we should be providing health services because that's where the kids are. That's where their stable environment is. That's where we ought to be supporting resources that help kids get primary care."**

In 1994, the Robert Wood Johnson Foundation awarded the Oregon Health Division a planning grant to study state policy and sustainability of school-based health centers. The grant program, entitled "Making the Grade: State and Local Partnerships to Establish School-Based Health Centers," helped create six SBHC sites throughout the state: at Lane and Whitaker Middle Schools in Multnomah County, at Scenic Middle and Jewett Elementary Schools in Jackson County, and at Pendleton High and Sunridge Middle Schools in Umatilla County. Two additional centers are scheduled to open in late 2000 in Oregon, at Binnsmead Middle School in Multnomah County and at Lewis and Clark Elementary School in Columbia County.)

> *"We have 45 current school-based health centers located in 13 counties. Two-thirds are in high schools, where we have the social-health-related problems. The rest are split between elementary and junior high schools, where we have the opportunity to prevent the kinds of problems we see in the secondary schools."*

On October 25, 2000, the Oregon Health Division convened a full-day forum to examine key issues surrounding "Making the Grade" following the program's two years of planning and four years of implementation. The forum was envisioned as a means of evaluating the program's progress, in part to determine its future course. By its public nature, the forum would also serve to inform educators, health care professionals, policymakers, youth advocates, and others about the program's successes and challenges.

A total of twenty panelists and speakers participated in the forum, which was divided into sessions concentrating on three especially critical areas: Financing and Reimbursement, Reproductive Health Care, and Mental Health/Unmet Needs. An invited audience of approximately one hundred attended the session.

> *"[In Oregon], significant numbers of our kids are getting health care and immunizations through school-based health centers. That is one of the critical features for protecting the community and individuals. We have done it successfully in the schools."*

This report presents the issues raised and discussed within each panel, accompanied by recommendations made and excerpts of key comments by the panelists.

The Oregon Health Division (OHD) has recently adopted standards by which a school-based health center can achieve OHD certification and thus become eligible for state funding. For copies, call (503) 731-4331.

**These quoted sections are from the welcome address by Martin Wasserman, MD, JD, former Administrator of the Health Division, Oregon Department of Human Services*

KEYNOTE ADDRESS

BY JULIA GRAHAM LEAR, PHD
DIRECTOR OF MAKING THE GRADE
ROBERT WOOD JOHNSON FOUNDATION

It's only been 15 years since a pediatrician from Boston, Phil Porter, traveled from Salem [MA] to testify before your state legislature. He was the head of paternal and child health in Cambridge, MA, and head of pediatrics for Cambridge Hospital. Dr. Porter had been impressed by what had happened when he removed the school nurses. In their place, he hired nurse practitioners and put them in the schools, instead of leaving them in clinics where, it frequently happened, they did not get enough business. That was the beginning of his idea of a school-based health system.

Not too long after that testimony, the Oregon legislature decided to put some money into school-based health care. About the same time, January 1986, Multnomah County itself invested money, and Roosevelt High School opened in January of 1986. Now, 15 years later, you have 45 centers, with two in the pipeline. Not bad in 15 years where we have dealt with all kinds of questions.

When you opened, there were 40 to 60 centers nationally. Now there are over 1,300. But it isn't just that we have more centers — the centers are more organized. They're organizing at the national level — National Assembly on School-Based Health Care started about 1995. A number of people from here have been very active in that organization. As is the case in Oregon, there are nearly 20 state associations of school-based health centers. That becomes important because those are vehicles of encouragement for sharing information, for professional development, and for doing the political business that is essential if you are going to be publicly supported at the local, state, or federal level.

HANDLING THE HARD WORK

Congratulations are in order to everybody who's been involved in opening these centers. This is hard work, but you have stuck with it. School-based health centers are hard because you can't do them without interagency collaboration. At the least, you have to work with schools and you have to work with a health care entity. If you're really doing prevention, you probably need a community base — American Cancer Society, American Heart Association, or others who are very interested in early intervention and working with children. We all know that everyone loves to talk about collaboration, and most of us run in the other direction when we're asked to sit in on meetings that are tedious and sometimes take a long time to produce results.

School-based health centers are hard because we have to spend a lot of time convincing payors that we're a legitimate part of the health care system. That's an ongoing job. Just when you think you've gotten someone convinced, they take another job and you start again with a new person. They're hard because across the country, not in every state but here in Oregon, there are very small groups of citizens who don't believe you should do school-based health care. This is a sufficiently important issue that we have posted several articles on our website that address the kind of political discussion that needs to occur, how to engage — in a respectful way — people who disagree profoundly with what you are doing, and how to address political controversy. Not all of your public health activities require from you this level of political sophistication and ongoing engagement with people who may not support you.

Dr. Porter once said, "Health care needs to be where students can trip over it. Adolescents do not carry appointment books, and school is the only place where they are required to spend time." You have been making his dream into a reality. You have done this not just here in Oregon, but nationally. Oregonians have been critical to the development of the National Assembly on School-Based Health Care. What started five years ago now brings together 820 people annually. You need leaders when you have that kind of growth. Denise Chuckovich was the third president, Tammy Alexander was on the first executive counsel who had to deal with all those institutional issues on how you get a national organization off the ground. Bob Nystrom has provided leadership as co-chair of the research committee.

"Having the standards of certification helps show payors and policy-makers that school-based health centers are real solid providers of documented quality."

Your contributions to the national field have been important. The standards for certification you developed help show payors and policy-makers that school-based health centers are solid providers of documented quality. In many locales, when people think of health services in schools, what comes to mind is bumps and bruises and acute injury. They aren't thinking about prevention, about how we can intervene early and effectively. But Oregon has always thought about prevention. You identify the important issues and you think about what can be done in the center.

One example is the tobacco-use cessation and prevention curriculum developed by Multnomah County and the Portland Public School system. When it came to my desk, I got about halfway through it and said we have to get permission to put it on our website. I'm sure we'll be getting a couple of hundred hits a day, because what you did was valuable not only for your city, but for communities around the country where that material can now be downloaded and used.

I often talk about Multnomah County as an example of how local leadership and community support and people working together can overcome limitations of dollars from the outside. Paul Ilinek, Vice President of the Robert Wood Johnson Foundation, asked me particularly to convey his sense that the investment the foundation made in Oregon has been wise and fruitful. "You know," he said, "they were doing it before we came in and we hope they'll do it afterwards, but we're glad we got to be part of that process."

NEW PRIORITIES AHEAD

As we move forward, we face changing priorities and new challenges. The three areas that we see as demanding increased attention are as follows:

1. **First, there is no question that documentation of clinical quality is simply going to be required.** That will be an expectation of payors and legislators. One of the most important things about school-based health centers is that they were born at the same time as the desktop computer. The consequence is that all of the centers very quickly got used to having electronic data management. Centers are comfortable with software use. I think that's one of the reasons they're fairly receptive to the notion of continuous quality improvement.

   Our office is putting together, with federal support, a continuous quality improvement tool specifically for school-based health centers. We are now putting together an advisory committee to review our work, and we expect to have a tool available by the end of the summer of 2001. Then, whether you're in elementary, middle, or high school, you can use what we call sentinel conditions

to rate yourself on how well you're doing and look at what areas you need to strengthen or improve. That's going to impress payors and people who are concerned about getting their money's worth if they invest in our kind of program. Even better, I think it's going to make the quality of our practices just terrific.

2. Second, prevention is the coming thing — and I think that Oregon is way ahead of the game. We've talked about prevention a lot in primary care, and we've done precious little. The reason is simple: it doesn't get reimbursed. When you have to make choices about how you use your staff, it is not surprising that you try to do the things that managed care will pay you for. There's an increasing awareness that we have to do more around prevention. While that is not news for you all, it is news for others, and that's one of the reasons that what you have done so far in prevention is so important.

3. Third, greater attention is going to be paid to having school-based health centers address gaps in care. The greatest gaps are dental and mental health. Because Making the Grade is reaching its end, our office has been funded by Robert Wood Johnson to become the Center for Health and Health Care in Schools in January 2001. If you listen to the words, you realize that we're going to be thinking not just about school-based health centers, but also about other ways people can promote the health and well-being of children in a school setting. That may be school nursing, it may be health education, it may be joint community-school partnerships targeting tobacco use or nutrition. Two areas we're going to pay particular attention to are dental health and mental health. The RWJ Foundation has funded us to make grants starting in 2001 supporting existing school-based health centers. This will not be an initiative for new centers. I think the foundation believes its days of funding new centers is at an end, that the states and local foundations are picking this up, that Robert Wood Johnson's job is really to help refine the model.

"We're going to be thinking not just about school-based health centers, but also about other ways people can promote the health and well-being of children in a school setting.'

What RWJ wants to do next is look at developing information for the field on what it would take to do certain kinds of dental services. You might have a full operatory, you might have a rinse program, you might do sealants. All of those are staffed differently, they cost different amounts. We're going to have a grant program where existing centers can apply for support.

Most school-based health centers have some kind of mental health connection. It is not clear exactly what the models of service are, and we don't know as much as we would like about what they cost, how they're reimbursed, and exactly what is required to have a mental health program truly equal to your physical health program. We hope to fund existing centers, look at the types of services, and begin to profile what makes sense as an initiative in a field that will remain underfunded for the foreseeable future. I can't give you the timeframe for that, but I can tell you that we will probably post the RFP on our site in February. There will probably be a date in May for a letter of intent to apply and an application in midsummer with grants to be announced in mid fall. We are thinking that the funding checks will be in the mail in January 2002, so that one could start in January 2002.

It's worth paying attention to that process, not because we're going to have a large amount of money, but because I'm absolutely convinced that there's going to be a federal emphasis on mental health, and that dental health seems to be a big area of interest. We also know that Robert Wood Johnson is likely to take a fairly major step toward mental health. One thing we are seeing is that you don't have to apply to a program that's labeled "school-based health center" to get funding.

