

Issue Brief

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The right care in the right place: *The promise of school-based health centers*

Nurse practitioner Jennifer Suchon amiably chats to the second grader walking with her from his Northside Elementary School classroom to the modular health clinic across the campus. She spoke earlier to the boy's parents, who gave her a review of his symptoms and set the appointment, but she catches further details directly from him on the way. By the time they reach the exam room at the school-based health center (SBHC), she's completed gathering his history. After the exam, she'll walk him back to class.

"We know we're saving lost time out of class; a lot of parents wouldn't even bring their kids back if it was an afternoon appointment."

— Jennifer Suchon, CFNP
Clinic Manager, Northside Child
Health Center

The average encounter takes a student out of the learning environment for only 11 minutes.

"We can say with certainty that if they were pulled out of class and taken to an outside provider's office, it would certainly be longer," Suchon says. "We know we're saving lost time out of class; a lot of parents wouldn't even bring their kids back if it was an afternoon appointment."

Easy access to care is the heart of the value proposition at Northside Child Health Center in Montrose and at more than 2,300 school-based health centers across the country.¹ SBHCs provide health services to students in pre-kindergarten through grade 12, most (94 percent) on a school campus or at an affiliated clinic.² SBHCs typically serve schools with predominantly low-income communities in both urban and rural areas; 78 percent are located in schools that receive federal Title 1 assistance.^{3,4}

¹ Schelar E, Love LH, Taylor K, Schlitt J, Even M. Trends and Opportunities for Investment in Student Health and Success: Findings from the 2013–14 Census of School-Based Health Centers. Washington, DC: School-Based Health Alliance; 2016. <http://www.sbh4all.org/wp-content/uploads/2015/02/2013-14-Census-Data-and-Methods.pdf>

² 2013-14 Census of School-Based Health Centers: Methodology, Key Report Data Details, and Acknowledgements. School-Based Health Alliance, 2014, pp. 1–14, 2013-14. <http://www.sbh4all.org/wp-content/uploads/2015/02/2013-14-Census-Data-and-Methods.pdf>

³ Ibid.

⁴ "School-Based Health Centers to Advance Health Equity A Community Guide Systematic Review." American Journal of Preventive Medicine, vol. 2016, no. 51, ser. 1, 2016, pp. 127–128. Elsevier, doi:<http://dx.doi.org/10.1016/j.amepre.2016.01.008>.

SBHCs are supported culturally by the school systems in which they reside. They are far different from the traditional “school nurse” office; most SBHCs resemble the integrated community health center model, offering primary care, preventive health, mental health, care coordination and other services.

Why offer health care at school?

The primary purpose of schools is education. Because co-locating a health center advances student performance, the number of schools hosting health centers is on the rise.⁵ SBHCs minimize missed time in the classroom and reduce student absenteeism.⁶ Researchers have found associations between low to moderate SBHC use and reductions in high school dropout rates for those at high risk.⁷ Behavioral issues identified in the classroom can be seamlessly referred to professionals in SBHCs for evaluation and intervention; research shows use of school-based mental health services is even associated with increases in grade point average.⁸

In 2016, the Community Preventive Services Task Force⁹ recommended implementation and support of SBHCs in low-income communities, citing evidence of effectiveness in improving educational and health outcomes. “As SBHCs are commonly implemented in low-income communities and communities with high proportions of racial and ethnic minority populations, many of whom are low-income, this source of student health care and health education may be an effective means of advancing health equity,” the recommendation notes.¹⁰

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Board Chair, NYSBS Foundation
Founding CEO, Emeritus,
Primary Care Development Corporation

SBHCs: An extension of the medical home

In 58 SBHCs across Colorado, more than 36,000 school children receive primary care services each year—most without ever leaving campus.¹¹ In many locations, the care is integrated with preventive dental and vision care, as well as counseling and mental health services. These services vary with local needs; for example, in Colorado, onsite dental cleanings are offered at 88 percent of rural SBHCs, but less than a third of urban clinics offer them.¹²

“There’s nothing like being in the school for immediate access to children,” says Ronda Kotelchuck, founding CEO of the Primary Care Development Corporation and board chair, New York School-Based Health Foundation. “The school is attuned to the needs of the community it serves, and so will be the SBHC staff. They provide a continuing relationship with a provider. They offer comprehensive services. And the school-based health center manages referrals and tries to ensure the students get to the services—and then follow up.”

