DOCUMENT RESUME

ED 365 892 CG 025 144

AUTHOR Hauser, Debra
TITLE Designing and Implementing School-Based and School-Linked Health Centers. Volume II. A Guide to School-Based and School-Linked Health Centers.
INSTITUTION Center for Population Options, Washington, DC.
PUB DATE 93
NOTE 94p.; For volumes I and III, see CG 025 143 and CG 025 145.
PUB TYPE Guides - Non-Classroom Use (055)

EDRS PRICE MF01/PC04 Plus Postage.
DESCRIPTORS *Elementary School Students; Elementary Secondary Education; *Program Design; *Program Implementation; *School Health Services; *Secondary School Students; Student Needs

ABSTRACT

Volume II of a three-volume guide to school-based and school-linked health centers, this document is designed to help community advocates successfully navigate the planning, implementation, and early evaluation stages of a school-based health clinic/school-linked health clinic (SBHC/SLHC). The individual chapters in this volume address the key stages of implementing an SBHC/SLHC in the community. Chapter 1 focuses on getting started, forming a working group, selecting a facilitator, finding a sponsor or head agency, and obtaining a planning grant. Chapter 2 discusses how to conduct a needs assessment and develop an SBHC/SLHC philosophy. Chapter 3 centers on selecting a site, forming an advisory board, and defining the clientele. Chapter 4 discusses how to design a health center. It identifies components of quality care, defines program components, and considers other design elements. Chapter 5 concentrates on developing the budget and staffing the center. Chapter 6 describes how to determine health center policies concerning confidentiality, parental consent/notification, billing, establishing protocols, and limiting liability. Chapter 7 considers integrating the center, the school, and the community. Chapter 8 focuses specifically on serving elementary-aged children. Chapter 9 deals with program evaluation. Relevant materials are appended. (NB)

A Guide to School-Based and School-Linked Health Centers

VOLUME II:

Designing and Implementing School-Based and School-Linked Health Centers

The Center for Population Options (CPO)
Margaret Pruitt Clark, Ph.D., President

CPO is a nonprofit organization that works to increase the opportunities for and abilities of youth to make healthy decisions about sexuality. Since 1980, CPO has provided information, education and advocacy to youth-serving agencies and professionals, policymakers and the media.

Support Center for School- based and School-linked Health Care/CPO
Debra Hauser, M.P.H., Program Director

The Support Center/CPO provides information, technical assistance, training, policy analysis and advocacy to assist in establishing school-based and school-linked health centers (SBHCs) and in enhancing their operations.

Public Affairs Program/CPO
Pamela Haughton-Denniston, M.Div., Program Director

The Public Affairs Program/CPO assists policymakers and advocates by providing information, consultation and publications on: adolescent health issues, state and federal legislation, model programs, policy options and the impact of public policy decisions on adolescents. The department also provides support at all stages of the legislative process, including assistance with testimony and identification of expert witnesses.

Principal Author: Debra Hauser, M.P.H., Program Director, the Support Center for School-based and School-linked Health Care/CPO

Special Chapter on Elementary Services written by Silvia Holschneider, M.P.H. and Tracy Stern. National Health/Education Consortium, Washington, D.C.

Editing: Lorie Kaplan, Marijke Velzeboer, Dr. P.H., Margaret Pruitt Clark, Ph.D., Pamela Haughton-Denniston, M. Div., Jennifer Hincks Reynolds, M.P.H., Susan Messina, M.S.S., M.L.S.P, Susan Flinn, M.A., Claudia Page

Design and Production: Charles Seagle, John Connors, Robin Hatziyannis

Interns: Carrie Meyerhoff, Marnie Lynne Glaeberman, Marge Mazie

CPO's Support Center would like to thank both the Brush Foundation and the Carnegie Corporation of New York whose generous support made this project possible. The foundations do not necessarily subscribe to the views in this series.

This document is an expansion of: *School-Based Health Clinics: A Guide to Implementing Programs*, Elaine Hadley, Sharon Lovick and Douglas Kirby, Ph.D, CPO, 1986.

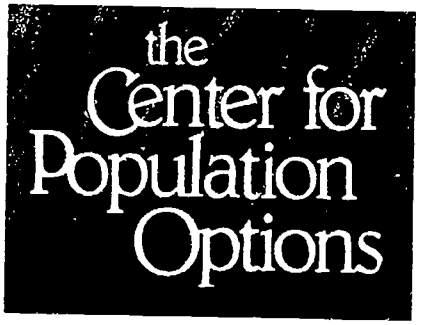

the
Center for
Population
Options

TABLE OF CONTENTS

INTRODUCTION

School-based and school-linked health centers (SBHC/SLHCs) have emerged as effective models for enhancing adolescents' access to health services. Located on or near school grounds, these comprehensive health centers offer a wide range of primary health care services needed by young people: health maintenance examinations and assessments, diagnosis and treatment of acute and chronic illnesses, first aid, laboratory tests, screening for sexually transmitted diseases, immunizations, gynecological exams, family planning counseling and reproductive health services and sports physicals. Many centers also provide nutrition education and weight reduction programs, alcohol and substance abuse counseling and counseling for depression and other personal problems. Dental services, job counseling, and prenatal, well-baby and day care are also offered at some SBHC/SLHCs.

Designing and Implementing School-Based and School-Linked Health *Centers*, the second volume of the complete *Guide to School-Based and School-Linked Centers*, is designed to help community advocates successfully navigate the planning, implementation and early evaluation stages of an SBHC/SLHC. Other modules include Volume I: Advocating for a School-Based or School-Linked HealthCenter, and *Volume III: A Guide to Potential Sources of Federal Support for School-based and School-linked Health Centers*. Together, these volumes provide a comprehensive picture of what's involved in moving the SBHC/SLHC concept forward in your community from a theory to a vital, ongoing reality. They represent a chance to benefit from the experience of the hundreds of SBHC/SLHCs currently serving youth across the country today.

CPO's Support Center also offers a resource for SBHC/SLHCs completing their first year of operation. *How to Use Site-Monitoring Teams to Evaluate School-Based and School-Linked Health Centers* describes an effective, low-cost method for completing a process evaluation.

The chapters that follow address the key stages of implementing an SBHC/SLHC in your community: conducting a needs assessment; selecting a site; designing the components of your program; staffing the center; planning a budget; developing an action plan; and more. Also included is a special chapter on Elementary Services, written by the National Health/Education Consortium.

Although the information is presented in a chronological order, in reality, planners will be working on several steps simultaneously. Figure 1 summarizes the major tasks and how they may overlap.

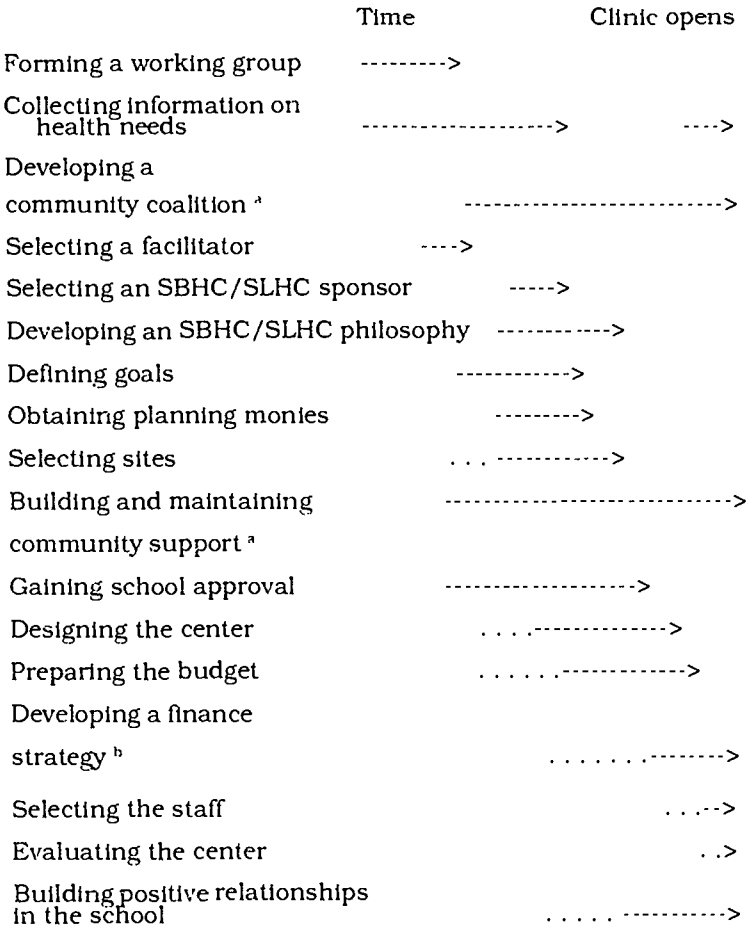
There are few hard and fast rules about SBHC/SLHCs. Just as the settings, the mix of services, and the people coming together to organize SBHC/SLHCs are unique to each community, so, too, design and implementation activities vary. Think carefully about which design components and implementation procedures will be the most effective in your own community.

By the summer of 1993, the network of SBHC/SLHCs had already extended to 42 states across the country, forming a wealth of information and experience on designing and implementing an SBHC/SLHC. Many organizers are willing to share their knowledge, and CPO's Support Center is also available to help. Call or write us for additional information or technical assistance.

Lastly, remember that implementing an SBHC/SLHC involves hard work, determination and commitment, but the rewards are tremendous. As some graduating students wrote to the staff at their St. Paul SBHC/SLHC:

Thank you! For being so nice and understanding and listening to our problems, and trying to help us solve them. You really helped us out a lot and we thank you very much. And we are going to miss all of you. You're really going to help a lot of people. And you *already have.*

FIGURE 1: POSSIBLE TIME LINE FOR DIFFERENT TASKS*



* The time-frame for planning a center varies from community to community. Some centers are operational within a year, others within three.
.... indicates that this is a minor activity at a given time
---- indicates that this is a major activity at a given time

a. the subject is covered in Volume I: A Guide for Advocates
b. the subject is covered in Volume III. A Guide to Public Funding

CHAPTER ONE: GETTING STARTED

School-based and school-linked health centers (SBHC/SLHCs) are primary health care clinics located on or near school grounds. Most offer on-site physical and mental health screening and treatment, provided by trained health care professionals. Recent studies indicate that SBHC/SLHCs are often accepted in their communities and well-used by the adolescent populations they serve. Data also indicate that SBHC/SLHC staff have helped young people by diagnosing previously undetected health problems, treating acute and chronic illness and providing mental health counseling. Some SBHC/SLHCs have even succeeded in reducing adolescent substance abuse, teenage pregnancy, absenteeism and other health and social morbidities.

Needless to say, the mere act of creating an SBHC/SLHC doesn't guarantee positive outcomes. Program planners need to identify and prioritize the needs of teens in the community and plan appropriate interventions to address these needs.

Performing a thorough, detailed planning process can seem like a daunting task, and it's tempting to charge ahead and open the health center doors. The experience of others, however, suggests that completing the initial groundwork builds a more stable program. This chapter walks SBHC/SLHC planners through the initial steps of the design process: forming a planning group, selecting a group facilitator and identifying a sponsor or lead agency for the health center.

Forming a Working Group

Planning an SBHC/SLHC means a multitude of tasks to accomplish, relationships to nurture, and decisions to make — decisions about services, staffing, site selection, parental consent and more. Most planners begin by developing a small working group of six to eight community experts to share these responsibilities.

Choosing Members of the Planning Group

Ideally, working group members should be diverse, energetic and multi-talented, and above all, committed to the SBHC/SLHC. Here are some qualities to look for when forming a working group.

Commitment — willingness to devote time and energy — not just a signature — to the cause.

Unity — shared concern for adolescents, their health, their families and their education.

Expertise — knowledge and experience in relevant fields (for example, adolescent medicine, social work, or substance abuse).

Variety — a blend of specific knowledge and/or tangible resources to bring to the implementation process.

Where to Look

In — or near — every community, there are individuals and organizations who can help marshall the resources needed to form a successful health center. Places to look include:

- Local medical institutions, health departments, hospitals and universities — consider the local health officer (or his/her designate), a public relations official at a nearby hospital or a faculty member of a teaching hospital;
- The school system — consider the principal (or his/her designate), the school nurse, guidance counselor or a health teacher;
- Local social service agencies — consider representatives from Medicaid, Welfare, WIC, etc.;
- Within the mental health and drug and alcohol treatment fields.

Finding the ideal members for your SBHC/SLHC planning group will depend on the unique considerations of your community. For example, if it's clear that construction will be needed, your group should look for an architect or a builder to participate. Forethought and coordination can help bring all the right puzzle pieces together.

As you meet with potential members of your planning group to win their support and participation, be specific about what's expected — how much time is involved and how frequently the group will meet — as well as what role they will have in the process. While your candidates will need time to decide whether to participate, invite them to the first meeting of the group. Also ask for names of others who might be helpful during the planning process.

Selecting a Facilitator

Although many individuals and organizations will become involved, one person should be in charge of coordinating the planning group. The facilitator will play a key role in establishing and maintaining an advisory board, seeking authorization to open the health center, identifying a sponsor or lead agency, negotiating contracts with other service providers and developing a working relationship with school faculty and administration. In short, the facilitator is responsible for the development of the health center from beginning to end.

How the facilitator is selected depends on the community. Some communities seek foundation or state support to hire a facilitator, while others seek the support of the school principal or superintendent and identify a facilitator from the school system. In communities that have secured a sponsoring agency early on, the sponsor may choose the facilitator.

Because of the crucial role of the facilitator in planning and implementing the SBHC/SLHC, he or she should bring a number of key qualities to the process:

- Commitment to the concept of an SBHC and an understanding of the challenging nature of the position.
- Relevant work experience, an understanding of the physical

and mental health needs of youth and a familiarity with other SBHC/SLHCs.

- Familiarity with the community, local politics, power mechanisms and the leaders of public, private and educational agencies.
- Enthusiasm for the project and an ability to sell the concept to others.
- Development and proposal writing skills — how to contact public and private sources, develop grant proposals and negotiate support from state agencies.
- An understanding of the position. When the planning phase ends, will the facilitator continue as the clinic director or in some other capacity such as chair or member of the health center's advisory board?
- Affiliation with an organization that has a strong, positive image in the community, a good track record on adolescent health, a history of community involvement, and the expertise and experience to design and administer an SBHC/SLHC.

Finding a Sponsor or Lead Agency

Early in the planning process, a sponsor or lead agency for the health center should be found — a community organization that administers the SBHC/SLHC, provides leadership, hires or lends staff, develops collaborative or subcontract agreements with the school system and other community agencies and identifies funding or underwrites for the long-term financial stability of the facility.

In seeking a lead agency, look for agencies that can provide or coordinate resources for the health center, such as clinical staff, medical equipment, billing services, laboratory work, or medical malpractice insurance.

Possible sponsors include local health departments, hospitals and medical schools, community health centers, mental health agencies, family planning clinics, community-based organizations and school systems. See Figure 2 for a look at what types of organizations currently sponsor SBHC/SLHCs.

FIGURE 2: PERCENTAGE OF SCHOOL-BASED AND SCHOOL-LINKED PROGRAMS BY SPONSORING AGENCY, Update. 1991. (CPO)

	School-based	School-linked
Hospital Medical School:		
Dept. of Adolescent Medicine	4	0
Family Practice	4	7
Pediatrics	7	0
Combination	2	0
Other	7	13
Community Health Clinic	28	7
Public Health Department	26	40
Family Planning Clinic	1	0
School System	7	0
Community-based Organization	6	13
Non-profit Agency	0	13
Mental Health Agency	1	0
Other	6	0

Each of these possible sponsors presents advantages and disadvantages. One SBHC/SLHC administrator, for example, considers medical malpractice insurance as a high priority for the SBHC/SLHC and urges planners to negotiate for insurance right from the start. Hospitals, clinics and public health agencies are in the best position to provide this insurance.

Your funding needs will also be a major consideration when choosing a sponsor. Public health departments have access to maternal and child health block grant money; community health centers have access to community and migrant health funds. Either may be used to support SBHC/SLHCs (see *Volume III: A Guide to Potential Sources of Federal Support for SBHC/SLHCs* for a complete discussion of sponsor access to funding.)

Federally Qualified Health Centers (FQHCs) are another potential sponsor. These special community health clinics can obtain 100 percent Medicaid reimbursement for their services. If your SBHC/SLHC plans to bill for services, you may wish to consider a FQHC as a sponsor.

The planning group should meet with a number of potential sponsors, assess how their own mission may be advanced by sponsoring an SBHC/SLHC. For a hospital, sponsorship may help reduce unnecessary emergency room visits. For a health department or community health center, sponsoring an SBHC/SLHC may bring in additional dollars or help meet their own mandate: improved health status for community residents.

Currently, few SBHC/SLHCs are sponsored by health maintenance organizations (HMOs). With health care reform on the horizon, however, it is likely that more HMOs will sponsor SBHC/SLHCs. HMOs sharing a catchment area with an SBHC/SLHC should consider sponsorship. The on-site care provided by SBHC/SLHCs encourages young people to seek early and preventive treatment, which can ultimately save money for the HMO by reducing the need for costly tertiary treatment.

In short, the planning group should choose a sponsor that is enthusiastic and interested in participating in the design and implementation process. A sponsor with a knack for collaborating with other groups and key resources to bring to the process is very desirable.

Obtaining a Planning Grant

Many communities seek separate financial support for the planning process. Although planning grants are not necessary, and not easily obtained, they are helpful. Local foundations, social service agencies, local hospitals, businesses, or social clubs may be willing to help support the planning effort.

Some states with SBHC/SLHC initiatives may also have planning monies available. To find out, check with state adolescent health coordinators, maternal/child health program managers or local community clinic administrators. (See *Volume III: A Guide to Potential Sources of Federal Support for School-based and School-linked Health Centers* for more information.)

CHAPTER TWO:
CONDUCTING THE NEEDS ASSESSMENT AND DEVELOPING AN SBHC/SLHC PHILOSOPHY

One of the most important initial activities of the planning process is building a body of knowledge about youth in your community by conducting a needs assessment. A needs assessment is a comprehensive profile of the physical and mental health of the youth in your community — and how well the community is currently meeting their health needs. This study is one of the most crucial components in designing an SBHC/SLHC; it can mean the difference between an SBHC/SLHC that is on target, and one that misses the mark.

A complete needs assessment includes two phases: comparing local rates of morbidity and mortality with state and national averages, and identifying local providers of mental and physical health services in the community — and gaps and barriers in those services.

The Local Needs Assessment

A close look at adolescent morbidity and mortality rates tells the planners what youth are in need of in the community, and will help determine the mix of services the SBHC/SLHC will offer. In this phase, the assessment involves a great deal of statistics-gathering. Statistics on adolescent mental and physical health can be obtained from local and state health departments, youth-serving agencies, hospital records, school records, local family planning clinics, local libraries, and municipal or county planning departments.

Try to gather the following data:

- School drop-out rate
- School absenteeism
- Teen birth/pregnancy rates
- Incidence of sexually transmitted diseases
- Prevalence of low-birth-weight babies born to teen mothers
- Abortion rate among adolescents
- Prevalence of adolescent and adult substance use/abuse
- Prevalence of child abuse and neglect
- Prevalence of sexual abuse/incest
- Number of AIDS cases among people 20-30 years of age who could have contracted the virus while in their teens
- Juvenile incarceration rate
- Teen homicide and suicide rates
- Accident and injury rates
- Income level of the community
- Number of children living with a single parent
- Immunization status of children
- Cases of malnutrition, anorexia, bulimia and obesity.

Using Interviews and Surveys

If local statistics are hard to find, information can also be gathered by surveying parents, teachers, school nurses and young people. Although interviews and surveys rely on self-reporting and are not scientifically perfect measures, they do provide useful information about key health indicators and risk factors among youth in your community. (See Appendix V for a sample student survey.)

Interviews and surveys can look at the proportion of youth who are:

- sexually active
- use alcohol or drugs
- come from a dysfunctional home
- are teenage parents
- have experienced child sexual abuse
- have thoughts of suicide
- have chronic illnesses
- have been involved in juvenile crime
- have been incarcerated
- live with a single parent
- live with foster parents
- have been left back a grade in school.

Your group may not be able to find the answers to every one of these questions. The goal is to accumulate enough data to document the level of adolescent morbidity in the community. As you analyze the data you've gathered, pay particular attention to local rates that have risen over the past few years and local rates that are higher than the national or state norms. These problem areas will help shape your vision for the SBHC/SLHC.