THE CHALLENGES WE FACE

There are three challenges. They're big and tough, and they have been with us since the beginning.

1. **The first challenge is to develop a vision.** Once you've gotten to 45 centers, it's time to ask, "Where are we really going with this? How many do we really need?"

In Oregon, at least according to the U.S. Department of Education, you have 1,222 public, elementary, and secondary schools. Forty-five represents a little under 4% of the total. Even if the entity that does the thinking about this is not making decisions about who is going to have a center, it helps to know where you're going. The same is true nationally. There are 97,000 public elementary and secondary schools nationally, and there are over 1,300 centers. That's 2%. Where should we be nationally? How many schools have enough kids who are likely to have unmet needs to justify putting a school-based health center there?

"The vision was that we think in this country, every child has a right to effective access to appropriate care. This was part of a much bigger and grander vision about a fair society and a fair chance for kids."

The vision is important because it is very easy, when you do a new thing, to get caught up as it grows. The vision wasn't "gee, we wanted to have 1,200 community health centers." The vision was that we think in this country, every child has a right to effective access to appropriate care. We don't think that should be a function of being lucky enough to live in this neighborhood or to have that set of parents. This was part of a much bigger and grander vision about a fair society and a fair chance for kids. The vision can help focus on that very important goal.

2. **The second challenge is to build political support for that vision.**

If the vision depends on public support, meaning tax dollars, it will not go anywhere without a substantial base of public understanding and public desire.

The January issue of Health Affairs, if all goes well, will carry an article in which the evaluators of Making the Grade write about what they learned. They walked into centers not believing there were many kids in need, and they came out stunned at the kinds of problems children face with no help. The second thing they say is that the states where support of school-based health centers has grown most rapidly, meaning dollars appropriated by the state legislature, are not necessarily Democratic or Republican, or led by a governor who supports the centers. The key is what they call good, old-fashioned distributive politics. In Louisiana, for instance, which is perhaps the champion in this area right now, once there were nine school-based health centers scattered around the state. People who wanted centers — not just professionals, but voters, community leaders, city council members and mayors — went to their state legislatures and said, "How come we don't get one of those?" After all, the state was putting in some money, and the people down the road had one. Of course, it was sometimes useful if the people who wanted a center also had a member who was a chair of a committee.

Having spent six years in Making the Grade, worrying about where we fit into managed care and what the technical issues are around contracting and allocation of the MCH block grant, I have to tell you that while those things were important, they don't hold a candle to the political process.

3. **The third challenge is how you get the financing.** All of us need to understand that the solution to this challenge is taken care of if you do the politics. That's not to say it's not important to do the quality, that it isn't important to document your services. But it's not going to get the funding. It's part of what you need to do, but we have to tell this story in a politically meaningful way.

Here's the kind of thing I mean. In 1988, Andrew Young, who had been a leader in the civil rights movement and elected mayor of Atlanta, gave a talk to a meeting of school-based officials. There were senior RWJ officials there to talk with him before the meeting began. These were the presidents and vice presidents, and they were saying, "Mayor Young, you're the kind of person who has to take up this model and support it, and we're doing this kind of research and we don't have this question answered," and there was 15 minutes of pondering over research that needed to be done and research in process. He listened, then smiled and said, "I just think it's wonderful that you all are doing that research, and I'm sure we're going to benefit. But if the question is what will it take for me to try to get my city council to put public dollars into school-based health centers, I got two questions: Is it mostly going to do good stuff? That seems pretty obvious. Second question, did the people who voted for me want it?" We need to pay more attention to the second question, because I don't think it's just Mayor Young who wants to know the answer.

"If the vision depends on public support, meaning tax dollars, it will not go anywhere without a substantial base of public understanding and public desire."

I want to end with a quote from Richard Reilly, the Secretary of Education. This is something he said 14 years ago:

"I would like to think that all of us would have sufficiently transformed the school's landscape in the next five years so that we'll help the young bodies and minds to support the growing requirements of an educated and productive citizen. The same positive impact which has been made on our public schools, also must be made in the health-related issues affecting infants, children, and teenagers. Our future success as a nation can be guaranteed only if we are willing to commit to the dual goal of healthy minds and healthy bodies preparing themselves in healthy classrooms. It is within our power to make these young lives healthy and productive in my judgment, but it will take planning and cooperation and common sense and wise use of resources and plain hard work. But I strongly feel that if we are to reap the full benefits of our current public school reform movement, then we must be sure that during these first critical years and beyond, we give our children every single chance at a healthy life and a healthy mind. Affluence should not be the criteria for good health or good education."

Dr. Lear's keynote address has been edited and slightly revised to accommodate the printed format of this report.

ABOUT THESE PANEL PRESENTATIONS

The goal in producing this printed report was to make a concise record of the issues forum for those who attended and, even more important, to provide those who were not able to attend with a picture of the event.

All discussion sessions were tape recorded, and those recordings were then transcribed word-for-word. The content of those discussions was then synthesized into the form you see on the following pages.

The panelists' comments have been edited for clarity and brevity. Care was taken to retain the speakers' meaning and exact wording wherever possible.

PANEL PRESENTATION: FINANCING AND REIMBURSEMENT

EXCERPTS OF PANELISTS' OPENING COMMENTS

Hank Collins: I'm the director of the Jackson County Health and Human Services Department in Medford. We were one of three sites that participated in the Making the Grade project, and I spent an inordinate amount of time in the four years we were involved in trying to figure out creative ways of financing our school-based health centers in Medford. We're in the process of opening our eighth school-based health center in Jackson County.

John Santa: I'm the administrator for the Oregon Health Plan Policy and Resource. I think it's just important to note how much flux and turbulence we're in the midst of, particularly around the Oregon Health Plan. But I think a lot's changing, I think the competitive market-based insurance model has clearly not worked in our state in terms of publicly funded health care. That's not a policy statement but a statement of reality. Many of our communities outside of Portland, as OHP has reached a crisis, have not responded.

Diane Linn: I serve on the Multnomah County Board of Commissioners. What I'd like to touch on is where do we go from here? We commit about $2.4 million dollars out of Multnomah County's general fund that's matched with some state money for STARS [Students Today Aren't Ready for Sex], all told about $2.5 million. We have estimated that each [high school-level] clinic costs about $220,000 to $300,000. Of course, the middle schools are less expensive. I think we're at a real crossroads right now about where we take the program from here.

Tom Fronk: I'm in the Director's Office of the Multnomah County Health Department. Immediately prior, I spent 12 years as the business services director. The marketplace has not worked well for publicly funded clinics. It's been my job over that time to make it work. It's been difficult. In some ways, the amount of county support is a problem.

Jim Rowland: I'm from the Office of Medical Assistance Programs. Probably the Oregon Health Plan is where you'd know me from, on the Title 19 or Medicaid side. Apparently, the interest in my talk will be about how we can continue to leverage state general fund dollars into federal dollars.

CHALLENGES

QUESTION 1: In Oregon and nationwide, school-based health centers have been proven to be an effective means of delivering primary care services to youth, but we continue to struggle with how to sustain and grow these programs with financial support. What's the strategy for school-based health center sustainability in the financial sense? What have we learned with the help of RWJ about some visions of how we accomplish this?

Recommendations and strategies:

- Establish a stable base of funding
- Set policy that mandates school district participation (10-20% or more)
- Use creativity:
  - in supplementing funding base (e.g., other governmental sources, such as U.S. Department of Education)

- in leveraging resources
- in negotiations (with state, insurance carriers, etc.)

- Consider the politics of tapping into community support
- Think outside of jurisdictional orientation; act across jurisdictions
- Be aware of additional sources of funds, through education
- Build relationships with school districts
- Follow the model of successful communities that feature delivery options
- Improve organizational abilities, especially around securing federal financial participation
- Become better at partnering and collaboration

Critical points:

- The state needs to assume a strong leadership role
- State general funds for SBHCs are near maximum allocation
- State action on waivers may hold some promise:
  - Use of Children's Health Insurance Program (CHIP) funds for direct payments to SBHCs
  - Linking SBHCs with single community or Medicaid Health Maintenance Organization (HMO)

Panelist Comments:

"One of the indicators of success that the more successful communities are doing is to include a set of delivery options. So, they include safety net operations, school-based clinics. The degree that we can get communities that are struggling to look at that model and figure out what's best for them will be relevant to what we're talking about today." **John Santa**

"This school-based health center thing was the only idea that came close to providing primary care to citizens. We don't do primary care at the Jackson County health department." **Hank Collins**

"After four years in Jackson County trying a number of options, when it came down to the wire, had the legislative assembly not approved the additional funds, we would have closed both our clinics for lack of funding." **Hank Collins**

"You have to have a stable base of funding. Then I think you need to be creative on how you go about supplementing that. We've used prevention dollars for mental health, we've used dollars from our commission on children and families. We've used tobacco prevention dollars. We've used grants to do after-school programs." **Hank Collins**

"Building a relationship with the school district is important, looking at what the needs of those kids are in a holistic way. One policy that we set up pretty early was that we will not attempt to do this [have SBHCs] unless the school district pays 20% of the cost." **Hank Collins**

"We're kind of maxed on how much we can continue to contribute from the general funds, so we've got to get creative about leveraging our resources, negotiating with the state, with insurance carriers. I encourage you to think about the politics of how we tap into communities and how we get their support for expanding this program aggressively." **Diane Linn**

"We've been trying to supplement and support the Portland School District so it doesn't lose the middle class family from the district. We get in-kind use of facilities and a very small percent of support, and, frankly, I don't think they're capable of anything more right now. I'd like to see us partner better with the schools, have their support, be a part of it." **Diane Linn**