SBHCs align with many of the principles of the patient-centered medical home: team-based care

⁵ 2013-14 Census of School-Based Health Centers: Methodology, Key Report Data Details, and Acknowledgements. School-Based Health Alliance, 2014, pp. 1-14, 2013-14. <http://www.sbh4all.org/wp-content/uploads/2015/02/2013-14-Census-Data-and-Methods.pdf>

⁶ Walker, Sarah Cusworth, et al. “Impact of School-Based Health Center Use on Academic Outcomes.” *Journal of Adolescent Health*, vol. 46, 2010, pp. 251-257. Elsevier, doi:10.1016/j.jadohealth.2009.07.002.

⁷ Kerns S.E.U., Pullman, M. D., Walker, S. C., Lyon, A. R., Cosgrove, T. J., & Bruns, E. J. (2011). Adolescent use of school-based health centers and high school dropout. *Archives of Pediatrics and Adolescent Medicine*, 165, 617-623.

⁸ Walker, Sarah Cusworth, et al. “Impact of School-Based Health Center Use on Academic Outcomes.” *Journal of Adolescent Health*, vol. 46, 2010, pp. 251-257. Elsevier, doi:10.1016/j.jadohealth.2009.07.002.

⁹ The Community Preventive Services Task Force is an independent, nonfederal panel that provides evidence-based findings and recommendations about community preventive services, programs, and other interventions aimed at improving population health. Its 15 members are appointed by the director of the Centers for Disease Control and Prevention. <https://www.thecommunityguide.org/task-force/community-preventive-services-task-force-members>

¹⁰ Promoting Health Equity Through Education Programs and Policies: School-Based Health Centers. Community Preventive Services Task Force, 1 Apr. 2016, http://www.thecommunityguide.org/sites/default/files/assets/Health-Equity-School-Based-Health-Centers_1.pdf.

¹¹ An Analysis of Colorado’s Rural and Urban School-Based Health Centers. Colorado Health Institute, 2017, An Analysis of Colorado’s Rural and Urban School-Based Health Centers, http://www.coloradohealthinstitute.org/sites/default/files/file_attachments/2017%20SBHC%20REPORT.pdf.

¹² Ibid.

approach, access and continuity of care with a primary care provider, care coordination and support, and quality improvement. “They can become, in and of themselves, a medical home,” Kotelchuck says.

In 2017, the National Committee for Quality Assurance developed patient-centered medical

home standards specifically for SBHCs, recognizing the first such program in November 2017.¹³ “They hold up a clear, public set of standards of excellence that are uniform and can be measured, which is essential in a young, developing field like school-based health,” Kotelchuck says. “The standards are important to establishing credibility and visibility in this field.”

¹³School-Based Medical Home Recognition Program. National Committee for Quality Assurance, <http://www.ncqa.org/programs/recognition/practices/school-based-medical-home>.

SBHCs *in the value-based payment landscape*

Alternative payment models like accountable care organizations and Colorado’s Accountable Care Collaborative are a ripe opportunity for providers to partner with SBHCs in the next decade. Innovators like Rocky Mountain Youth Clinics (based in Denver) and Partners for Kids, the nation’s largest exclusively pediatric ACO (based in Columbus, Ohio), recognize the inherent value of placing clinics within easy reach of covered children—in the schools where they spend most of each weekday. RMYC partners with nine SBHCs across the state, in addition to its clinics and mobile health units; Partners for Kids contracts with managed Medicaid plans to provide care for 330,000 children. A physician-hospital ACO, it operates 17 SBHCs and provides care in multiple affiliated medical sites across 34 counties.

“If you’re at financial risk for providing health care, behavioral health and dental services for a challenging student population, your motivation should be to have these kids seen in a convenient, high-quality, cost-effective setting. And I would argue there’s not a better such setting as a school-based health center,” says Ben L. Bynum, M.D., portfolio director of private sector engagement for the Colorado Health Foundation.

Bynum also serves on the board of directors of the School-Based Health Alliance and chairs the board’s Outreach and Engagement Committee.

Bynum notes that innovative organizations like RMYC and Partners for Kids see SBHCs as a crucial partner in alternative payment models that pay providers for services for a defined population on a per-member, per-month basis (versus a fee-for-service option). The integrated care model they provide aligns with the new alternative payment model world—if incentives and partnerships are wisely structured.

