California HealthCare Foundation

It's Elementary: Expanding the Use of School-Based Clinics

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by

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About the Foundation

The **California HealthCare Foundation,** based in Oakland, is an independent philanthropy committed to improving California's health care delivery and financing systems. Formed in 1996, our goal is to ensure that all Californians have access to affordable, quality health care. For more information about CHCF, visit us online at www.chcf.org.

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I. Introduction

Governor Arnold Schwarzenegger has declared his intention to open health centers in 500 elementary schools across the state,[1] which would bring the total number of such school-based clinics to 646. This initiative builds on California's 30-year history of using the school setting to increase access to care for children,[2] improve clinical outcomes,[3] and save money for public and private payers of child health services.[4]

This report explores the options and issues associated with the potential launch of a new school health center initiative in light of previous experience in California and other states. It concludes with a discussion of state policy development and possible directions for future state action.[5]

II. Background

There have been school-based health centers in California since the late 1980s, when centers were established in Los Angeles, San Jose, and San Francisco, with support from local and national foundations. Over the following two decades, the number increased from fewer than 10 to 146. During the '90s there was steady expansion driven by county- and community-based public and private support.[6] Public third-party payers—Medi-Cal, Healthy Families, the Child Health and Disability Prevention program, and Family PACT—also helped support the centers by reimbursing for some of the care provided to their beneficiaries.[7]

Although California state government has played a limited role in promoting school health centers, that role received new emphasis in 2006 with passage of AB 2560, the Public School Health Center Support Program. The California Department of Health Services (CDHS), collaborating with the state's Department of Education, must now create "a coordinated state program to strengthen collaborative efforts between health and education to reach children and youth who are most at risk."[8] The new program will be located in the CDHS Maternal, Child, and Adolescent Health in Schools office (formerly known as School Connections). Its function is to:

- Help school health centers conduct Medi-Cal and Healthy Families outreach;
- Provide technical assistance to the centers;
- Identify funding sources;
- Convene a public advisory committee; and
- Report to the legislature on the program's progress, with help from the Institute for Health Policy Studies at UCSF.

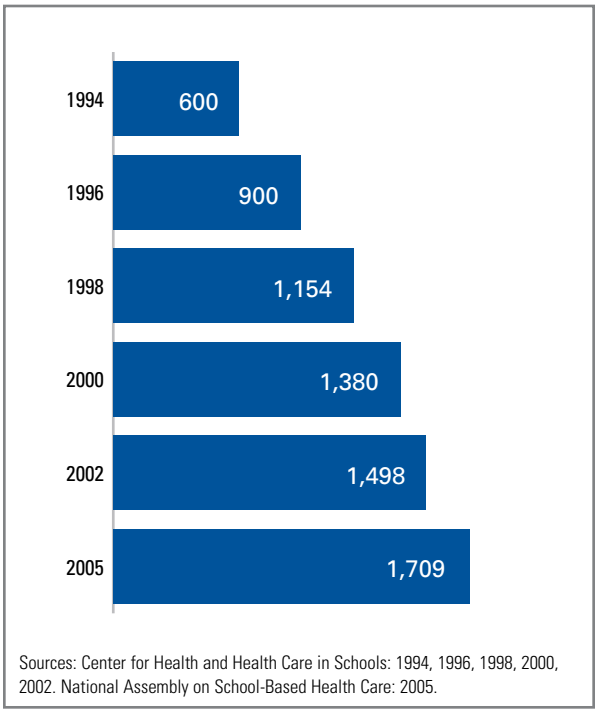
Because AB 2560 did not provide funding, staffing for the state effort remains on hold.[9]

Across the nation, pioneers in the school health center movement focused on two challenges: teen pregnancy prevention and providing access to comprehensive, teen-friendly care. In the early 1970s, a pair of obstetricians in St. Paul, Minnesota teamed up to open a school health center in Mechanic Arts High School

that offered pregnancy prevention, prenatal care, and postnatal care services at a high school with high rates of pregnant and parenting teens. Almost simultaneously, pediatricians at Parkland Memorial Hospital in Dallas opened a health center at Pinkston High School to provide age-appropriate care to teens who refused to attend the community-based kids' clinics. In the decade that followed, health centers tended to locate in high schools and focus on either reducing teen pregnancy or increasing access to health care for low-income adolescents.

The early health center programs were nurtured by federal grants or private foundation dollars (especially from the Robert Wood Johnson Foundation).[10] By the mid-1980s, a number of state governments—New York, Arkansas, Connecticut, Delaware, Michigan, and Oregon—launched their own initiatives. In 1985 there were 40 to 50 centers nationwide, and by the end of the decade there were approximately 150. Increased state funding during the 1990s helped raise that number to 1,380 in 2000,[11] and to 1,709 in the school year 2004–05.[12] Appendix A summarizes school health center data by state for school years 1999–2000, 2001–02, and 2004–05. Appendix B shows the relative availability of the centers to schoolchildren in states with large numbers of centers. Appendix C provides a sample of state definitions of school-based health centers, suggesting the range of approaches taken.