Assessing Gaps in Services

Beyond analyzing the statistics, planners need to take a close look at the health care services already available in the community. Are there gaps in services? Are teens using the services now available? If not, why not? A review of local social service and health care directories, combined with surveys of parents school nurses and teens, will provide a valuable overview of the local situation. Questions to ask include:

- What primary health care services exist in the community?
- Are these services private or public?
- What insurance do existing providers accept?
- Are mental health/substance abuse services available for teens?
- Is reproductive health care available?
- Are dental services available?
- What percentage of teens have private insurance?
- What percentage are covered under Medicaid?
- What percentage are uninsured?
- What percentage have a family physician?
- What percentage used the emergency room last time they needed health care?

- Is transportation to services available?
- What factors keep teens from using existing services?
- What services are not available?

In this process of analyzing the local needs and the quality and scope of existing services, a sharper vision of the role of the SBHC/SLHC in your community will begin to unfold.

Developing an SBHC/SLHC Philosophy

Every planning group should develop a philosophy, or vision, for the mission of the SBHC/SLHC. Analyzing the needs assessment will probably help to shape this philosophy. As the planning group meets to review the needs assessment and define its service philosophy, the group should also take the time to articulate its underlying beliefs about a health center. The group should try to develop a consensus on such issues as:

- adolescent development;
- the major problems affecting youth;
- teenage sexuality;
- family roles and responsibilities in relation to youth;
- the school's role in addressing the health needs of teens and pre-teens and
- the role of the SBHC/SLHC in addressing these needs.

How you express the philosophy is not important. What is important is that the philosophy offer a guide to the type and scope of services that the SBHC/SLHC will provide. Here's how one planning group described its philosophy:

"Children who are not healthy cannot learn and although parents are ultimately responsible for the health and welfare of their children, some are unable to adequately access the heath care system. Given then, that all children have the right to comprehensive, quality physical and mental health care, it is the community's responsibility to bring these needed services to youth by placing them on school grounds and by providing services to those students whose parents provide the SBHC/SLHC with permission."

Another group wrote:

"Adolescence is a time of experimentation that can sometimes lead to risky behaviors with negative consequences. The nature of the behaviors in question can be so grave that the community has the responsibility to provide teens with confidential, accessible education, services and referral for all of their health care needs, including those related to mental health, drug and alcohol treatment and family planning. The group further believes that young people should be encouraged to consult their parents regarding their health care concerns."

Still another decided:

"The process of prevention and early intervention must begin with young children and their families. The group believes that the SBHC/SLHC should be placed in the elementary school and should work with the entire family unit to provide linkages to needed mental, physical, and social services."

Whatever your group's philosophy, keep in mind the six "C's" of adolescent health care:

Commitment: Working with young people in a school setting requires a high level of commitment; your community's SBHC/SLHC needs committed personnel and a planning group that will help them maintain that commitment.

Counseling: Youth need formal counseling sessions offered by a social worker or psychologist who can address the students' overall social and psychological well-being.

Communication: The SBHC/SLHC should be a setting that encourages comfortable and informal interaction between young people and health center staff; take steps from the start to eliminate communication barriers.

Confidentiality: Youth, especially teens, crave privacy and have a right to confidentiality; guaranteeing that privacy is important.

Convenience: Students are more likely to use services that are convenient, easily accessible and free of obstacles.

Cost: Many young people will not or cannot pay significant fees; services should be offered for free or at low cost.

As a philosophy begins to take shape within the planning group, the facilitator plays a key role in formalizing the process. The facilitator should record the philosophy, convictions and commitments articulated by the group and circulate the written record to members of the group for consensus. The group is now ready to move forward in the planning process.

CHAPTER THREE:
SELECTING A SITE/FORMING AN ADVISORY BOARD/DEFINING THE CLIENTELE

Early in the planning process the group should identify one or more schools as possible SBHC/SLHC sites. The needs assessment may demonstrate which school districts, and which schools within those districts, are most in need of health services. This chapter will help the planning group select the site and clientele for the SBHC/SLHC.

Criteria for Site Selection

The two most important criteria for selecting a school are need (demonstrated in the needs assessment) and community acceptance — (will the students, school personnel, and the community accept the services offered?).

Need for Health Services

Within the community, some schools and neighborhoods may demonstrate a particular urgency for youth health care services in the needs assessment. Do children at one school experience higher rates of morbidity or mortality than those at another? Are more students uninsured or underinsured? Are greater numbers of students on the school lunch program? Are medical services located farther from one school than from others? A school where students do not have accessible, quality health care, is clearly a good candidate for an SBHC/SLHC.

School Acceptance and Support

No SBHC/SLHC will succeed without the acceptance of the school administration — the principal, teachers, guidance counselors and the school nurse. This is true even if the health center is located off school grounds, because outreach to students and faculty will be necessary. Consider the whole picture. Is the school known for its innovative programs? Is the staff receptive to the SBHC/SLHC? How will the SBHC/SLHC interact with the existing school health program? Is the school nurse supportive of implementing an SBHC/SLHC?

Support of the students is also extremely important. Do students perceive a need for health services? What do students want and need in a health clinic? Can those needs be met? Be sure to talk to a variety of students from the schools being considered. While student leaders, athletes and academic achievers may be the most accessible, other students should also be interviewed.

Parental and Community Support

The planning group also needs to determine whether a school under consideration serves a community that would support school-based or school-linked health services. Does the school serve a single neighborhood or diverse communities? Do the neighborhoods support school health services? Although health centers can thrive in schools that do not serve their immediate neighborhood, building community support in many neighborhoods at once can be very

challenging. (See *Volume I: Advocating for a School-based or School-linked Health Center* for a more complete discussion of winning community and school support for SBHC/SLHCs.)

Selecting a School-based or School-linked Site

There are advantages and disadvantages to implementing a health center near — versus on — school grounds. Because they are accessible, school-based centers are often well-used, and often excel at outreach and follow-up. When the clinic is located at the school, however, the school administration can restrict the services and who uses them. For example, some principals prohibit out-of-school youth from attending a school-based program; some school boards restrict reproductive health care services.

School-linked programs, on the other hand, may serve out-of-school youth, define their own service mix, and can serve more than one school. The obvious disadvantage to a school-linked center is its location. Outreach, follow-up and case coordination are more difficult. At this writing over 424 centers are school-based, while only 75 are school-linked.

Selecting an Elementary, Middle or High School

Although traditionally SBHC/SLHCs have focused on the needs of adolescents, many health centers have been implemented at the elementary level. Elementary programs offer a number of advantages -- especially the chance to prevent and intervene early in antecedents of teen pregnancy, violence, drug and alcohol use and illness. Vision and hearing screening, immunizations and family counseling can also be highly effective for this age group. The primary disadvantage is complexity. Young children are not always able to communicate what ails them, which often means frequent contact with parents (who may not always be accessible). (For a more complete discussion of providing services at the elementary level see chapter eight.)

Most communities open centers in high schools or middle schools where the health problems are often more pressing. There are several approaches for reaching middle school and high school youth. Some communities design a center that can serve a high school as well as "feeder" middle schools in the same district. Others open SBHC/SLHCs for different educational levels in stages, over time. By offering continuity of care, these district-wide approaches may have the greatest impact on the health and well-being of all youth in the community.

If your planning group is considering starting several health centers at once, a word of caution is in order. Some groups that have done so have experienced less involvement from the community and lower utilization by students than those concentrating on one site. Local needs and concerns often become lost in the big picture. Start small; success at the first site will fuel expansion.

Other Considerations

There are other factors to consider when choosing a site for the SBHC/SLHC. Does the school have room for the health center? Will renovations be necessary? Is there a building nearby that may be donated or obtained at a reasonable cost for a school-linked center? Are there political reasons for choosing one school over another? Is there a sponsor or lead agency willing to participate at one school but not at another? Does the location for the SBHC/SLHC embody the philosophy of the planning group? (For example, an elementary school would not

be an appropriate site if improving access to reproductive health care for teens is one of the primary goals of the group.)

Finally, remember that the success of the first health center will set the tone for future projects. It may not be wise to choose the most challenging site for your initial project. Other communities or school officials may reject the idea of an SBHC/SLHC if a health center at a neighboring school generates controversy and only lukewarm results. Success, on the other hand, is a great motivator. Choose a site where success is assured, even if need may be greater elsewhere.

The SBHC/SLHC Advisory Board

Once a site is selected and approval is obtained to implement an SBHC/SLHC, the planning group should develop a advisory board to represent the community served by the SBHC/SLHC site and help design the components of the health center.

Ideally, the board should have some 20 members, including students, parents, medical and mental health professionals, clergy, the school nurse, the principal (or his or her designee), a school board member and a representative of the sponsoring agency. If other community organizations will be collaborating to provide services, their staff should also have a seat on the advisory board. Parents and students participating on the advisory board should reflect the diverse academic, cultural and economic groups of the community.

Beyond program design, the SBHC/SLHC advisory board serves a number of purposes. As the health center becomes operational, the planning group may disband, but the advisory board continues intact to:

- monitor the health center's progress;
- review programming;
- suggest new programming;
- examine and offer suggestions on written materials;
- play a public relations role with the community and
- help the health center director seek additional resources.

Approaching Potential Board Members

After the planning group decides who to include on the advisory board, the planning group should meet with each individual to explain the purpose and responsibilities, define the length of involvement expected from each member (two year terms are common), explain policy and power limitations of the group (the group's role is to advise) and articulate the time commitment that membership would require (meeting twice a month, once a month, once a quarter, etc.). Advisory boards are usually relied upon very heavily during the planning stage, but meetings are typically less frequent once the center is operational.

If the community is establishing more than one health center, the planning group should consider whether to set up an advisory board for each one. Working with several boards is time-consuming. However, if each SBHC/SLHC receives individualized attention, the result may be better program designs and, ultimately, superior quality of care.

Defining the Clientele

Once the planning group has selected a site and obtained permission from the school board and the principal to implement the center (see *Volume I: Advocating for a School-based or School-linked Health Center* for information on gaining school approval), the advisory board needs to define who will be using the health center. Existing SBHC/SLHCs provide services for one or all of the following groups:

- students enrolled in the school;
- students enrolled in feeder schools;
- siblings of students enrolled in the school or feeder schools;
- out-of-school youth from the community;
- children of students or out-of-school youth from the community;
- parents and families and/or
- faculty.

In some communities, school policy will affect decisions regarding clientele. For example, the principal may prohibit out-of-school youth from entering school grounds, or teenage parents may be prohibited from bringing their babies in the school building. Figure 2 describes the percentage of health centers serving different populations in 1991.

FIGURE 3: PERCENTAGE OF SBHC/SLHCS SERVING YOUTH IN LISTED CATEGORIES

	School-based	School-linked
Youth in school	100	100
Youth from other schools	30	78
Out-of school youth	20	85
Siblings of students	30	72
Children of students	22	42

CPO, Update, 1991

The planning group and the advisory board will also need to consider the resources available. Clearly, the larger the clientele, the more resources needed — money, staff and equipment. Remember that the SBHC/SLHC can expand its reach as more resources become available.

In short, defining the site and the clientele for the SBHC/SLHC in your community is a critical step in the planning process, shaped by the philosophy of the planning group, the needs of youth in the community, the available resources, and political realities. Once the planning group and the advisory board have weighed these factors, it's time to move into the design stage.

CHAPTER FOUR:
DESIGNING THE HEALTH CENTER

Providing health care in a school-based or school-linked health center is similar in some ways to providing care in other medical settings. But because the SBHC/SLHC is associated with a school and serves mainly young people, there are unique factors that will affect how health care services are offered.

Components of Quality Care in an SBHC/SLHC Setting

To establish an effective program, several features must be incorporated:

Parental Consent. One of the goals of SBHC/SLHCs is to support families and involve parents; obtaining parental consent is an essential part of this policy. Parental consent procedures are discussed below.

Holistic Approach. SBHC/SLHCs address the needs of the whole young person by treating the immediate health problem and addressing the underlying causes as well. Drug abuse, for example, is not merely a case of taking too many drugs. It is often based in low self-esteem, stress and family problems. To the extent possible, SBHC/SLHCs should offer many services in a "one-stop-shopping" approach.

Confidential Care. Despite the need for parental consent, privacy and confidentiality should not be compromised. Teens will not use health centers if privacy is not ensured. By obtaining one-time parental consent for treatment, SBHC/SLHCs can maintain the student's privacy while also encouraging the student to discuss his or her problem with a parent. Never share confidential information with school staff or administration without the student's consent.

Caring, Multidisciplinary Staff. Most centers have limited funds, and, consequently, limited staff. Each staff member must be versatile and willing to deal with the physical, emotional and psychological needs of the young people enrolled in the program. Even with generous funding, space and services, no program will enjoy success if the staff is not caring and qualified. (Chapter five is devoted to guiding the advisory board on how to identify and train appropriate personnel.)

Adequate Time. Trust is built over time. If staff spends sufficient time with the student during the first visits, he or she will be more likely to return for additional attention. Staff members will also gain a better sense for the patient's current

and future needs, and can educate him or her about health issues and when to visit the SBHC/SLHC.

Intense Follow-up. The most successful SBHC/SLHCs have implemented rigorous follow-up procedures. Every student treated should return for a follow-up examination. Written notification, including a rationale for the return visit, can be sent to the student through the school. Missed appointments should be followed up by the social worker, the school nurse or other health center staff.

Cooperative Relationships. Cooperative agreements are mutually beneficial: community providers can expand their client base; the SBHC/SLHC provides more services under one roof; and students have easier access to the services they need. Here, the relationships that planning group members have established in the community and the school system will help to expand the range of services that students can access.

There are many ways to forge cooperative relationships with other providers. Community agencies can offer their services on the health center site while still continuing to bill Medicaid or collect grant money for these services. In this scenario, administrative responsibilities for these services may remain with the community agency, or the sponsor of the health care center may agree to share these responsibilities.

Alternatively, the health center can subcontract with a community agency to provide services on-site under the direction of the SBHC/SLHC sponsor in exchange for a negotiated payment. Subcontracting agreements allow the SBHC/SLHC sponsor more control over how services are provided but the SBHC/SLHC will have to allocate funds for the sub-contract.

Some SBHC/SLHCs have established a system of referral, triage and coordination with existing providers in the community. When students need services that are not provided at the center, they can be referred to other community providers. Special arrangements may be made for priority appointments, transportation and/or special fee scales. For these kinds of agreements to work effectively, the center will need to set up a system of record sharing, case coordination and follow-up.

Comprehensive Monitoring. Monitoring and record-keeping is useful not only for programmatic reasons but is also invaluable for seeking funding, opening another health center or justifying the expansion of the current program. At a minimum, an SBHC/SLHC should document the number of student visits and client encounters by specific purpose. Ideally, center staff should also document the percentages of patient who follow recommended health routines (compliance rates) and how long the routines are continued (continuation rates).

Defining Program Components

With a group philosophy and the above criteria in mind, and the needs assessment in hand, the advisory board can begin to hammer out the details on what services will be provided at the health center.

Determining Services

Based on local needs and trends, the group should make a list of the core problem areas that the health center could reasonably address. Here are some examples of services that can be offered by the SBHC/SLHC:

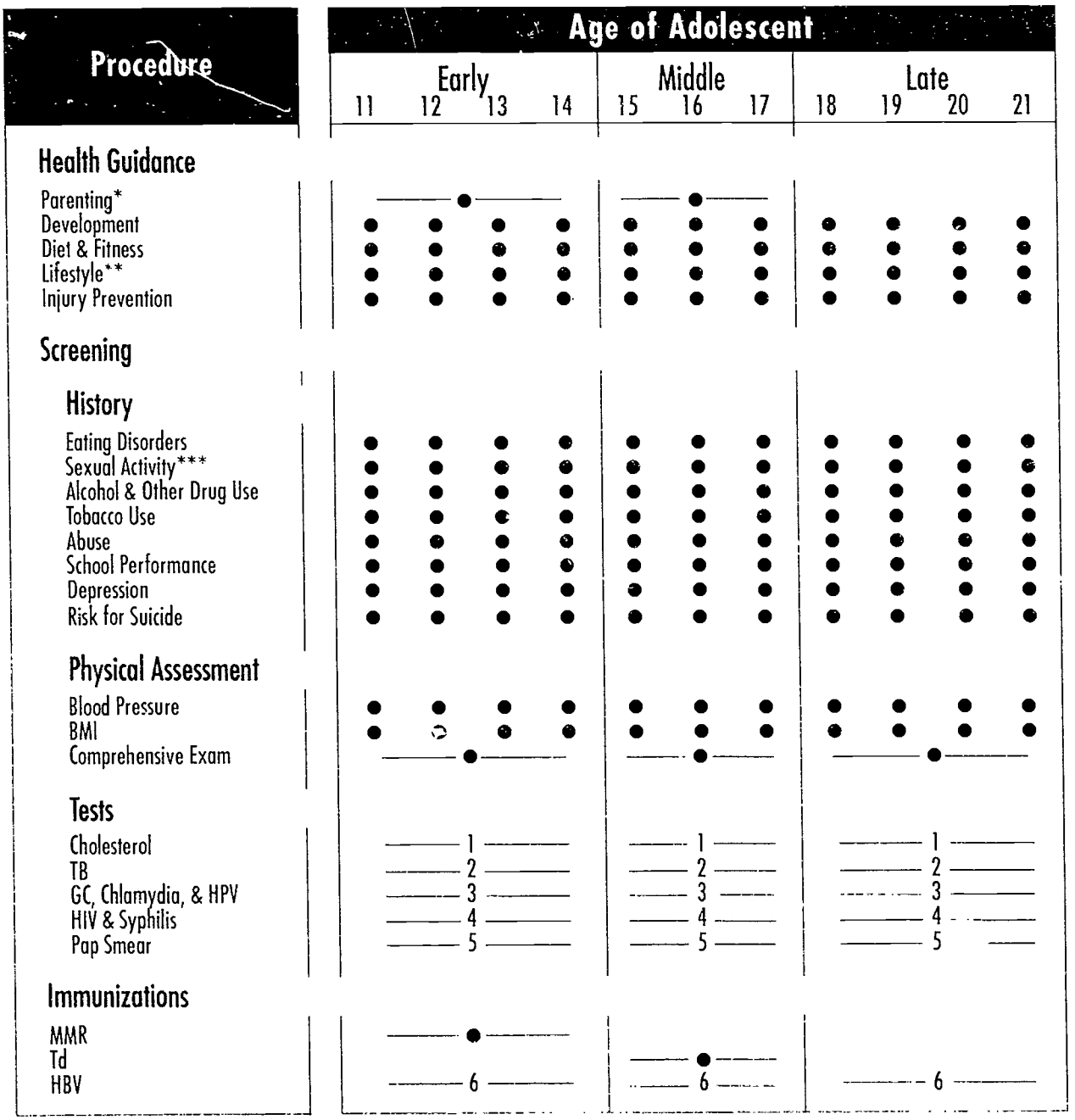
NEEDS	SERVICES
Acute illness	primary health care health education laboratory screening
Gum disorders, cavities and other dental care	dental services, dental care workshops, nutrition education
Stress, behavioral problems, physical and sexual abuse	psychosocial counseling, family counseling, stress reduction workshops, substance abuse counseling
Sexuality and pubertal development	sexuality education, counseling, gynecological exams,contraceptive availability, prescription or referrals, follow-up exams, STD tests, pregnancy testing
Drug and alcohol abuse	medical treatment, individual and group counseling, education and workshops

(For a more comprehensive list of recommended services see AppendixVI)

The American Medical Association (AMA) has also developed a set of guidelines for adolescent preventive care, entitled *Guidelines for Adolescent Prevention Services (GAPS)*. The table on the next page describes the AMA's service recommendations.

Guidelines for Adolescent Preventive Health Services

Adolescents and young adults have a unique set of health care needs. The recommendations for Guidelines for Adolescent Services (GAPS) emphasize annual clinical preventive services visits that address both the developmental and psychosocial aspects of health, in addition to traditional biomedical conditions. These recommendations were developed by the American Medical Association with contributions from a Scientific Advisory Panel, comprised of national experts, as well as representatives of primary care medical organizations and the health insurance industry. The body of scientific evidence indicates that the periodicity and content of preventive services can be important in promoting the health and well-being of adolescents.