"We need to promote this community school notion and think outside of our jurisdictional orientation and more at a higher level across jurisdictions. That has to do with the integration projects and our collaborative efforts to really talk about what the state, city, county, school district, and the ESD [Education Service District] could do." **Diane Linn**

"Any grant that comes out of the U.S. Department of Education must go to an education entity. In other words, even though those dollars are coming from multiple agencies, the grants must go to a school system. I haven't heard of anyone sitting down with the school system and saying, okay, you guys are eligible for the money that the rest of us can't touch, and some of those dollars are clearly usable in a school-based health center." **Julia Lear**

"I have never had anyone sit and volunteer, 'Oh, I'm getting money from someone, would you like to share it?' I think that we have to educate people so you can sit down with the school district and say, 'This is what we understand.' Once you've put it on the table, maybe the negotiation is possible." **Diane Linn**

"Those who are knowledgeable in the public health and school-based health center arena are not always aware of what is available in an adjacent silo called education." **Barney Speight**

"The Health Division's annual report says an ideal model of local government is a 20% participation in funding school-based health services… It needs to be a community effort to fund these clinics. In Multnomah County, it is not. The county is still the major payor — 64% last year. That's an improvement; it has been as high as 80% in the past. It's taken us 14 years to get down to 64%, and it's a long way between 64 and 20." **Tom Fronk**

"One of the things that need to happen in Oregon — the state needs to assume a stronger leadership role, and I've really seen that start to happen. FPEP [Family Planning and Expansion Project] has had strong positive effects on school-based health care." **Tom Fronk**

"I think we're starting to learn to partner together such as on efforts to improve funding for safety net clinics throughout Oregon. That is going to be a very fertile area for us to explore in the future, trying to find places where we can just organize ourselves better, particularly around drawing down federal financial participation." **Tom Fronk**

"The state of Oregon may be leaving $100 or $125 million of Children's Health Insurance Program (CHIP) funds on the table. That's the Oregon allocation, and there's been an little bit of 'use it or lose it' mentality in Congress. Is there any opportunity that CHIP dollars might become diverted and become a form of state support?" **Barney Speight**

"There are going to be a lot of opportunities for change and communities that can respond to those opportunities will have an advantage. One key question involves what the role a safety net will be in

those efforts. School-based clinics are somewhere in between safety net operations and more traditional operations." **John Santa**

"We do have a couple specific ideas that we're going to pursue waivers on at some point. One would be to allow the use of CHIP funds to make direct payment to school-based health centers and other safety net clinics for services provided to CHIP-eligible children. Essentially acknowledge the whole infrastructure that we have is too complex for an awful lot of children and their parents. Essentially not have to go through the eligibility process on a child-by-child basis." **John Santa**

"The second waiver idea is linking school-based centers with a single community Health Maintenance Organization, Medicaid HMO. Basically, you'd have an integrated health-based system for Medicaid- and CHIP-eligible children. Essentially they'd have a school-based health center, a community HMO system that would take care of them seven days a week. The funds that were put towards the school-based center by any government entity would be credited to the state's match." **John Santa**

QUESTION 2: The public sector government is a major purchaser of health insurance for their employees' independence. Is it possible to envision a time when the public sector purchaser actually leads the way and says, "As a condition of providing a policy for our employees, we want you to make school-based health centers part of the in-network delivery system"?

Recommendations and strategies:

- Be persistent in seeking leverage and aggressive about applying it
- Where Public Employees' Benefit Board (PEBB) does not have leverage, it should explore combining forces and creating strong partnerships

Critical points:

- Confidentiality issues complicate the matter
- Timing is tricky: contracts with labor unions must follow a definite cycle
- The health care system has changed the least among service organizations since the post-World War II era, but change is beginning to happen. Those changes may bring opportunities.

Panelist Comments:

"There are some confidentiality issues that complicate the matter. Frankly, we're out of ideas on how to approach the companies in a way that would be voluntary, or we could come to some kind of mutual agreement. The hard part is these are all negotiated contracts with labor unions; they happen in a certain cycle. I have actually talked to the labor union leadership about the prospect of using our purchasing power to negotiate insurance coverage, and they're amenable to discussing that. The timing is tricky, but I think we've got to use some kind of leverage and get very aggressive about it." **Diane Linn**

"It's time for purchasers and consumers to say, 'Well, we just want what we want…Some of us want to be taken care of in groups, some of us want our children to be taken care of in school-based health centers, and some of us want the old one-on-one with our doctors. We're not going to pay

this kind of money and just get the one-on-one. We want some changes.' I'm sure the response will be, 'Well what are you willing to give up?' Or, 'What stakeholder group are you willing to take on?'" **John Santa**

"The Public Employees' Benefits Board (PEBB) needs to look at markets that it has influence in, where it has significant leverage, like Salem and Eugene and Portland. But then it needs to look at markets where it doesn't have leverage and see if it can combine forces. Combined, we can be more powerful than we have been in the past." **John Santa**

"An article in the September 2000 Harvard Business Review characterizes the health system as the organization of services that have changed the least in the post-World War II era. But change has begun to occur at the subterranean level. If you read it, you'll be able to sort of insert the words 'school-based health center,' and I think you may see some opportunities there for taking your case to the employers." **Julia Lear**

QUESTION 3: For many involved with the SBHC movement, politics has not been a primary focus. Yet, political issues are increasingly critical to the continued support — and therefore the existence — of school-based health centers in Oregon. How can we deal with this reality? At what level should political activity occur? Should it center around a particular health issue or under an umbrella of a kind of service delivery, community-based mechanism like a school-based health center?

Recommendations and strategies:

- Form partnerships to develop strategies targeting leaders and future leaders in state legislature
- Be aggressive in tapping support bases locally and throughout the state; connect with those who have a political base or inclination
- Hold policy-makers accountable for their actions and promises as candidates
- Make sure policy-holders are knowledgeable about SBHCs: what they do, whom they serve, how they help
- Find and support champions at various levels of government
- Improve efforts at self-promotion

Critical points:

- The Health Division can help with leadership in forming partnerships
- A vocal minority have intimidated communities and policy makers away from SBHCs because of the reproductive health issue
- Politics is like sales: you have to have a close; you have to ask for the sale
- Should private donations to SBHCs be explored?

Panelist Comments:

"We need to get together as a group and target those people that are going to be representing us in Salem, who we think will be in leadership positions. I know there have been some pushes from

the Health Division to do something about tobacco with your legislators or show them what you do in communicable disease, but the Health Division needs to exert leadership to bring the locals in and together strategize." **Hank Collins**

"I believe that there's a community of people who have intimidated the general community, and people in political office to some extent, away from even trying to assess whether we can establish more health clinics because of the reproductive health piece of it. We have got to be much more aggressive and tap that support base that actually exists in this community and some places around the state." **Diane Linn**

"The trick is to connect with people in your communities that actually do have a political orientation and get them thinking more about who gets elected to office. Because, we underestimate how much we actually impact people who end up getting elected. So, there's a process in the election cycle that has to do with starting to ask candidates, "Would you support funding for school-based health clinics? Do you think that reproductive health should be included or not?'" **Diane Linn**

"When people do get elected, hold them accountable to what they said they would do as a candidate. That part of the process is showing them in real terms what the center looks like, having them talk to kids who benefited from the center, getting them as close as possible. Then connecting them with constituents that can hold them accountable to seeing it through." **Diane Linn**

"You also have to get some champions at different levels of government to help advance these negotiations; it's not even so much just asking them for money, because they get asked for money all over the place for everything." **Diane Linn**

*"**Politics** is much like sales. You have to have a close, and the close of the issue is you have to ask."*

Barney Speight

"If you want money for school-based health centers, you have to say you want money for school-based health centers, and you have constituents who say we don't have one yet because you guys aren't appropriating enough money. Give us more money." **Julia Lear**

"We probably need to start focusing a little bit more on self promotion. Every clinic should have a 'here's how to continue to support your school-based health clinic' message. Use a flyer or something to get people thinking. Maybe we ask the question about whether or not private donations to school-based health clinics might be appropriate and how might that be structured?" **Julia Lear**

QUESTION 4: A primary goal of SBHCs is prevention, yet it is frequently difficult to gain interest in or funding for this, although it would save millions of lives and health care dollars over the years. How can the value of prevention be promoted when seeking funding from all sources, including the legislature, school districts, foundations, communities, and other advocates?

