SCHOOL-BASED
HEALTH ALLIANCE
Redefining Health for Kids and Teens

2010-2011
Census Report of School-Based Health Centers

Purpose and Summary

The School-Based Health Alliance Census for the 2010-2011 school year is the 12th request for data from school-based health centers (SBHCs) since 1986.

SBHCs are health centers that provide comprehensive care to children and adolescents in a setting that is trusted, familiar, and immediately accessible: their school. SBHCs serve at the intersection of primary care, public health, and education to ensure optimal health outcomes for students. Improved health can lead to increased academic success. This model of care eliminates barriers to accessing primary care, mental health care, oral care, and nutrition counseling.

Since the 2007-2008 Census, several pivotal pieces of health care reform legislation were signed into law:

- The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)
- The Health Information Technology for Economic and Clinical Health (HITECH) Act made possible through the American Recovery and Reinvestment Act of 2009 (ARRA)
- The Patient Protection and Affordable Care Act of 2010 (ACA)

The 2010-2011 Census illustrates the strengths of the school-based health care model — promoting quality practices, providing prevention and early intervention programs, and serving as centers for wellness and safety as they relate to national health care reform goals.

The Census is a one-of-a-kind, exhaustive catalog that documents:

- the role of SBHCs in redefining health for underserved children and adolescents and in meeting their health and wellness needs; and
- the full range of SBHC clinical services, prevention activities, staffing models, funding and sustainability, policies, and school demographics.

Data for the 2010-2011 Census were collected from October 2011 — November 2012 and 1930 centers and programs connected with schools nationwide were identified. Since the 2007-2008 Census, 340 new centers have been recognized in the database. These figures demonstrate the sustainability and continued growth of this health care model.

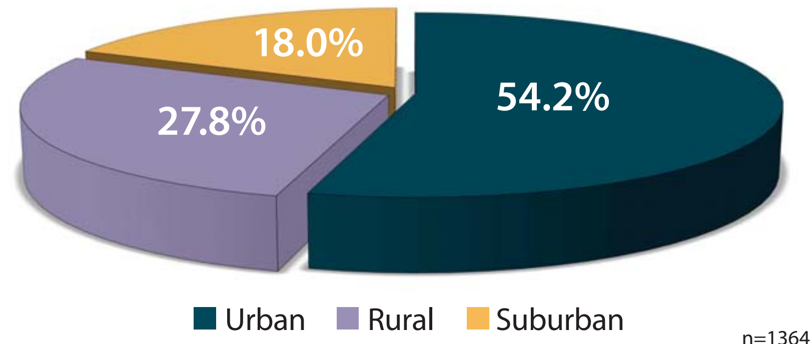
Of known programs, 1485 responded to the survey — a 76.9% completion rate. The analysis includes those SBHCs that provide primary care (n=1381). The 104 centers excluded from the analysis provide access to mental and/or oral health services but not primary care. They were excluded because unlike those providing primary care, their identification was arbitrary and we are not confident that the data pertaining to these alternative models is generalizable.

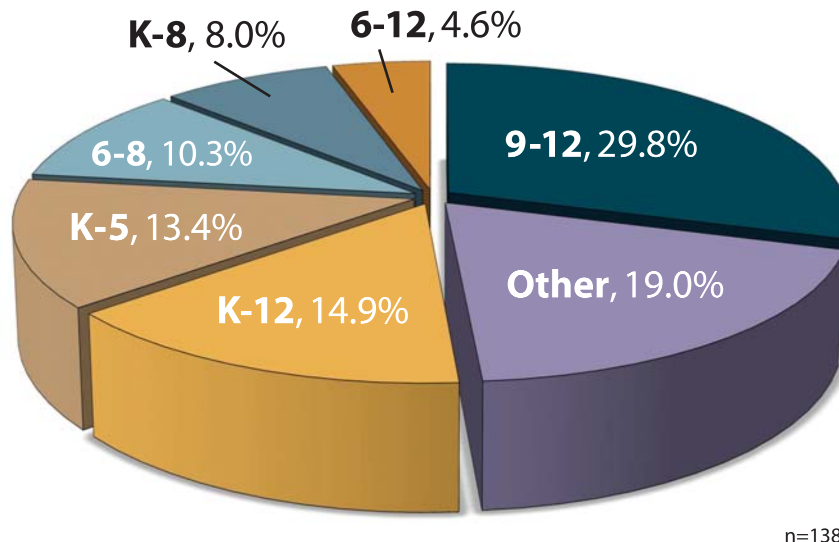
SBHCs at the Intersection of Health and Education

LOCATION n=1364

The large majority of SBHCs (94.4%) are located in a school building or on school grounds. The remaining SBHCs (3.5%) are not on the school's campus and are described as school-linked programs. Only 2.1% are located in non-fixed — or mobile — locations.

SBHCs are in geographically diverse areas. For as long as data have been collected, the majority of SBHCs have been located in urban areas; however, there are also large numbers in rural and suburban areas.