Figure 1. The Growth of School-Based Health Centers Nationwide, Selected Years



Sources: Center for Health and Health Care in Schools: 1994, 1996, 1998, 2000, 2002. National Assembly on School-Based Health Care: 2005.

III. Health Centers in Elementary Schools

Initially the most visible health centers were opened in high schools, but the potential for health centers to serve younger children was highlighted in the 1991 *Report of the Advisory Council on Social Security.* It recommended a "School-based Health Services and Referral Act that would establish a federal grant program… to reimburse states for their administrative expenditures in establishing and operating health clinics in public elementary schools or in locations reasonably adjacent to the schools."[13] The clinics would provide preventive and primary health care services and basic dental care, and would be available to all children in the schools. The plan called on the federal government to share in the cost of providing the services to children from low-income families. Although federal interest in school health centers waned in the 1990s, the report heightened awareness of the centers and validated interest in the elementary school model.

In California, elementary schools are currently the most common site for school health centers.[14]

Table 1. School Health Centers by Type of School California vs. United States, 2004–05

LOCATION OF CENTER	CALIFORNIA N=140	U.S. N=1709
Elementary schools	35%	20%
Middle schools	10%	15%
High schools	32%	29%
Mixed grades	5%	37%
Off-campus programs & mobile vans	18%	—

Source: Personal communication from Linda Juszczak, Ph.D., deputy director, National Assembly on School-based Health Care (NASBHC), May 31, 2007. Data taken from the school year 2004–05 NASBHC Census of School-based Health Centers.

Although elementary schools are typically smaller than middle or high schools; the centers in elementary schools do not differ greatly from those in schools for older children in terms of location, sponsorship, and population served.[15] The services are tailored to the needs of younger children.[16]

- **Location.** Nationally, 85.5 percent of elementary school health centers are located inside a school building and 12.9 percent

are situated on the school campus. Only 1.6 percent of the centers describe themselves as mobile programs. The majority of elementary school health centers are located in urban areas (66.4 percent). Twenty percent are found in rural areas and 13.6 percent in suburban communities.

- **Sponsorship.** Similar to data from all school health centers, the lead sponsoring agency for elementary centers is a hospital or medical center (33.6 percent). Community health centers sponsor 25.6 percent of the centers; local health departments sponsor 13.2 percent; and school systems sponsor 12 percent.
- **Services and students served.** Sixty percent of the centers provide primary care and mental health services; 40 percent provide primary care but not mental health care. The race/ethnicity of the student population in schools with a health center is Latino (44 percent), African American (28 percent), White (24 percent), Asian (3 percent), other (1 percent), and Native American (<1 percent).
- **Hours of service.** Nearly three-quarters of the health centers are open five days a week, with more than half (54.1 percent) providing 31 or more hours of service weekly.
- **Billing and collection.** Eighty-three percent of elementary school centers report billing for care: 75 percent bill Medicaid; 52.6 percent bill the State Child Health Insurance Program (SCHIP); and 54 percent bill private insurance.[17] While some centers indicate that collections are significantly lower than billings, the size of the gap and reasons for collection difficulties require further analysis.

Possible Roles for Centers

California's proposed initiative raises important questions about the role that school centers might play within a reorganized health care system in the state. One possibility is that the centers would be adjuncts to the formal system of care, providing public health services or focusing on specific issues such as child development problems and mental health issues. Alternatively, school clinics might be essential providers in the child health system, offering the basic medical services associated with a medical home. National Assembly of School-Based Health Care (NASBHC) survey data show that many existing centers provide services associated with a medical home: 77.7 percent have pre-arranged after-hours services; 77.7 percent provide laboratory services; 95.3 percent provide prescriptions for medications; 90.2 percent treat chronic illnesses; and 97.5 percent treat acute problems. Some of these school health centers may choose to assume a formal medical home role. Others may partner with community providers, sharing responsibility for the care of individual children.

Outstanding Issues

Three issues unique to elementary school health centers require additional exploration.

- **Parental involvement.** Because parental participation in health care for young children is essential, information from existing elementary school programs should be sought to determine how to secure sufficient involvement of parents.
- **Eligibility.** It is important to determine which types of elementary schools will be eligible for the program. Possibilities include: K–5 schools, K–8 schools, and the K–5 or K–6 grades of rural K–12 schools.
- **Provider perspectives.** The opinions of the state pediatric society and individual pediatricians and family physicians must be taken into account with regard to elementary school health centers.

The last issue is sensitive because an elementary school-targeted initiative could destabilize the current political environment, which has favored school health clinics. It is commonly believed that physicians have supported clinics in middle schools and high schools because these do not compete with young-child-oriented, office-based practices.