1. Screening test performed once if family history is positive for early cardiovascular disease or hyperlipidemia.
2. Screen if positive for exposure to active TB or lives/works in high risk situation, e.g. homeless shelter, jail, health care facility.
3. Screen at least annually if sexually active.
4. Screen if high risk for infection.
5. Screen annually if sexually active or if 18 years or older.
6. Vaccinate if high risk for Hepatitis B infection.

* A parent health guidance visit is recommended during early and middle adolescence.

** Includes counseling regarding sexual behavior and avoidance of tobacco, alcohol and other drug use.

*** Includes history of unintended pregnancy and STD.

Designing Interventions

Once needs and related services are identified, the SBHC/SLHC group can begin to develop a plan of actions and interventions. Interventions dig down to the source of the problem and focus on causes as well as symptoms. An intervention is a complete picture of what services are provided, how services will be combined to enhance their success, and how they will be marketed to achieve their desired effects.

For example, if your SBHC/SLHC has decided to address injuries related to gang violence, the intervention may include first aid for those injured, counseling sessions on gangs, mediation skill-building sessions, employment programs, recreation and possibly mentoring projects. To address sexually transmitted diseases, the intervention may include aggressive STD education, abstinence promotion, condom availability, walk-in STD screening and treatment and sexuality counseling. While both problems call for medical and counseling services, the interventions will also focus on alleviating root causes.

SBHC/SLHCs are never a panacea. Planners should identify problems that can be addressed and plan interventions to confront these problems directly. Handing out a list of agencies that provide STD screening is not an intervention, merely a service. In planning appropriate interventions, you may wish to take additional steps to gather more information about the root causes of physical and mental health problems faced by youth. Members of the advisory board and planning group, and local public and university libraries are excellent resources for this information. These resources will also offer additional ideas of model interventions to address these problems.

Creating the Program Plan

The next step is the actual program plan. Program plans identify the goals and objectives of the SBHC/SLHC, and what interventions the health center will use to achieve these objectives.

Planners should develop a few general goals that reflect the needs of the target population and the philosophy of the group. Examples used by existing health centers include:

- Improving pre-teens' and teens' access to physical and mental health care services.
- Reducing rates of morbidity and mortality among community youth.

Objectives are more specific than goals, and they typically focus directly on identified health needs. Some possible objectives include:

- Enrolling 50 percent of the student body in the health center by the end of the first year.
- Reducing the number of teens who use the emergency room inappropriately by 50 percent in two years.
- Reducing the number of teens who have not had a physical exam in the past year by 70 percent in three years.
- Reducing the teen pregnancy rate by 30 percent in five years.
- Reducing the number of violence-related suspensions by 50 percent in three years.
- Reducing the incidence of depression among teens from 30

percent to 12 percent by 1999.

- Reducing the number of repeat pregnancies by 30 percent by 1997.
- Reducing the incidence of student absenteeism related to chronic asthma by 20 percent in the first year and by 30 percent in the third year.
- Reducing the number of drug- and alcohol-related suspensions by 50 percent in three years.
- Reducing cigarette smoking by teens enrolled in the center by 40 percent in two years.

There may be as many potential objectives as there are SBHC/SLHCs. Nonetheless, it would be overly ambitious for an SBHC/SLHC to try to achieve every one of the few objectives listed above. Objectives should be achievable, measurable and time-framed so that progress can be accurately evaluated at a later date.

Objectives also help define interventions. For example, to enroll 50 percent of the student body in the center by the end of the first year, an aggressive outreach campaign will be needed. The campaign may include classroom presentations, parent orientations and faculty inservices.

Try to avoid including objectives for which interventions cannot be provided. Don't specify school drop-out reduction as an objective if the center can't implement a tutorial program and employment related counseling. Similarly, don't expect to reduce teenage pregnancy if the center can't offer a comprehensive package of family planning services.

Ultimately, the group will identify a few goals, a number of objectives and even more interventions designed to meet the objectives. Here are some examples for using the goal/objective, intervention framework:

Example:

Goal I: To improve access to mental health services for teens attending Anytown High School.

Objectives:

1) To reduce the incidence of reported classroom violence by 30 percent in two years.
2) To reduce the incidence of reported depression by 30 percent in two years.

Interventions:

- Hire a full-time masters-prepared mental health counselor by October 1994.
- Administer a mental health risk assessment survey to 50 percent of the student body by the end of November.
- Provide ongoing counseling for 20 percent of the students in need by the end of the first year; 40 percent by the end of the second year.
- Develop cooperative arrangements with three community

mental health and drug and alcohol agencies by the opening of the health center.

- Make appropriate referrals for 100 percent of the students visiting the center in need of drug and alcohol treatment
- Provide case management and follow-up for all students referred.

Goal II: To improve students' access to primary physical health care screening and treatment.

Objectives:

1) To enroll 50 percent of the student body in the health center by the end of the first year, 70 percent by the end of the third year.
2) To provide comprehensive physical assessments for 30 percent of the enrolled students by the end of the first year, 50 percent by the end of the second year and 70 percent by the end of the third.
3) To lower the rate of "inappropriate" student use of the emergency room by 50 percent in three years.
4) To lower the percentage of students with no primary care physician (as reported on student and parent surveys) by 50 percent in three years.

Interventions:

- Obtain (through sub-contract or other arrangement) a full-time nurse practitioner trained in adolescent health by the opening of the health center.
- Develop a contractual arrangement for physician supervision and back-up by the opening of the health center.
- Hire a health educator or outreach worker by October 1994
- Develop arrangements for emergency and 24-hour care by the opening of the health center.
- Establish a mini-laboratory and make contractual arrangement for providing other laboratory services by September of 1994.
- Develop parental consent and enrollment forms by August 1994 and distribute 2,000 by June 1995.
- Provide classroom presentations on health center services for 70 percent of the student body by June 1995.
- Provide parent and faculty orientations twice a year.
- Provide comprehensive physical assessment, treatment of minor injuries, diagnosis and management of chronic and acute illness by walk-in and appointment.

Goal III: To improve access to reproductive health care services for teens at Anytown High.

Objectives:

1) To lower the rate of sexually transmitted diseases among students at Anytown High by 50 percent in three years.
2) To lower the pregnancy rate from 150 per 1,000 to 110 per 1,000 in three years.

Interventions:

- Hire a nurse practitioner familiar in gynecology and family planning by the opening of the health center.
- Provide outreach through classroom education on adolescent sexuality to 90 percent of the school by the end of the first year.
- Develop a system of referral from faculty, school nurses and administration.
- Administer risk assessment surveys to 90 percent of the students visiting the health center each year.
- Provide contraceptive counseling for at least 70 percent of enrolled teens who are (or who are planning to become) sexually active.
- Provide pelvic exams, pregnancy testing, STD screening and treatment by appointment and on a walk-in basis.
- Make contraceptives, including condoms, available to students through the health center.
- Provide ongoing mental health services for teens reporting child sexual abuse and family drug and alcohol addiction.
- Provide contraceptive counseling for teens requesting pregnancy tests or STD screening.
- Provide mental health counseling for teens repeating pregnancy tests or STD screens more than once per school year.

These are only examples. Each group must develop goals, objectives and interventions that best embody their philosophy and that best address the health care needs of youth in their community.

Getting Started

When developing your own program plan, start by envisioning the perfect SBHC/SLHC. Include all the services and interventions the group would like to offer for young people of the community. Then determine which services are absolutely necessary and which the group would be willing to forfeit, if necessary due to resource or other constraints.

The group may believe, for example, that services should be available to students of all grade levels for greatest impact. If resources are limited, the planners may choose to begin at the middle school, implement a center at the high school two years later, and add an elementary program in the fifth year. Likewise, the group may have identified teen pregnancy and drug and alcohol addiction as high priority needs. Controversy over appropriate pregnancy interventions may force the group to address drug and alcohol addiction in the first two years and add reproductive health services in year three.

Other Design Considerations

There are a number of other details that should be considered as the group designs the health center.

Hours. What hours will the SBHC/SLHC be open? Will it be open in the summer? Who will provide services on evenings and weekends?

If the SBHC/SLHC aims to be the primary care provider for students, the health center must offer after-hours care and emergency back-up services at a local hospital or community clinic. Some SBHC/SLHCs link their phones directly to the back-up provider; others provide taped messages that tell the caller how to contact the alternate provider. Off-hours care should be accessible and unintimidating for students.

Summer scheduling may be more difficult to negotiate. A number of possibilities exist:

- remain open all summer;
- close during the summer but maintain ongoing service at another location, such as a community clinic or hospital;
- consolidate several SBHC/SLHC programs at different locations into one site;
- remain open during the summer, but reduce staffing and hours;
- focus on sports physicals during the last few weeks of the summer, to prevent overcrowding at the beginning of the school year and help health center staff prepare for the coming school year.

When determining the hours of operation, consider the needs of the students, the program budget, staff arrangements, program size, accessibility of other services and the school district's permission. Also consider the requirements of funding sources; some funds are only available to centers with evening, weekend and summer hours. Others require 24-hour care arrangements. (For a description of the requirements of each funding source, see Volume III: Potential Sources of Federal Support for *School-Based and School-Linked Health Centers*.)

Walk-in Policy. An SBHC/SLHC designed with teens in mind should permit "walk-ins." Many adolescents don't actually plan visits to their school health center — they tend to "show up" when a need seems serious enough. Accommodating walk-ins will require a few special procedures: Schedule walk-in slots in place of appointments; assign staff to screen walk-in clients when they arrive; develop a policy with school authorities regarding hall passes for visits to the SBHC/SLHC; and define criteria to help teachers judge when it is appropriate to excuse a student from class for a visit to the health center.

Some SBHC/SLHCs allow walk-ins only during study hall, lunch period or other periods when classes will not be missed. Others permit walk-ins when the visit is approved by the school nurse. Still others permit walk-ins long enough to discuss the reason for a visit and to schedule an appointment for later that day, during a free period or after school.

Medication Dispensation Policy. The planning group will want to decide whether to dispense medications at the health center. Dispensing medications on site has several advantages:

- Students can begin treatment immediately at the time of diagnosis.
- Students are more likely to obtain and use the medication if they don't need to go elsewhere to fill their prescriptions.
- Students' use of medication can be monitored more closely.
- The health center may be able to provide medications at lower prices, especially if there is funding for medications.

However, there are also some disadvantages:

- Storing medications in the health center increases the security risk.
- Dispensing prescriptions (such as antidepressants) in school might be controversial.
- There must be a careful understanding with local pharmacies so that the SBHC/SLHC is not viewed as a competitor.
- Dispensing medication may require an additional staff member or consultant.

Policy will depend upon need, funding and school district restrictions. At least one SBHC/SLHC restricted from distributing pharmaceuticals arranged for funds to go directly to a nearby pharmacy. Students were given prescriptions that could then be filled, without fee, at the pharmacy.

Costs and Available Funding. Obviously, the cost of different kinds of services and the amount of available funding will affect the design of the health center. Always look for opportunities for donated or in-kind services. Are there avenues for sharing staff and resources with other agencies? Can available funding and personnel be used more creatively? (For more information on funding, see *Volume III: A Guide to Potential Sources of Federal Support for School-based and School-linked Health Centers.*)

Interagency Collaboration

Using outside agencies can enlarge the range of services available to students; it can also reduce costs if the agency agrees to share staff, or (even better), to donate its time and services. The extent of interagency collaboration in the SBHC/SLHC depends upon the budget, the staff and the relationships between the SBHC/SLHC and other local providers.

Collaboration can work in a number of ways. The SBHC/SLHC sponsor may hire or donate staff to deliver certain services on the center site. Or, agreements can be forged with other community agencies to provide other needed services, either by subcontract or through agreements to locate staff on the center site.

Working within the SBHC/SLHC's budget, staff and space constraints, the planning group should decide which services can be reasonably provided at the health center — whether by SBHC/SLHC staff or by the staffs of other agencies. As a rule of thumb, try to provide as many services as possible at the center site. Youth need specialized care, and the "one-stop-shopping" approach will improve compliance. This does not mean that SBHC/SLHC staff should never make

referrals; but when students are referred to other providers, the SBHC/SLHC should be sure to track the results of the referral and provide follow-up care if necessary.

Setting Up Interagency Relationships

Establishing a system for providing services demands a great deal of organizational ability — striking up relationships, settling contracts, devising communication procedures, managing patient cases, etc. The final result, however, is a sturdy network of care for SBHC/SLHC clients.

It is likely that many of the groups represented in the planning group and the advisory board can provide some of the services needed by the SBHC/SLHC. If not, the group's earlier assessment of local services will highlight other possible sources of collaboration. Basic information about specific services, staff, qualifications, hours and fees can be gathered by phone. If a linkage to the SBHC/SLHC seems possible, further contact should be made with the agency director to explore formal arrangements.

Preparing Contracts

Formal contracts are a must when outside agencies will be providing services for SBHC/SLHC clients. This is true regardless of whether services are offered on site or through referral. Contracts should outline:

- a system of billing and payment (if services are not donated);
- an agreement on liability;
- eligibility requirements for service;
- a procedure, including a reporting form, to monitor SBHC/SLHC clients;
- an agreement regarding shared staff (if applicable);
- an agreement determining authority (the SBHC/SLHC sponsor should try to maintain control);
- arrangements for sharing information and controlling students' medical records;
- a contact person within each agency responsible for referred SBHC/SLHC clients and for updating SBHC/SLHC staff on clients' progress;
- an agreement as to the role of parents' in consenting for services for minor patients.

Contracts should be time-framed with options to renew. By limiting the time of the contract, the group will have the flexibility to change service providers or alter the contractual agreements.

Always have a lawyer review contracts before they are formalized.

Contractual Arrangements with the School System

A contract will also be necessary to formalize agreements with the school district. This contract is especially important, as it will itemize both the school's and the sponsor's responsibility in providing health services to the students. A contract between the school district and the sponsor should:

- identify the proposed school site and define the space occupied by the SBHC/SLHC;
- explain which renovations will be handled by the school and

which by the sponsor;

- spell out the cost (if any) associated with the use of the space (rental lease) and define options for renewal (usually a five year minimum if possible);
- address ongoing costs for maintenance and utilities associated with the space;
- describe specific services to be made available by the school system — all in-kind contributions should be assigned mutually agreed-upon dollar amounts for future budgetary purposes;
- delineate the authority of school officials vis-a-vis the sponsoring agency;
- spell out services that will be offered in the health center and the minimum level of liability coverage that the sponsoring agency should have;
- delineate any restrictions placed by the school district on the sponsoring agency about services that can be provided or who can use the health center;
- describe parental consent requirements.

(A sample contract is provided in Appendix IV.)

The Physical Facilities

The physical design of the SBHC/SLHC should also reflect the philosophy of the health center. Young people should feel comfortable, respected and safe.

Location

Whether the group opts to locate the center inside the school building, outside of the school but on school grounds, near the school's front door or halfway between the middle school and the high school, there should be a reason for the decision. For example, if the group wants to serve students as well as out-of-school youth, it may be best to locate the center on school grounds, but not inside the school building. If students want their health center to be visible and readily accessible, place it on the first floor. If they want privacy and quiet, locate it in a less-traveled corridor.

For many planning groups there will be little choice. Available space may be limited and the group may be a the mercy of the school district. Explain to school authorities that the placement of the center sends a message — and that the message should be a good one. Negotiate for the best space possible and ask the school district to make any renovations necessary.

Floor Plan

While the group may have little choice over space, control over the floor plan may be more possible. If space allows, provide for a separate waiting room, counseling room and examination room. An ideal design might include several examination rooms, counseling rooms, a lab, staff offices, a group room for education or counseling, and, if the group chooses, a daycare center.

Other suggestions concerning the floor plan include:

- Design the waiting room so that staff can handle walk-ins as well as appointments; provide adequate seating space.
- Ensure that examination and counseling rooms are truly private; no one should be able to see into them, or hear conversations from within them.
- Use rooms for various purposes; do not designate a special room for drug abuse counseling, HIV testing or family planning.
- Emphasize confidentiality and privacy by keeping medical records out of sight and by placing locks on bathroom doors.
- Ensure the security of the medical records, medications and expensive or dangerous medical equipment by planning secure storage areas and budgeting for quality locks on a few cabinets and doors.
- Reduce physical barriers to accessing the center and ensure that the center is accessible to handicapped students.
- Consider the center's electrical needs; multiple outlets should be available in each examination and counseling room, in the laboratory and by the receptionist's desk.

Interior Decoration

When decorating the health center, keep the students in mind. The best way to make the center attractive to young people is to allow them to decorate it themselves.

Here are some decorating ideas that have worked for other centers:

- Paint the walls with bright colors, using posters and photographs that would interest youth. Do not overdo posters with a single message, such as teen pregnancy prevention. Vary the topics and keep the messages positive.
- Provide reading material that encourages reading. Set up a pamphlet library in the corner, and keep it well-stocked with informational pamphlets. Be sure to include material on topics such as sexuality, suicide and child abuse.
- Make the seating seem welcoming. Don't line up long rows of chairs side-by-side or around the perimeter of the waiting room; instead, place the chairs in conversational clusters or around a table filled with magazines.
- Position the receptionist in an open area of the waiting room, not behind a window or half-wall. This will encourage interaction between the receptionist and the students.

In short, the interior design and decoration of the health center should be warm and caring. Through careful planning, the space can relay messages concerning confidentiality, respect and care — messages that will make young people feel comfortable visiting the health center.

CHAPTER FIVE:
DEVELOPING THE BUDGET/STAFFING THE CENTER

Budget development becomes an ongoing and necessary concern. A realistic picture of the group's financial needs takes shape only through a constant process of developing and modifying the budget during the planning stages. The group should always be searching for ways to increase in-kind contributions and decrease monetary needs. As these possibilities take shape, several draft budgets will probably be necessary.

Tasks in Building a Budget Framework

While the budget process will differ depending on the local situation, budgets commonly evolve in stages as the planning group:

- identifies the health needs of the young people targeted;
- plans the mix of services that will be offered;
- estimates the costs of services;
- identifies sources of funding or in-kind contributions.

Budgets should project services and costs for three to five years. Remember that expenditures will vary over time; the first year will have start-up costs, while subsequent years may reflect greater staffing needs as student's increase their use of the health center's services.

Identifying Needed Health Services

The obvious place to begin when developing a budget is to identify the services that will be provided. The needs assessment helped to identify the health problems students face; the program plan outlined the services and interventions the group will implement to address these problems and set priorities for the health center. As a first step in drawing up the budget, review the program plan and list all services the group wishes to offer at the health center. Be sure to also include any services that the group will provide by referral.

Next the group will need to estimate expected utilization rates. Start by identifying the number of potential clients the center could serve. then estimate the expected number that will enroll year one, two and three.

After forming an estimate of possible enrollment, take the process one step further by estimating expected encounters for each type of service. This obviously is more difficult, but it can be very helpful. As a guide, the following table shows the experience of 24 SBHC/SLHCs funded by the School-Based Adolescent Health Care Program of the Robert Wood Johnson Foundation. The encounter patterns in each community, however, will vary.

FIGURE 6: PERCENTAGE OF TOTAL PATIENT ENCOUNTERS PER SERVICE TYPE

Service	Percent of Total Encounters
Acute Illness	29
Mental Health	18
Physical	15
Other/immunizations/vision/ hearing	12
Reproductive Health/ STDs/ Family Planning	10
Chronic Health Problems	6
Acne/Skin Problems	4
Nutrition/Eating Disorders	3
Drug/Alcohol Abuse	2
Prenatal Care	1

Source: *The Answer is A School: Bringing Health Care to Our Students.* School-Based Adolescent Health Care Program. The George Washington University. 1993.

As the health center opens, the needs of students might reflect different patterns than the group anticipated. Try to build flexibility and expansion into the budget.

Estimating Costs

To create a budget, estimate the costs of all staffing requirements, space (if not donated), medical supplies, equipment, contracts for services with outside agencies, etc. This can be cumbersome. To make estimates as accurate as possible, the group may wish to:

- determine the costs of such items as telephone usage and installation and utilities (if not donated);
- obtain cost figures from other medical providers in the area who serve similar populations;
- contract for specific services with another agency at a fixed rate fee.

Included in this chapter is a budget framework that can act as a guide to anticipating different costs to estimate.

Determining Sources of Funding and In-Kind Contributions

Although it's best to determine need and then identify sufficient funding to meet those needs, budgets should be tempered by reality. No SBHC/SLHC has unlimited funding; in-kind services and donated resources are important to support services in the face of financial limitations.