TYPES OF SCHOOLS

SBHCs exist in all types of schools. The great majority describe themselves as being located in traditional public schools (81.3%, n=1200) and schools characterized as Title 1 (68.7%, n=1199). SBHCs are also in a variety of other school types such as:

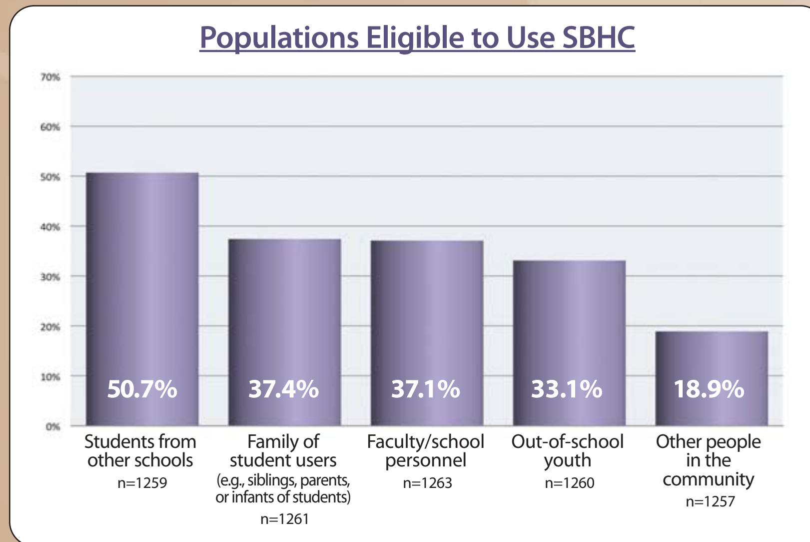
- Community schools (8.3%, n=1197)
- Alternative schools (7.9%, n=1197)
- Charter schools (5.9%, n=1197)

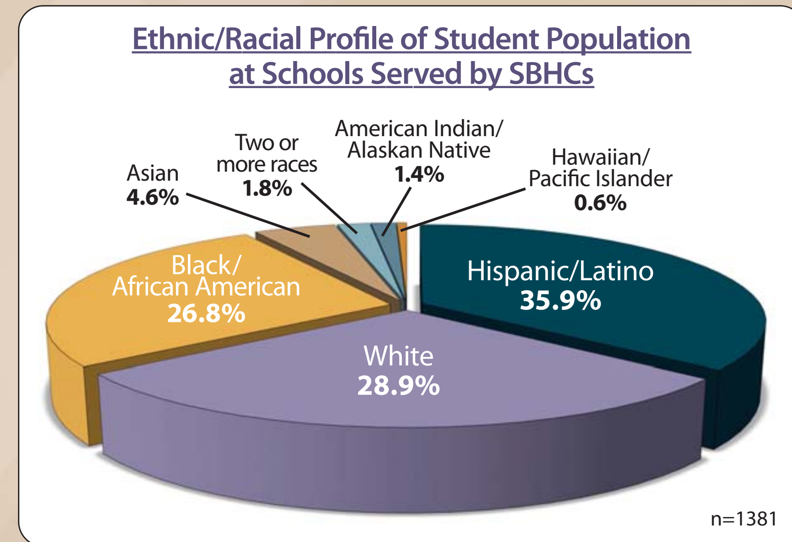
SBHCs serve elementary, middle, and high school-aged students. The majority of SBHC programs (82.7%, n=1381) report serving at least one grade of adolescents (grade six or higher).

An increasing number of SBHCs are located in schools with non-traditional grade combinations (19%, n=1381). This reflects a growing trend to restructure larger schools into smaller grade combinations, with a focus on improving student achievement.

STUDENTS SERVED

The top priority of SBHCs is to provide health care for students in the school; however, many provide health care to diverse populations in the community. Nearly seventy percent (66.7%, n=1264) of SBHCs provide access to families of students in the school, students from other schools, out-of-school youth, faculty, or members of the community. The 2007-2008 Census reported a dramatic increase in the percentage of SBHCs seeing populations other than the students in the school and 2010-2011 data show that this trend has been maintained. SBHCs also serve youth from ethnically-diverse backgrounds.





SBHC STAFFING PROFILES n=1381

While we require all SBHCs included in this report to offer primary care services, SBHCs across the country are also providing access to mental health (70.8%) and oral health (15.9%) providers on-site. Some also have clinical support staff (85.8%), a health educator (16%), and/or a nutritionist (10.7%) as a member of the staff.

The three most common staffing models for SBHCs are: **Primary Care**, **Primary Care & Mental Health**, and **Primary Care & Mental Health Plus**

29.2% **Primary Care** — This model is typically staffed by a primary care provider such as a nurse practitioner, physician assistant, or physician. These SBHCs have no mental health provider on staff, though many of them have an oral health provider and/or a health educator on staff.