“It’s about aligning care delivery with who holds the medical risk,” he says. “If the holder of the capitated payment is the private pediatric clinic, and you have students [on your panel] with significant histories of asthma, wouldn’t you want them to have access to an SBHC for chronic disease management and to greatly lessen the likelihood of ER visits and hospitalizations? It makes sense for me, as the holder of that capitated payment, to go out and make sure all of my students have access to an SBHC in the event of an emergency, where it costs four times less to provide high-quality care.”



Making a case for Quality

Quality improvement and performance measurement is required for school-based health centers to participate in most Medicaid managed care programs that reward value. NCQA's recognition program for SBHCs also includes performance measures and quality improvement. Some 65 percent of SBHCs collect data based on HEDIS measures and more than half (55 percent) collect the core measure set required by the Children's Health Insurance Reauthorization Act.[†]

Tracking and reporting these efforts can be a challenge for SBHCs simply because they serve such small populations. The School-Based Health Alliance, a national non-profit organization that provides resources, training and research on behalf of SBHCs, established five performance measures that align with activities required by some state Medicaid quality initiatives:

- Annual well-child visits;
- Annual risk assessments;
- Body mass index (BMI) assessments and nutrition and physical activity counseling;
- Depression screenings and follow-up plan for positive screens; and
- Chlamydia screenings.[‡]

The SBHA's Quality Counts initiative, funded by a federal grant, allows SBHCs to upload data directly from an EHR, and then compare their performance against other SBHCs. It will also develop a national performance data set that may help build the case for the value of SBHCs across the board.

[†] 2013-14 Census of School-Based Health Centers: Methodology, Key Report Data Details, and Acknowledgements. School-Based Health Alliance, 2014, pp. 1-14, 2013-14. <http://www.sbh4all.org/wp-content/uploads/2015/02/2013-14-Census-Data-and-Methods.pdf>

[‡] Alliance, School-Based Health. "Performance Measures: Quality Counts Initiative." *School-Based Health Alliance RSS*, http://www.sbh4all.org/current_initiatives/nqi/.

Because SBHCs are typically open only when school is in session, access to care is augmented by partnerships with other community providers. Northside Child Health Center, for example, is partnered with Montrose Pediatric Associates, which employs Suchon and manages her insurance coverage. It's also responsible for after-hours care and hospital admissions, when needed. Suchon sees students, but also sees their siblings and a small number of adults. Although the clinic is housed at the elementary school, Northside serves clients from birth through high school. Her team includes a receptionist, a part-time licensed social worker (who provides mental health services), and a grant-funded dental hygienist.

"We're the only medical office for a lot of the kids we see."

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"We're the only medical office for a lot of the kids we see," she says. About 60 percent of her patient population is Hispanic, compared to only 21 percent of the general school population. "Some are DACA teens, and some are undocumented younger kids," she says. Both Suchon and her receptionist are bilingual.

About 98 percent of Suchon's patients are considered low income. Sixty percent are enrolled in Health First Colorado (Colorado's Medicaid program) or the Children's Health Insurance Program, and most of the remainder have no insurance coverage.

No one is turned away based on ability to pay. Access to health care for the uninsured and undocumented is a key role of school-based health centers, Kotelchuck says.

"Any time you're undocumented, you're fearful of institutions, like going to the emergency room for care," she says. "Going to a provider at the same place your child goes to school is different. You just

naturally enroll your child in the health center service when they start school, and then your child goes to the health center when he or she needs to. It's an effective way of dealing with this fear."

Access is about trust

In SBHCs, access to care is defined by more than just the hours the center is open. In the low-income communities where most are located, it's a hardship for parents to leave work to take a child to a doctor's appointment. Parents with students enrolled in SBHC care need only set the appointment; everything else is handled by the SBHC staff.

As students pass into middle and high school, they visit the health centers on their own. Co-location of physical and mental and behavioral health services removes the stigma of seeking services—a major barrier for teens, especially in rural areas.

"Trust is the most important factor for increased access, and it's where we're really making a dent," says Haidith Ramirez, program director for Roaring Fork SBHCs, which serve schools in the rural Basalt and Carbondale school communities in Colorado. Last school year, the combined sites saw 714 students in 3,034 encounters. Of those students, 150 accessed confidential services at least once.

"For reproductive and behavioral health, everyone can go to a community health center and get care," says Ramirez. "But kids are really uncomfortable about it; they think, 'if I go there, I may run into someone I know, or someone will see me and tell my mom.' They don't see it as a safe, confidential place to go to get the care they need.