Recommendations and strategies:

- Continue to make the cost-effectiveness argument, using statistics, studies, and logic

- Encourage state powers (e.g., Office of Medical Assistance Programs) to demand accountability from providers and insurers
- Understand compromise: realize that some services may have to be given up in the interest of achieving preventative care benefits
- Learn from the dental care model for preventative care
- Mobilize support from local communities and the state legislature
- Develop grass-roots support for fluoridation; get the issue on the ballot

Critical points:

- Adolescents are underutilizers of the "sick-care" system, producing a greater need for preventative care
- Preventative care can be a hard sell because of the added (apparent) cost
- Water fluoridation is still seen as "rat poisoning" to some people. They will fight to prevent it

Panelist Comments:

"One of the things that never left me is the incredible disconnect between school-based health centers trying to create a preventative health-care model and what is a sick-care system of medicine in my opinion. Combine that with trying to target our resources at a population, at least with adolescents, that are underutilizers of the sick-care system." **Bob Nystrom** (in audience)

"When you go to do preventative care, that's really an entirely different thing that nobody is willing to pay for and that's probably going to cost you a little bit more money than what you're currently doing over on the sick-care side." **Bob Nystrom**

"Until the powers that be, be they in the office of medical assistance programs or wherever in this state, demand some accountability in this arena from the providers, from the insurers and providers, we are not going to get anywhere." **Hank Collins**

"I think the state has a role, but I think the problem is more us. I think the question is, what are you willing to give up? I think we have a governor who is going to go at basic benefits again. We are going to have the fight of our lifetime on our hands with the federal government again. On the private side, how much is it going to take to get people mad about prescription drugs? And mad about technology? And mad about where we're headed? Ok, so we could design a basic benefit plan that would emphasize access, prevention, early diagnosis, and early treatment, but we've got to give up something." **John Santa**

"In the May Pediatrics there was an article by a university professor and a physician who studied all the Medicaid costs associated with kids who attended a school that has a school-based health center and compared them against the cost associated with serving rural children in a comparison site. They found that the overall Medicaid costs were lower for the kids who had access to the school-based health center. What we don't have is states holding the plans accountable for the contracts that have been signed. Nothing you or I can say is going to have any effect." **Julia Lear**

"SBHCs are exactly where we want to be. They are the number one place where you're going to get sealants applied effectively and comprehensively. You can also apply other preventive services that don't even involve dental personnel to do the actual manpower. The cost effectiveness is just outrageously overwhelming here." **Whitney Payne, D.M.D.**, Oregon State Dental Director (in audience)

"The clear and compelling dental health mandate is statewide optimal community water fluoridation. We'd realize millions within three years if we had that." **Whitney Payne**

"When I was in high school, fluoride was a communist plot. Now it seems to me that science should prevail on these things." **Barney Speight**

"Fluoride is still rat poisoning to some people. The dental approach is modeling some of the best prevention services in the standard model. Most of you know they're now doing sealants on kids to prevent cavities. It was never done before. There's a whole lot of work on how to get kids to brush and floss and at least do some fluoridation in the dental offices. We have a lot to learn from the area of study to apply to the medical model." **Diane Linn**

"I think the only way we're ever going to begin fluoridating public water supplies in this state is to work to develop the grass-roots support and have committees of our public community citizens going out and collecting signatures and forcing political bodies to put it on the ballot." **Hank Collins**

"We fought like hell to get the insurance companies to step up and cover mammograms and gynecological exams, even though it would save us hundreds of thousands of dollars of care costs for early prevention and early detection of cancer. It just doesn't make sense. We can make that cost-effectiveness argument." **Diane Linn**

"Imagine the costs we save in preventing even one pregnancy. In some counties of this state, 60% of the babies born go right on to welfare. Point blank, that high. And now we recast this whole argument using the dental model and any other way we can prove with all the data we know right now, that the money we can save will pay for everything we're talking about trying to provide today 10 times over in not much time at all. I don't know how we persuade the insurance companies to see the benefit of that. They don't seem to want to talk about it in that way." **Diane Linn**

"Community support is the only way that this is going to happen. The private sector, parents, classroom teachers, counties, local health care entities, and most importantly, I think the courage of the state legislature have to say yes to all of the above." **Whitney Payne**

QUESTION 5: In Oregon's current political climate, most of the education focus (and funding) seems to be on issues of academic accountability, with other aspects, such as school-based health centers, often perceived as fluff. How can that focus be broadened to give SBHCs their proper importance in Oregon's education system?

Recommendations and strategies:

- Use the holistic argument: We have to deal with the whole child

- Establish positive partnerships with school districts
- Develop and disseminate information about the way SBHC services meet the specific needs of the school system

Critical points:

- Students who face health issues can have great difficulty achieving academically, regardless of academic or testing standards
- School districts are under great pressure for academic improvement
- A vocal minority can sometimes override the wishes of the community at large

Panelist Comments:

"We all know that, for some kids, if they have health issues or mental health issues or problems at home, they are not going to achieve. There's nothing in the world a teacher can do. We've got to surround kids with better supports, and a health clinic in schools can really help us do that in a very dramatic way." **Diane Linn**

*"**The** argument is, in order to succeed at academic achievement, we've got to deal with the whole child. We have to talk about what's going on with them as human beings." **Diane Linn***

"School districts are under extraordinary pressure. So, while we have to understand the context in which they're operating right now, we can't be accusatory, we have to be helpful. We have to figure out how to get into working with the school district in a positive partnership." **Diane Linn**

"I think if you can develop some information around the way the kinds of services you're talking about meet the very specific needs of the school system has, you may get a little bit more resonance." **Julia Lear**

"Many kids are sexually active because of grief issues, because of abuse issues. There's all kinds of things that impact a kid's health. We have 6,300 kids who are served by Multnomah County clinics for 33,000 visits a year, and I probably get calls from fewer than 10 parents who create a tsunami, but there are a whole lot of parents who I think are really thrilled that we're dealing with the issues their kids need a response to." **Valerie Whittlesey**

PANEL PRESENTATION: REPRODUCTIVE HEALTH ISSUES

EXCERPTS OF PANELISTS' OPENING COMMENTS

Paul Cosgrove: My history with this issue starts in 1974 when I worked for Washington County Family Planning on a contract with the state Health Division to try to do some research on why young women failed to come back into the program. Thereafter I worked for a number of years at Multnomah County Health department in family planning, maternal child health, and as a business manager. I am currently the co-chair of Friends of Public Health, an organization that's trying to fill in some gaps in the public health care financing system where the needs are greatest.

Sharon Black: I walked out of nursing school in 1969 and right into public health and family planning. I've managed family planning clinics, primary care centers, and all kinds of different things for Multnomah County. I now do consulting in public health, ambulatory care, so I get to work with outpatient clinics all across the country. I've been permanently moved by the needs of the children in those clinics, the opportunity to not only affect them but affect the next generation that comes behind.

Mary Ann Deagen: I, too, went out of school into public health. I was a nurse practitioner in the early years of Benton County. Then in the '90s, we started some of our school-based health centers, and I've been working with them to strengthen them. I have a real passion for family planning. I also have a passion for care, and that does include family planning.

Sharon Kline: I am a rural public health nurse. I get asked to sit on a lot of panels because I've been around in public health in Oregon for a lot of years and always speak in reference to rural health. Family planning issues have been most interesting in rural Oregon. This is likewise true with the school-based health center. When the issue of reproductive health and teen pregnancy came up in Pendleton, it was decided that public health would withdraw from any visible involvement in the school-based health center because we were automatically associated with family planning and birth control. So, the school-based health center had no connection to the general population in reference to the health department. We could start the center and then figure out a way to incorporate reproductive health.

Jackie Rose: As a new public health nurse, I took over running the family planning program going to all of the schools in Clackamas County. I got involved with Family Planning Advocates of Oregon and Oregon Teen Pregnancy Task Force in the formative years. Unlike Multnomah County, we have 11 different school districts. When I used to have to go out and talk, I had a list of whether you could show a condom or if you could draw a picture, if you could mention it. It was different in every school district. We did find one district which would site a school-based health center, and it continues to be the only one in Clackamas County.

Jon McDaid: Fourteen years ago, I started working at Insight's teen parent program as one of their student interns. It was my job to go out and see some of the young teen dads. The goal is helping them to be the best parents they could be as well as always looking at subsequent pregnancies. I predominantly have worked with support and parenting groups in North and Northeast Portland

between Open Meadow, Roosevelt High School, and Jefferson High School, three high schools with high teen pregnancy rates. I am the program manager for the STARS program and also involved with both young teenage boys and girls in prevention, working with 6th and 7th grade students across the state. I also manage the other abstinence grants that the state does through AFS.

CHALLENGES

KEY QUESTION: What strategies would you or could you employ to get the concept of comprehensive reproductive health care out to and understood by the general public?

Recommendations and strategies:

- Be creative and persistent in efforts
- Emphasize reproductive health services, not contraceptives
- Develop increased awareness of the need for reproductive services; educate parents and community:
  - "Repetition is retention": use teen pregnancy statistics again and again
  - Focus on policy makers, church leaders, schools
  - Get parents involved; show respect for them and their ideas
  - Involve the media; make creative use of opportunities to educate
  - Develop and disseminate information (individual SBHC annual reports, brochures, reports, etc.) showcasing services and results
  - Provide information on all services to illustrate the comprehensive nature of SBHCs and de-emphasize the controversial aspects of family planning
  - Involve advisory board for input, support, and feedback
- Mobilize grass roots efforts to develop champions, make use of referrals:
  - Tap into families SBHCs have touched significantly; they can be good PR and strong allies
  - Work to build long-term relationships over time
  - Remember that each community is unique: listen to the specific needs and cultures of your community
- Encourage communication between parents and kids on the kids' sexual activity
- Look at challenges as learning opportunities
- Keep the focus on the kids

Critical points:

- Family planning and dispensation of contraceptives, for the prevention of both STDs and pregnancy, are becoming more accepted nationwide.
- A recent Kaiser study showed that the majority of parents want these services offered to their children.
- With the exception of Portland Public Schools, Oregon SBHCs are not permitted to offer family

planning services (Lane County 4J school district does dispense condoms to treat STDs).

- Those who make decisions about school-based clinics are often outside the health care field school boards, staff and principals, and parents.
- Those who oppose reproductive services are often a vocal minority that has the ear of very key decision makers.
- It often doesn't matter how good a job the parents do. When adolescents reach the critical years, it seems most of them go through a brief period of developmental insanity and rebelliousness.