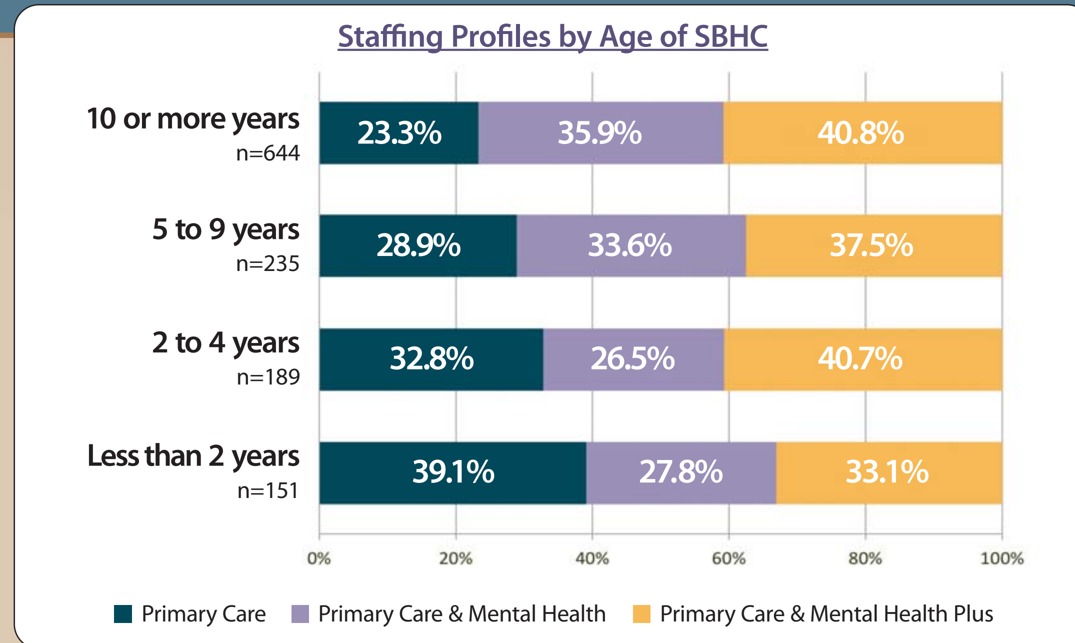
33.4% **Primary Care & Mental Health** — This model is staffed by a primary care provider in partnership with a mental health professional such as a licensed clinical social worker, psychologist, or substance abuse counselor.

37.4% **Primary Care & Mental Health Plus** — This model is the most comprehensive. In this model, primary care and mental health staff are joined by other provider types to complement the health care team such as a health educator, oral health provider, social service case manager, and/or a nutritionist.

SBHC LONGEVITY n=1219

One hundred fifty-one SBHCs have been open for two years or less. Many SBHCs (19.3%) have been open between five and nine years. The majority of SBHCs (52.8%) have been open for ten years or more.

Data suggest that staffing models differ significantly based on how long the SBHC has been open. The highest percentage of programs open ten years or more are Primary Care & Mental Health Plus (40.8%), and the highest percentage of those open less than two years are Primary Care (39.1%).



SBHC PARTNERSHIPS

Sponsors (n=1341) SBHCs are typically sponsored by local health care organizations including community health centers (CHCs) (33.4%), hospitals (26.4%), and local health departments (13.3%). During the past ten years there has been an increasing trend toward CHCs serving as sponsors and a decreasing trend in the percentage of school system-sponsored SBHCs.

School Nurses (n=1303) Among SBHCs who responded, 42.5% have a school nurse located in the school separate from the SBHC, 34.8% have a school nurse co-located in the SBHC, and 22.6% do not have a school nurse in the school.

School Safety and Wellness SBHCs work in collaboration with school staff to ensure the safety and wellness of the students and school community. The majority of SBHCs (67.6%, n=1286) participate in school wellness committees, which bring together principals, teachers, school staff, students, and parents to improve access to health and wellness activities in the school. SBHCs also report participating in the:

- Crisis management team (50.0%, n=1283)
- School improvement team (31.3%, n=1284)
- Community school committee (27.8%, n=1281)
- Student-led groups (student government, clubs) (25.9%, n=1284)
- After-school program team (18.9%, n=1281)
- Individuals with Disabilities Education (IDEA) team (18.1%, n=1282)

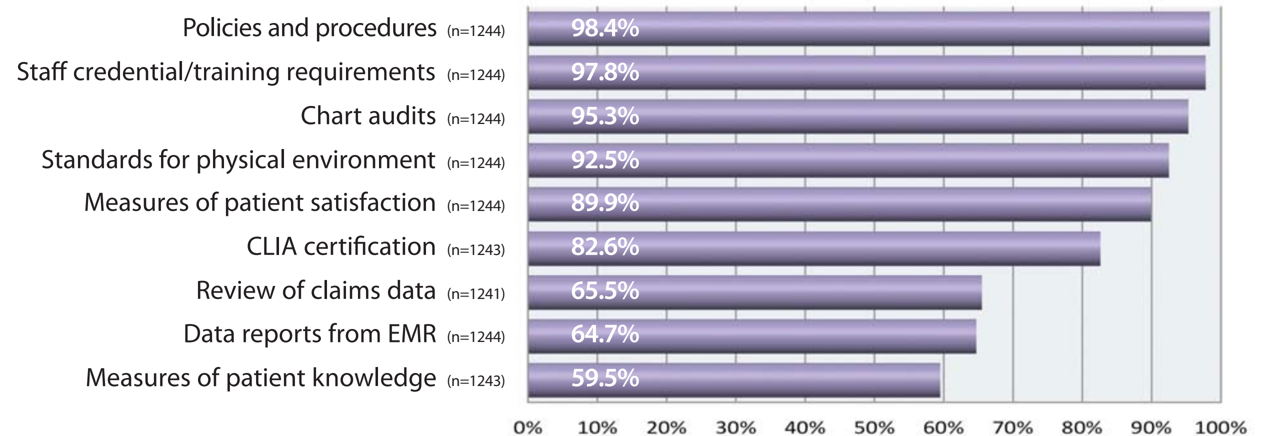
School-Based Health Centers and the Changing Face of Health Care