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"Both transportation and general community access are barriers," she says. "Having those services in the school breaks the stigma of having depression and anxiety, and the schools realize that. Bringing all the resources into the schools can really normalize the experience."

While availability of reproductive health services is common in SBHCs, the level and range of services vary based on community norms. Roaring Fork began providing these services just two years ago. The SBHC provides clarity in parent consent forms and is sensitive to parental concerns. "Our providers try to involve parents, but also respect the students' right to privacy. This ensures trust and opens up further communication with the students," Ramirez says. "And often the students come back to us and say, 'I've talked to my parents.' If the parents want to talk to us, and if the student is a minor, we meet with both the students and the parents and talk to them about being strong advocates for their health."

The combination of counseling and preventive services for reproductive health is valuable; studies estimate \$14,936 in societal costs are averted for every teen pregnancy avoided.¹⁴ Ramirez says 78 percent of reproductive health services administered by Roaring Fork Health Centers go to students who are uninsured and would otherwise have to pay out of pocket. "The cost to go to a medical provider is prohibitively high," Ramirez says. "Thirty to 40 percent of the process is about education—it's about choices, and why it's important for them to take care of themselves. That's not readily available in the community setting."

¹⁴"School-Based Health Centers to Advance Health Equity A Community Guide Systematic Review." *American Journal of Preventive Medicine*, vol. 2016, no. 51, ser. 1, 2016, pp. 127–128. Elsevier, doi:<http://dx.doi.org/10.1016/j.amepre.2016.01.008>.

Care management and coordination

Alongside access and comprehensiveness of services, coordinating care and managing chronic conditions are key strengths of SBHCs. “Kids spend the majority of their waking hours at school. Even when they have a primary care physician with responsibility for the whole body of services, SBHCs are effective partners with parents and primary care physicians in chronic care management,” she says.

For children with asthma, for example, the ability to leave class briefly for a breathing treatment and then return to class without leaving campus is a benefit for both parents and children. A recent clinical trial showed supervised administration of asthma medication at school resulted in more symptom-free days for students and a 50 percent reduction in emergency room visits or hospitalization for asthma.¹⁵ Both Roaring Fork and Northside SBHCs help manage care for students with asthma, diabetes, seizure disorders, ADHD, depression and anxiety. “I can do that management during the school day, so the parent doesn’t have to miss work,” Suchon says.

A study of SBHCs that coordinate with a student’s primary care physician saw higher rates of adherence with preventive and chronic disease management than patients seen in a primary care practice alone.¹⁶ Consistently, research shows students that use SBHCs attend more well-child visits and have better immunization rates as well.¹⁷ Roaring Fork employs a bilingual care coordinator who does both medical and behavioral health care coordination. She also coordinates resources for students who need services from community partners to help pay for food, mental health and medical services.

Both Ramirez and Suchon say their SBHC staff coordinate specialty care services for students who

need referrals, and often provide the followup therapy prescribed by other physicians. For example, if a student is diagnosed with attention deficit hyperactivity disorder by a specialist, followup and medication adherence is provided through the SBHC. “We can communicate that back to the provider outside the school; the communication is very fluid,” Ramirez says. Roaring Fork SBHCs are connected to one another and to other providers via a certified electronic health records platform. They’re also part of the Colorado Regional Health Information Organization and Quality Health Network Health Information Exchange, which allows them to access records and send updates electronically to other providers.

A community hub for health

More than half of the nation’s SBHCs serve populations other than the students in the school. Most of these (84 percent) serve students in other schools, but two-thirds serve family of student users, 61 percent serve out-of-school youth and 60 percent serve faculty and staff. Some also serve other people in the community.¹⁸

The benefits of SBHCs to the community include reduced absenteeism for both students and their parents from employment. But they also extend to preventive services; obesity programs and immunizations are common. SBHCs often train teachers in their host schools on topics such as hand washing, cold and flu prevention, cultural sensitivity and ADHD behavioral strategies.

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¹⁵ Halterman, Jill, et al. “Effect of the School-Based Telemedicine Enhanced Asthma Management (SB-TEAM) Program on Asthma Morbidity.” *JAMA Pediatrics*, 8 Jan. 2018, doi:doi:10.1001/jamapediatrics.2017.4938.