Panelist comments:

"The message that gets across to the public better than anything else is to tell them what's going on in our county. I say, every year, I have at least two 12-year-olds who have a baby, 32% of our babies are born into the public welfare system. About the same percent are single moms, and a very large percentage of those moms do not have a high school education. But to say it once and to say it this year, is not going to accomplish it. It really does take a champion who will say it over and over and over again." **Sharon Kline**

"Pregnancy tests were not allowed in our school-based health center until we said, if the person came in with the symptoms of a urinary tract infection, would we not do a urinalysis? Likewise, if a person came in with symptoms of pregnancy, would we not do a pregnancy test? It was then allowable for us to actually do a pregnancy test." **Sharon Kline**

"Repetition is retention. Focus on your policy makers, commissioners or councilmen, your church leaders, your schools. They need to know why you're there and that you're an active participant. I'd also say that you have to have the parents in that base. You have to be out there asking their advice, getting their input, and really showing what you're going to do with their input and be respectful of that." **Sharon Kline**

"Communities are each different and have a different set of needs. I hope that our persistence and information can dovetail with the individual needs of a community, and in that way, we have partners whose needs we can champion." **Reproductive Health panelist**

"Involve media and be aware of what you do. Finding opportunities and using educational moments like this issues forum is a very important format to bring up the issues." **Jackie Rose**

"Ever since we started in '88, we've put out our own annual report on the services that we do. And we've involved our advisory board to try to keep that active and alive as our base of support and feedback on what we're doing. Also try to tap into the families that you make a difference with." **Jackie Rose**

"Every year, we send out information at registration to make sure that everyone registering knows what services we have available. I always get some phone calls back from people saying, 'Does this mean that you can see my student without my permission?' And yes, it does. I always look on those as learning opportunities. Sometimes these end up being some great potential advocates." **Jackie Rose**

"The reality is that nobody ever makes decisions about whether to engage in sexual activity based on whether or not they use a contraceptive method on a consistent basis, no matter what the age level is." **Jackie Rose**

"Grass roots: The story that we in public health often tell is the education story, we educate our clients in our communities about public health needs. But the most effective protection in times of controversy is when people outside the community become your advocates." **Paul Cosgrove**

"The people who make decisions about school-based clinics are often outside our field, meaning the school board and the staff and the principals and the parents. I think it's well worth the time and effort to identify those who will tell the story of how their student was helped or how the family in their church was helped. They can tell the same story with a great deal of conviction and more persuasiveness often than we can ourselves." **Paul Cosgrove**

"The words that I would use are 'relationship-building' and it's over a long period of time. We know, based upon surveys, that most parents want their kids to have comprehensive sexuality education, but there's very often a vocal minority that really trips this up and also has the ear of very key decision makers." **Jon McDaid**

"I never view a parent who calls me as an enemy. They can scream and rant and rave and say hateful things and want to sue us and take providers' licenses away and go to the media, but they really do care about their kids." **Audience member**

"There doesn't seem to be any age restriction in beginning sexual activity. I try to talk to parents about the importance of having parents involved in that decision. It's really up to the kids to involve their parents in that." **Barney Speight**

"We're not just working on reproductive health issues, we're talking about all of those self-esteem issues that are so important to the adolescent. Having a relationship, a place that feels safe and comfortable to come and talk, allows kids to begin to make those responsible decisions. So, if we can't provide contraceptives or condoms in the school, there's a lot of other things that we can do and that are a lot better received by the parents in our community." **Barney Speight**

"Even when you do a great job with kids, when they get into some of those critical years, it doesn't matter whether you did a great job with them or not. They all go through a little brief period of developmental insanity and rebelliousness." **Julia Lear** (in audience)

QUESTION 2: Compare the year 2000 to 14, 15, 20 years ago. Is the public more sophisticated? Does your message resonate with a larger audience? How does the changing technology of contraception impact reproductive health education at the school-based center? Does it help, does it hinder, does it improve? What about those who oppose providing contraceptives at SBHCs? They can be strongly organized, very vocal. Do they represent a minority or the community's true feelings? How do we deal with this opposition?

Recommendations and strategies:

- Understand your community and its needs. Work to get buy-in over a period of time
- Educate your constituencies about the health care needs of students and how SBHCs offer comprehensive services to serve the whole student
- Proceed gradually and incrementally on controversial issues:
  - Consider starting a program without visible reproductive health services while you build credibility and respect
  - Use that credibility and respect to gain acceptance for reproductive health services
  - Provide abstinence-based counseling, plus protection for sexually active kids — from STDs and HIV as well as pregnancy
  - Start with an elementary school where reproductive health is not an issue, then evolve beyond
- Continue to educate parents about parenting skills
- Recognize that parents are facing new experiences; they need help dealing with them
- Be persistent and patient: Realize that effecting change can take many years
- Continue to promote the message that every woman has the right to access family planning
- Refer patients elsewhere for contraceptives
- Educate the public better about the differences between types of contraception
- Keep the issues of abortion, contraception, and emergency contraception separate; educate the public about the differences between them
- Work toward improved access to methods of contraception (through SBHCs and elsewhere)

Critical points:

- The community at large is more knowledgeable about contraceptives today
- SBHCs founded 10 or so years ago are more likely to offer reproductive health services than are the newer ones.

Panelist comments:

"You raise that issue of fluoridation in my community today, and we're right back to the 60s again. It is a communist plot. That's sort of how the family planning, birth control, teen pregnancy issues appear to me as well. You make a big deal out of it, and the silent majority is very quiet, and those half-dozen vocal minorities are right there saying, 'We don't want family planning, birth control, condoms, or any part of sexuality education in this school. It is not the school's responsibility, it is the parent's responsibility.'" **Reproductive Health panelist**

"I think we just have to look at what our community looks like. It's going to be a long time before we change that whole image, and part of that starts with the newborn home visit program where we're trying to work with very young parents and their infants to develop good parenting skills. That takes 20, 30, 40 years." **Reproductive Health panelist**

"We don't come fully formed as adults. Parents develop with their children through their ages. They are for the first time dealing with a difficult subject of their own child's sexuality. It's new to them, and they need help on how to deal with those issues." **Reproductive Health panelist**

"For me, it's a different playing field. When my kids were 4 or 5 (and they're 26 now), I needed to teach them not to open a box when it came to our door because I worked in family planning and we were under a bomb threat." **Sharon Black**

"It was really a struggle to have family planning in the beginning. In fact, pills could cause cancer, pills could do all this stuff, the '60s was free love, and now you're going to make it safe love, so there was a lot of resistance there. We had to really legitimize ourselves, that we are part of the community, we are part of the network of health care." **Mary Anne Deagen**

"From the '70s to the '80s, family planning had been legitimized. It's part of 'every woman has the right to access family planning.' I think it's really important for us to keep that message going there." **Mary Anne Deagen**

"A lot of people think we're providing them with services as a front for reproductive health. We need to educate our constituency that teens have a whole bunch of needs, and we need to supply that." **Mary Anne Deagen**

"If you look at other health clinics that are 10 years or older, 40 to 50% have reproductives. But if you look at the younger clinics, only 20% have reproductives. We are making gradual steps, but it's very gradual." **Mary Anne Deagen**

"We have a very successful school-based health center. I would not want to not have the funding cut simply because the culture is not appropriate for us to do reproductive health. Our job is to see that it gets done, not that itís done in the school-based health center." **Sharon Kline**

"These are real needs even if reproductive health services are not directly provided at the site. Sometimes these programs start without visible reproductive health services and they evolve." **Paul Cosgrove**

"You have to gain the support of the community, and the community has to start to know what the needs of the children in your school-based health center are. By doing that, then you're in a position to gain their respect and confidence that you can bring something more." **Mary Ann Deagen**

"You have buy-in for a period of 10 or 11 years. When people are starting in the first few years, it may be that you have to show that you're going to do that community service and then start to have that buy-in." **Audience member**

"We have a nurse practitioner working in our school-based health center, but if she diagnoses appendicitis, she's not going to do the surgery. She's going to find a referral. Likewise, we can do the same thing with the other needs of the kids.We're not seeing kids for reproductive health issues. However, when you look at what we are seeing — headaches, cramps, tummy aches, toothaches — maybe we are talking about reproductive health. But we may be looking at it from that very broad

perspective of prevention, education, and wellness, which encompasses all of those things that allow kids to feel good about themselves. This is probably a real good way to present it to a community that when faced with the fact is very conservative." **Sharon Kline**

"In 30 years, I've come from, 'Ok, it's acceptable, women should have access.' Now, teens should have access. Where they have access is the next point, and we're starting to get there." **Mary Anne Deagen**

"I just think it's really important to keep the issues quite separate, of abortion and contraception and the morning-after pill. That's where the confusion exists, and it's good for us to help inform people about the differences." **Audience member**

"People do get the methods of emergency contraception confused. I think that is an area that does beg for improved focus and education and outreach." **Jackie Rose**

"In Southwest Washington, there are no school-based health centers. But they have emergency contraception. You can go to High School Pharmacy and step up there and get emergency contraception on Saturday night. I look at what is available to not just young people, but women of all ages in this state. It's really not an option very easily accessible to people because places are closed when they need to have it." **Jackie Rose**

QUESTION 3: How have you involved your communities of color in terms of challenges and opportunities about reproductive health, and to what extent are folks involved?

Recommendations and strategies:

- Speak at ESL classes as well as regular classes to educate about services
- Involve minority populations as focus group participants
- Use interpreters available from county health department
- Have materials in several different languages and formats
- Use SBHC as a community clinic after school hours
- Educate community about how reproductive health services can help to reduce abortion numbers
- Place more focus on this important issue

Panelist comments:

"We serve the school during school time and then the community in the evening time and provide reproductive health in that community. That's an area that both geographically and economically does not have access to health care, so we're the primary source." **Mary Anne Deagen**

"In Clackamas County our utilization by students of color is higher than their percentage of the high school population. We have our materials in Spanish, and I do have the resources of interpreters from the county health department. I do go out to classrooms to let them know about the services, and I also go to the ESL class." **Jackie Rose**

QUESTION 4: Compared to the United States, Europeans seem to do a better job at promoting contraception use, at providing sexuality education, and at reducing unintended pregnancies. They also tend to delay first intercourse until later. What can we learn from that?