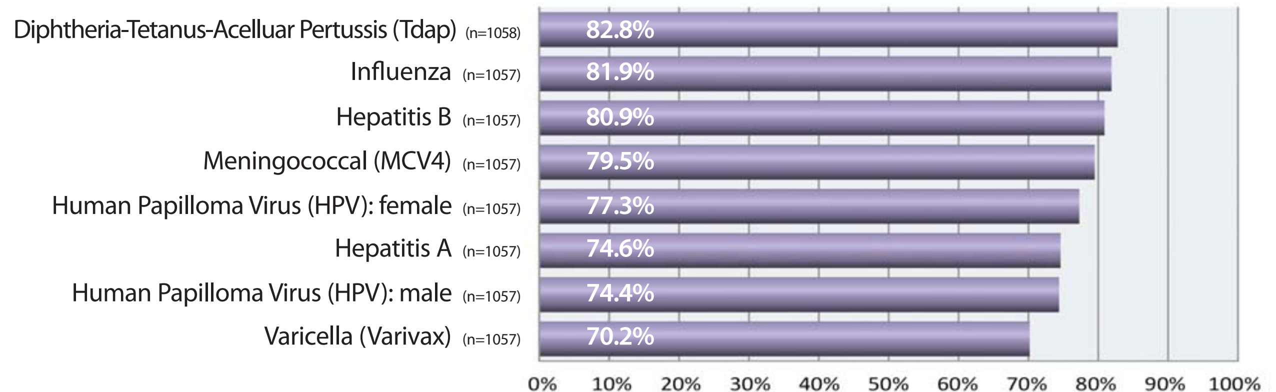
SBHCs are keeping pace with an evolving health care system that is requiring new business practices, demanding greater value, and seeking improved coordination across providers.

The majority of SBHCs (56.9%, n=1284) report following federal guidelines for health supervision focused on infants, children, and adolescents as identified in the ACA. In addition to following these guidelines, SBHCs are committed to high quality practice by: collecting core pediatric quality measures, ensuring after-hours coverage, adopting health information technology (HIT) infrastructure, and billing public and private health insurers.

Quality Care SBHCs are committed to delivering high quality care—a core component of health care reform. Centers have a history of being early adopters of new initiatives and programs and of having a major influence on improving the quality of care for children and adolescents. SBHCs are ideally positioned and report being well-equipped to provide adolescent immunizations.

***29.2%** of SBHCs report collecting quality assurance data that is aligned with the National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) standards.*
n=1238





After-Hours Coverage

SBHCs are typically open five days a week (77.8%), with 66.6% open 31 hours or more during the week (n=1295). Nearly all SBHCs (99.7%, n=1295) are open during school hours, 60.8% (n=1285) are open to patients before school, and 73.1% (n=1284) are open after school. Additionally, 70.6% (n=1295) of SBHCs have a pre-arranged source of after-hours care for patients.

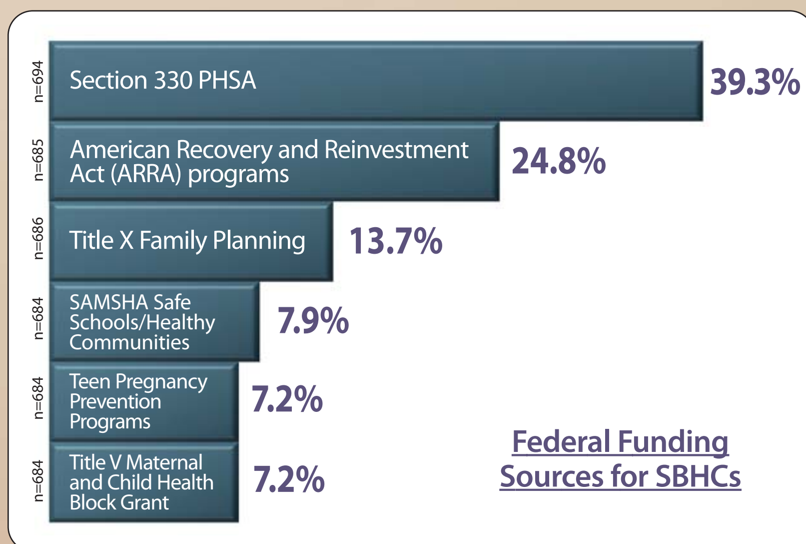
Health Information Technology (HIT)

HIT is an important tool for SBHC quality improvement, operations, and sustainability. More than half of SBHCs use electronic health/medical records (EHR/EMR) (52.7%, n=1297), up dramatically from 32% (n=1096) in 2007-2008. CHC-sponsored SBHCs are leading the way in adopting EHR/EMR in their centers with 80.9% (n=1275) currently using them.

EMR/EHR use among SBHCs has increased by 65% in three years.

Data show that 67.7% (n=1297) of SBHCs bill electronically, 39.1% (n=1297) use an electronic prescription medicine system, and 46.9% (n=1297) have a management information system in place. Twenty-three percent (n=1297) of SBHCs report using Clinical Fusion, a clinical management information system software program specifically developed for SBHC programs for clinical charting and data collection.