¹⁶ Riley, Margaret, et al. “The Adolescent “Expanded Medical Home”: School-Based Health Centers Partner with a Primary Care Clinic to Improve Population Health and Mitigate Social Determinants of Health.” *Journal of the American Board of Family Medicine*, vol. 29, no. 03, Mar. 2016, pp. 339–347., doi:10.3122/jabfm.2016.03.150303 .

¹⁷ Ibid.

¹⁸ *2013-14 Census of School-Based Health Centers: Methodology, Key Report Data Details, and Acknowledgements*. School-Based Health Alliance, 2014, pp. 1–14, 2013-14. <http://www.sbh4all.org/wp-content/uploads/2015/02/2013-14-Census-Data-and-Methods.pdf>

“They rely on our providers to help them handle issues in the classroom. We can offer them resources to help them de-escalate episodes and get back to learning.”

— Haidith Ramirez, Program Director
Roaring Fork School-Based Health Centers

“SBHCs function both as public health entities and health care delivery entities. They service the entire school through preventive screenings, and in many cases with health education,” says Kotelchuck. “The focus is very much on the health of the population.”

Because they’re in the schools, SBHCs are supremely attuned to the needs of that population. Many work with school administration on preventive activities targeting substance abuse, suicide and violence prevention. More than half of SBHCs nationwide provide group-based education to leverage peer influence for positive behavior change.¹⁹

For example, the Roaring Fork region is host to a population of undocumented minors who come into the country without families. They often arrive from high poverty areas in Central America and choose to attend Basalt High School.

“The experience they have when they come from El Salvador or Guatemala is a traumatic event itself,” Ramirez says. “They arrive with a huge amount of stress, and no elementary education because they’ve been working since they were five or six years old. They don’t speak the language. If they are 16, it’s expected that they should be able to do math, read, write a paper. But they don’t have any of that preparation—and they’ve come here to work and make money to send back to their families. Legally, they have to stay in school. How do we help them balance that?” she says.

Two years ago, the Basalt High SBHC created a “newcomers” program that shepherds these

students through the cultural transition. Over lunch, the SBHC’s social worker uses a trauma-informed education curriculum to help the students express their experiences and relate them to one another. The topics are customized for the audience: nutrition, “because the way we eat is so different from their home countries,” reproductive health and preventive dental health are all on the agenda. “They learn how the culture works here, how they can start thinking about the education they can get, and why it’s important,” Ramirez says.

Similarly, SBHC staff help teachers navigate classroom issues with trauma-informed care workshops. “They rely on our providers to help them handle issues in the classroom. We can offer them resources to help them de-escalate episodes and get back to learning.”

Rural SBHCs face their own challenges

Although the Community Preventive Services Task Force backs expansion of SBHCs—based on both savings to Medicaid programs and advancement of health and education benefits for students—expanding the model in rural areas is called out as a challenge because of low population density, lack of qualified providers and the need for local champions.

“We have some challenges, but we try to overcome those challenges with good communication, and with how we’re doing our work.”

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Roaring Fork School-Based Health Centers

Northside Child Health Center in Montrose, for example, was spearheaded by a former school superintendent who pushed for its launch, but who has since retired. Roaring Fork began as a grassroots effort in 1993 and opened its first clinic in 2007. It has since expanded to four sites and makes services available at 10 schools. Both

¹⁹Ibid.

Suchon and Ramirez would like to further expand staff and services but doing so requires both funding and community support.

Urban centers can expand more quickly through local resources and economy of scale. The Roaring Fork SBHCs had to forge a more distant partnership with Rocky Mountain Youth Clinics, a non-profit pediatric practice that operates nine SBHCs and is headquartered in Denver. The relationship is primarily administrative; Roaring Fork SBHCs refer patients to local practices and it doesn't depend on Rocky Mountain Youth Clinics for funding. "We are rural, and it's hard for the local providers to not see us as competition," Ramirez says. "We have some challenges, but we try to overcome those challenges with good communication, and with how we're doing our work."

Funding: Both a challenge and an opportunity

SBHCs are typically funded by a mix of federal and state-based program dollars, plus income from Medicaid, CHIP and commercial insurance for providing services. The Colorado Department of Public Health and Environment provided \$5 million for fiscal year 2017-2018 to SBHCs, although not all centers received funding.²⁰ They receive in-kind funding from their host schools and fill in gaps with grants and charitable donations. Most are self-sustaining entities, without much margin for growth or expansion.