In-kind contributions often form a significant part of SBHC/SLHC budgets. Schools may donate some of the school nurses's time, as well as space, utilities and custodial services. The health center's sponsoring agency may provide full- or part-time nurse practitioners, physician supervision, medical malpractice insurance, billing services, auxiliary laboratory services, etc. Other community agencies may donate the staff time of a social worker or drug abuse counselor. Equipment, medical supplies, furniture, etc. should also be solicited as in-kind contributions.

Try to reflect in-kind contributions in the health center budget. By doing so, the budget will present a more complete and accurate financial picture of the cost of providing services.

The Budget Framework

Budgets are usually divided into sections defined by types of expenses. Within these divisions, line items provide added detail.

Most program planners also provide a budget narrative — a written description of individual budget items — in their program plan. This narrative should describe justifications or explanations for each item, the major assumptions made in estimating each item, sources of information for each estimate, and any other important information. For example, separate items in the statement might specify the expected rate of inflation used to estimate salaries, the rationale for a particular trip or the need for a particular piece of equipment.

As noted earlier, budgets should be prepared for more than one year. Subsequent year budgets should reflect:

- changes in the need for construction or new equipment;
- changes in the use of the health center;
- merit increases for salaries;
- increases due to overall inflation and
- other special increases that can be anticipated in advance.

Budget Categories

The budget format shown below reflects a number of categories with line items suggested for each. Categories are large expenditures for similar items and may include:

Staffing. Staff salaries will undoubtedly be the single largest expenditure in any health center budget. Budget narratives should indicate, for each position, the number of hours the position will be filled and the hourly, or annual, salary. Donated or in-kind staff time can be noted separately.

Contracts. Some services offered at the health center may be provided by outside agencies such as hospitals, health departments or mental health agencies, typically under a signed contract. In these contractual agreements, agencies agree to provide services at a general fixed rate, at a reduced fixed rate or free of charge. If the rate is a fee-for-service charge, the planning group will need to estimate the number of encounters for that service and multiply that by the service cost. If the rate is per capita, multiply by the estimated number of student enrollees for year one, two and three.

Many sites include liability insurance under Contracts; others include it under Staffing. Diagnostic services and medical supplies may also be included under Contracts.

One-time Start-up Costs. When SBHC/SLHCs first open, they often have one-time expenses, such as building renovation and equipment. If these expenses are major, treat them as a separate category, and provide adequate explanation for the expenditure. If the expenses are small, include them in the Other category.

Other. This category commonly includes a wide range of items. If insurance or rent are large, they can be put into separate categories.

In-kind Contributions. Because in-kind contributions are free, some groups don't include them in the budget. They should, however, be included in project plans and "in-house" budgets. In-kind service estimates provide a more complete picture of expenses and revenues; in addition, funders sometimes ask for "local matching funds" which in-kind contributions may satisfy.

Administrative Overhead. Sometimes overhead expenses are spelled out and included in line items; other times they are not. For example, time spent on administrative tasks can be included in either the Overhead or the Staffing categories.

Revenue. Initially, it may not be possible to specify all sources of projected income and numbers may vary from time to time. But at minimum, projected income should match expenses. If in-kind contributions were included under expenses, remember to include them as revenues as well; otherwise expenses and revenues will not match.

The following sample budget (without cost estimates) illustrates one possible way of presenting these and other expense categories.

FIGURE 7: SAMPLE BUDGET FRAMEWORK

	Year 1	Year 2	Year 3
STAFFING			
Project director			
Physician			
Nurse practitioner			
Social worker			
Educator			
Medical assistant			
Nutritionist			
Other			
Subtotal			
Fringe (___%)			
Subtotal			
CONTRACTS			
Insurance			
Hospital			
Health department			
Mental health agency			
Accounting firm			
Other			
Subtotal			
ONE-TIME START-UP COSTS			
Building renovation			
Equipment			
Furniture			
Other			
Subtotal			
OTHER			
Rent (if not donated)			
Utilities (if not donated)			
Maintenance (if not donated)			
X-Rays			
Laboratory work			
Medical supplies			
Pharmaceuticals and diagnostic agents			
Office supplies			
Telephone			
Travel/conferences			
Educational supplies			
Other			
Subtotal			
IN-KIND CONTRIBUTIONS			
School personnel			
Other personnel			
Fringe (___%)			
Health center space			
Maintenance			
Utilities			
Other			
Subtotal			
SUBTOTAL OF ABOVE SUBTOTALS			
ADMINISTRATIVE OVERHEAD			
TOTAL EXPENSES			
REVENUE			
In-kind contributions			
Grants			
Medicaid collections			
Other fees collected			
Other revenue sources			
TOTAL REVENUE			

Selecting Staff

The importance of selecting the appropriate staff for the health center cannot be underestimated. SBHC/SLHCs housed in old janitors' closets have been successful because of the caring, qualified staff who worked there. High technology, luxurious interior design, and 24-hour on-site services cannot make up for hiring the wrong people to staff the center.

Staffing Patterns

How to staff the SBHC/SLHC depends primarily on the interventions and services that will be provided. Conversely, if one of the interventions planned requires the services of a social worker, the group may want to consider other interventions that this employee could also ably address.

Look for creative ways to acquire the staff time that the center needs. Some staff should be available full-time to bring consistency to the center. Other staff may be subcontracted or "on loan" from community agencies.

The staffing patterns of the SBHC/SLHC may "cluster" around the priority interventions. For example, if the group has decided to provide services for pregnant teens, the center should have an ob/gyn physician, perhaps an ob/gyn nurse practitioner, a parenting educator, and perhaps a family life educator. This doesn't necessarily mean that the health center needs to hire four full-time staff members. However, at this stage it's best to list all conceivable types of providers necessary for the interventions planned.

The following examples show the "cluster" effect:

Service	Staff
Substance abuse	Physician (GP)
	Social worker
	Therapist
	Psychologist
	Health educator
Dental care	Dental hygienist
	Dentist
Teenage pregnancy prevention	Physician (gynecologist)
	Nurse practitioner
	Family planning counselor
	Social worker
	Psychologist
	Health educator

After the group has identified all possible providers for each chosen intervention, examine the list to see how a single staff position can be involved in a number of interventions. In the interventions listed above, the health center only needs to hire one health educator, but he or she should be experienced both in drug and alcohol education and family planning.

Minimum Staff Requirements

For quality care of a modest sort — physical exams, diagnosis and treatment of acute conditions, counseling and referral for psychosocial problems — a health center should be minimally staffed with a part-time physician/medical director, a full-time nurse practitioner/administrator, a full-time social worker/counselor and a full-time receptionist.

Here are some additional tips for creative, budget-conscious hiring:

- Rely mainly on nurse practitioners in place of physicians as the primary clinicians on-site.
- Use medical directors for supervision, back-up and medical record review.
- Hire multi-talented staff who can provide a variety of services.
- Select health care providers with administrative experience.
- Hire some part-time staff members.
- Develop interagency relationships; allow other agencies to provide services at the health center.

Ideal Staff

An ideal SBHC/SLHC staff would include a physician (pediatrician or adolescent specialist), a health center administrator, a full-time nurse practitioner (pediatric or adolescent specialist with experience in family planning and /or gynecology), a full-time social worker experienced with young people, a health/family life educator, a psychologist, a medical assistant or nursing support staff, a receptionist and a number of part-time, shared and contracted service providers.

In general, it's better to have a smaller staff working longer hours than a larger staff working only a few hours. There should be a core of staff members in the center during all operating hours, to ensure that "walk-ins" will have a reasonable chance of seeing the clinician they seek. Avoid having too many part-time, occasional staff; students like continuity and seek care from staff they know and trust.

Staff Responsibilities

As the group writes job descriptions for the health center, emphasize that the ideal candidates must be flexible and able to adapt easily. Clearly list all responsibilities that each position will include as well as those responsibilities the position might include. Some unorthodox positions may result; for instance, nurse practitioners will undertake many of the same responsibilities in an SBHC/SLHC as elsewhere, but may also be asked to supervise staff and/or provide counseling.

(Appendix III includes sample job descriptions for some staff positions.)

The Critical Positions

Some SBHC/SLHC staff positions are critical and are discussed here in further detail:

Physicians. Doctors can provide the widest range of care, and support from staff physicians can help gain community acceptance of the health center. Physicians with a background in health care delivery systems can be a valuable resource if more than one center is being implemented.

All SBHC/SLHCs have at least part-time access to a physician, and all centers use physicians as preceptors. The physician:

- establishes the clinic's protocols;
- acts as the primary consultant for medical issues;
- provides advanced services that the nurse practitioner cannot provide.

Unfortunately, doctors are the most expensive staff, and few centers can afford more than one full-time physician. Many resort to just one part-time doctor.

There are, however, ways to limit expenses and still have access to a physician:

- Hire physicians who have recently completed their residencies. They are eager to gain additional experience, especially if they have a specialty in adolescent medicine.
- Contract with a teaching hospital. Resident physicians need work experience and are willing to work at reduced fees. If residents are used, make sure that they can commit to a regular schedule. The group should also clarify liability issues. (Will the hospital's liability coverage extend to the health center?) Above all, be sure that they (and their teaching staff supervisor) are trained in serving youth.
- Explore pro-bono physician time from the local health department or a private practice.

Administrators. The role of the health center administrator is an important one. The administrator is responsible and accountable for the health center; his or her duties include:

- overseeing all personnel-related duties — hiring, management, quality control, etc.;
- maintaining relationships with the school, referral agencies and other service providers;
- acting as project director — responsible for networking, management of the various sites and perhaps supervision of research and evaluation within the health center;
- finding funding and maintaining contacts with funders — this can take 25 to 50 percent of the administrator's time.

In smaller health centers, the nurse practitioner often doubles as a center administrator, but even in these cases, at least half of his or her time should be spent seeing patients. In some instances, a full-time physician serves as administrator. A fully-trained health administrator who knows both health management and business is an excellent choice for this position.

Nurse Practitioners. The nurse practitioner is often the central staff person in an SBHC/SLHC. The nurse practitioner:

- provides basic medical care and medical assessment, prescribes some treatments and refers students to other services;
- manages staff and chairs staff meetings. He or she is frequently responsible for the day-to-day operations of the health center;
- has responsibility for patient records.

A nurse practitioner should be multi-talented. Juggling many responsibilities demands flexibility, patience, and a high level of organization.

Social Workers. Social workers address the psychosocial component of an SBHC/SLHC and can fulfill many other duties. Social workers can take charge of referral services and follow-up, and act as the liaison between the family and the health center, and the health center and other community agencies.

School Nurses. Because they usually report to the school administration, school nurses do not ordinarily have access to patients' medical records. Even so, the school nurse can play a vital role in the SBHC/SLHC:

- acting as liaison between the students and the health center;
- providing referrals for medical services;
- helping to obtain parental consent;
- serving as a member of the advisory board;
- helping to plan the center by providing vital information about students needs and school policy;
- participating in staff meetings;
- performing the role of the health educator;
- counseling and referring those students not enrolled in the health center.

Receptionist/Medical Assistant. Because the receptionist is the first person the students will see when they enter the health center, this staff member will be a key part of the all-important first impression. A friendly, concerned and perceptive person is the best choice for this position. Duties of the receptionist include:

- identifying the reason for a visit and referring clients;
- maintaining health center records and monitoring appointments;
- assisting the nurse practitioner and physician during consultations if he or she has training in screening techniques.

Personal Qualities of Staff Members

Being part of an SBHC/SLHC requires both professional qualifications and strong personal qualities. When hiring staff, seek out candidates who are:

Team players. SBHC/SLHCs provide comprehensive care. Staff members need to recognize their limitations and refer their patients effectively to the appropriate staff person. This kind of coordination calls for a high degree of communication among staff. SBHC/SLHCs typically are small, but the case load can be large. Team work is essential.

Flexible. Young people can be changeable and unpredictable. Staff members must be flexible. Look for people who enjoy variety and rise to every occasion. A sense of humor also helps.

Experienced with young people. Look for employees who have provided care to young people, or at the very least, have specialized in adolescent health care. A nurse practitioner who has training in drug and alcohol abuse counseling, but not for teenagers, may not be appropriate for a high school health center.

Knowledgeable about young people. All staff members should have a working knowledge about youth, including their physical and cognitive development, social milieu, values, pressures, fears, families, friends and romantic relationships.

Interested in young people. Caring about young people is the most important qualification for an SBHC/SLHC staff member. Ask potential candidates about their previous work experience with young people. What did they most enjoy? What did they least enjoy? What do they do during their free time? Do they spend time with young people by choice? Do they volunteer their leisure time? How do they look back on their own adolescence?

Comfortable with young people. Many young people are risk-takers and experimenters, and they sometimes engage in unusual behavior. Staff members should feel comfortable providing service and support regardless of the situation. Ask candidates how they feel about drug and alcohol use by young people, violent behavior and teenage sexuality.

Know their own values. Look for candidates who have clear values, who are tolerant of differences and can serve as role models. People who are unclear about their own values and uncomfortable with the values of others send mixed messages that can confuse young people.

Skilled at Counseling. Every staff member should have counseling skills – a good ear, concern, compassion, empathy, objectivity, accessibility and trustworthiness. Staff should be adept at asking open-ended questions and perceptive enough to detect subtle messages and effectively refer students to the services they need.

Tolerant. Staff members need to be comfortable with the cultural, ethnic and racial variety of the school population as a whole. Differences in habits, sexual orientation, attitudes and values must be understood, particularly in the examining room.

In short, professional credentials are important, but personal qualities are just as vital. Centers often succeed or fail because of the people who staff them. Planning groups should take as much time as needed to bring together a caring, committed, compassionate and qualified staff.

CHAPTER SIX: DETERMINING HEALTH CENTER POLICIES

The advisory board will play a crucial role in determining policies to guide the day-to-day management of the heath center. This chapter examines policy issues concerning confidentiality, parental consent and notification, staff and center liability and billing.

Confidentiality, Parental Consent and Notification

All SBHC/SLHCs have the hard task of balancing young people's right to privacy with policies regarding parental consent and notification. Most SBHC/SLHCs require parental consent for minor students to receive care at the health center, typically through use of a written parental consent form. Each SBHC/SLHC must formulate its own policies on the type of form, how often to require consent, what to do when consent is not available and when services do not require consent by state law.

Type of Form. Most consent forms consist of a description of the health center, a comprehensive list of all available services, a contact name and telephone number of the center and a space for a signature of consent. Some forms ask that parents mark the services that can be provided for their children; others instead ask parents to indicate which services they do not want for their children. A third option is a "blanket" permission form — the parent is asked to sign the form to indicate that the student is eligible for all services provided. (Appendix II offers a sample consent form.)

Timing. Parental consent can be obtained either once for the duration of the student's tenure in the school, or yearly. Obtaining consent every year is time-consuming, and can discourage students from enrolling in the center. However the more frequent interaction between the health center staff and parents can be beneficial.

Procedures for Obtaining Consent. If the planning board has decided that only young people with consent can be served by the health center, it is impossible to enroll students if their parents cannot be contacted. Such factors as busy work schedules, erratic living situations, on-again-off-again home telephone service and other problems can make it difficult to gain parental consent.

Some SBHC/SLHCs have tackled this problem by hiring a "parent facilitator" from the community, or by enlisting the help of the school nurse or social worker, to try to reach parents through home or job visits. This strategy can increase the number of consent forms completed, while also improving family involvement and allowing for additional information-gathering about family medical and social histories.

State Laws on Confidential Services. State laws regarding parental consent and treatment for minors vary considerably. Most states guarantee confidential family planning services, drug and alcohol treatment and outpatient mental health care. Staff administrators should investigate state laws by calling the state family planning agency, the state health department or the state department of human services.

Even if state law allows the SBHC/SLHC to provide services without parental consent, the school district or sponsoring agency may require it. In other cases, SBHC/SLHCs are able to provide services regardless of consent. If the center's policy is to follow state law regarding consent requirements, this should be explained on the parental consent form.

Parental Notification. The SBHC/SLHC should also form policies regarding when a medical condition warrants parental notification. Most young people understand that serious medical conditions should be discussed with their parents. By informing them of the center policy regarding "reportable information" from the start, the health center can avoid confusion over this sensitive issue.

To Bill, or not to Bill?

Most SBHC/SLHCs do not charge for the services they provide, but some charge for enrollment, and others bill private and public insurance companies. Third-party payment, however, typically accounts for only a small portion of SBHC/SLHC revenue.

When debating whether to bill for services, health center planners should weigh the benefits and costs of their decision. It can be cumbersome for SBHC/SLHC personnel to establish provider status with insurance companies, gather student insurance information, and arrange for billing services. The time and expense involved can consume much of the revenue generated.

However, in this time of fiscal constraints, many centers are billing insurance companies more aggressively than ever before. Some have contracted with Medicaid eligibility workers to help students apply for Medicaid coverage — increasing the percentage of students for whom the center can then bill. To date, Medicaid reimbursement accounts for only 7 percent of all SBHC/SLHC revenue. Many SBHC/SLHCs have become Early Periodic Screening, Diagnosis and Treatment (EPSDT) providers — allowing them to bill for many of the services they were already providing.

Ultimately, the decision to bill should involve comparing the cost of billing (contracting billing services, hiring and training staff and completing paperwork) with expected financial returns. If only 40 percent of the center's target population is Medicaid-eligible, planners should not expect to recoup even half of the costs from reimbursement.

Moreover, planners must consider the issue of confidentiality and billing. In some states, notification of insurance payment is sent to the parent — which can compromise confidentiality. If a center does decide to bill, a clear policy is needed concerning whether and when to obtain the student's consent before a bill is sent.

Medicaid reimbursement policies vary from state to state and program planners should consult state Medicaid officials for more information on requirements and restrictions. (Also see *Volume III: A Guide to Potential Sources of Federal Funding for School-based and School-linked Health Centers* for further discussion of the Medicaid and EPSDT programs.)

Establishing Protocols

Another key element of providing services in the SBHC/SLHC is developing protocols, or standards, for the care and treatment of common physical and psychosocial problems. Protocols should be established for all categories of service: medical, mental health, drug and alcohol, pregnancy, etc. Protocols should also be established for service referral, case management, follow-up and billing.

Medical directors are responsible for writing protocols for medical services. These protocols should reflect the special needs of pre-teens and teens -- including confidentiality, privacy, counseling, and holistic care.

The group will also want to enlist a psychologist or mental health agency to establish protocols for psychosocial and mental health services in accordance with standard mental health practice. The protocols should address suicidal behavior, depression, violent behavior, rage, drug and alcohol use, and other mental health issues, and should be distributed to all health center staff.

The planning and advisory groups should also address establishing other protocols concerning:

- minors' consent;
- informed consent;
- disclosure of confidential information;
- release of center records;
- exchange of information with school and other agencies;
- reporting requirements for child abuse, sexually transmitted diseases and other contagious diseases;
- other reporting requirements.

The group should also seek advice from a qualified accountant to help establish protocols on billing services, collecting fees, generating revenue and payroll procedures. Legal advice is essential throughout the entire process.

Limiting Liability

One of the most common concerns of school districts and SBHC/SLHC planners is the issue of liability. Technically, the SBHC/SLHC sponsor is medically liable for the services provided at the health center, and so should take steps to insure its staff. In addition, individual staff members are often covered by other policies. For example, if a doctor or other staff member is affiliated with a hospital, health department or community health center, he or she may be covered by that agency's malpractice insurance. Theoretically, schools are only liable for their in-kind donations such as space and furniture.

Because services provided by SBHC/SLHCs are mostly preventive and not invasive, liability should not be a major issue. Nonetheless, precautions should

be taken. Representatives from the school district and the sponsoring agency should consult a lawyer to determine the appropriate level of insurance.

The best protection against legal liability is to have clear policies and procedures consistent with the legal obligation of a health care provider. Health center staff should follow established protocols and thoroughly document all actions in health center records.

The following is a list of possibilities on which a liability suit may be filed against an SBHC/SLHC (reprinted from *SBHC/SLHCs: Legal Issues*, The Adolescent Health Care Project and CPO, 1986):

- failure to obtain consent or informed consent;
- unauthorized disclosure of confidential information;
- unjustified failure to disclose information under legal compulsion;
- negligence in providing treatment, failure to provide appropriate treatment, or referral to an allegedly incompetent provider of services.

Where consent is obtained from a patient or parent and standard protocols are followed, the risk of liability is limited.