SBHC providers (36.4%, n=1258) report participating in the Centers for Medicare and Medicaid (CMS) EHR Incentive Program, a key program established under the HITECH Act that provides incentive payments for health care providers that meaningfully use EHR technology. The HITECH Act of 2009 set meaningful use of EHR in the health care system as a national goal to improve health care quality and efficiency. Although not reported here, the 2010-2011 Census collected data on SBHC ability to meet the Act's meaningful use standards. This data is available upon request.



Billing and Revenue

Effective billing practices continue to be a priority for SBHCs around the nation. Most SBHCs (87.9%, n=1272) report billing at least one insurance program. The majority of SBHCs bill a state Medicaid agency (81.6%, n=1309), Medicaid managed care organizations (71.4%, n=1311), Children's Health Insurance Program (CHIP) (63%, n=1307), and private insurance (64%, n=1310). Forty percent (n=1307) of SBHCs bill Tri-Care —the health care program that serves active duty, National Guard, Reserve, and retired military, their families, and survivors.

Managed care organizations (MCOs) play an important role in reimbursement opportunities for SBHCs with 47.3% (n=1282) of SBHCs reporting being recognized as primary care providers/preferred providers, a notable increase from the 2007-2008 Census.

Nearly 60% of SBHCs (58.2%, n=1291) report assisting patients to complete Medicaid or CHIP enrollment forms and 51.4% (n=1288) are considered facilitated enrollees for Medicaid or CHIP.

In addition to billing practices, SBHCs report revenue from sources including state governments (74.7%), the federal government (53.4%), private foundations (40.4%), school districts (33.1%), hospitals (32.6%), city/county governments (32.3%), managed care organizations/private insurers (27.4%), corporations/businesses (18.4%), NASBHC (6.6%), state network/associations (5.1%), and tribal governments (1.1%) (n=1286).

To expand their reach and services within the school, many SBHC staff — including nurse practitioners, physicians, health educators, and mental health providers — offer small group and classroom health promotion and outreach. In doing so, SBHCs help increase the number of students exposed to programs and activities that discourage potentially harmful behaviors including alcohol, tobacco, and drug abuse, and violence and bullying. These programs also serve to help promote healthy eating and active living. SBHCs excel at ensuring adolescents — a hard-to-reach population — have access to the services they need to stay on a path to success.

SBHCs provide comprehensive activities in the areas of alcohol, tobacco, and drug use prevention:

53.2% (n=1267) provide substance abuse counseling

9.6% (n=1381) have a trained alcohol and drug counselor on staff

The Census collected extensive data on a variety of prevention and early intervention activities provided by SBHC staff, a selection is highlighted here. Additional data are available upon request.

Injury and Violence Prevention Activities Provided by SBHCs

	Individuals	Small groups	Classroom/ school-wide
Sexual orientation/ gender identity differences n=1300	65.3%	20.2%	18.5%
Violence prevention/bullying and cyber-bullying prevention/weapon avoidance n=1300	82.5%	34.3%	34.8%
Sexual assault/rape prevention and counseling n=1300	76.2%	22.2%	20.2%
Intimate partner/teen dating violence prevention and counseling n=1300	75.8%	26.5%	22.7%
School safety/climate n=1299	76.1%	31.4%	30.1%

Alcohol, Tobacco, and Drug Use Prevention Activities Provided by SBHCs

n=1301	Individuals	Small groups	Classroom/ school-wide
Alcohol use	77.9%	30.5%	33.8%
Tobacco use	81.6%	31.0%	35.7%
Drug use	77.5%	29.7%	32.8%

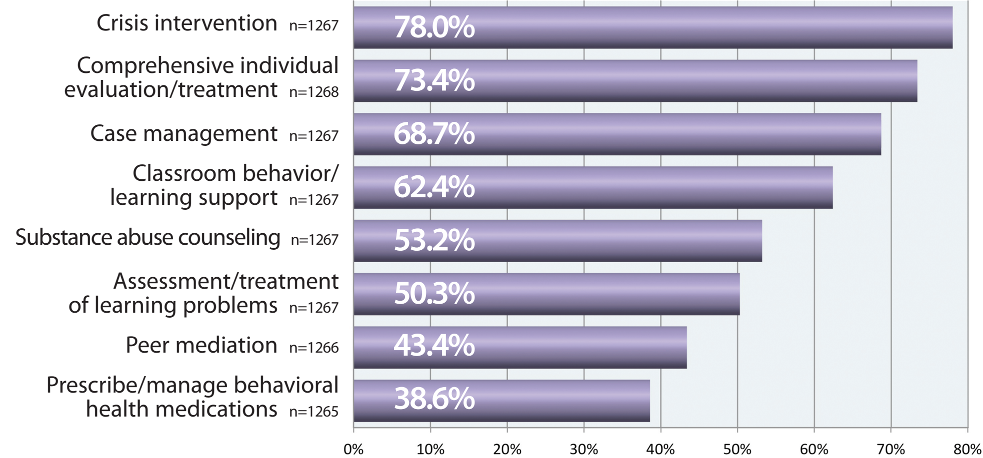
Healthy Eating and Active Living Promotion Activities Provided by SBHCs

	Individuals	Small groups	Classroom/ school-wide
Healthy eating/active living/weight management n=1300	90.1%	43.7%	37.3%
Chronic disease management (asthma, diabetes) n=1299	89.6%	27.1%	17.6%

MENTAL HEALTH SERVICES

SBHCs eliminate barriers to accessing mental health care among children and adolescents. In many SBHCs, primary care and mental health care staff work side-by-side to address students' physical and mental health needs. These complementary strengths may contribute to improving success in school and in life.