IV. States Help Define Centers

In most states, school health center growth has been driven by grant programs, and state health departments, which typically are responsible for the grant dollars, have helped define the centers by designating the populations they will serve, establishing goals, suggesting or mandating service standards, and determining the types of institutions that can apply for a grant. Following are some typical characteristics of existing school-based centers:

Populations Targeted

Most centers serve low-income children; some target adolescents. Targeting criteria typically include one or more of the following: income, age, insurance status, and health care access.[18] The most common target population is low-income children. Less frequently used criteria include the number of adolescents to be served, the number of uninsured children in the community, and the capacity of centers to overcome barriers to care such as transportation or a shortage of community providers. Because urban school districts tend to be economically and racially segregated, school health centers are sometimes used to reduce disparities in access to health care, as well as disparities in health outcomes.

Performance Standards

States typically set standards for school health centers, matching program goals to state priorities. Usually, Requests for Proposals define program goals and set service and staffing standards.[19] In 2002, 21 states that supported school health centers either mandated or recommended performance standards. Among the 18 states and the District of Columbia that reported sponsoring competitive programs, 14 states and D.C. required (and four states recommended) compliance with standards. Standards typically responded to the questions posed in Table 2 on the following page.

Table 2. Questions Addressed by State Standards for School Health Centers

LOCATION	Is the health center located in the school building or on the school campus?
HOURS OF SERVICE	Is there a minimum number of hours per week the center is opened and staffed by health professionals?
FACILITIES	What are the minimum space standards, arrangements to assure confidential care and privacy-protected communication, availability of hand-washing sinks in exam rooms, and compliance with state laws and regulations governing health facilities?
GOVERNING STRUCTURE	What are the requirements for the governing structure for the school health center and requirements related to the project director and advisory board?
ACCESSIBILITY OF PROVIDERS	Are there minimum hours per provider type and requirements for after-hours care?
SCOPE OF SERVICE	What are requirements for on-site services for preventive care, acute care, and mental health care, as well as specialty referral arrangements?

State service standards incline toward a comprehensive model. For the most part the field has embraced a model of care that includes physical and mental health services, as well as a continuum of care from prevention to treatment (see Appendix C). The 2001–02 survey of school health centers reported by the NASBHC indicated a broad approach to school health center staffing and services.[20]

As the centers have sought participation in third-party payment arrangements, they have had to clarify their objectives, services provided, and standards of care in order to persuade health plans that they can offer a unique service for the plans' young enrollees.

Table 3. Leading Physical Health Services Provided by School-Based Health Centers

SERVICE TYPE	% OF CENTERS PROVIDING CARE
Treatment of acute illness	96%
Screenings – vision, hearing, scoliosis	93%
Asthma treatment	92%
Prescriptions for medication	91%
Comprehensive health assessments	90%
Treatment of chronic illness	86%
Immunizations	86%
Nutrition counseling	85%

Source: National Assembly on School-Based Health Care. National Census of School-Based Health Centers, School Year 2001–02, Washington, D.C., 2003.

Table 4. Leading Mental Health Services Provided by School-Based Health Centers

SERVICE TYPE	% OF CENTERS PROVIDING CARE
Referrals	89%
Assessment	80%
Crisis intervention	78%
Screening	77%
Grief and loss therapy	67%
Brief therapy	67%
Conflict resolution/mediation	64%
Tobacco use counseling	62%

Source: National Assembly on School-Based Health Care. National Census of School-Based Health Centers, School Year 2001–02, Washington, D.C., 2003.

Table 5. Leading Reproductive Health Services Provided by School-Based Health Centers

SERVICE TYPE	% OF CENTERS PROVIDING CARE
Pregnancy testing	76%
Counseling for birth control	64%
HIV/AIDS counseling	62%
STD diagnosis and treatment	60%
Sexual orientation counseling	60%
Chlamydia screening	59%
Gynecological exams	56%
Pap smear	55%

Source: National Assembly on School-Based Health Care. National Census of School-Based Health Centers, School Year 2001–02, Washington, D.C., 2003.

V. State and Other Funding

State grants have been the prime mover in health center growth in almost all states. In 2002, the most recent year for which information is available, 26 states and the District of Columbia spent $71.1 million in support of school health centers. Eighteen of those states[21] allocated funds through a competitive grant program. Other states allocated funds through non-competitive processes to provide core funding to agencies that were deemed to offer essential services to the targeted populations.[22]

As indicated in Table 6, 2001–02 data show that general funds and Maternal and Child Block Grants provided more than half of the state dollars explicitly available to school health centers. States also tapped into tobacco tax and settlement dollars, and several states have used Preventive Health and Health Services Block Grant dollars and the Title XX Social Services Block Grant.