Below are some recommendations from *SBHC/SLHCS: Legal Issues* on principles to follow to limit an SBHC/SLHC's general liability:

- incorporating as a non-profit, tax exempt organization with the Internal Revenue Code;
- providing in the articles of incorporation for the indemnification of officers and directors;
- keeping good corporate records, especially of payroll taxes;
- checking the legal requirements of any funding contracts, including insurance, payroll records, confidentiality, and others;
- relying on written contracts with major employees and contractors whenever possible, rather than informal understandings.

Again, clear written policies and protocols play an essential role in limiting the liability of the health center. If the staff adheres to these protocols, and documents its actions in medical records and accounting files, liability should not present a major barrier to health center operations.

CHAPTER SEVEN:
INTEGRATING THE SBHC/SLHC, THE SCHOOL AND THE COMMUNITY

After months of community organizing and program planning, the SBHC/SLHC doors are finally ready to open. The success of the center now depends on how well the staff reaches out to students, faculty and school administration. Young people's concerns about accessing health care will inhibit their first visit to the SBHC/SLHC. Heightened self-consciousness, combined with uncertainty about whether services are truly confidential may prevent some young people from using the SBHC/SLHC at first. Many students will not be accustomed to seeking support and using health services. Faculty and school staff may be reticent to refer a student to the SBHC/SLHC.

For the program to succeed, students and faculty must perceive the center as a positive addition to the school environment. This chapter will address building relationships with students and faculty both during the initial months and for the duration of the program's existence.

Before the Doors Open

Of course, developing good relations with the school should start well before the center opens . Planners may have met with students, administrators and faculty during the planning process. These working relationships should continue if the program is to succeed.

The Students

Students are the clients and SBHC/SLHC staff should actively interact with them by:

- talking with students;
- providing the school newspaper with up-to-date information on the progress of the health center;
- involving a few students in presentations about the health center to officials;
- holding a school assembly about the health center before opening the doors.

Even though serving students is the SBHC/SLHC's reason for being, they are sometimes overlooked in the flurry of administrative details and political imperatives that can surround the opening of the health center. SBHC/SLHC staff should make every attempt to ensure that this does not happen. If students feel slighted by the process, they will be less accepting of the center when it opens.

As one disappointed student noted:

"I think it's a good idea, but they should of gave (sic) us notice of what it really was going to be like . . . They didn't even ask for our opinions about how we felt about it. And it's supposed to be pertaining directly to the student body."

The School Staff

The planning group should also ensure that accurate information is channeled to the school staff before the center opens. There are many ways to develop positive relationships with faculty early in the process:

- include supportive faculty members on the advisory board;
- survey them about student needs and services to offer;
- educate them about the possibilities and limitations of an SBHC/SLHC program and
- work with them to establish policies and procedures for making referrals to the SBHC/SLHC.

In short, a relationship with the students and the faculty should exist before the center opens.

Establishing Relationships As the SBHC/SLHC Opens

During the first weeks of operation, an SBHC/SLHC will rely on the relationships established with students and staff early in the process. Students already familiar with the center can communicate positive messages about services to their classmates, while supportive faculty can discuss the center with students and begin to make referrals.

The types of activities an SBHC/SLHC staff can initiate, or participate in, are of an infinite variety and, in fact, quite fun. Below are suggestions for participating in activities that affect students.

Encouraging Student Participation

When the SBHC/SLHC first opens many students will not know what services are offered. SBHC/SLHC staff must venture out into the hallways, classrooms and lunchroom to talk about the center, staff and services available at the SBHC/SLHC.

As one SBHC/SLHC staff member explains:

"Classroom presentations about the center, walking the hall and shooting the breeze with kids, hanging out at lunch-time, helped these kids get to know me. The information I provided was not as important as the fact that they could see that I was O.K., that I could relate."

Here are some suggestions for drawing the attention of students to the fine qualities of the SBHC/SLHC:

Be visible. Attend school events such as assemblies, plays and sporting events. The more that students see staff, the more they will trust them. Attendance at events will help demonstrate that SBHC/SLHC staff really cares for young people.

Be outgoing. When walking down the halls, when eating in the cafeteria, when hanging outside of the school, acknowledge the students. Within the center, a friendly manner should always be the norm.

Be accessible. Be willing to enter the classroom. Do a series of presentations. Encourage other staff members to participate in extracurricular activities

related to health and fitness. Spend time with student clients -- both during consultations and during the school day.

Be circumspect. Although staff should be visible and friendly, they should also act respectful of students' needs. Young people will test staff to ascertain if they truly are respectful and trustworthy.

The Student Advisory Committee

One way to drum up interest in the health center is to appoint a student advisory committee. This committee formalizes the link between students and the activities of the SBHC/SLHC, helps increase enrollment and helps monitor some of the health center's programs.

There are numerous ways to form a student advisory committee. Some students may have already expressed an interest in the health center. Many SBHC/SLHCs announce the committee's existence and then ask for applications. School faculty may be able to nominate students to participate.

Some suggestions for the committee:

- Try to limit the size of the committee to 10 to 15 members.
- Have members convene at least once a month. Some committees become quite active and meet more often.
- Write up an informal constitution describing the responsibilities of committee members. Agree on a length of tenure.
- Provide an orientation program to inform committee members about the health center, its procedures and its services.
- Do not use committee members as health center assistants. The presence of students within the SBHC/SLHC calls into question the confidentiality of care.

The student advisory board can be responsible for a number of activities for the health center, such as:

- Naming the health center or holding a school-wide contest to name the center. This is an excellent way to give students a sense of ownership and control over their health center. The committee could solicit names, select the winning name and present an award to the winner.
- Plan and perform assemblies. The committee can develop presentations on health topics of current concern. Some committees write skits and develop student theater groups to present at assemblies, classrooms and teacher inservices.
- Help devise a student satisfaction questionnaire. With staff assistance, the committee could write an evaluation survey to administer to students after the initial health center visit.
- Write articles for the school newspaper on the health center or create an SBHC/SLHC newsletter.
- Help plan and implement extracurricular activities.

These are just a few possibilities for using the energies and talents of the student advisory committee. As the committee becomes active in the health center, it will become its own source of ideas.

School Media

A good way to attract the attention of students to the SBHC/SLHC is to use school media sources:

- Hang posters and hand out flyers around the school advertising the center, its services and hours.
- Announce the opening of the SBHC/SLHC over the public address system. Make the announcement amusing and welcoming.
- Request that the school newspaper interview the SBHC/SLHC staff for an article or offer to have the health center staff write an article for the paper. Some school newspapers have devoted an entire issue to the opening of the SBHC/SLHC.
- Write a regular column in the school newspaper or enlist one of the student advisory committee members to write one. The column could cover interesting and current health topics or act as an advice column.
- Publish an SBHC/SLHC newsletter or flyer. The student advisory committee could be responsible for layout, articles and distribution.

Other Promotional Activities

In addition to using the school media and establishing a student advisory committee, other activities can be successful in promoting the SBHC/SLHC. Here are just a few:

- Give presentations in homeroom or health classes about the health center and its services. Introduce the staff, describe the SBHC/SLHC procedures and stress the confidential and comfortable nature of the center. This can also be a good opportunity to distribute consent forms. Some health teachers have offered 25 extra-credit points to students who have returned their signed consent form within the week.
- Offer educational presentations in health classes. Students will form bonds with staff that are visibly comfortable discussing topics such as family planning, stress management, child sexual abuse, etc. Be sure to collaborate with the sexuality and physical education teachers when planning the presentations.
- Set up special hours for less sensitive services such as sports physicals, immunizations and blood pressure screening.
- Run an all-day health fair. Provide posters, balloons and pamphlets on various health topics and concerns. Offer "free" and immediate services such as blood pressure, weight and height assessment. Set up a few game booths dealing with health issues. Show videos.
- Offer an after-school health film festival or health film series. Students can learn about dieting, safe body-building and sexual responsibility and decision-making.
- Start an exercise or aerobics class.
- Sponsor an assembly on a health topic of particular concern.

Remember that a school population is transient; there is always a need to inform new students about the health center. Activities such as the health fair or assembly can be held as annual events. Conduct as much outreach as possible, but remember to budget for staff time and the cost of outreach materials.

Encouraging Faculty and Staff Participation

The adult population within a school represents a valuable advocacy source for any SBHC/SLHC. If health center staff make no effort to communicate with the faculty and staff, problems are almost certain to arise. The staff should be sensitive to the priorities of school personnel and demonstrate a sense of a common mission.

SBHC/SLHCs can help students meet their health needs by integrating health education and information with available health services. School personnel are the key to outreach, student referral and student follow-up. If they believe the health center will ease their job in the classroom, they are more likely to work with SBHC/SLHC staff.

Ideally, SBHC/SLHC staff and school administrators have already established good relationships and activities within the school. As the center opens, take the time to solidify personal and professional relationships with the faculty. Some SBHC/SLHCs have provided limited care for faculty and school staff. Doing so, however, may require different clinical expertise than for treating students. Decisions should be made regarding which services, if any, will be offered to school staff. A few SBHC/SLHCs offer such services as blood pressure and weight monitoring, smoking cessation programs and nutrition counseling for school personnel.

There are a number of other ways to build these relationships to encourage support and referral of students to the health center, for example:

- Give a faculty presentation, to explain the center's services, hours and procedures — preferably before the health center opens. Stress ways in which teachers can make referrals and utilize the center and its staff.
- Behave as much like a faculty member as possible. Demonstrate an interest in the school, its educational goals and its problems. Show faculty members that the SBHC/SLHC staff is sympathetic to their cause. Work on in-service days if possible. Attend faculty meetings. Following the same schedule and living the same life as faculty demonstrates that SBHC/SLHC staff are genuinely part of the school.
- Offer the faculty similar versions of presentations offered to young people. Hold workshops on topics that pertain to the faculty's relationships with students, such as adolescent development, detecting emotional problems or identifying signs of substance abuse.
- Treat school rules and regulations with respect. Remember that while SBHC/SLHC staff should act as much like faculty as possible, they are still guests in another's "home". Showing respect for school rules and regulations will garner respect for health center staff.

Clearly no SBHC/SLHC can do all of the activities suggested above. Whether the staff decides to hold open houses, develop assemblies, write newsletters or attend faculty meetings, the goal should always be to participate in the life of the school and become an integral part of the environment.

A Word About School-Linked Centers and School Integration

Despite the physical separation from the school, staff members of school-linked programs should also make it a priority to establish relationships with school faculty and administration. Depending upon the clientele served by the center, outreach may need to occur in a number of schools, as well as neighborhoods and youth "hang-outs". Nurturing relationships with school nurses, guidance counselors and teachers is imperative. School-linked center staff should be available on school grounds as much as possible. Staff members should be encouraged to make presentations to faculty and students, run health fairs, write a column in the school newspaper, etc.

Here are a few other suggestions specifically for school-linked programs:

- Establish a schedule and location within the school for health center staff to be available to talk with students or faculty, set up appointments, or provide one-time counseling sessions. Some school-linked programs have a social worker and nurse practitioner available during lunch each day in the school nurse's suite or other accessible location. The idea is not to provide treatment but to enhance visibility and provide an opportunity for students to become comfortable with staff.
- Provide open-houses for students and arrange classroom trips to the health center. Once students visit the SBHC/SLHC under "safe" conditions they are more likely to return when they need services.
- Sponsor extracurricular activities such as aerobics classes, weight-lifting or smoking cessation both at the school and at the center.
- Develop relationships with guidance counselors and school nurses. These key personnel can help follow up with health center clients and help notify students about appointments.
- Sponsor an open house for faculty -- try to make it an in-service program. If school personnel are not familiar with the location and facility of the SBHC/SLHC, they will be less able to make accurate referrals.

The possibilities for interaction are endless. Whatever the school-linked center staff decides, it is essential that at least some staff members are visible and involved at the school.

Maintaining Community Support

Once the SBHC/SLHC opens, ensuring ongoing community support is another high priority for the health center. To be truly effective, SBHC/SLHC programs depend on the good will of the community — parents, teachers, elected officials,

and school administrators. If the center hopes to increase its sites and services, enlarge its funding base, or expand its role in the community in other ways, then it is imperative to maintain a mutually supportive relationship with the community.

Parents

When the center opens, invite parents to visit the center, meet with staff and ask questions. Hold an annual open house, if possible, to coincide with a school function — a PTA meeting, parent's night or parent/teacher conferences. Schedule presentations for the PTA on health center services, or other issues of interest to parents, such as adolescent development, identifying signs of substance abuse, management of asthma, or other topics.

Each fall, provide a comprehensive written summary of the center's services, operations and procedures — and a consent form — for parents of new students, and invite them to come to the center to meet SBHC/SLHC staff.

If the SBHC/SLHC introduces a new service or staff member or alters a procedure, parents should be informed of the change through the school, the PTA or the SBHC/SLHC newsletter.

School Authorities

Ongoing contact with school authorities — particularly the school principal, but also the school board — is also essential. Set time aside to meet with each. Inform the principal of any new plans, programs or changes in policy. Encourage him or her to discuss health- and behavior-related issues with the health center staff.

The principal can be the center's greatest ally and his or her support can benefit the SBHC/SLHC in a number of ways. One SBHC/SLHC was permitted to offer support groups during school hours by rotating the schedule so students did not miss the same class twice in less than seven weeks. Another center began providing drug and alcohol treatment for students on-site as an alternative to suspension for students caught in drug-related offenses.

SBHC/SLHC administrators should also attend school board meetings. Provide annual updates of the SBHC/SLHC's progress; summarize the services and the number of students served, and highlight any successes, limitations and future plans. Be sure to provide the school board with written interim reports of new developments and programs, bi-annual statistics, changes in staffing and any other important information.

The Community Advisory Board

After the center opens, the community advisory board continues to play an important role for the SBHC/SLHC by providing linkages to the community, helping to monitor operations and suggesting changes in policy. Hold monthly meetings with the advisory board during the early stages of implementing the health center, and then quarterly after the center is operational.

Whenever possible, SBHC/SLHC administrators should supply advisory board members with a written agenda and solicit input before each meeting. Use meetings not only to present issues for approval, but to discuss problems and request solutions. Inform members of program strategies and share successes with them.

The Community In General

In general, it is wise to involve community groups and organizations both as the health center opens and occasionally throughout its operation. Promote the SBHC/SLHC in terms of local concerns, such as its impact upon education or its influence on the economic and social well-being of the community. Have staff offer presentations to community organizations on health-related topics such as HIV or substance abuse. Donate staff time, energy and expertise to projects that others have initiated or plan some joint initiatives. The good will created by working with other community agencies will foster support for the center.

CHAPTER EIGHT:
SERVING ELEMENTARY-AGED CHILDREN: SPECIAL ISSUES IN IMPLEMENTING SCHOOL-BASED HEALTH CENTERS FOR YOUNG STUDENTS

Written by Sylvia Holschneider, M.P.H. and Tracy Stern. The National Health/Education Consortium, Washington, D.C.. 1993.

Although most SBHC/SLHCs service adolescents, elementary SBHC/SLHCs are opening with increasing frequency. Many planners realize that by the time students enter middle school, many of them have developed unhealthy habits and conditions that should have been addressed at a younger age. Reaching children and their families at an earlier stage of their development, as well as working with their families, could alleviate the need for more costly, and even stigmatizing, services later on. The interventions can, in turn, help children reach their full learning potential by ensuring their physical and emotional health early in their academic careers.

Research indicates that the benefits and gains of early intervention programs, such as Head Start and WIC, dissipate if they are not reinforced. To address children's health needs in a timely, comprehensive manner, many professionals are becoming interested in the development of elementary school-based health centers to serve as the crucial link in providing a continuous, integrated web of support services from pre-school through adolescence.

Why in Elementary Schools?

Providing such an integrated network of services to children is a key rationale for implementing health centers in elementary schools. Additional reasons to consider include:

- Elementary schools often can reach children and their families more effectively than can many other community-based agencies or institutions. In many communities, the local elementary school is the one true community-based organization, serving as the hub of community activity and providing a safe haven for children and adults alike.
- Because most elementary-age children, unlike many middle, and high-school aged children, attend school regularly, health care providers working in schools are guaranteed initial access to large numbers of children and can work with them over a longer period of time.
- Since parents or caregivers are likely to be more directly involved with their children during the crucial elementary years, health care providers will have greater opportunity to involve family members in the care of their children and in the services provided by the clinic.

Issues to Consider for Elementary Services

When planning and implementing an elementary school-based health center, planners need to consider many of the same issues as when implementing an adolescent center: conducting a needs assessment, building community support, obtaining funding, selecting a site, staffing the center with appropriate personnel, setting up an ongoing evaluation plan, and designing parental consent forms. However, because young children are developmentally different from older children, organizing an elementary school-based center also will present different challenges.

The elementary school-age years are a unique period of development. On one hand, planners will find that elementary school-age children are not able to communicate about how they feel and what is bothering them as well as older children. This often leaves illnesses undetected or untreated. On the other hand, SBHC/SLHC practitioners should remember that just because younger children may not yet have learned to verbalize how they feel does not mean that they are immune to the world around them. It is increasingly recognized that the elementary school years are a critically important period of intellectual, social, emotional, and moral development. Attitudes and behaviors are developed during this age that significantly influence children's later health and well-being. This is the time when active intervention can reap the most comprehensive benefits. Understanding how this vital developmental stage profoundly influences the health and social needs of elementary school-age children is important when planning an elementary school-based health center. The following data are startling reminders of the issues being faced by young children:

Young children are growing up in different family circumstances than they did in the past. Over the past three decades, social, demographic and economic changes have greatly affected the American family, causing more women to work outside the home, more families to spend less time with children, and more children to be poor, live with only one parent, and be cared for by an adult other than a parent or relative.[1]

- One in five children lives in poverty.[2]
- 26 million children under age 13 are cared for on a regular basis by adults other than their parents. An estimated 19 million are most often cared for by someone not related to them.[3]
- A 1990 survey found that 663,000 children age five to 12 cared for themselves during the hours when they were not in school.[4]
- The percentage of working mothers with six to 17 year-old children rose from almost 55 to over 74 percent from 1975 to 1991.[5]

Children are witnessing violence at younger and younger ages.

- Surveys of children age six to 11 in Washington, DC and New Orleans found that over 90 percent had witnessed some type of violence and over one-third had witnessed severe violence.[6]

- In 1988 almost 1.8 million teenagers were the victims of violent crimes.[7]

High-risk behaviors start at an early age. During the elementary school-years, children make important health-related decisions.

- An estimated twenty-five percent of ten to 17-year-olds engage in high-risk behaviors that have potentially damaging effects on their health, well-being, family and community.[8]

- Sixty percent of all smokers start by the age of 14.[9]
- Nearly twenty five-percent of 12 to 13 year-olds and nearly fifty percent of 14 to 15 year-olds have used alcohol during their lifetime.[10]
- The earlier a child begins using alcohol, the more likely a child will drink alcohol at a later age.[11] Children who drink "heavily" by the 10th grade, typically have consumed their first drink in grades four through eight.[12]

Children are at risk for poor nutrition.

- A 1991 survey found that one of every eight children under age 12 living in the United States is hungry.[13] Inadequate nutrition and hunger is associated with learning impairment, developmental disabilities and greater susceptibility to illness.[14]

A growing number of children are diagnosed with serious mental disorders, and millions more are at risk.

- Approximately 10 percent of children age three to 17 were treated for serious mental, emotional or behavioral disorders, including autism and depression, according to a 1988 survey. This is an increase from 6.5 percent in 1981. [15]
- Approximately 12 percent of American children under age 18 suffer from seriously handicapping mental disorders, including developmental impairments, emotional disturbances, behavioral problems and psychosomatic conditions.[16]

These stark statistics graphically illustrate the need for the earliest possible identification of problems and early intervention in the lives of young people, especially those living in disadvantaged circumstances. Within this context, planners should examine some of the special considerations in implementing school-based health centers for children at the primary level: involving parents or caregivers more directly with their children's care, dispensing medication to parents rather than children, taking a medical history from a child too young to be able to give an accurate history, treating different illnesses and conducting health education programs appropriate for the relatively short attention spans of children.

Working with Parents

Parents or caregivers tend to be more involved with their children at the elementary level than at the high school level. Routine contact with parents will prove both necessary and invaluable in the day-to-day operations of an elementary school-based health center. Given the young age of clients at the center, some services, such as initial physical examinations, cannot be administered without direct involvement of parents. Other services, such as health education or prevention, will prove more effective if there is active family involvement.