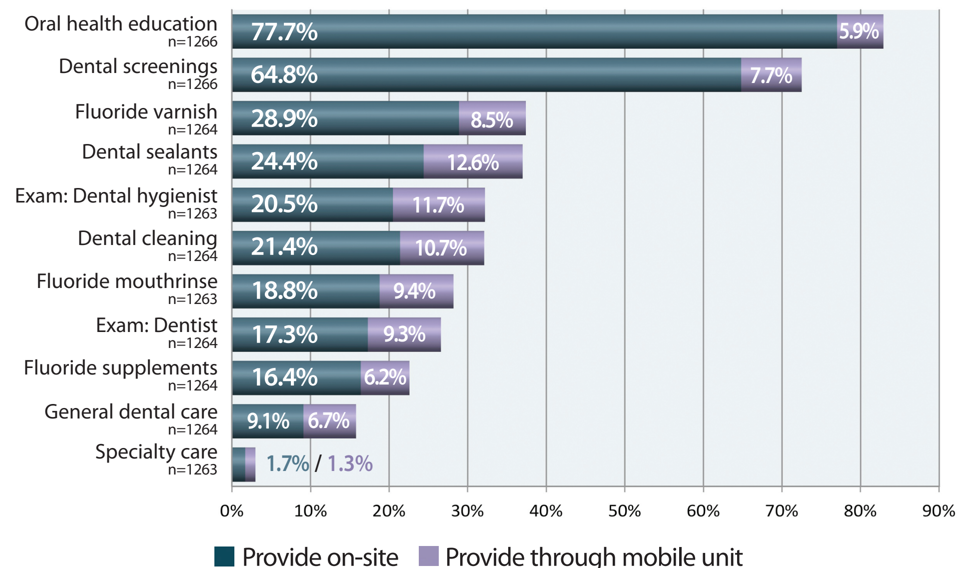
Nearly one thousand SBHCs have a mental health provider on staff. Their proximity to students and ability to provide mental health care in a safe, private, and confidential environment allow for the development of ongoing relationships between practitioner, patient, and family to support positive behavioral change.



ORAL HEALTH SERVICES

Access to oral health care services can contribute significantly to improving health among children and adolescents. SBHCs across the nation are adding and expanding oral health services both on-site and through mobile units. The table to the right shows that more than one-third (38.7%) of all SBHCs provide dental examinations by either a dentist or dental hygienist (n=1264). The majority of SBHCs provide oral health education (83.6%, n=1266) and dental screenings with or without an oral health provider (72.5%, n=1266).

The barriers to providing oral health services among SBHCs that do not have an oral health provider on staff include: cost (72.5%, n=1065), equipment (71.5%, n=1066), provider availability (71.4%, n=1067), space (68.6%, n=1066), and reimbursement (63.8%, n=1065).



Data show an emerging role for primary care providers to play in the assessment of oral health. The large majority of SBHC primary care providers provide guidance/referral (85.8%, n=1266), risk assessment (82.5%, n=1265), and 45.3%, (n=1265) also perform diagnosis.

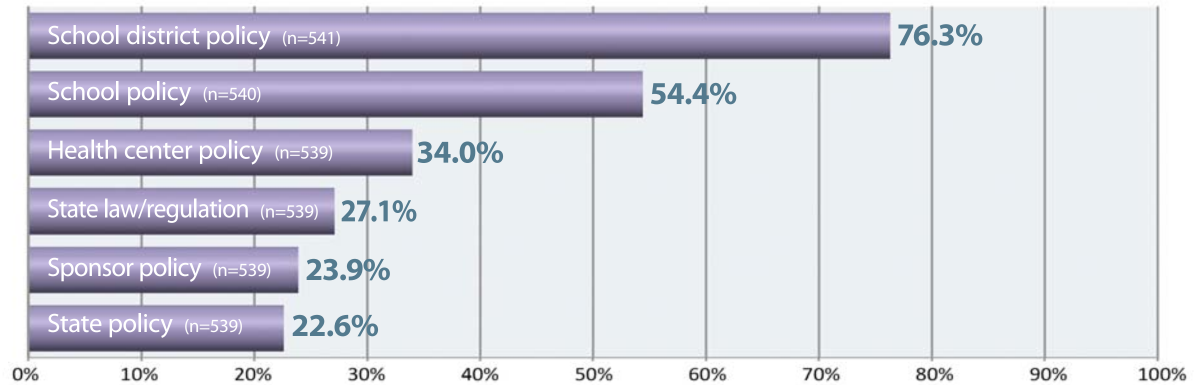
49.8% ***of SBHCs are prohibited from dispensing contraceptives***
n=1087