Under the Affordable Care Act, the Department of Health and Human Services provided \$200 million

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in capital funds for SBHCs. The funds enabled centers to build, renovate and update equipment.²¹ Because most services are reimbursed via public health programs or commercial insurance, they are operationally viable, even after accounting for the extended services they offer.

Although location within schools is an essential value point for SBHCs, Kotelchuck acknowledges the lack of visibility to the public is also a drawback for ongoing sustainability. "They're usually sponsored by hospitals or federally-qualified health centers, but as community-oriented as those organizations may be, SBHCs are just not very visible in the eyes of their sponsors," she says. In her role as chair of the New York School-Based Health Foundation, Kotelchuck cites work towards NCQA medical home recognition as a win, but there's work to do in terms of building awareness.

"Look at how sensible, how effective school-based health centers are, and at what a small cost," she says. "What a great investment this is if you want good health outcomes." ■

²⁰ An Analysis of Colorado's Rural and Urban School-Based Health Centers. Colorado Health Institute, 2017, An Analysis of Colorado's Rural and Urban School-Based Health Centers, http://www.coloradohealthinstitute.org/sites/default/files/file_attachments/2017%20SBHC%20REPORT.pdf.

²¹ Diane Kilpey, et al. *The Affordable Care Act and Adolescents*. Department of Health and Human Services, 2013, https://aspe.hhs.gov/system/files/pdf/180281/rb_adolescent.pdf



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RONDA KOTELCHUCK was the founding CEO of the Primary Care Development Corporation (PCDC), a public-private partnership with a mission to expand access to primary and preventive care in underserved communities. Prior to that, she served as vice president of the New York City Health and Hospitals Corporation, where she spearheaded development and adoption of its first strategic plan, focused on community-based primary care. She holds a bachelor's degree from Lewis and Clark College and a master's degree in regional planning from Cornell University.



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JENNIFER SUCHON is clinic manager and certified family nurse practitioner at Northside Child Health Center, which provides medical, mental health, dental and family services needs for children in the community, from pre-kindergarten through high school. She earned her master's degree from Johns Hopkins University. She also serves on the board of the Colorado Association of School-Based Health Care.



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H Aidith RAMIREZ is the program director for the Roaring Fork School-Based Health Centers, which serve the students of the school district through sites at Basalt High, Basalt Elementary, Basalt Middle and Roaring Fork High. She holds a bachelor's degree in international business from the Jorge Tadeo Lozano University in Bogota, Colombia. She also serves as secretary of the Aspen to Parachute Dental Health Alliance, which provides access to oral health services to the underserved.



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As the portfolio director of private sector engagement, **BEN BYNUM** develops the Colorado Health Foundation's impact investing strategy and manages the impact investment portfolio. Prior to that, he helped to plan and execute the creation of Vital Healthcare Capital, a nonprofit organization that provides flexible financing and development services to support health care and health care jobs in low-income communities. He holds a bachelor's degree from Tuskegee University, a medical degree from Howard University College of Medicine, and dual master's degrees from Columbia Business School and Columbia University Mailman School of Public Health. Bynum is a guest lecturer at the University of Colorado Graduate School of Public Affairs and the Graduate School of Public Health; he also serves on the board of the national School-Based Health Alliance.

About Rocky Mountain Health Plans

Founded in Grand Junction, Colo. in 1974, as a locally owned, not-for-profit organization, Rocky Mountain Health Plans provides access to affordable, quality health care enabling its more than 229,000 members across the Western Slope to live longer, healthier lives.

About the Community

Western Colorado is creating an accountable community that uses health IT in a meaningful way, adopts value-based payment models, coordinates care and empowers patients to take charge of their health.

We aspire to ensure the following:

- High-quality health care is affordable and accessible to all.
- Those who purchase health care are assured that care is effective, safe and appropriate.
- Patient care is a team effort, with roles that are well-defined, connected and collaborative.
- Patients have access to the support and information they need to take charge of their health and make their own decisions.
- Payment reform will foster reimbursement models that support accountability for population health and resource use.

- Information technology supports population health, helping providers predict outcomes, prioritize interventions and prevent disease.
- Health data is a community resource used in a secure way to support coordinated care at the population, practice and personal levels.
- Investments in information technology and health system transformation will improve quality of life and economic well-being across the state.
- Health is a community resource that requires leadership, stewardship, individual responsibility, community support and ongoing maintenance.

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