Special issues to consider are:

Medical History

Because young children cannot be expected to give complete accurate histories of their illnesses, the presence of a parent or guardian, especially during initial physical examinations and if possible during acute care, is necessary to recount past illnesses, treatments or medications. In addition, different history forms than those used for adolescent health centers will have to be developed. These should include more information on prenatal, birth and developmental milestones.

Parental Notification and Consent

As with adolescent school-based health clinics, individual elementary health centers will have to negotiate this issue, based on community needs and expectations. However, because of the young age of the children, administrators and staff must take particular care to design the health center so that parents are notified of services and have consented to them.

Dispensing Medications

In adolescent school-based centers, medications may be dispensed directly to the student. At the elementary level, however, this is neither feasible nor advisable since younger children tend to lose medications and often cannot understand their instructions. A parent must therefore be present during a child's visit in order to receive the medication and instructions on its use, or be contacted at home so that he or she can be told to pick up the medications and instructions at the school.

Outreach

Efforts to involve families in the day-to-day operations of elementary school-based health centers will produce diverse results and will require different approaches depending on the community. Often, parents or caregivers look to schools for assistance and are eager to be involved. Sometimes, however, parents may be wary of schools because their own school experiences were not positive. SBHC/SLHC staff will need to work closely with school personnel to design innovative strategies to encourage active parent participation.

Because parent involvement is so important in establishing elementary school-based health centers, outreach strategies must include not only encouraging parents to bring their own children in for care but also informing other parents about the availability of services. For example, some centers provide a recreational or training activity aimed at parents as a first step. These centers report that, once a parent visits the school, it is much easier to get them involved in the full range of services provided for their children.

School functions, such as parent-teacher gatherings, are an opportune time for administrators, health care professionals, and educators to reach out to parents or caregivers. During such events, center staff can advertise their services and help parents to feel more comfortable with the concept of school-based health services. In addition, many school functions provide an opportunity for getting parents more involved in the clinic itself. Many parents want to help, but don't know how. Engaging parents, for example, in the initial needs assessment on appropriate health center services, and holding health education or parenting seminars for the parents (see below) can encourage subsequent parental involvement. In cases where parents are distrustful of or unfamiliar with the school, staff and administrators will have to make a more concerted effort to reach out into the community. This may require home visits, mailings, or other innovative strategies such as working with community churches.

Structure and Type of Service

Implementing a school-based health center at the elementary school level provides unique opportunities and challenges in planning the types and structure of services to be provided. Although many of the health and social needs of elementary school children and adolescents are similar, there are also important differences. Students in their primary years have special clinical needs, based on their level of cognitive and physical development. In addition, because elementary school generally covers a full five- or six-year period there is a great opportunity to address primary, preventive, and education needs in a continuous, comprehensive manner.

Clinical Needs and Diagnoses

In comparison to adolescents, the clinical needs of young children tend to be more focused on their primary physiological development. For example, immunizations, screening and treatment for vision and hearing, and speech therapies are most effectively addressed and most needed at the elementary school level, providing an increased opportunity for prevention and early intervention services. These types of services can later reduce the need for crisis intervention at the adolescent level.

Young children, of course, have a great need for acute care as well, from treatments for colds and flu, to injuries received on the playground. Anyone who has worked with young children knows that they are far from immune to trauma and acute illness. When working with children on an elementary school level, however, staff will notice that their causes of the trauma tend to differ from those of older students. For example, acute injuries in young children are more likely to result from accidents than from sports injuries or deliberate violence. In addition, because health centers in elementary schools have the opportunity to follow children on a long-term basis, they are uniquely poised to address chronic illnesses, such as asthma.

Although elementary school-based health centers do not address sexuality issues as often as centers dealing with older children may, the topic of reproductive health services will still arise. While the often controversial need for clinical services related to pregnancy and sexual choices is rarer in serving young children, these issues can still be a problem. Existing elementary school-based health centers have seen children, as young as ten or eleven years old, coming in because of pregnancies or to receive pregnancy tests. Sexuality issues

in younger children, however, are more likely to be related to sexual abuse than consensual activity, as at the adolescent age. One elementary school-based health center estimates that 50 percent of the pregnancies among the young children they serve are the result of incest. Since abuse and sexuality in young children can be even more controversial than reproductive health services for adolescents, you will need to be highly sensitive to these issues in planning and implementing your elementary school-based health center.

Health Education

Children at young ages already are beginning to make choices which will affect their health. By focusing on prevention, health education at the elementary level can effectively address such issues as safety, nutrition, exercise and avoiding risky behaviors (especially the use of alcohol, drugs, and tobacco).

In creating a health education program as part of a school-based health center, planners need to consider particular issues such as the appropriateness of the activities to students' developmental levels. This will influence the materials used, the teaching methods, the content and the level of detail of information. One method that has been used successfully with elementary students is peer teaching. Older children can lead groups, engaging younger children in basic health and safety activities. Because of young children's short attention spans, staff may also want to consider using more visual aids, greater reinforcement, and more group exercises. Children tend to think in more concrete terms than adults do. In order for them to understand the relationship between a behavior and how it may affect them in the future, the cause and effect must be immediate and clear.

As mentioned previously, elementary school children tend to be more involved with their parents and their teachers. Sponsoring health education classes for parents and teachers and involving them in the classes for children is therefore a good opportunity to heighten their understanding about important health issues. Teachers and parents who are knowledgeable about their own health and their children's health can serve as role models, and are better able to alert staff about any health problems the children may have.

Clearly, addressing all of these considerations requires careful planning and implementation. Especially when working with young children and focusing on primary and preventive care, the active participation of the school staff, including teachers, is of the utmost importance. Teachers are an invaluable source for detecting the types of health services needed by the students.

Staffing Issues

Staffing an elementary school-based health center will be closely tied to the types of services that will be offered and the involvement of the parents or caregivers. As with an adolescent school-based health center, planners need to develop a staffing pattern which allows staff to address the full range of comprehensive services for the students, and at the same time remain within budget limitations.

Beyond the obvious basic need for appropriate staff, however, there are some special considerations in staffing an elementary school-based health center. For example, as discussed earlier, the presence of a parent or guardian at time of treatment is especially important at the elementary school level. Therefore, in order to encourage and ensure maximum parental involvement, the health

center will probably need to remain open beyond regular school hours. This, of course, requires that staff remain and/or work on shifts. In addition, during regular business hours, if the parent or caregiver cannot be present at time of services, many feel that a second adult in addition to the practitioner should be present. This is to ensure the safety of the child and avoid any possibility of allegations of abuse.

Another example of special staffing issues at the elementary level is the need for students to be escorted to the health center. This is especially true for the youngest children, and/or if the health center is in a separate building on school grounds. Health centers can address this issue through student escorts, parent volunteers, outreach workers or other arrangements.

Staffing shortages and special needs can be addressed in a variety of ways. In the best situation, close connections and active working relationships with parents, school staff, and other community members will allow staff to tap into the community's resources to design a staffing pattern and organization of services that is appropriate for each student's special needs.

The elementary school years are a critically important time in a child's physical and emotional development. Offering school-based health and social services to children in a setting that is convenient and familiar to them and their parents is a solution for providing children with the care they need and deserve. Awareness needs to be raised about why elementary school-based services are so important to keeping America's children healthy, how these centers are the missing link in providing integrated services from the pre-school age to adolescence and how they are both similar and different from the more common adolescent school-based health centers. By involving teachers, parents, health practitioners and community leaders in the beginning phases of planning and implementation to elicit their support and involvement, planners will insure that the elementary school-based health center will become a more integral part of the school and community it will serve.

CHAPTER NINE:
EVALUATING SBHC/SLHC PROGRESS

It is imperative both for the continued growth of the SBHC/SLHC field and for the success of the individual health center to evaluate the progress of each SBHC/SLHC program. Most administrators will not have the time or the knowledge to complete this task on their own. Consider contracting with an outside agency or finding a graduate student or researcher interested in adolescent health to do the evaluation. To heighten the administrator's awareness on the need for and process of evaluation, the following chapter presents some general concepts of evaluation. It is not intended as a guide to evaluation.

Process Evaluation

There are three types of evaluations that all SBHC/SLHCs should consider — process, impact and outcome. Process evaluations analyze the manner in which the health center operates, and are most helpful when scheduled about a year after the center opens. Outside evaluators can be invited into the SBHC/SLHC to review the needs assessment and assess the appropriateness of the services provided, the staff hired, the location and layout of the facility, the center's consent form and other policies.

Evaluators can also assess the medical records and forms, medical and mental health protocols, and health center procedures for handling walk-ins, appointments, follow-up and case management. By evaluating the systems set up to meet the objectives of the health center, evaluators can determine if the program should be modified in any way.

The Support Center/CPO has developed a monograph entitled, How to Use Site-Monitoring Teams to Evaluate School-based and *School-linked Health Centers*. This document was designed to help administrators conduct a process evaluation. (For more information contact the Support Center.)

Impact Evaluation

An impact evaluation measures changes in behavior which may be due to the operations of the health center. For example, health service utilization, contraceptive use or enrollment in drug and alcohol treatment programs are impact indicators. Impact evaluation measures the ability of the health center to change those factors that may bring about desirable health outcomes. This kind of evaluation can be performed annually, and the data can be compiled relatively easily.

Outcome Evaluation

Outcome evaluations analyze how successful the program has been at improving health indicators identified in the needs assessment and the program plan — such as reducing rates of teenage pregnancy, substance abuse or school violence. Outcome evaluations measure the extent to which program interventions were able to bring about these desired changes. Outcome evaluation analysis should take place only after the center has provided services for a number of years.

Initial Considerations

Although conducting an evaluation can be difficult and time consuming, there are several good reasons to take this extra effort. First, SBHC/SLHC staff needs research and evaluation results to clarify or modify service interventions. Second, staff will want to determine if the health center is effective and document that effectiveness. Finally, strong evidence of success can help the center maintain community, political and financial support for its services. This kind of concrete evidence can also help other SBHC/SLHC planners design and implement new health centers.

Evaluation Timing

The best time to design an evaluation is before the health center opens. In this way, staff can be sure to collect baseline data that will be used later for comparison after the program is operational.

Guiding Principles

There are at least two basic principles that should guide the evaluations of an SBHC/SLHC. First, be sure to use more than one method for evaluating any program. Every method of collecting data has its flaws and sources of error. Different data collection methods, when combined, can counterbalance one another.

A second key principle is that evaluation is often meaningless unless it provides comparisons. Without baseline statistics from before the opening of the health center, statistics gathered later tell nothing about whether community youth are better or worse off, and whether the health center is having a positive effect. If there is no baseline data, the SBHC/SLHC should at least compare current statistics to those of a similar school nearby or to national averages.

Preparing for the Evaluation

Conducting an evaluation requires a good deal of preparation. Here are some ideas to help staff get ready:

Program administrators will need part-time or full-time help managing the evaluation; make sure this is built into the program budget. If there's not enough funds to budget for this, try contacting a nearby university where faculty or graduate students in psychology, sociology or public health might be willing to lend their expertise to help evaluate the center. If outside evaluators are brought in to conduct the evaluation, make certain the following is clarified:

- the basic purpose of the evaluation;
- any research limitations that the health center or school administration impose;
- who will "own" the data and who will get copies of the raw data;
- who will be the author of any reports or articles;
- who will have final say on any publicly released information and
- whether the center will remain anonymous if information is released.

Reviewing SBHC/SLHC Goals and Objectives

Goals and objectives in the original program plan may have identified both impact and outcome indicators. Before beginning an impact or outcome evaluation, review the program plan to determine if the stated goals and objectives were:

- realistic;
- measurable;
- related to specific interventions provided at the SBHC/SLHC.

Did the SBHC/SLHC hope to reduce absenteeism, but fail to offer any interventions to meet this objective? If the group aimed for 90 percent enrollment in the first year of operation, was this realistic? Staff should discuss the stated goals and objective with evaluators to determine if they were realistic. If they were not, staff may wish to modify the objectives before evaluation begins.

Basic Sources of Data

There are a variety of data that can be used to evaluate health centers' effectiveness. Chapter Two discussed ways to collect baseline data for evaluation comparison. Below are some suggestions for additional sources.

Encounter Summaries. SBHC/SLHC staff should keep records of each visit or encounter with a patient. These records can then be tallied by hand or by a management information system (MIS). These tallies provide documentation that the services are used.

When documenting visits or encounters, distinguish between the number of duplicated and unduplicated visits. This will help evaluators analyze how many different students visited the center, how many visits each student made and the average number of times each student used the center in a given period of time.

Try to provide breakdowns per age, school year, sex, type of visit, and other student and visit characteristics. By aggregating data each year, it will be easy to produce trend data and determine whether the percentages are increasing as rapidly as expected.

Some centers ask referral agencies to document changes in their client loads and numbers of encounters that result from the opening of the health center. Increases may indicate that the SBHC/SLHC has improved the extent of student utilization of the health care system.

Compliance Rates. There are at least two different kinds of compliance rates that should be calculated. The first is based on compliance with subsequent appointments for various health reasons — for example, the percentage of students with a positive STD test who return for treatment and a final STD check. This type of compliance is relatively easy to measure, because it is based upon whether or not patients returned when appropriate to the health center or to another referral agency. This information can be found in the patient's record or in the encounter log.

Calculating this type of compliance can prove very important. If the health center can show that compliance is better at the SBHC/SLHC than for other providers of care, then one type of success is documented. Pregnant teens do not typically

attend all of their prenatal visits, and those with positive STD tests do not always return for follow-up checks. Some SBHC/SLHCs, however, have had great success in improving these compliance rates within the school population.

The second type of compliance rate is that based upon compliance with various regimens outside of the health center — for example, compliance with attendance for family counseling, or use of medications for the entire period specified by the clinician. It is far more difficult to measure this kind of compliance because additional data must be obtained and recorded from each patient and for each regimen. Moreover, it is difficult to find data with which to compare these compliance rates.

Management Information Systems Data

Most SBHC/SLHCs will want to install a management information system (MIS) to help staff track clients and collect some of the data needed for evaluation. By installing the system from the start, SBHC/SLHC administrators will be able to assess enrollment, client utilization and continuation rates on a periodic basis. These systems can also record patient histories, update patient charts and facilitate client follow-up. For centers wishing to bill insurance companies, many MIS programs record ICD-9 or diagnosis codes as well.

To date, the only MIS program designed specifically for SBHC/SLHCs is *School HealthCare - ONLINE*. For more information about the system contact David Kaplan, M.D. Ph.D, Medical and Educational Software, Inc., P.O. Box 1183, Denver, CO 80201-1183 or call (303) 861-6133.

School Surveys

The data discussed above are collected as services are provided. Student surveys are another source of information that can help administrators evaluate the impact of health center services on health behaviors.

Questionnaires can incorporate a wide variety of behavioral and health measures like those listed below.

- time elapsed since getting routine or preventive medical care;
- use of emergency medical facilities;
- number of nights spent in a hospital;
- use of safety belts;
- eating habits;
- use of drugs and alcohol;
- extent of sexual activity, use of birth control and pregnancy history;
- depression, suicide ideation;
- obesity.

Overall Design

Administrators using student surveys as one type of SBHC/SLHC evaluation tool should administer the same (or similar) survey to students before the SBHC/SLHC opens and each year thereafter. Simultaneously administer the same (or similar) questionnaire to students at a non-SBHC/SLHC school

nearby. Using this system, staff can compare the change in health and behavior patterns over time in the SBHC/SLHC school with the change over time in the comparison school.

If the SBHC/SLHC is already open and data has not yet been collected, use the non-SBHC/SLHC school as a basis for comparison. If no comparison school is available then it is imperative that the SBHC/SLHC have access to pre-opening data to compare with figures collected later.

When administering yearly surveys, the best timing and pacing is to administer them prior to opening the center and then in the spring of each year. Administer the survey to either all the students in a school or to a large random sample of the students. It is an unfortunate fact of statistics that sample sizes must be very large for small changes to be statistically significant. A good rule of thumb is that if the school population is larger than 1,500 students, select a random sample of 1,000. If the school population is less than 1,500, administer the sample to all students.

Ensure the anonymity of the respondents when administering and collecting the information. Also take note of any unexpected problems, absences or other events that may affect survey administration.

There are several evaluation factors of which staff should be aware. First, major factors other than the SBHC/SLHC will influence the data over time. The composition of the school may change, unemployment in the community may rise, other agencies may have initiated related programs that convolute changes recorded, etc.

Second, the questionnaires are, of course, self-reports. Although most students complete most questions honestly, some students may intentionally distort their answers. Some may make honest mistakes. All questionnaires should be examined for obvious distortions. Those that are clearly invalid should be discarded. Nevertheless, an unknown amount of error will remain.

Third, although the health center may have an important impact on a group of students in one health area and a different effect in another area, the evaluation, may not find any significant impact upon the entire student body if the center attempts to evaluate these groups separately.

This problem can be overcome to a certain extent by including questions on the questionnaire about participation in a particular program and then comparing those that participated with those who did not. This method still does not overcome the

problem of self-selection, however. It may be necessary to evaluate the impact of a particular intervention with separate research studies.

Separate Research Studies

When health center interventions are believed to have important effects upon small numbers of students, it may be necessary to conduct separate evaluations with those students. For example, if the school has a substantial number of overweight students and the center initiates a nutrition and exercise program for them, staff can identify the overweight students in the school and randomly assign half of them to the program. Data can be collected and compared to those assigned to the control group. Those students who serve as the control for

several months could then be invited to participate in the program after the evaluation was completed.

Separate studies do have their drawbacks -- by definition, they require a study separate from the overall evaluation and a separate sample of students for each intervention evaluated. They also do not provide evidence on the impact of the SBHC/SLHC on the student body as a whole. Nevertheless, in many situations, only these separate studies will provide statistically significant results for the impact of SBHC/SLHC programs.

Other Sources of Data

Many communities use data collected by other agencies to help evaluate the impact of the health center. Three problems exist. First, community statistics provided on absenteeism, teenage pregnancy or drug addiction may not be specific to the population served by the health center. Second, many factors other than the health center services could cause fluctuations in these statistics and finally, there is a tendency to use statistics that are not related to the interventions implemented at the health center. Outside evaluators should be consulted to suggest, and in fact to collect, school and community statistics relevant to SBHC/SLHC evaluation. Below are a few suggestions on places to find data.

School Records

Absenteeism and Drop-out Rates. Schools usually keep records of the number of students absent each day and the percentage of days missed during the school year. Many, but not all schools, also know the number of students who have dropped out. Occasionally they have estimates of the number of girls who have dropped out because of pregnancy, but these estimates may greatly underestimate the number of pregnancies experienced by the school population. Because this data has already been collected, it is tempting, and sometimes useful to use it to observe trends in data over time. Be wary, however. Absenteeism and dropout rates are affected by many things and changes may not become evident for some time. Unless reducing these rates is a specific goal of the health center, it may be unfair to evaluate the center on the basis of these data.

Public Health Records

Birth Rates and Low Birth Rates. By comparing lists of female students enrolled in school with community birth records, staff can probably produce fairly accurate annual birth rates for schools in the community. Most schools can provide lists of enrolled students dating back many years. Hospitals, departments of health or other city and state agencies house birth records. The institution that houses birth records may be concerned about maintaining the confidentiality of the birth records. If so, the SBHC/SLHC may need to subcontract with that institution to compare the list of names itself and provide the staff with the annual number of births to teen mothers.

A major advantage of this evaluation method is that it can be completed long after the health center has opened. All that is necessary is that the schools keep a copy of all female students enrolled each semester. Again, a word of caution

is warranted. Do not evaluate for reductions in teenage pregnancies, if no intervention was implemented to bring about this reduction.

To summarize the evaluation process: plan the evaluation before the health center opens; collect data in different ways; seek outside help. Lastly, do not be afraid of the results. Evaluations will lead to improved programs, and offer strong benefits to youth, the health center staff, the school and the community.

ENDNOTE

This guide to designing and implementing school-based and school-linked health centers was written to aid SBHC/SLHC planners in their quest to bring health services to youth in their communities. Clearly, each community will differ in its needs and thus in the services that it decides to provide. There are no hard and fast rules about staffing, consent, facility location; rather this document provides some concepts and ideas to guide the design process. Most communities are not able to implement the ideal center right from the start. Instead, time and success motivates expansion both in site location and scope of services. The Support Center/CPO hopes that this guide has been helpful and that the journey to providing health services on or near school grounds is a fruitful one for each and every community engaged in the process.