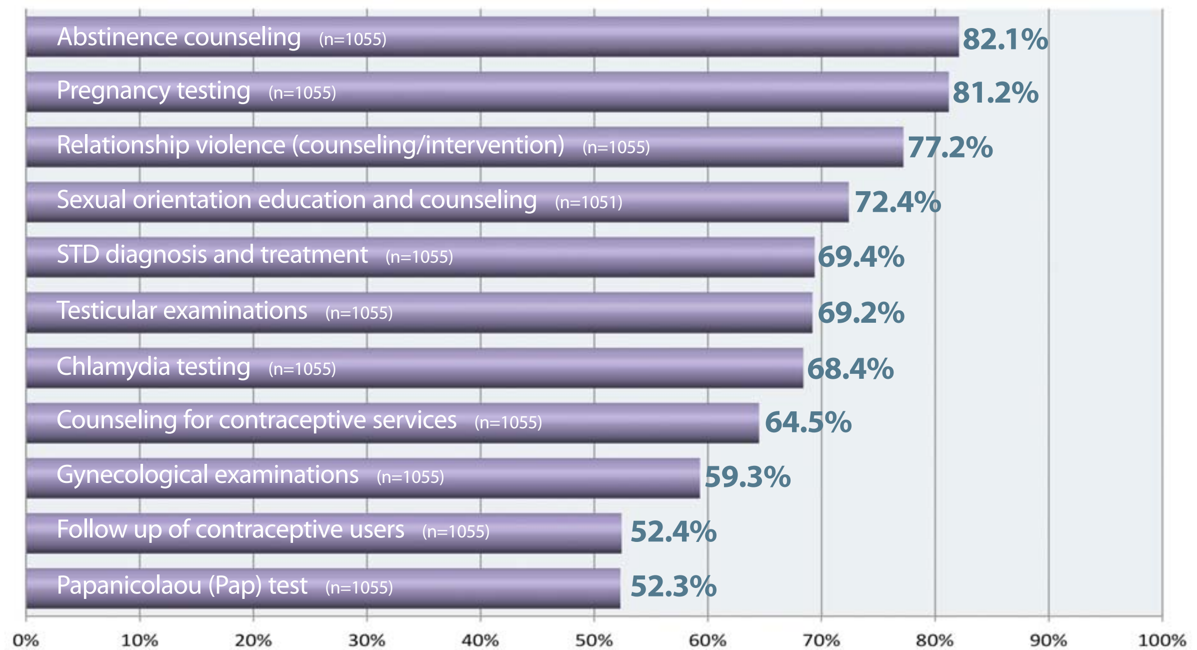
Reproductive Health Services Offered to Adolescents On-Site

The majority of SBHCs (n=1055) that serve middle and high school-aged students offer abstinence counseling (82.1%), provide on-site diagnosis and treatment for sexually-transmitted diseases (69.4%), and other diagnostic services such as pregnancy testing (81.2%). These services are provided with community support that is usually established during the SBHCs planning phase.

HIV Testing, Counseling, and Barriers

More than half of SBHCs report providing HIV testing (55.1%, n=1055) and HIV/AIDS counseling (59.8%, n=1054). Examples of barriers to providing HIV testing reported by SBHCs include: cost (22.7%, n=1046), transporting the specimen (21.1%, n=1046), and policies that prohibit testing (19.4%, n=1047).





PARENT INVOLVEMENT

SBHCs encourage parental involvement and work in concert with parents to advance quality practices, prevention, and early intervention, and to ensure school and student safety.

SBHCs (n=1301) report engaging parents in programs and activities to prevent tobacco use (23.6%), alcohol use (22.4%), and/or drug use (20.2%).

Nearly one-third of SBHCs (27.3%, n=1300) involve parents in programs and activities in the areas of healthy eating/active living/weight management and also in chronic disease management (asthma, diabetes) (24.2%, n=1299).

Parents are a part of programs designed to ensure school and student safety. SBHCs report that parents of adolescents participate in programs and activities in the areas of:

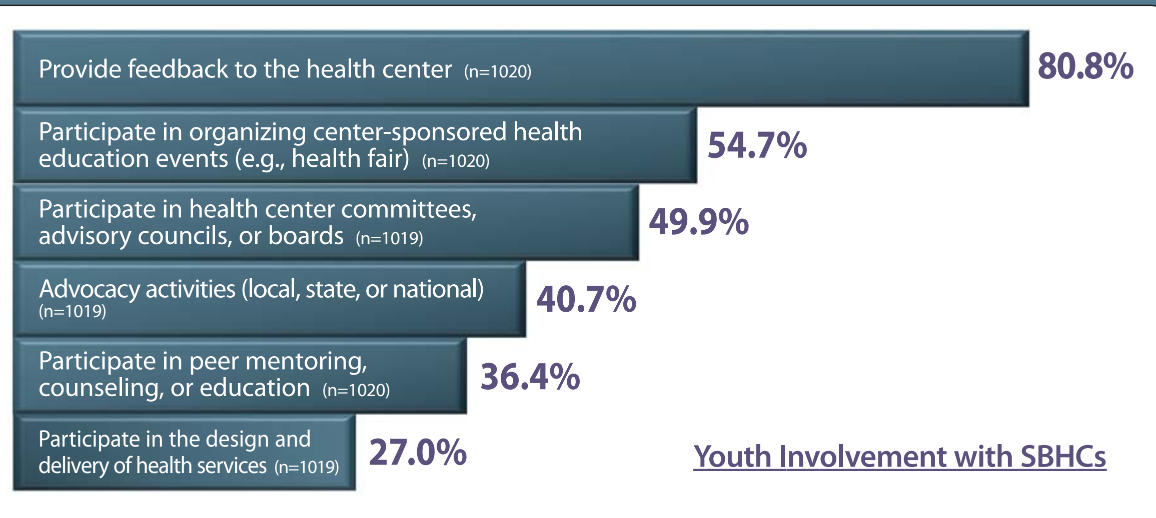
- Sexual orientation/gender identity differences (LGBTQ respect) (10.8%, n=1078)
- Violence prevention (e.g., bullying and cyber-bullying prevention, weapon avoidance) (22.4%, n=1078)
- Sexual assault/rape prevention and counseling (16.3%, n=1078)
- Intimate partner/teen dating violence prevention & counseling (16.0%, n=1078)
- School safety/climate (18.3%, n=1077)