While grant funding has increased substantially, state governments are urging, and sometimes mandating, that centers diversify their funding mix and secure more third-party reimbursement dollars. According to the 2002 survey conducted by the Center for Health and Health Care in Schools:

- Five states require, and 11 more states encourage, Medicaid managed care plans to include school health centers in their provider networks. For SCHIP plans, five states require and nine states encourage inclusion of the centers.
- Thirty-eight states permit school health centers to bill for services under fee-for-service (FFS) Medicaid and SCHIP.
- Thirty-nine states report that nurse practitioners are eligible to bill for their services under FFS Medicaid; in 34 states, nurse practitioners are eligible to bill for services under FFS SCHIP. In some states, providers such as psychologists and social workers are also eligible to bill for services in school health centers.
- Thirty-one states permit nurse practitioners to participate as primary care providers in Medicaid managed care plans; 29 states permit nurse practitioners to participate as primary care providers in SCHIP plans; and 24 states permit nurse practitioners to participate as primary care providers in commercial plans.

Table 6. State Funding, 1996–2002

SOURCE	NUMBER OF STATES PARTICIPATING IN 2002	1995–96	1997–98	1999–2000	2001–02
STATE GENERAL FUNDS	13	$27,508,882	$29,606,245	$31,978,697	$27,592,656
TITLE V MCH BLOCK GRANT	13 plus D.C.	$13,079,033	$10,248,969	$10,126,326	$10,488,074
TOBACCO TAX	4	—	—	$ 7,950,000	$12,679,869
TOBACCO SETTLEMENT	8	—	—	$5,583,457	$12,444,591
OTHER	2	$ 1,392,987	$ 8,110,388	$6,307,954	$ 7,900,709
TOTAL	**26** unduplicated states	**$41,981,802**	**$47,965,602**	**$61,946,434**	**$71,105,899**

Source: Center for Health and Health Care in Schools. 2002 State Survey of School-Based Health Center Initiatives.
Available at www.healthinschools.org /Health-in-Schools/Health-Services/School-Based-Health-Centers/State-Surveys.aspx.

School health centers note that even with effective billing and collection arrangements, they will be unable to sustain their operations on third-party payments alone. Essential activities, such as health promotion and classroom-based, psycho-education interventions are not reimbursable. Further, when center staffers work with classroom teachers and other members of the school community to support their work with children, those services are unlikely to be reimbursed by public or private insurers. In the case of managed care, unless children belong to plans with which the health center has a contract, none of their care at the center is reimbursed.

VI. Lessons Learned

In order to address the ongoing challenges of school-based health centers—and gear up for the proposed major enlargement of the program—it is useful to consider the lessons learned over 30 years of experience. Three stand out:

Define the Model Clearly

If school health centers are to solidify themselves within the health care mainstream, they must provide clarity in defining their purpose, location, population served, and detailed service description. Such clarity is crucial to the stakeholders. For example, policymakers will know what gap in service a provider will fill. Health plans will know what services are offered and what standards of care will be followed. Local child health professionals will grasp the opportunities that may be available for school-community collaborations. Clarity will also make it possible to measure the impact of these services, making long-term, large-scale public funding more likely. This is not to say that there must be only one model of school health centers. There might be several, but each must be defined in detail.

Defining a school health center model can be difficult in states with a tradition of being less directive and less regulatory than others. National Assembly executive director John Schlitt commented, "The common denominator across the guidelines is the states' desire to strike a careful balance between being prescriptive to ensure a standard of care and allowing for community flexibility in program development."[23] Nevertheless, over time, states have tended to tighten their definitions and standards for school health centers.

Maintain the Integrity of the Model

Social scientist Lee Schorr warned that the greatest challenge in taking a winning model "to scale" is resisting pressures to dilute that model.[24] Dilution occurs when available funds are insufficient to support the number of sites desired or when local circumstances result in major changes to the model.[25] For example, it may be tempting to open a clinic even when the appropriate staff is unavailable or space is inadequate. But implementing select pieces of a model often leads to disappointing results.

Encourage Participation by State and Local Associations of School Health Centers

State membership organizations have played critical roles in securing legislative support for the school health centers. They educate local representatives about the value of the centers, organize technical assistance for their members, and work with state offices to develop operational standards. Locally large, multi-site school-based health center programs also organize politically, working at both the community and state levels to persuade local leaders to advocate for the centers. During a fiscal crisis early in the decade, advocacy efforts by parents and students—organized primarily by the state associations—staved off program reductions in many states.[26] As long-time Connecticut Assemblymember William Dyson commented, "There's nothing that has a greater effect on influencing what takes place in the state legislature than the groundswell of a group that appears to be together and unanimous in what they want to do."[27] School health center associations also keep an eye on state and local politics.

VII. Looking Ahead

California communities, health providers, and county governments displayed remarkable energy, creativity, and speed in building the state's network of almost 150 school health centers. If the governor's proposal to add 500 more comes to fruition, the safety net for children will be significantly strengthened. As specifics of the broader health care reform strategy emerge, the school health center initiative will be affected by an exceptionally fluid policy environment in which anything can happen. While there may be support for the school health center initiative, there will also likely be competing claims on public health dollars.

Despite the uncertainty, three scenarios suggest themselves as possible directions for the school health center policy in California.