Recommendations and strategies:

- Continue to promote positive, healthy messages about sex:
  - It's a natural, normal part of life
  - It's OK to talk about it
  - It's not something you use to sell merchandise
- Be sensitive to cultural, regional, attitudinal, and ethnic differences, and let those differences help guide approaches

Panelist comments:

"I had an exchange student from Sweden, and wasn't this going to be wonderful because I was going to find out how their teen pregnancy rate was so low and what their sexuality education was all about. Three-fourths of the way through the year, she still couldn't figure out what I was asking. It's such a normal process she didn't know how to address it. I think that's a real good lesson. We can't get there by forcing it. We have to get there by ongoing, continuing education that sex is an okay thing to talk about." **Sharon Kline**

"It's a different culture in Pendleton than it is in Portland, and to be successful and to have these programs work, we're going to have to be sensitive to all aspects of that culture, whether it be racial differences or ethnic differences or attitudinal differences, and assess those as accurately as we can and chart a slightly different path in each community." **Reproductive Health panelist**

"I think we're still selling everything with sex. We're giving the message that everything's about sex, except you can't talk about it, you can't talk about controlling your fertility." **Reproductive Health panelist**

PANEL PRESENTATION: MENTAL HEALTH

EXCERPTS OF PANELISTS' OPENING COMMENTS

Ralph Summers: I work in the state mental health and disability, developmental disability services division. I am primarily in charge of the Oregon Health Plan components to mental health services and also some of the community-based mental health services that aren't considered part of our long-term care. My clinical training is in kids and families work. I worked in the Multnomah County system for a while about 10 years ago before getting into the policy works.

Adrienne Greene: I'm the Children's Injury Prevention Coordinator here at the Oregon Health Division, and I'm not a mental health specialist. The work I do is mostly focused on what's killing kids, and that, in Oregon, is motor vehicle crashes and firearms.

Ron Bloodworth: I'm the Youth Suicide Prevention Coordinator here at the Oregon Health Division. My job description as defined by the legislature is to facilitate the development of the statewide plan for youth suicide prevention and to do outreach to unified high risk youth groups or populations with higher risks for suicidal behavior, and then to provide technical assistance to communities in developing and implementing suicide prevention strategies.

Kathy Lovrien: I started working with adolescents almost 20 years ago. I worked with emotionally disturbed adolescents, kids with substance abuse problems in many different capacities in the community and community agencies. One of the givens in most community agencies when you work with adolescents, they get dragged in by somebody else, they don't want to be there. That's just what you work with. It's kind of like pushing the rock uphill all the time. I was at Marshall High School as a mental health consultant for five years, and I've been doing supervision of the 13 SBHC sites with the mental health consultants for the past six years.

Sandy Haffe: I started in combination mental health/addictions work about 30 years ago. I have spent my whole career doing both, and it wasn't until five or six years ago that I finally got it that people didn't get to do both addictions and mental health. A lot of years, I was working in provider agencies maybe evenly split between adults and adolescents. Then I spent about eight years doing private practice that was mental health and addictions, late adolescence into adulthood. I came back to the county six years ago and joined the school-based health clinic staff a little over a year ago.

Suzanne Udall: I am the only mental health person for the school-based health center in Pendleton, Oregon. We have two sites, so I am the provider for about 2,000 kids there. Ever since I have been a social worker — I have a master's degree in social work — I have worked with at-risk youth and children, and I believe the work that all of us here do, physical health and mental health, to sustain families and children in the community, is very important. I've only been in the position for a very short time, since January of last year, and just really feel that we are making the grade. We haven't changed their [kids'] lives, but we have planted a seed.

Challenges:

QUESTION 1: What do you think is the largest concern in adolescent mental health and what role, if any, should or can or do school-based health centers play in addressing that issue?

Critical concerns and issues:

- Suicidal ideation (in Multnomah County at least)
- Stressful environments at school and home
- Stigma about mental health issues that scare kids from dealing
- Access to care and destigmatization.
- Lack of a community consensus and shared view of the role of SBHCs
- Funding issues: Education vs. health care; treatment vs. prevention
- Local control vs. statewide models
- The stigma attached to mental health and emotional issues

Recommendations and strategies:

- Include suicide ideation in every screening tool for both physical and mental health sides of each student seen
- Reach out to whole family unit to reduce kids' stressors
- Engage parents (e.g., provide forums at schools)
- Apply asset model from the Search Institute
- Provide training to school staff, clinic staff, parents on symptoms of depression, suicide, etc.

Panelist comments:

"The single biggest concern we see in Multnomah County is their suicidal ideation. I did a survey a few years ago of the caseloads of the mental health workers in the school-based health centers, and about 80% of the kids that they saw had some form of suicidal ideation. That doesn't mean that they wanted to kill themselves right then, but maybe they were thinking like dying or it sounded like it had an appeal to them." **Kathy Lovrien**

"The second area that I think is the most concerning is the environment that the kids are in, both at home and at school. Schools are stressed because their funding is reduced at the same time that they are having to comply with all the reform mandates. Their ability to look at kids as individuals has been reduced. The families are stressed because of economic reasons mostly, or because of their own emotional. Mental health folks can have a huge impact on both of those things." **Kathy Lovrien**

"If kids are able to feel connected with an adult or other people in their environment, their ability to be successful is going to be a lot higher. School-based health centers are able to provide them with adults that they feel connected with, they can feel part of the school." **Kathy Lovrien**

"We can also help parents in all sorts of different ways, providing forums for parents after school, just being an open place for parents to come and talk where they're not going to feel like they're the

bad guys at school because their kids aren't doing well." **Kathy Lovrien**

"In the world of injury prevention, we're working on the same kind of model, looking at what's stressing families and what's stressing kids and how can kids get connected to adults. Some of the work we do is working with the asset model of the Search Institute, trying to get kids building assets. We know kids with over 30 assets are far less likely to engage in the high-risk behaviors." **Adrienne Greene**

"What I see as some of the most critical things are community consensus and a shared view of what is the role of school-based health centers, and how does that play out within our systems. That's contrasted with the battles we all have in our state about funding. Oftentimes, education gets pitted against health care. Nobody likes that, but it happens every legislative session; it's only gotten worse. Treatment vs. prevention, different perspectives about that and local control vs. statewide models. All of those kinds of things really need some balance." **Ralph Summers**

"There's a major stigma about mental health issues. I see a lot of kids that come to me and they just want to fit in more than anything. I would like to see more group work in things like that. Some of these emotional problems are things that everybody grapples with. I'm trying to fix the kid who's really reacting to the environment, which is oftentimes very dysfunctional and very stressed out. It would be great to be able to have more resources to look at the whole family unit." **Suzanne Udall**

"My most current theme is to engage parents. The research is pretty clear that our long-term outcomes become far more positive the more we can bring those parents in. The other thing is that we have to keep training school staff, clinic staff, ourselves, parents about symptoms of depression, symptoms of suicide, so that kids are surrounded by people who can pick up on those symptoms." **Sandy Haffey**

"The stigma of receiving mental health care or support for emotional problems is one of the biggest barriers that teens face, and I'm just going to make a really big plug for school-based health centers. The fact that they're located in schools makes them much more easily accessible than community services that are outside the school setting. Also, young people can go to a school-based health center, and for all anybody else knows, they're going there for care around a physical complaint. They may be presenting themselves with emotional issues that need to be addressed." **Ron Bloodworth**

"With mandatory sentencing, many of our kids don't live with parents, they live with neighbors. One of our schools has a huge percentage of single parents due to murder and violence. We ought to remember that all the money we're putting into jails right now is affecting kids on two levels, with the education dollars being deleted and also with parents who are put away for a long time. There's no mental health service for them oftentimes." **Mental Health panelist**

QUESTION 2: In managing a SBHC, one has to deal with mental health practitioners, school counselors, academic counselors, parole and probation officers, school psychologists, and sometimes outside service providers. One of the major problems is turf battles. How do you deal with that?

Recommendations and strategies:

- Establish student service teams (all players on board)
- Remove barriers to open communication
- Make use of a facilitator with focused mission
- Provide clear role delineation for all involved
- Ensure message consistency throughout the "food chain"
- Develop a basic, consistent definition for lay people addressing the mental health component of SBHCs
- Educate the public better about the role played by SBHCs
- Make use of stories by SBHC clients about the impact of services on young lives
- Use education to reduce the stigma attached to emotional problems and mental health issues
- Work closer with colleagues to reduce misunderstandings that can lead to turf battles
- Use documentation and data to bolster credibility when presenting programs
- Develop confidentiality education, standards, and support mechanisms

Panelist comments:

"In Portland, we're starting with student service teams in all the schools with all the players. That's outside providers, mental health folks from the county and schools, and whoever else is there. If that group can figure out how to get along, it has a ripple effect throughout the entire school, and people are able to collaborate more around kids. It's a good idea to have a facilitator, as opposed to the group getting together whenever they can." **Mental Health panelist**

"Professionals that are engaging in turf battles are really not trying to be a problem. They are usually trying to do something that in their mind implements what they think they're supposed to do. You change people's beliefs one person at a time, and it takes a long time. You also have to engage the people higher up the food chain to make sure the same messages are going down each silo." **Audience member**

"Some people's perception of a school-based health center is the nurse who puts on a band-aid. Trying to explain the difference, when you add the mental health component, that it really is health — maybe we need to come up with a basic definition that can be presented to lay people." **Suzanne Udall**

"I think a lot of parents, particularly maybe 30 and up, don't have a good understanding what goes on in schools and what is school health." **Barney Speight**

"Human service providers typically want to focus on providing their services to other people and are not too much involved in the political process or tooting their own horn. We have to educate the community, and I think our clients can offer testimony about the impact on their lives of the services that they've received." **Audience member**