APPENDIX I: SCHOOL-BASED AND SCHOOL-LINKED BIBLIOGRAPHY

Articles:

Ahartz, J. et al., "The St. Paul Story: A Working Manual on The Pioneer School-Based Clinics In St. Paul, Minnesota." *Health Start, Incorporated*. St. Paul, Minnesota. 1986.

American Academy of Pediatrics. Task Force on School-Based Health Clinics. "Guidelines: School-Based Health Clinics." *AAP News*. April 1987.

Balassone, Mary Lou, D.S.W. et al., "A Comparison of Users and Nonusers of a School-Based Health and Mental Health Clinic." *Journal of Adolescent Health*. Vol 12, No. 3, May 1991.

Bar-Cohen, Annette, Lia-Hoagberg, Betty, and Edwards, Laura. "First Family Planning Visit in School-Based Clinics." *Journal of School Health*. Vol. 60, No. 8, Oct 1990.

Black, Jeffrey L., "School-Based Clinics: Filling Unmet Needs for Teens." *Contemporary Pediatrics*. Vol. 6, No. 3, Mar 1989.

Blum, Robert. "A School-Based Comprehensive Health Clinic for Adolescents." *Journal of School Health*. Oct 1982.

Brindis, Claire. "A Synthesis of Recent Evaluation Findings on School-Based Health Centers." Paper presented as part of a National Health Policy Workshop. Nov 28, 1989.

Buser, Bess N., "The Evolution of School Health Services: New York and Nationwide." *Journal of School Health*. Vol. 50, No. 8, Oct 1980.

Chilton, Lance A., "Informal Provision of School Health Services by a Physician." *Journal of School Health*. March 1982.

Connell, David B., Turner, Ralph R., and Mason, Elaine F., "Summary of Findings of the School Health Education Evaluation: Health Promotion Effectiveness, Implementation and Costs." *Journal of School Health*. Vol. 55, No. 8, Oct 1985.

Council on Scientific Affairs. "Providing Medical Services through School-Based Health Programs." *Journal of School Health*. Vol. 60, No. 3, March 1990; also *Journal of the American Medical Association (JAMA)*. Vol 261, No. 13, April 7, 1989.

Cullen, T.F., "School-based Clinics' Birth, Fertility and Abortion Rates." [letter]. *JAMA* 262:3271, 1989.

Dale, Sandra, et al., "The Effects of Health Aides on School Nurse Activities." *The Journal of School Health*. Oct 1981.

Demsko, Tobin W., "School-Based Health Clinics: Analysis of the Johns Hopkins Study." *Family Research Council of America*. 1987.

Dryfoos, Joy G., "School-Based Health Clinics: A New Approach to Preventing Adolescent Pregnancy?." *Family Planning Perspectives*. Vol. 17, No. 2, Mar/Apr 1985.

Dryfoos, Joy G., "School-Based Clinics: Three Years of Experience." *Family Planning Perspectives*. Vol. 20, No. 4 Jul/Aug 1988.

Dryfoos, Joy G., et al., "School-Based Clinics: Their Role in Helping Students Meet the 1990 Objectives." *Health Education Quarterly*. Vol. 15, No. 1, Spring 1988.

Dryfoos, Joy G., and Santelli, J.S., "Involving Parents in Their Adolescent's Health. A Role for School Clinics." accepted for publication. *Journal of Adolescent Health Care*.

Earls, Felton, et al., "Comprehensive Health Care for High-Risk Adolescents: An Evaluation Study." *American Journal of Public Health*. Vol. 79, No. 8, Aug 1989.

Edwards, L.E. et al., "Adolescent Pregnancy Prevention Services in High School Clinics," *Family Planning Perspectives*, 20:193-200, 1988.
Edwards, L.E. et al., "An Experimental Comprehensive High School Clinic," *American Journal of Public Health*, 67:765-766, 1977.

Galavotti, C. and Lovick, S.R., "School-based Clinic Use and Other Factors Affecting Adolescent Contraceptive Behavior," *Journal of Adolescent Health Care*, 10:506-513, 1989.

Gillman, Susan Brink, and Nadar, Philip R., "Utilization of School and Primary Health Care Resources for Common Health Problems of School Children," *Pediatrics*, Vol. 68, No. 5, Nov 1981.

Gonzales, Carlos, "Adolescent Health Care: Improving Access by School-Based Service," *The Journal of Family Practice*, Vol. 21, No. 4, 1985.

Hirsch, M.B. et al., "Users of Reproductive Health Clinic Services in a School Pregnancy Prevention Program," *Public Health Reports*, 102:307-316, 1987.

Keenan, Terrance, "School-Based Adolescent Health Care Programs," *Pediatric Nursing*, Vol. 18, No. 1, Jan/Feb 1986.

Kenney, Asta M., "School-Based Clinics: A National Conference," *Family Planning Perspectives*, Vol. 18, No. 1, Jan/Feb 1986.

Killip, Diana C., et al., "Integrated School and Community Programs," *Journal of School Health*, Vol. 57, No. 10, Dec 1987.

Kirby, Douglas, "Comprehensive School-Based Health Clinics: A Growing Movement to improve adolescent Health and Reduce Teenage Pregnancy," *Journal of School Health*, Vol. 56, No. 7, Sep 1986.

Kirby, Douglas, Waszak, Cynthia, and Ziegler, Julie, "Six School Based Clinics: Their Reproductive Health Services and Impact on Sexual Behavior," *Family Planning Perspectives*, Vol. 23, No. 1, Jan/Feb 1991.

Kort, M., "The Delivery of Primary Health Care in American Public Schools, 1890-1990," *Journal of School Health*, 54 453-457, 1984.

Lansky, David and Brownell, Kelly D., "Comparison of School-Based Treatments for Adolescent Obesity", *Journal of School Health*, Aug 1982.

Lear, Julia Graham, et al., "Reorganizing Health Care for Adolescents: The Experience of the School-Based Adolescent Health Care Program," *Journal of Adolescent Health*, Vol. 12, No. 6, Sept 1991.

Lear, Julia Graham, et al., "The School-Based Adolescent Health Care Program: An Initial Report," submitted for publication, 1991.

Lovick, Sharon R., "School-Based Clinics: Meeting Teens' Health Care Needs," *Journal of School Health*, Vol. 58, No. 9, Nov 1988.

Lyons, Julie A.F., "Adolescent Health and School-Based Clinics," *Issues in Comprehensive Pediatric Nursing*, Vol. 10, 1987.

McCormick, Kathleen, "Bringing Health Care to the Kids," *Governing*, Sept 1989.
Meeker, R. et al., "A Comprehensive School Health

Initiative," *Journal of Nursing Scholarship*, 18:86-91/Miller, Sharon S. and Moltz, Kathleen A., and Taylor, D. Kay, "Adolescent Health Care: An Assessment of Referral Activities," *Adolescence*, Vol. 26, No. 103, Fall 1991.

Nader, Philip R., et al., "Factors Influencing Access to Primary Health Care via School Health Services, *Pediatrics*, Vol. 65 No. 3, March 1980.

Newacheck, Paul W., et al., "Financing Health Care for Adolescents: Problems, Prospects, and Proposals," *Journal of Adolescent Health*, Vol. 11, No. 5, Sept 1990.
Newman, Ina M., Newman, Enid, and Martic, Gary L., "School Health Services: What Costs? What Benefits?," *Journal of School Health*, Aug 1981.

Oda, Dorothy S. et al., "The Resolution of Health Problems in School Children," *Journal of School Health*, Vol. 55, No. 3, March 1985.

Pacheco, Mario, et al., "Innovation, Peer Teaching, and Multidisciplinary Collaboration: Outreach from a School-Based Clinic," *Journal of Adolescent Health*, Vol. 12, No. 3, May 1991.

Porter, P., Avery, E. and Fellows, J., "A Model for the Reorganization of Child Health Services within an Urban Community," *American Journal of Public Health*, 64:718-719, 1974.

Porter, P., and Butler, J.C., "Healthy Children: An Assessment of Community-Based Primary Care Health Programs for Children and their Impact on Access, Costs and Quality," *Advances in Pediatrics*, 34:379-410, 1987.

Riggs, S. and Cheng, T., "Adolescent's Willingness to Use a School-based Clinic in View of Expressed Health Concerns," *Journal of Adolescent Health Care*, 9:208-213, 1988.

Santelli, J.S. et al., "Bringing Parents into School Clinics: Parent Attitudes Towards School Clinics and Contraception," accepted for publication, *Journal of Adolescent Health Care*.

Siegel, Lucille, P. and Krieble, Todd A., "Evaluation of School-Based, High School Health Services," *Journal of School Health*, Vol. 57, NO. 8, Oct 1987.

Society for Adolescent Medicine (prepared by T.M. Algin), "Position Paper of School-based Health Clinics," *Journal of Adolescent Health Care*, 9:526-530, 1988.

Tereszkiewicz, Lillian and Brindis, Claire, "School-Based Clinics Offer Health Care to Teens," *Youth Law News*, Vol. 7, No. 5, Sept/Oct 1986.

U.S. Congress, Office of Technology Assessment, "Adolescent Health - Volume I: Summary and Policy Options," OTA-H-468, Washington, D.C., U.S. Government Printing Office, April 1991.

Warren, C., "Improving Student's Access to Health Care: School-Based Health Clinics, A Briefing Paper for Policymakers," *Center for Public Advocacy Research, Inc.* 12 West 37th Street, New York, N.Y. 10018, Oct 1987.

Weitzman, M. et al., "High-risk Youth and Health, The Case of Excessive School Absence," *Pediatrics*, 78:313-322, Aug 1986.

Welfare Research, Inc., "Health Services for High School Students: Short-Term Assessment of New York City High School-Based Clinics," 11 Broadway, New York, N.Y. 10004, June 3, 1987.

Zabin, Laurie Schwab, Stark, H.A., and Emerson, M.R., "Reasons for Delay in Contraceptive Clinic Utilization: Adolescent Clinic and Nonclinic Populations Compared," *Journal of Adolescent Health Care*, 12:225-232, 1991.

Zabin, Laurie Schwab, and Hirsch, M.B., "Evaluation of Pregnancy Prevention Programs in the School Context," *Lexington Books*, D.C. Heath and Company/Lexington, Massachusetts/ Toronto, 1988.

Zabin, Laurie Schwab, et al., "The Baltimore Pregnancy Prevention Program for Urban Teenagers: How Did it Work?" and "What Did it Cost?" *Family Planning Perspectives*, Vol. 20, No. 4, Jul/Aug 1988.

Zabin, Laurie Schwab, et al., "Evaluation of a Pregnancy Prevention Program for Urban Teenagers," *Family Planning Perspectives*, Vol. 18, No. 3, May/June 1986.

APPENDIX II: SAMPLE CONSENT FORM

ANYTOWN HIGH SCHOOL-BASED HEALTH CENTER

1154 Main Street
Pleasant USA

(202) 333-9999

Dear Parent or Guardian,

We are pleased to announce that the Anytown School District and the Anytown Medical Center have received funds to provide free comprehensive medical and mental health services and counseling for teenagers who attend, or who are eligible to attend, Anytown High.

This means that your child can obtain, with your permission, a wide range of services including health screening and physicals, personal counseling, health and substance abuse counseling and a variety of school and community education programs. In respect to the individual clients, all interactions between the providers and teens will be kept confidential.

We are excited to bring this service to the families of Anytown High. Our goal is to enable adolescents to graduate, to continue their education, to be employable, physically and mentally healthy and drug free.

Eligible teens may receive any of the available services with parental consent. Parents or guardians should sign and return the attached consent form to: the School-Based Health Center, Anytown High School, 1154 Mainstreet, Pleasant, USA.

If your family is eligible for Medicaid, please provide the appropriate information on the consent form.

We look forward to serving you and your teenager. If you have any questions or would like further information, please call the phone number listed above.

Services Available

Medical: general health assessment, immunizations; sports and job physicals, problem screenings and referrals; laboratory and diagnostic screenings; pregnancy testing, counseling and education; family planning education, counseling and referrals; sexually transmitted disease testing, treatment and counseling; nutrition counseling.

Personal Counseling: general screening, counseling and referral for various concerns related to teenagers including depression, behavior disorders, personal relationships and family problems.

Health Education: various school and community programs relating to teen health issues.

Consent Form

DATE _____

I, _____consent to have _____
(Parent or Guardian) (Name of Child)
receive services provided by the School-Based Health Center Program at Anytown High School.

_____
(Signature of Parent or Guardian)

While I consent to have services provided to my child, I do not want him/her to receive the services I have noted below:

_____

Does your son/daughter use a family doctor? _____
If so, please indicate name and telephone number below:

_____ (Name)
(Phone)

If you have a Medicaid number, please provide it.

_____

APPENDIX III: SAMPLE JOB DESCRIPTIONS TEEN HEALTH CENTER ANYTOWN HIGH SCHOOL

Health Center Coordinator/Project Manager Job Description
The center coordinator is responsible for coordinating all education, counseling and medical services of the Teen Health Center.

A. Performance Requirements

1. Ability to implement philosophy and objectives of program.
2. Ability to work cooperatively with sponsoring agency, school district and school administration, the staff and students.
3. Ability to function independently and recognize when consultation is appropriate.
4. Skill in working with other professionals and a diverse clientele.
5. Ability to assess and evaluate self.
6. Ability to manage clinic administrative issues.
7. Ability, if necessary, to seek funding and write grant proposals.

B. Examples of Job Duties and Responsibilities

1. Administrative
   a. Attend inservice, planning and staff meetings.
   b. Allocate time regularly to update professional practice.
   c. Seek funding contacts and funds.
2. Clinic
   a. Supervise other Teen Health Center staff, delegating tasks and responsibilities, taking charge of performance evaluations and problem-solving.
   b Coordinate the activities of the community advisory committee (scheduling, communicating with members, developing the agenda, making sure minutes are taken and typed).
   c. Collect periodic statistics on clinic activities and other relevant data and submit them to appropriate people.
   d. Serve as liaison to Anytown High School.
   e. Schedule physician, nurse practitioner and other contract staff as needed.
   f. Plan and implement public relations activities of the program in consultation with the sponsoring agency, including contact with community agencies, organizations and political figures.
   g. Develop budgets in consultation with the funding agency.

C. Supervision

1. Supervise the nurse practitioner, medical assistant and other staff members of the clinic.
2. Report to executive director or program director at the sponsoring agency.

Nurse Practitioner (Ob/Gyn or Pediatric) Job Description

The nurse practitioner functions under the supervision of the physician and delivers primary health care to patients, and fulfills such duties as assessment, planning, teaching and counseling. The practitioner functions as a health team member in meeting the objectives of the program in school.

A. Performance Requirements

1. Ability to implement philosophy and objectives of project.
2. Ability to work cooperatively with sponsoring agency, school district and Anytown High School administration.
3. Ability to collect adequate patient database information, including conducting specific physical exams.
4. Ability to interpret physical findings and refer or treat the patient as the condition dictates.
5. Ability to work effectively with individuals and groups in a teaching situation.
6. Ability to make comprehensive assessments, make decisions and plan care.
7. Ability to function independently and recognize when consultation is appropriate.
8. Knowledge in providing health education on an individual or group basis.
9. Skill in working with other professionals and a diverse group of clientele.

B. Example of Job Duties and Responsibilities

1. Establish a database of information on the pediatric patient by:
   a. obtaining a health and developmental history;
   b. conducting a basic periodic physical assessment using appropriate tools;
   c. ordering appropriate screening and/or routine diagnostic tests;
   d. conducting a developmental assessment of the client using appropriate techniques;
   e. recording findings in a systematic and accurate form.
2. Assess the status of the client by
   a. discriminating between normal and abnormal physical findings;
   b. recognizing deviations from normal growth and development.
3. Manage client care by
   a. providing routine immunizations according to AAP standards;
   b. providing treatment for minor illnesses and accident, either in consultation with the physician or according to established protocol;
   c. assisting other members of the health team, including physician, social worker, nutritionist, dentist, psychologist and other health professionals, with management of students referred for physical and developmental problems;
   d. participating in and, when appropriate, continuing health care plans involving the child, family, school or other agencies and resources.
4. Manage family planning clients by
   a. obtaining history--menstrual, obstetrical, family planning, personal and general health;
   b. conducting breast and pelvic exams;
   c. counseling regarding family planning options as well as instructing in the use of the chosen method;
   d. making pregnancy determination.
5. Maintain care for pregnant adolescents by
   a. conducting prenatal interview and exams;
   b. providing care during the neonatal period.

6. Provide outpatient follow-up treatment by
   a. encouraging families to call with concerns and providing appropriate phone management of these concerns.
   b. following up on emergency, clinic and hospital visits;
   c. following up on missed appointments;
   d. participating in educational classes.
7. Maintain professional responsibility in the community by
   a. contributing to the health education of individuals and groups when needed;
   b. identifying community resources available to help clients and their families and guiding them in their use;
   c. contributing to the development of new and/or improved community resources and patterns of health care delivery;
   d. continuing to update personal knowledge, both formally and informally, in order to provide up-to-date information and improved care to clients.
8. Participate in the community advisory committee.
9. Assist in the school clinic team management; assume responsibility for daily clinic management; act as a resource person for other staff members involved in the care of students.
10. Contribute to program planning, evaluation, report preparation and development of articles.

C. Supervision

1. Receive supervision and/or consultation from the Project Director.
2. Receive medical supervision from physicians and, if a applicable, the sponsoring agency.
3. Assume direct supervision of a medical assistant assigned to the school clinic.

D. Employment Standards

1. Graduation from an accredited school of nursing.
2. Current license to practice nursing in the state.
3. Bachelor's degree in nursing required; master's degree in nursing preferred.

Social Worker Job Summary

The social worker is responsible for providing social services to patients, using various social work methods. These functions are performed under general supervision; the position require the ability to exercise independent and sound judgement.

A. Performance Requiremcnts

1. Ability to implement philosophy and objectives of the program.
2. Ability to work cooperatively with sponsoring agency, school staff and students.
3. Ability to function effectively with other staff members in a team setting.
4. Ability to teach classes and lead groups within a school setting.
5. Ability to initiate relationships within the community and maintain liaisons with the lay and professional community.
6. Ability to do public speaking relating to clinic services and adolescent health.
7. Ability to write narrative sections for reports and grants.

B. Examples of Job Duties and Responsibilities

1. Participate with interdisciplinary team members in developing and implementing program policies and procedures.
2. Assess the social and emotional needs of patients.
3. Assist, upon request, in classes and groups.
4. Coordinate social work services and patient referrals between the program and other agencies providing social and educational services.
5. Serve as an advocate for patients' rights within the clinic community.
6. Be available for crisis intervention social work as the need arises or arrange for such coverage by emergency social services.

C. Supervision

1. Primarily responsible to the clinic director and nurse practitioner.

D. Employment Standards

1. Bachelor's degree in social work and two years experience in a social service agency.

Medical Assistant Job Description

The medical assistant is responsible for organizing and maintaining records, collecting data and responding to communications concerning patients at the Teen Health center. The medical assistant is responsible for carrying out a variety of direct and indirect patient care activities under the supervision of professional nursing personnel. He or she works cooperatively with the staff to help provide comprehensive patient care and meeting the objectives of the program.

A. Performance Requirements

1. Ability to answer phone and relay communications in the clinic settings.
2. Ability to prepare charts prior to the scheduled clinics; prepare laboratory and charge slips; make chart entries.
3. Ability to greet and register patients arriving for clinic appointments at the primary care satellite clinic.
4. Ability to arrange referral appointments in other clinics.
5. Ability to perform in-house lab procedures.
6. Ability to perform simple medical care activities.

B. Examples of Job Duties and Responsibilities

1. Organize and maintain record-keeping and data collection systems, including patient registration cards for office files, clinic data and encounter forms; transfer address changes; handle medical referrals and referral communications; identify and code financial status on patient's records.
2. Work cooperatively with sponsoring agency regarding the financial identification and follow-up of the patients in the Teen Health Center.
3. Review patient registration cards and charts regularly.
4. Assist with ordering and restocking clinic supplies.
5. Request and return charts to medical records.