SCENARIO 1: No State Action

The first scenario assumes that statewide health care reform will preclude a state initiative to expand the number of school health centers. With comprehensive health care reform on the agenda in Sacramento and the Mental Health Services Act moving toward implementation, opportunities for synergy with a school center initiative are apparent. However, it may be difficult to gain traction for a school center initiative in this frenetic policy environment.

Even without a state initiative, the number of school centers will most likely continue to grow, picking up financial support locally and maximizing third-party reimbursement from state insurance programs such as Family PACT and CHDP. Over time, these efforts will lead to a somewhat larger number of health centers helping very needy children. However, the services provided will tend to be acute care, with the harder-to-fund services such as prevention and mental health care less likely to be offered. Also important, the state will not have created an expanded network of providers located in low-income neighborhoods. Given California's size, incremental growth of health centers is unlikely to have a statewide impact on child health outcomes.

SCENARIO 2: A State Grant Program

If California launches a grant initiative for new school health centers, the result will be a greatly enlarged safety net of health and

mental health providers for poor children, which would improve their health status. The RFP process would inevitably define program priorities, service objectives, and operating standards. Assuming a per-center grant of $300,000, the program itself would require $150 million to open 500 centers. Additional resources would be needed for a state office to provide program oversight and guidance.

The initiative will likely require new dollars. Some sponsors of school health centers—hospitals, community health centers, and rural health centers—have access to money that might be re-directed toward new centers and might serve as a match for state health center grants. However, reports suggest that the safety net in California is stretched thin.[28] Therefore, current federal Disproportionate Share Hospital dollars or state grants targeted to safety-net providers may have limited room for more claimants.

Passage of a new grant program will require robust state leadership. Governor Schwarzenegger's proposal is a good first step. Developing a public and private constituency is an essential second step. Recent meetings and conversations involving providers, state policy leaders, foundations, and consultants suggest that momentum is building in support of the initiative.

SCENARIO 3: A School-Based Health Access Program

If California adopts a health care reform plan that covers all of the state's 763,000 uninsured children, what would be the role of school health centers?[29]

Because health insurance has demonstrated its capacity to increase access to care and to improve health outcomes,[30] a school-based strategy might help connect children and their families with health plans, individual providers, or provider organizations. School-based access sites could serve as outreach points and as ground-level monitors of enrollment and care in low-income communities. Under such an arrangement, the school health centers would provide outreach and enrollment rather than direct services.

However, if they chose to do so, third parties could decide to support the centers in providing health services. For example, health plans with large numbers of members attending a single school might choose to support a health center as a cost-efficient way of performing well on HEDIS measures such as immunizations, well child or well adolescent exams, and access to primary care practitioners.[31] In these instances the centers would continue to function as health care providers rather than become administrative supports to the health care system. However, if the plans provide funding for the centers, the task of defining the health centers' functions and standards of operation would become a private, as opposed to a public, responsibility. Moreover, while existing centers might continue to attract their current mix of public and private grant dollars, to sustain current patient care revenues would require the centers to secure payment arrangements with the health plans. And historically school health centers have had difficulties negotiating these arrangements.

VIII. Final Thoughts

While all providers benefit when all patients have a means of payment, the experience of health centers in California and nationwide is that centers cannot be sustained by billing alone. In part this is because not all services provided by school health centers are covered under Medi-Cal or other publicly funded insurance. Typically, prevention, mental health, and substance abuse services are poorly reimbursed, especially when the care is preventive or an early intervention.

During the past several years, the State of Oregon has been working on expanding access to health care for children by pursuing a three-part strategy. These efforts by a northern neighbor may offer some helpful insights. Named the Healthy Kids Plan, the strategy addresses insurance, enrollment, and creation of a child-focused health safety net. The first component focuses on providing affordable health insurance for children in families that make too much money to qualify for plans offered by the state. The second is dedicated to increasing funding for outreach to make sure that children and families that qualify get signed up. The third component continues expansion of the state's grant initiative that supports school health centers. This is how Governor Ted Kulongoski, explained his strategy:

> "There are 117,000 kids in Oregon who do not have health insurance. And that is 117,000 too many. That's why I am determined to make sure that every child in Oregon has access to both physical and mental health care. I call my vision the Healthy Kids Plan—and it will meet the health care needs of Oregon's children in three ways:
>
> First, the plan will provide affordable insurance to children in families that make too much money to qualify for programs that are already offered by the state.
>
> Second, the plan will increase funding to reach out to kids and families that do qualify for state supported health insurance but are not enrolled. A lack of good information by parents must never be the reason for a lack of good health care coverage for Oregon's children.
>
> And third, my Healthy Kids Plan includes approximately $2 million in new funding to continue the expansion of Oregon's

school-based health centers—and to sustain the 45 centers that we already have.