"A lot of us haven't been adolescents for a while, but if you think back on it, or if you're with one for 10 minutes, you remember how stressful that time can be. It shouldn't be a stigma to have emotional problems. We need to talk more about that." **Mental Health panelist**

"It's important that we work with each other as colleagues. I think we get into arguments with each other or we don't understand each other fully if we don't spend enough time together. That includes working with family members that are activists and partners with us in trying to implement services. That needs to be done before we can create a coalition or educate other community members." **Mental Health panelist**

"One thing I wanted to say is the importance of documentation and data collection. That gives you the numbers and facts and figures to present the impact of your program." **Ron Bloodworth**

"I had a communication problem with some counselors, and I don't know if they saw me as a threat or what. People weren't communicating to me that they had a problem with the services I was providing and it was all second hand. I just forcefully forced the issue and brought everyone to the table and said, 'Here I am, shoot darts at me, let's talk about it.'" **Suzanne Udall**

"I'm a team player as much as anyone, but sometimes it can be a battlefield. The kids do suffer. That's what's unfortunate." **Mental Health panelist**

"The mental health component has multiple disciplines. It'll work very effectively when coordinated and teamed, but if that doesn't happen, it can be a really dysfunctional family in that school." **Barney Speight**

"We all have an ethical responsibility with regard to confidentiality, but when we're working professionally as a team, we can share information within that team for the benefit of that child and the family. We have to communicate a vision to educators and administrators that this is really in the best interest of children and families. I think we also need to have more communication across our professional organizations so we can get that level of support." **Ron Bloodworth**

"After a suicide, people will say we didn't see any warning signs, we had no indication that this kid was depressed. Typically, if enough people are asked, somebody saw something or heard something that, if shared with other people could have made a difference in whether that kid lived or died. It's like the scientists holding on to different parts of the elephant. We all bring our own part of the elephant to the discussion, and in the process we begin to get a sense of what this whole thing looks like." **Ron Bloodworth**

"It seems like what happens when the clinic starts in the school is that the school has a lot of control issues. The one thing that we don't ever give in on is letting all of the referrals go through somebody else. One of the things that is tried sometimes is the school counselor or psychologist wants all referrals to go through that person. We always need to keep that door open, that families or teachers are able to refer with confidentiality." **Mental Health panelist**

QUESTION 3: One in five diagnoses made in a school-based health center has a mental health component. Fully 20% of students will self-report that they had emotional or mental health needs, and at least one-third of those will tell you that those needs went unmet in the last year. Faced with this reality, how do we determine the best mix of modalities for mental health programs? What part screening, what part case management of intensive problems, what part individual or family therapy, what part skill-building of educational and health groups best fit the model for school-based health centers?

Recommendations and strategies:

- Use developmentally appropriate settings
- Form collaborations to minimize resource limitations and duplication
- Bring in outside providers who have staff and money to help with services
- Adopt a "mental health consultant" model (as used in Multnomah County) to expand staff capacity
- Adopt zero tolerance policies for bullying and harassment
- Include injury prevention and health educators in SBHCs
- Engage local policy planners in determining the model and mix of services, based on community resources, needs, and culture
- Include prevention, education, outreach services: "social supports that don't rely on a diagnostic condition or even a clinical assessment in order for a professional with good common sense to create an environment that kids think is a great place to go"
- Include clinical treatment-oriented services "that are based upon a good assessment and some clinical judgment, some crisis intervention, and a range of treatment type services."

Panelist comments:

"I work to collaborate and bring other agencies into the school-based health center. We work to make those connections there and then slowly move them out. When I send a kid out to go to a therapy session without having that stepping stone, a lot of times they never make it back." **Suzanne Udall**

"If you're in a high school, you're probably going to use more of an individual approach than if you're in the middle school or elementary school." **Mental Health panelist**

"One thing we have done is to enlist medical providers to do the screening, and then they pass on to the alcohol and drug staff for the assessment. We've brought providers on-site to provide treatment." **Mental Health panelist**

"In Multnomah County, we call our mental health folks mental health consultants because it's kind of a combo model, direct services with kids with emotional problems. We want them to expand their capacity to affect as many of the kids in the school as possible, so we encourage activities where they go outside of the walls of their office. They go to the health classes, they talk about suicide and depression. We take a few minutes at the end or a time where the kids can talk to them if they need to. They point people in the right direction about those kids without actually having to see those kids themselves in the clinic." **Kathy Lovrien**

"I've always seen school-based health centers as the on-site safety net for kids. Something that you really have to play up is that you are the first point of intervention for a whole spectrum of problems and that families and kids can get some help." **Adrienne Greene**

"School-based health centers can be a catalyst for community change and school policy change. Things that I'm thinking of in terms of violence are having zero tolerance, not just for having guns in the school, but also for any sort of harassment or bullying. I would like to see injury prevention going into the school-based health centers, actually going on-site, to have health educators in there also. Use it as a model of a more open-door place." **Adrienne Greene**

"What model is used, what mix of those services. I think the local policy planners need to make that call based upon their resources, the culture of the community, and the culture of the systems that are coming together to create the school-based health centers." **Mental Health panelist**

"What's important is it's not prevention or treatment; there needs to be the presence of both. It's a zero-sum game, so the local planners need to decide if the resources you have available are what meet your needs the best." **Mental Health panelist**

QUESTION 4: Oregon's suicide rate is unnaturally high in comparison to most of the country. What role should SBHCs take in reducing not only the "successful" but the attempted suicides? Can SBHCs be sold as a real contributing asset with the educational community, school administration, school boards, and communities generally?

Recommendations and strategies:

Oregon has developed a statewide plan for youth suicide prevention. Ron Bloodworth, the Youth Suicide Prevention Coordinator at the Health Division and a key architect of the plan, sees SBHCs as a perfect vehicle for addressing this issue. During the panel discussion, he outlined the plan's five basic strategies:

1. Access to mental health care.

"Young people will go to a school-based health center for mental health care when they won't go any place else. One of the major barriers is the stigmatization of receiving mental health services. Going to a school-based health center, who knows? You might be going there for an eye exam."

2. Gatekeeper training.

"We have a project going on in southern Oregon, applied suicide intervention skills training. In those nine counties, there are workshops to train 1,000 community members on how to identify young people at risk for suicide and how to intervene with them. That's a wonderful collaboration between school-based health centers and community members."

3. Screening and referral.

"We have a couple of projects looking at universal screening and referral for kids who are depressed and/or who are having suicidal ideation. School-based health centers are a perfect place for that kind of activity."

4. Public education.

"School-based health centers can play an important role in educating the public. The American Foundation for Suicide Prevention, NW, here in Portland has launched a nationwide media campaign entitled 'Suicide Shouldn't Be a Secret,' and it's really aimed at teens. PSAs are showing as trailers in movie theaters, and there's an ad and radio campaign. It's to break through that code of silence that teens have about not helping a friend get to a resource if they're talking about suicide."

5. Safe schools.

"School-based health centers are positioned in a wonderful place to work with school staff and the community in general in creating and improving school climate so that students are not victimized by harassment, violence, and other kinds of social issues that make people feel isolated and rejected."

Panelists' comments:

"There's been a ton of progress in the last three to five years. Part of what we've done is to create a coding structure for preventive services, and now we're developing a data-tracking net to provide some standardization in communities about what people are doing for prevention. Just these kinds of acts help decrease stigmatization; being able to work with people without opening a clinical record and having a specific diagnosis." **Ralph Summers**

"As we move further into the area of tracking outcomes and as a measure of performance, one of the outcomes we are looking at is the decrease of civil commitments as a sign of progress that people can be treated voluntarily and not have their civil liberties taken away." **Ralph Summers**

QUESTION 5: What are the unique issues of delivering mental health services in a rural community where the service area may be broad and where support is not as robust as it is in larger towns or urban areas?

Critical concerns and issues:

- The stigma issue
- Developing relationships in a school setting within a small, close-knit community
- Small pool of providers; limited access to care
- Lack of resources (such as youth shelters)
- Staff retention; difficulty of forming bonds in short time to communicate successfully as a team or to build relationships with the kids and families
- On the positive side: People in rural areas are often more adept at using the technology of tele-medicine (out of necessity, and at great expense)
- Recommendations and strategies:

Panelist Comments:

"I am like an enemy. I walk into every situation wanting to help, and as soon as I say I'm a mental health person, I could just be the devil or something. Also, it's difficult developing relationships in a school setting because it is a small close-knit community. People know everyone." **Suzanne Udall**

"We're looking to expand this program, and it's hard to find people who are qualified and willing to work in the setting that we have. It's also hard to find the resources for kids when I need to send them out. We don't even have any type of adolescent shelter, emergency shelter for kids." **Suzanne Udall**

"Stigma, confidentiality, staff retention, and access to specialty care: Now, people in the metro area would say we've got all those things too, so it's not really a rural/urban problem. In rural areas, stigma takes on some other characteristics. If everybody in town knows your pick-up truck and it's parked outside the mental health center, everybody in town knows that you're going to the mental health center." **Audience member**

"If your professional staff rotate out of town every couple of years, you don't have time to build those kinds of bonds." **Audience member**

"To some degree, our colleagues in rural and frontier parts of the state are way ahead of the valley in using telemedicine in order to get psychiatric consultation from OHSU or specialty care like screening from a child psychologist. But, it still makes every unit of service very expensive, and it takes a level of service and technology that brings demands on an already stretched system." **Audience member**

SPEAKERS AND PANELISTS

Welcome and Introductions

Martin Wasserman, MD, JD, is former administrator of the Health Division of the Oregon Department of Human Services. The administrator is the state's chief health official, overseeing more than 100 specific programs to protect the public's health. Dr. Wasserman had previously served as the secretary of the Maryland Department of Health and Mental Hygiene. In that capacity, he created HealthChoice, a managed care program for the indigent that included school-based health centers. Dr. Wasserman has also worked as the local health officer for Prince George's and Montgomery Counties, Maryland, and Arlington County, Virginia.

