SCHOOL-BASED HEALTH ALLIANCE of ARKANSAS
Redefining Health for Kids and Teens

How School-Based Health Centers Intersect Arkansas Healthcare System Reform: Care Coordination

Effective patient care coordination is a pillar of Arkansas's health system transformation efforts both in terms of assuring patients receive the care they need to lead healthier, more productive lives and in controlling costs by avoiding duplication and unnecessary services. The success of the Patient-Centered Medical Home (PCMH) and Episodes of Care models employed by the Arkansas Health Care Payment Improvement Initiative is highly reliant on care coordination.

School-Based Health Centers (SBHC) have a history of partnership with local health organizations to coordinate an array of healthcare services to meet student needs, including medical, nursing, behavioral counseling, oral health care, reproductive health, nutrition education, and health promotion. Importantly, SBHCs create an environment of service coordination and collaboration that addresses the health needs and well-being of youth living in areas with health disparities and poor access to healthcare services.

Care coordination is identified by the Institute of Medicine as a key strategy that has the potential to improve the effectiveness, safety, and efficiency of the American healthcare system. Everyone involved in the healthcare process—patients, providers and payers—benefit from appropriate, well-designed, and targeted care coordination. Recognizing that coordinated and integrated care leads to a reduction of inappropriate use of medical services and cost-savings, Arkansas Medicaid and private payers provide support to participating practices to ensure that all patients—especially high-risk patients—receive holistic, wrap-around, coordinated care across providers and settings.

The U.S. Department of Health and Human Services, Agency for Health Research and Quality notes the following as examples of specific care coordination activities:

- Establishing accountability and agreeing on responsibility.
- Communicating/sharing knowledge.
- Helping with transitions of care.
- Assessing patient needs and goals.
- Creating a proactive care plan.
- Monitoring and follow up, including responding to changes in patients' needs.
- Supporting patients' self-management goals.
- Linking to community resources.
- Working to align resources with patient and population needs.

Examples of SBHC participation in these activities are abundant. From the requirement to maintain a working relationship with the physician of a child's medical home to the wide array of services and resources integrated into patient care, SBHCs work to improve continuity of care, reduce fragmentation, and prevent duplication of services.

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