I used to be the Insurance Commissioner in Oregon. One thing that experience taught me is that having insurance is no guarantee of access to health care. That's why even as we work to enroll more eligible children into our public insurance programs, school-based health centers will remain a critical part of my Healthy Kids Plan. And the reason is simple: Students are in school—so their health care should be in school too."[32]

It is an important moment in California, with the governor, state agencies, and private partners attempting to fix long-standing barriers to care for children. School health centers have been identified as potential partners in a strategy to overcome these barriers. It remains to be seen if policymakers and other stakeholders will make the proposed huge expansion of the school center program a reality. Whether or not this happens, a multi-dimensional strategy will be necessary to see that existing and new centers receive the funding they need to make a difference in children's health throughout the state.

Appendix A: School-Based Health Centers, by State and School Year

STATE	1999 – 2000	2001 – 02	2004 – 05
AK	1	1	2
AL	7	5	9
AR	6	0	1
AZ	116	97	91
CA	102	135	140
CO	33	41	36
CT	56	68	73
DC	2	5	5
DE	27	27	26
FL	80	89	123
GA	3	3	3
HI	1	0	0
IA	26	6	15
IL	43	45	53
IN	32	31	88
KS	1	30	3
KY	6	21	15
LA	40	53	56
MA	44	67	58
MD	59	57	64
ME	17	27	27
MI	42	53	69
MN	20	19	21
MO	13	9	3
MS	32	33	36
MT	1	0	0
NC	41	37	51
NE	1	1	0
NH	3	5	1
NJ	17	16	82
NM	30	49	42
NV	1	1	3
NY	159	170	195
OH	20	10	26
OK	7	6	8
OR	44	44	45
PA	31	26	23
PR	—	—	2
RI	7	7	7
SC	26	23	11
SD	0	0	4
TN	12	18	19
TX	70	63	72
UT	2	2	4
VA	15	14	18
VT	3	4	5
WA	10	12	18
WI	38	35	16
WV	34	33	41
TOTALS	1,380	1,498	1,709

Appendix B: K–12 Students and School-Based Health Centers, 2004–05

STATE	NUMBER OF STUDENTS	NUMBER OF CENTERS	RATIO OF CENTERS TO STUDENTS
California	6,441,557	140	1:46,011
Connecticut	577,390	73	1:7,909
Delaware	119,091	26	1:4,580
New York	2,836,337	195	1:14,545
Maryland	865,561	64	1:13,524
West Virginia	280,129	41	1:6,832
Oregon	552,322	45	1:12,274
Louisiana	724,281	56	1:12,934
Michigan	1,750,919	69	1:25,376
Indiana	1,021,348	88	1:11,606
Texas	4,405,215	72	1:61,184

Source: National Center for Education Statistics. State Education Data Profiles. National Assembly on School-Based Health Care. Census Data, 2004–05.

Appendix C: State Definitions of School-Based Health Centers (SBHCs)

CONNECTICUT	Connecticut's SBHCs are comprehensive primary health care facilities licensed as outpatient clinics or as hospital satellites. The SBHCs are located within or on school grounds and serve students in grades pre-K-12. The health centers are staffed by multi-disciplinary teams of pediatric and adolescent health specialists, including nurse practitioners, physician assistants, social workers, physicians and in some cases, dentists and dental hygienists. SBHCs provide primary medical and mental health services to students enrolled at the site school, regardless of ability to pay or insurance coverage. SBHCs emphasize prevention, as well as the early identification and treatment of physical and mental health concerns. SBHCs are licensed by the state.
LOUISIANA	SBHCs are designed to serve and support children, providing quality comprehensive physical and mental health care. SBHC services include: preventive health care, physical examinations, immunizations, laboratory testing, prescription medications, case management for chronic diseases (such as diabetes and asthma), mental health services, care for acute illness and injury, and referral services.
MAINE	SBHCs in Maine provide primary health care and mental health services to students from pre-kindergarten through twelfth grade. These centers are located on school grounds, where students have easy access, and are staffed by licensed medical providers. The may be operated by the school or by community health agencies. Some SBHCs may include primary care providers from the community as staff, and some SBHCs may also play the role of "primary care provider of last resort." All SBHCs play a critical role as a partner with community providers to optimize health outcomes for students by monitoring their health and enhancing their access to needed care.
NEW MEXICO	New SBHCs funded by the New Mexico Department of Health (DOH) provide three levels of service depending on their funding and staffing. **Level One** (basic) provides a minimum staffing of eight hours per week of primary care and eight hours of mental health services. **Level Two** (intermediate) provides a minimum staffing of 16 hours per week of primary care and 16 hours of mental health services. **Level Three** (comprehensive) provides a minimum staffing of 40 hours each of primary and mental healthcare. Each local community decides which services will be offered at its SBHC. SBHC staff aim to build cultural sensitivity into all the services they provide. Those services vary but many include the following: **Medical:** primary care for injuries and illness; annual comprehensive physicals; sports physicals; immunizations and laboratory tests; over-the-counter medications and prescriptions; referrals and coordination of outside services, such as x-rays, dental work, and other services not available at the SBHCs. **Mental Health:** alcohol and substance abuse counseling; mental health awareness and outreach, including suicide prevention, screening for depression, individual, group, and family therapy; and crisis intervention. **Prevention:** health promotion and risk reduction programs, including educational efforts that encourage healthy lifestyles to reduce, among other things: teen pregnancy, obesity/diabetes, and STDs; health risks and assets assessments; AIDS awareness education; nutrition; sports; and physical activity promotion. **Other Services that May Be Offered:** clinical and behavioral health case management; health education; "telehealth" services; and reproductive health services (Note: This service varies by the community, with some schools offering care on-site, others referring students to community clinics, and some not offering any type of birth control or other reproductive service.).
NEW YORK	Comprehensive SBHCs provide primary and preventive care, acute or first contact care, chronic care, and referral as needed. They regard and provide services for children and adolescents within the context of their family, social/emotional, cultural, physical and educational environment… SBHCs are based directly in a school and SBHC services are made available only to the students enrolled in that school. SBHC services are provided at no out of pocket cost to those students who enroll in the SBHC with parental consent. As appropriate, SBHCs may bill third party payors for services. These revenues must be returned to support the operations of the SBHC. SBHC services are provided by a multi-disciplinary team, which must include, at a minimum, but not be limited to: nurse practitioner/physician assistant, mental health professional, physician, and health assistant. The number of staff will depend on the number of students enrolled in the SBHC and the services to be provided.
OREGON	SBHCs in Oregon are primary care clinics located at schools. They provide developmentally appropriate physical, emotional, behavioral and preventive health care to students regardless of their ability to pay. SBHCs are staffed like a local pediatrician or family practice office with a receptionist, nurse, clinical provider (nurse practitioner, physician assistant, or physician), and at some sites, qualified mental health professionals.
TEXAS	An SBHC is an entity established by a school district independently or jointly with a public health agency, health care provider, or university to delivery health care programs, prevention of emerging health threats that are specific to the district, and health services for students and their families at one or more district schools.