Keynote Address

Julia Graham Lear, PhD, is director of Making the Grade: State and Local Partnerships to Establish School-Based Health Centers, a national grant program supported by the Robert Wood Johnson Foundation. She has worked with foundation grant programs supporting school-based health centers for the past 12 years and was recently awarded the National Achievement Award for Outstanding Contributions to the Field of School-Based Health Care. Dr. Lear is an associate research professor at the George Washington University School of Public Health and Health Services in the Department of Health Services Management and Policy, and serves as co-principal investigator on a leadership training program in the Graduate School of Education and Human Development. She teaches courses on medicine, health, and school health issues and writes and speaks frequently on the organization of health care for children and adolescents, especially the delivery of health services through schools. A graduate of Brown University, Dr. Lear received her doctorate from Tufts University.

Panel Moderator

Barney Speight is director of Public Policy and Government Relations with Kaiser Permanente's Northwest Region. His previous roles in Oregon health care include: administrator, Office for Oregon Health Plan Policy and Research; public policy work at Regence Blue Cross Blue Shield of Oregon, Oregon Association of Hospitals and Health Systems, Oregon Medical Association; and operations management at Legacy Good Samaritan Medical Center. He is a graduate of Portland State University with post-graduate and executive studies at PSU and Duke University.

Financing & Reimbursement Panel

Hank Collins is the director of Jackson County Health and Human Services, where he has served for 13 years. For many years prior to that, he worked in a similar capacity on the local and state levels in North Carolina.

Tom Fronk has been with Multnomah County for 20 years, the last 13 with the county health department. Most of that time he served as the department's business services director. Today he is involved with developing strategic relationships between the health department and its external partners.

Sandra Haffey has 25+ years' experience in the social service/substance abuse field, where she has worked at a variety of levels, from counselor and clinical supervisor to executive director of an alcohol and drug agency. Her responsibilities have included treatment and clerical staff supervision; staff

development; treatment planning; case management; preparation and supervision of client evaluation procedures and of case management procedures; conducting individual, group, and family counseling; and utilization review. She has also participated in on-site review teams for the Office of Alcohol and Drug Abuse Programs and is currently a trainer for this office. She holds a master's degree in counseling.

Diane M. Linn is the Multnomah County Commissioner for District 1. Currently she is a member of the PPS (Portland Public Schools) Strategic Planning Core Team; PPS Strategic Plan Implementation Committee; Mental Health Design Team; Commission for Children, Families and Communities; and the Family Violence Intervention Steering Committee. Previously, she has served as director, City of Portland Office of Neighborhood Associations; executive director, Oregon National Abortion and Reproductive Rights Action League; vice president for programming & government affairs, Rogers Cable TV; and staff member at the Linn Group Home for teenage foster children. She is a graduate of Portland State University.

Jim Rowland worked as a manager with Adult and Family Services for 20 years until 1995. He joined the staff of the Office of Medical Assistance Programs five years ago as manager of the Communications and Provider Relations Unit, responsible for the development of written materials for the Oregon Health Plan and provider relations related to billing and claim services. In his current position as assistant section manager, he is responsible for liaison with other Department of Human Services sections such as Adult and Family Services and Senior and Disabled Services. Mr. Rowland coordinates with Health Care Financing Administration on issues related to the approval of the 1115B waiver for the Oregon Health Plan and State Plan Amendments.

John Santa, MD, is a general internist who has practiced in a variety of settings, including solo, small group, and large group practices. He is now working in state government as the administrator of the Office for Oregon Health Plan Policy and Research. Dr. Santa has been involved in medical administrative issues for most of his career, teaching at Good Samaritan's Internal Medicine Program, directing the Primary Care Clinic at Good Samaritan, and has served in medical director roles in independent practice associations, Blue Cross Blue Shield of Oregon, and for HealthFirst Medical Group. Now pursuing a master's in public health at Oregon Health Sciences University, he has been involved with school-based health centers in many of his roles.

Reproductive Health Care Panel

Sharon Black, of Sharon N. Black Consultants is a health care consultant. She has served the Multnomah County Health Department in a variety of areas and capacities during her career including director and associate director of the Primary Care Division (with 350 staff and 40,000 clients), Family Planning Program management and Primary Care clinic and program management. Sharon's broad range of experience includes working with the midwest states to integrate HIV and family planning services and has taught clinic efficiency to providers and managers in 10 U.S. states.

Paul Cosgrove is an attorney affiliated with the law firm of Lindsay, Hart, Neil & Weigler, where his emphasis is on government relations and business law. He has worked for a number of different community health agencies including Planned Parenthood of the Columbia/Willamette, Oregon Health

Division (research contract), Washington County Public Health Department, and Multnomah County Health Department. He attended Antioch College, Portland State University, Western Washington University (Fairhaven College), and Northwestern School of Law of Lewis & Clark College.

Mary Anne Deagen is the interim health administrator for Benton County. She is a registered nurse and Women's Health Care Nurse Practitioner. She has been with Benton County for 29 years and with SBHCs since 1994.

Sharon Kline is administrator of the Umatilla County Health Department. She has 38 years of nursing experience, all of it in rural Oregon. She has served in a wide range of venues, including hospital, emergency room, physician's office, as a VISTA volunteer, and, for 26 years, in public health. She serves on several local and state health-related committees.

Jon McDaid has a master's in counseling with emphasis on marriage, family, and child therapy and has been working with adolescent health issues for the last 14 years. In 1986, he began working as an outreach worker to teen dads at Insights Teen Parent Program. Since then he has provided outreach services to teen moms and dads. In 1997, he began working as a trainer in the STARS program (Students Today Aren't Ready for Sex) and is currently the STARS program manager. He is also a member on the male involvement subcommittee of the Governor's Action Agenda on Teenage Pregnancy Prevention.

Jackie Rose has served as a nurse-practitioner/SBHC coordinator for the Clackamas County Public Health Division, Oregon City High School SBHC, since 1990. In that capacity, she provides primary care and adolescent health promotion and prevention services. She previously worked as a community health nurse for the Clackamas County Public Health Division. She is a graduate of the University of Portland, the Oregon Health Sciences Center, and the University of Oregon.

Mental Health /Unmet Needs Panel

Ron Bloodworth is the Youth Suicide Prevention coordinator with the Oregon Health Division. Prior to joining the Health Division, he worked many years as a teacher and school counselor in K-12 schools. He is a licensed professional counselor and has worked with clients in agency settings.

Adrienne Greene is children's injury prevention program coordinator for the Oregon Health Division. She is responsible for planning and implementing a Children's Injury Prevention Program with an overall goal of reducing the injury morbidity and mortality to Oregon children aged 0-17.

Sandra Haffey has a Masters degree in Counseling with 25-plus years' experience in the social service/substance abuse fields. She has worked on a variety of levels, from counselor and clinical supervisor to executive director of an alcohol and drug agency. Her responsibilities have included treatment and clerical staff supervision; staff development; treatment planning; case management; preparation and supervision of client evaluation procedures; preparation and supervision of case management procedures; conducting individual, group, and family counseling; and utilization review. She has also participated on site review teams for the Office of Alcohol and Drug Abuse Programs and is currently a trainer for that office.

Kathleen Lovrien is a clinical supervisor for the Multnomah County School-Based Health Centers Mental Health Program. She previously worked there as lead mental health consultant, and has also served as an intake supervisor, adolescent substance abuse therapist, and substance abuse therapist. She attended the University of Oregon and Portland State University. A certified clinical supervisor for licensed professional counselor candidate, she is a member of the National Association of Social Workers.

Ralph Summers is the manager of the Community Services Section of the Office of Mental Health Services. He has held a variety of clinical and administrative positions in both public and private sectors, all with an emphasis on working with children/adolescents and their families. He began working for the state mental health agency in 1991, coordinating grant-funded projects aimed at integrating family support philosophies, individualized wraparound service planning, interagency collaboration, and managed care concepts. He is currently responsible for a wide variety of publicly funded community-based mental health services for children, adolescents, adults, and older adults. His primary responsibility is the mental health component of the Oregon Health Plan.

Suzanne Udall joined the Pendleton School-Based Health Centers as a mental health specialist in January 2000. She has worked as a school social worker and has many years of experience working with at-risk youth and their families. She received her master's degree in social work from Highlands University, Las Vegas, New Mexico, in 1995.

APPENDIX: ISSUES FORUM AGENDA

October 25, 2000

8:30 — 9:00	**Registration**
9:00 — 9:20	**Welcome and Introductions** Martin Wasserman, MD, JD Administrator, Oregon Health Division
9:20 — 9:45	**Keynote Address** Julia Graham Lear, PhD Director, Making the Grade
9:45 — 10:00	**Break**
10:00 - 11:20	**Panel Presentation: Financing and Reimbursement** Barney Speight, Moderator **Panel Members** Hank Collins Tom Fronk Julia Graham Lear, PhD Diane Linn Jim Rowland John Santa, MD
11:20 — 12:00	**Lunch**
12:00 — 1:15	**Panel Presentation: Reproductive Health Care Issues** Barney Speight, Moderator **Panel Members** Sharon Black, RN Paul Cosgrove, JD Mary Anne Deagen, RN, WHCNP Sharon Kline, RN Jon McDaid, MA Jackie Rose, FNP

1:30 — 3:00 **Panel Presentation: Mental Health Services — Unmet Needs**

Barney Speight, Moderator

Panel Members:

Ron Bloodworth, LPC

Adrienne Greene, MPA

Sandra Haffey, MA

Kathleen Lovrien, MSW, LCSW

Ralph Summers MSW

Suzanne Udall, MSW

3:00 — 3:30 **Evaluation and Close**