6. Assist in clean-up activities in the clinic--return supplies, wash equipment and transport laboratory specimens and supplies.
7. Assist in patient care activities during each appointment, including weighing and measuring patients; assist in exam room; prepare charge and request slips; perform lab procedures; perform urinalysis.
8. Perform errands as requested by clinic personnel.
9. Report pertinent patient observations to nurse.
10. Participate in patient care conferences.
11. Assist in evaluating patient care and the effectiveness of program operations.
12. Contribute to program planning and evaluation.

C. Supervision

1. Directly responsible to nurse practitioner assigned to school clinic.
2. Responsible to clinic director.

D. Employment Standards

1. Ability to communicate effectively with clinic personnel, patients and students.
2. Ability to maintain strict confidentiality regarding patient records and contacts.
3. Ability to promote positive public relations between students and personnel.

APPENDIX IV: SAMPLE SCHOOL DISTRICT-HEALTH CARE PROVIDER CONTRACT OPERATING AGREEMENT FOR ANYTOWN SCHOOL HEALTH CLINICBETWEENANYTOWN SCHOOL DISTRICT AND ANYTOWN HEALTH CARE PROVIDER

This agreement is made and entered into by and between Anytown School District of Anytown, Anystate, located at _____ and Anytown Health Care Provider, located at _____.
The parties hereto agree as follows:

A. Responsibilities of Anytown School District

1. The School District will permit the establishment by Anytown Health Care Provider, of a primary care clinic in space owned by the District at Anytown High School.
2. The School District will provide approximately _____ square feet of space for clinic use on the first floor in the space currently identified as _____. There will be no charge to Anytown School District for this space. The School District will allow renovation of this space so that it meets state and local requirements as well as the operational needs of the clinic. Any renovation will be paid for by Anytown Health Care Provider at no cost to the school District.
3. The School District will provide, at its expense, heating, cooling, water and custodial services for operation of the clinic.

B. Responsibilities of Anytown Health Care Provider

1. Anytown Health Care Provider will establish and operate a primary care clinic at Anytown High School, offering the services listed in Attachment A, which is incorporated into and made a part of this agreement. Any changes in the plan as set out in Attachment A must be jointly approved by Anytown School District and Anytown Health Care Provider.
2. Anytown Health Care Provider will arrange for all personnel to operate the Clinic. These personnel will include one or more people in the following positions: secretary/receptionist, counselor, educator, nurse practitioner and physician, whose work shall be coordinated and supervised by Anytown Health Care Provider.
3. Anytown Health Care Provider shall handle billing and payment for all services, and ensure that appropriate health care liability insurance is provided. Anytown Health Care Provider acknowledges that the School District does not assume any cost or liability for the operation of the clinic, except as specifically set out herein.

C. Terms of Agreement

This agreement shall be effective as of the date it has been executed on behalf of both parties, and shall continue in effect until ___, unless it is terminated pursuant to the provisions of Paragraph D, below; provided, however, that this

agreement is contingent upon receipt by Anytown Health Care Provider of a grant award from _____ to help fund this clinic.

D. Termination

In the event that the grant award referred to in Paragraph C is received and subsequently terminated, the agreement will terminate when notice of the grant termination has been received by both parties hereto; provided, however, that each party shall be liable for any expenses or obligations incurred by its prior to said termination.

In the event that Anytown School District decides to close Anytown High School during the term of this agreement, the agreement will terminate as of the last day classes are held in the building, provided Anytown Health Provider has been given at least two weeks notice, in writing, of the closing.

Written notice as provided for herein shall be sent by registered mail postage prepaid, to the address of the party as indicated in the signature lines below, or to such other address as the party may subsequently indicate, and shall be deemed received three days after the date of mailing.

E. Insurance

1. Anytown Health Care Provider agrees to maintain or require those performing services through the clinic to maintain professional liability insurance applicable to all health care services offered at the clinic, and to indemnify and hold harmless the School District for any loss or liability it may incur as a result of the rendering of professional services at the Clinic, including expenses incurred in defending any legal action brought against the District as a result of professional services rendered at the Clinic.
2. Anytown Health Care Provider shall provide evidence of such insurance coverage to the School District thirty days before any services are to be rendered under this Agreement. Failure of the School District to provide written notice of objection of coverage shall constitute acceptance of the insurance as meeting requirements of this paragraph.

F. Authorization

The persons executing this Agreement on behalf of Anytown Health Care Provider and the School District by affixing their signatures hereto, warrant that they are duly authorized to execute this Agreement on behalf of the entity for which they sign.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement in quadruplicate this _____ day of _____, 19_____.

For ANYTOWN Health Care Provider For ANYTOWN School District

By:_____ By:_____

Title:_____ Title:_____

Address:_____ Address:_____

_____ _____

Attachment "A": MEDICAL SERVICES TO BE PROVIDED

General primary health care

Routine physical examinations (including sports physicals)

Diagnosis and treatment of acute illness

Diagnosis and management of chronic illness

Referrals for illnesses not suitable for diagnosis and/or treatment in the school clinic

Treatment of minor injuries

Referrals for injuries not suitable for management in the school clinic

Immunizations

EPSDT screening

Laboratory tests

Gynecological exams

Prescription of medications for treatment

Dispensing of medications for treatment

Sexuality education and counseling

Referrals for family planning methods

Prescriptions for contraceptive methods

Dispensing of contraceptive methods

Pregnancy tests

Pregnancy counseling

Prenatal care

Post-partum care

Pediatric care for infants of adolescents

Day care

Dental services

Health education

Nutrition education

Weight reduction programs

Drug and alcohol abuse programs

Parenting information

Family counseling

Mental health and psychological counseling

Job counseling and employment training

APPENDIX V: SAMPLE STUDENT HEALTH SURVEY

To the student:

The purpose of this survey is to give the school district information that will be helpful in planning school and community services for young people. We are interested in your honest opinions about health-related problems and concerns.

This survey is not part of a test and is not part of your regular school work. It is VOLUNTARY **and all information is strictly confidential.** DO NOT put your name on this questionnaire. The questions have no right or wrong answers. We hope you will answer each question honestly and exactly how you feel.

Thank you for your help.

A. General Questions

1. Age: ____ years

2. Sex: ____Male ____Female

3. Grade: ____ 9 ____10 ____11 ____12

4. With whom do you live? (CHECK ONE ANSWER)

( ) Both parents
( ) Mother only
( ) Father only
( ) Parent & Stepparent
( ) One parent & grandparent(s)
( ) Grandparents
( ) Other relative)
( ) Other guardian
( ) Other arrangement

5. What is the *total* number of people in your household? (include yourself) _____

6. Are you:

( ) White (not Hispanic)
( ) Black
( ) Hispanic
( ) Asian
( ) Other (please specify ____)

7. How far did your parents go in school? (CHECK ONE FOR EACH PARENT)

MOTHER	FATHER
( ) 8 grades or less	( ) 8 grades or less
( ) Some high school	( ) Some high school
( ) High school graduate	( ) High school grad.
( ) College graduate	( ) College graduate
( ) Don't know	( ) Don't know

8. Do you have a job outside your home for which you are paid? (CHECK ONE)

( ) No
( ) Yes, less than 30 hours per week
( ) Yes, 30 hours or more per week

9. What kind of grades do you usually get in your high school classes? (CHECK ONE)

( ) Mostly A's
( ) Mostly A's and B's
( ) Mostly B's and C's
( ) Mostly C's and D's
( ) Mostly D's and F's
( ) Mostly F's

B. General Health

1. Right now, do you think you are: (CHECK ONE)

( ) Underweight
( ) About the right size
( ) Overweight

2. During the LAST FOUR WEEKS, how many whole days of school have you missed because of illness? ___days.

3. During the LAST FOUR WEEKS, how many whole days of school have you missed because you skipped or "cut"? ____days.

C. Dental Health

1. How many times a day do you brush your teeth?

2. When did you last visit the dentist (not including the orthodontist)?

( ) In the last year
( ) 1 - 2 years ago
( ) Over 2 years ago
( ) Never
( ) Don't remember

3. Why did you last go to a dentist? (CHECK ONE)

( ) Regular checkup
( ) Crooked teeth
( ) Sore gums
( ) Bad teeth
( ) A toothache
( ) Teeth cleaned

D. Eating. How often do you eat: (CHECK ONE FOR EACH)

		Hardly everyday	Some	Never
1.	Breakfast	( )	( )	( )
2.	Some green vgtbles.	( )	( )	( )
3.	Some fruit	( )	( )	( )
4.	Snack food (chips. candy. etc.)	( )	( )	( )
5.	Milk	( )	( )	( )
6.	A meal with adult/ family	( )	( )	( )
7.	Snacks rather than a regular meal	( )	( )	( )
8.	Diet sodas	( )	( )	( )
9.	Cola. coffee. chocola	( )	( )	( )

10. How many times a week do you have a meal at a fast food restaurant. like McDonald's or Kentucky Fried Chicken? ___ times.

11. Have you ever tried to lose weight? (CHECK ONE) 47
( ) Yes ( ) No

12. If so. how often?

( ) Rarely ( ) Occasionally
( ) Frequently ( ) Constantly

13. Have you ever tried to gain weight? (CHECK ONE)

( ) Yes ( ) No

14. If so. how often?

( ) Rarely ( ) Occasionally
( ) Frequently ( ) Constantly

15. Have you ever tried to lose weight by throwing up on purpose or by going without food for several days? (CHECK ONE)

( ) Yes ( ) No

16. Would you like help in learning how to lose or gain weight? (CHECK ONE)

( ) Yes ( ) No

E. Doctor Visits

1. When did you last go to the doctor? (CHECK ONE)

( ) In the last year ( ) Never
( ) 1-2 years ago ( ) Don't remember
( ) Over 2 years ago

2. Do you have a doctor or clinic that you usually go to when you are sick? (CHECK ONE)

( ) Yes ( ) No

3. In the last year have you wanted to see a doctor or nurse about a sports or P.E. injury?

( ) Yes ( ) No

4. Was this care available to you? (CHECK ONE)

( ) Yes ( ) No

F. Drugs, Alcohol and Tobacco. *Remember, NO ONE* will ever be able to tell how you answered any of these questions. Please answer honestly.

1. Do you smoke cigarettes? ( ) Yes ( ) No

2. If yes, about how often do you smoke?
( ) Hardly ever ( ) Nearly every day
( ) Sometimes ( ) Every day

3. Do you use chewing tobacco or snuff? (CHECK ONE)

( ) Yes ( ) No

4. About how often do you use each of the following? (CHECK ONE ANSWER FOR EACH)

	Never	Hardly ever	Sometimes	Nearly every day	Every day
a. Aspirin	☐	☐	☐	☐	☐
b. Diet pills	☐	☐	☐	☐	☐
c. Laxatives					
d. Alcohol (beer, wine hard liquor)	☐	☐	☐	☐	☐
e. Tranquilizers	☐	☐	☐	☐	☐
f. Amphetamines (ups, speed)	☐	☐	☐	☐	☐
g. Vitamins					
h. Marijuana or Hash	☐	☐	☐	☐	☐
i. Inhalants (rush, glue)	☐	☐	☐	☐	☐
j. Hallucinogens (acid, LSD, PCP, mushrooms)	☐	☐	☐	☐	☐
k. Barbiturates (GSP, bracers, starshine)	☐	☐	☐	☐	☐
l. Heroine	☐	☐	☐	☐	☐
m. Cocaine	☐	☐	☐	☐	☐
n. Crack/rock	☐	☐	☐	☐	☐
o. Cough syrup	☐	☐	☐	☐	☐

5. In the past school year, have you missed school as a result of using drugs or alcohol? (CHECK ONE)

( ) Yes ( ) No

6. In the past school year have you been in trouble at school or with the police because of drugs or alcohol?
(CHECK ONE)

( ) Yes ( ) No

G. Activities. About how often do you: (CHECK ONE FOR EACH)

	Never	Hardly ever	Sometimes	Nearly every day	Every day
1. Exercise	☐	☐	☐	☐	☐
2. Watch T.V.	☐	☐	☐	☐	☐
3. Read	☐	☐	☐	☐	☐
4. Study	☐	☐	☐	☐	☐
5. Get at least hrs. sleep	☐	☐	☐	☐	☐
6. Date	☐	☐	☐	☐	☐
7. Hang out with friends	☐	☐	☐	☐	☐
8. See fights or arguments	☐	☐	☐	☐	☐
9. Get into fights or arguments	☐	☐	☐	☐	☐
10. Hang out in places that are dangerous or have high crime rate	☐	☐	☐	☐	☐
11. Carry a knife or other weapon	☐	☐	☐	☐	☐
12. Drive around with friends	☐	☐	☐	☐	☐
13. Use a seatbelt	☐	☐	☐	☐	☐
14. Wear a helmet when you ride a motorcycle or bicycle	☐	☐	☐	☐	☐

15. Have you ever had sexual intercourse (gone all the way)? (CHECK ONE)

( ) No ( ) 3-5 times
( ) Once or twice ( ) More than 5 times

16. How often have you had sexual intercourse in the last 30 days? (CHECK ONE)

( ) None ( ) 3-5 times
( ) Once or twice ( ) More than 5 times

17. If you have had sexual intercourse, did you or your partner use any kind of birth control? (CHECK ONE)

( ) I have not had intercourse
( ) Never used birth control
( ) Used birth control some of the time
( ) Used birth control all of the time
( ) Not sure

18. If you used birth control, what kind do you or your partner usually use? (CHECK ONE)

( ) The pill
( ) Withdrawal (pulling out)
( ) Time of the month (safe time)
( ) Foam or gel
( ) Condom (rubber)
( ) Other

19. Have you ever seen a doctor because you had a sexually transmitted disease/venereal disease (STD/VD)? (CHECK ONE)

( ) Yes ( ) No

20. Have you ever been pregnant? (CHECK ONE)

( ) Yes ( ) No

21. Have you ever had a baby? (CHECK ONE)

( ) Yes ( ) No

22. Have you ever had an abortion? (CHECK ONE)

( ) Yes ( ) No

FOR BOYS ONLY

23. Have you ever gotten a girl pregnant? (CHECK ONE)

( ) Yes ( ) 2 No ( ) Uncertain

H. Worries and Concerns

How much are you bothered by the following things? (CHECK ONE)

	Not at all	A little	Quite	Extremely
1. Feeling low in energy	☐	☐	☐	☐
2. Your feelings being easily hurt	☐	☐	☐	☐
3. Having a hard time sleeping	☐	☐	☐	☐
4. Having to avoid some things because they scare you	☐	☐	☐	☐
5. Feeling hopeless about the future	☐	☐	☐	☐
6. Thoughts of ending your life	☐	☐	☐	☐

7. Not having friends	☐	☐	☐	☐
8. Feeling that others do not understand you	☐	☐	☐	☐
9. Feeling that people don't like you	☐	☐	☐	☐
10. Not feeling good about yourself	☐	☐	☐	☐
11. Feeling angry or mad too much	☐	☐	☐	☐
12. Wondering how far to go with sex	☐	☐	☐	☐
13. Having been abused physically or sexually	☐	☐	☐	☐

14. Have you ever attempted to end your life? (CHECK ONE)

( ) Yes ( ) No

15. To whom would you prefer to talk about your health and problems? (CHECK TWO)

( ) Doctor
( ) Friends
( ) Psychologist/therapist
( ) Priest, minister or rabbi
( ) Social Worker
( ) Brothers or sisters
( ) Dentist
( ) Teacher
( ) Health educator
( ) Counselor
( ) Nurse

16. Check any of the following that you would like information about. (CHECK **ANY** BELOW)

( ) Drugs
( ) School
( ) Menstrual periods
( ) Parents or family
( ) Getting along with adults
( ) Sex
( ) Pregnancy
( ) Sexually transmitted diseases
( ) Birth control

17. Are there any other health areas about which you would like to have more information?

YOU ARE THROUGH. THANK YOU FOR YOUR HELP!

APPENDIX VI: SERVICES THAT COULD BE PROVIDED BY SCHOOL-BASED AND SCHOOL-LINKED HEALTH CENTERS.

Medical Services
Assessment, treatment, management and follow-up in the following areas, provided either on site or by referral:

General Primary Care

Routine or Sports Physicals

Laboratory Tests

Diagnosis/Treatment of Minor Injuries

Chronic Illness Management

Dermatological Services

Pregnancy Tests

Prenatal Care

Gynecological Exams

Diagnosis/Treatment of Sexually Transmitted Diseases

HIV Counseling and Testing

Pediatric Care of Infants of Adolescents

Immunizations

EPSDT Screenings

Dental Services

Medication Prescribed or Dispensed

Referral for Prenatal Care

Assessment and Referral to Other Providers

Family Planning Services
Provided on-site or through referral for appropriate age groups:

Counseling for Birth Control Methods

Examinations for Birth Control Methods

Condoms Made Available

Foam Made Available

Prescriptions for Birth Control Pills

Birth Control Pills Dispensed

Referrals for Contraceptives

Follow-up on Contraceptive Users

Referral for Other Family Planning Services

Counseling Services
For individual clients, families or groups counseling on issues including but not limited to:

Drug and Substance Abuse

Sexuality and Relationships (including sexual orientation)

Suicide, Depression and Rage

Family Dysfunction

Child Abuse

Psychosocial Counseling

Life Options

Stress

Health Education
Delivered in the classroom and in the health center on topics including, but not limited to:

Nutrition and Weight Management

Sexuality, Relationships and Reproductive Health

Drug and Alcohol Abuse

Decision-making Skills

HIV/AIDS

Stress Reduction and Coping Techniques

Parenting

[1]National Commission on Children, *Just the Facts — A Summary of Recent Information on America's Children and Their Families* Washington, DC, 1993, p. 3.

[2]Children's Defense Fund, *Child Poverty in America.* Washington, D.C., 1991, p.2.

[3]S.L. Hofferth, A. Brayfield, S. Deich, and P. Holcomb, National Child Care Survey, 1990 in *Just the Facts -- A Summary of Recent Information on America's Children and Their Families,* National Commission on Children, Washington, DC, 1993.

[4]Ibid., p. 10.

[5]Bureau of Labor Statistics, Handbook, table 56; Bureau of Labor Statistics, unpublished data 1991.

[6]National Center for Clinical Infant Programs, Can They Hope to Feel Safe Again in National Commission on Children, *Just the Facts -- A Summary of Recent Information on America's Children and Their Families,* Washington, DC, p. 68.

[7]Children's defense Fund, *An Opinion Maker's Guide tp Children in Election Year 1992.* Washington, D. C., 1991, p51.

[8]J. G. Dryfoos, *Adolescents at Risk: Prevalance and Prevention.* (New York, NY: Oxford University Press, 1990.) p. 107

[9]American Lung Association, "Estimated Magnitude of Respiratory Disease by Lung Association Service Area," Washington, DC, 1987.

[10]Substance Abuse and Mental Health Services Administration (SAMHSA) Office of Applied Studies, National Household Survey on Drug Abuse, Rockville, MD 1991.

[11]Barnes, G.M. and Welter, J.W. "Patterns and predictors of alcohol use among 7th-12th grade students in New York State" in *Alcohol World, Vo. 15,* No.1, 1991, p. 8.

[12]Windle, p.8.

[13]Food Research and Action Center, Community Childhood Hunger Identification Project. *A Survey of Childhood Hunger in the United States.* Washington, DC, March 1991, p. 11.

[14]Food Research and Action Center, Community Childhood Hunger Identification Project. *A Survey of Childhood Hunger in the United States.* Washington, DC, March 1991, p.11.

[15]Health Statistics, no. 190, National Center for Health Statistics, Hyatsville, MD, 1990, p. 5.

[16]N. Zill and C. A. Schoenborn, *Developmental, Learning, and Emotional Problems: Health of our Nation's Children, United States, 1988.* Advance Data from Vital and Health Statistics, no. 190, National Center for Health Statistics, Hyatsville, MD, 1990, p.5.

About the Author

Debra Hauser currently serves as Director of the Support Center for School-Based and School-Linked Health Care, a project of the Center for Population Options. In this capacity Ms. Hauser monitors national growth in the school-based and school-linked health center field, provides technical support, delivers regional trainings, develops resource materials and publishes a quarterly newsletter to aid proponents of school-based health care in advocating, designing, implementing and evaluating their services.

Prior to her tenure at CPO, Ms. Hauser served first as Health Educator and then as Director of Community Health Services and Health Education for the City of Atlantic City. In both capacities she devoted herself to advocating, designing and implementing innovative programming, including school-based services, to improve adolescent health in her community. She holds a Master's of Public Health Degree from the University of Michigan, Ann Arbor.