Endnotes

1. Office of the Governor. Press release: Governor Schwarzenegger Convenes Summit on Health Care Affordability, July 24, 2006. Available at gov.ca.gov/index.php/press-release/2570/.

2. Barnet B., Arroyo C., Devoe M., Duggan A.K. "Reduced School Dropout Rates Among Adolescent Mothers Receiving School-based Prenatal Care." *Archives of Pediatric Adolescent Medicine.* 2004 Mar; 158(3):262–8. Brindis C.D., Klein J., Schlitt J., Santelli J., Juszczak L., Nystrom R.J. "School-based Health Centers: Accessibility and Accountability." *Journal of Adolescent Health.* 2003 Jun;32(6 Suppl):98–107. U.S. General Accounting Office. *Health Care Reform: School-based Health Centers Can Promote Access to Care.* Washington, D.C.: U.S. Government Accounting Office, 1994. GAO/HEHS 94–66. Guo, J.J., Keller K.N., McCracken A.L., Pan W., Cluxton R.J. "Impact of School-based Health Centers on Children with Asthma." *Journal of Adolescent Health.* 2005 Oct;37(4):266–74. Juszczak L., Melinkovich P., Kaplan D. "Use of Health and Mental Health Services by Adolescents Across Multiple Delivery Sites." *Journal of Adolescent Health.* 2003 Jun;32(6 Suppl):108–18. Tiezzi L., Lipshutz J., Wrobleski N., et al. "Pregnancy Prevention Among Urban Adolescents Younger than 15: Results of the 'In Your Face' Program." *Family Planning Perspective.* 1997;29(4):173–6, 197.

3. Key J.D., Washington E.C., Hulsey T.C. "Reduced Emergency Department Utilization Associated with School-based Clinic Enrollment." Journal of Adolescent Health. 2002 Apr;30(4): 273–8. Nystrom R.J., Timmons A.J. "Completion of Hepatitis B Vaccination Series in School-based Health Centers." *Journal of Adolescent Health.* 2000;26(5):320–1.

4. Adams K.E., Johnson V. "An Elementary School-based Health Clinic: Can It Reduce Medicaid Costs?" *Pediatrics.* Key J.D., Washington E.C., Hulsey, T.C. "Reduced Emergency Department Utilization Associated with School-Based Clinic Enrollment." *Journal of Adolescent Health.* 2002;30:273–8.2000;105 (3):780–8. National Assembly on School-Based Health Care. *Partners in Access: School-based Health Centers and Medicaid.* Washington, D.C. 2001.

5. School health centers are variously known as school-based health centers, school-based clinics, and school-linked clinics. This paper uses the term preferred in California, "school health centers" to refer to what other states most commonly name school-based health centers. In both instances the term typically refers to a health care organization that offers health and mental health services and is located on a school campus.

6. Center for Health and Health Care in Schools. Four 50-state surveys conducted by the Center's predecessor organization, Making the Grade, in 1995–96, 1997–98, 1999–2000, and 2001–002 are available at. For 2004–05 data, see: National Assembly on School-Based Health Care. *National Census of School-Based Health Centers, School Year 2004–05,* Washington, D.C.: 2006.

7. California School Health Centers Association. *An Overview of California's School Health Centers.* Available at www.schoolhealthcenters.org.

8. AB 2560 (Ridley-Thomas) accessible, as amended, at info.sen.ca.gov/pub/05-06/bill/asm/ab_2551-2600/ab_2560_cfa_20060911_101853_asm_floor.html.

9. Personal communication with Bob Sands, California Department of Health Services, April 6, 2007.

10. In the late 1970s and early 1980s, two Robert Wood Johnson Foundation (RWJF) national grant programs_The School Health Services Program and the Community Care Funding Partners Programs_funded health centers in Commerce City, CO, Posen-Robins, IL, Houston, TX, Chicago, IL, Kansas City, MO, New York City, NY and New Haven, CT. From 1986 to 2005, RWJF launched a series of national programs that focused on school health centers: The School-Based Adolescent Health Care Program, Making the Grade: State and Local Partnerships to Establish School-Based Health Centers, and Caring for Kids: Expanding Mental and Dental Health in School-Based Health Centers.

11. Center for Health and Health Care in Schools. *School-Based Health Centers: Results from a 50-State Survey, School Year 1999–2000.* Available at www.healthinschools.org/static/sbhcs/factsheet.aspx. Accessed October 2, 2007.

12. National Assembly on School-Based Health Care. *National Census of School-Based Health Centers, School Year 2004–05.* Washington, D.C.: 2006.

13. Advisory Council on Social Security. Also known as the Steelman Commission. Commitment to Change: Foundations for Reform. Washington, D.C.: Advisory Council on Social Security, December 1991.

14. See note 12.

15. Additional data about California's elementary school health centers were not available from the 2004–05 National Assembly at the time of this writing.

16. According to the National Assembly 2004–05 Census, 65.9 percent of elementary school health centers are located in schools with fewer than 500 students; 25 percent are located in schools with 500–999 students; and 3.2 percent are located in schools with more than 1,500 students.

17. National Assembly on School-Based Health Care, Census 2004–05, unpublished data,Washington, D.C., June 2007.

18. Center for Health and Health Care in Schools. *2002 State Survey of School-Based Health Center Initiatives.* State policies regarding third-party payments for school-based health centers. Available at www.healthinschools.org/static/sbhcs/table04.aspx.

19. There are exceptions: in Maryland, oversight of school-based health centers, initially the responsibility of the Governor's Office for Children, Youth and Families, has been moved to the Maryland State Department of Education.

20. National Assembly on School-Based Health Care. *National Census of School-Based Health Centers, School Year 2004–05.* Washington, D.C.: 2006.

21. CO, CT, DE, IL, KS, LA, MA, MD, ME, MI, NC, NJ, NM, NY, OR, RI, TX, and WV.

22. See Note 18.

23. Schlitt J.J., K.D. Rickett, L.L. Montgomery and J.G. Lear. "State Initiatives to Support School-Based Health Centers: A National Survey." *Journal of Adolescent Health.* 1995;17:68–76.

24. Schorr L.B.. *Within Our Reach: Breaking the Cycle of Disadvantage,* New York: Doubleday, 1988.

25. Ibid.

26. States that sidestepped threatened closures included Michigan, New York, and Rhode Island. Massachusetts and Oregon both were forced to close sites; in those states as well as others, it was reported that additional centers were forced to trim back their services as state grants shrunk.

27. Koppelman J. and J.G. Lear. *From the Margins to the Mainstream: Institutionalizing School-Based Health Centers.* The Center for Health and Health Care in School (formerly Making the Grade: State and Local Partnerships to Establish School-Based Health Centers.) The George Washington University School of Public Health and Health Services. June 2000. p. 14.

28. Vesely R. "Funding Crisis Averted at California's Hospitals." *Oakland Tribune,* February 19, 2006. The California Endowment, The Health Care Safety Net, Health… in Brief. Vol 3(3) December 2004.

29. Lavarreda S.A., E.R. Brown, J. Yoon and S. Glenn. *More than Half of California's Uninsured Children Eligible for Public Programs but Not Enrolled.* UCLA Health Policy Fact Sheet. Los Angeles: UCLA, October 2006.

30. Ku L., Lin M., and Broaddus M. *Improving Children's Health: A Chartbook About the Roles of Medicaid and SCHIP.* Washington, Center on Budget and Policy Priorities, 2007 edition.

31. Personal communication with Steve Rosenberg, principal, Rosenberg Associates, Richmond, CA on April 17, 2007.

32. Governor Ted Kulongoski, State of Oregon. Remarks to the National Assembly School Based Health Centers Conference. Available at www.oregon.gov/Gov/speech/speech_061506.shtml.

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