Communication (n=1269) To help facilitate parental engagement and involvement, SBHCs rely on a variety of ways to communicate with parents. While the vast majority currently use written materials (92.0%) and the telephone (90.7%), SBHCs are beginning to incorporate social media as part of their communications channels with parents. Nearly half (49.3%) use the school website, 14.7% use Facebook or Twitter, and 16.1% utilize texting.

Parental Consent (n=1245) Sixty percent of SBHCs report that parents have the ability to restrict access to specific services.

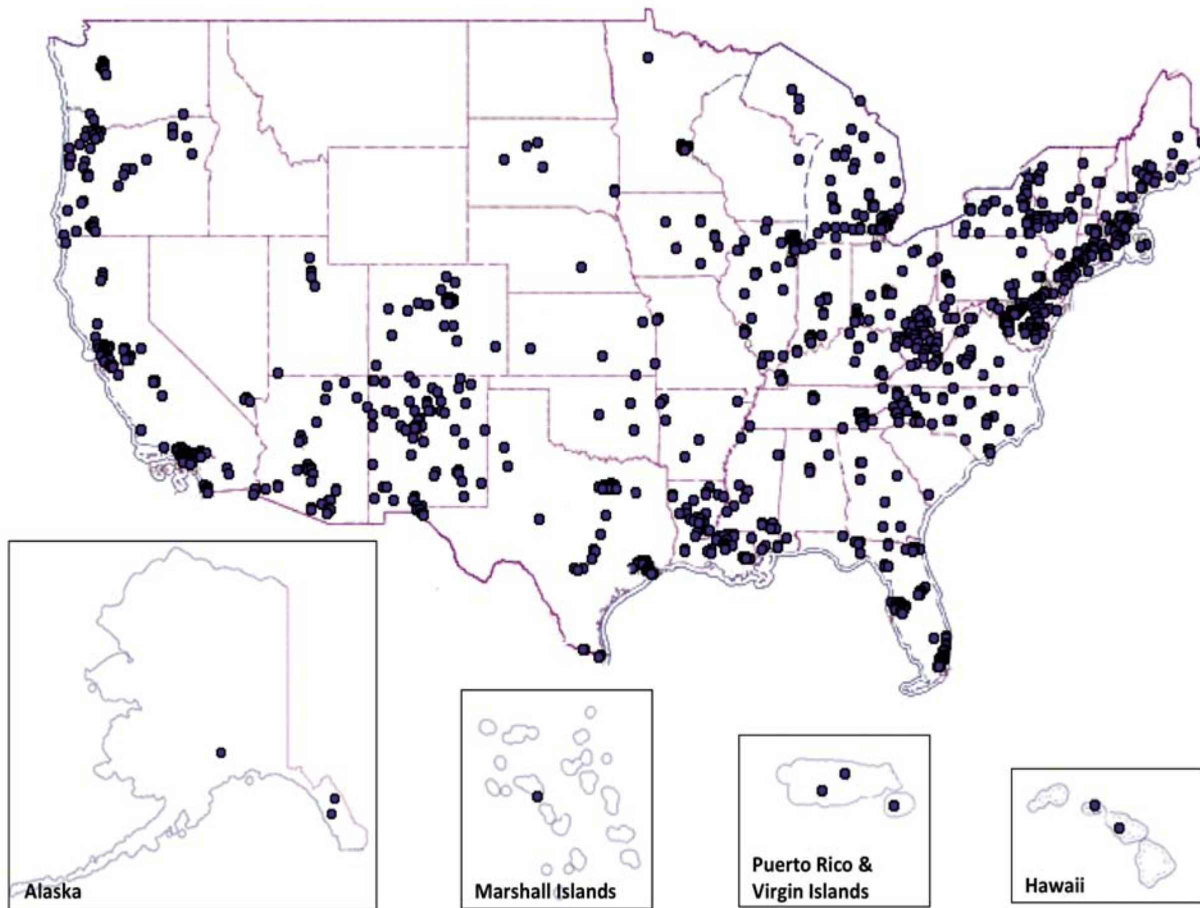
YOUTH INVOLVEMENT

Adolescents take ownership of their health care by involving themselves in a variety of SBHC activities and efforts. Data show that 80.8% (n=1020) provide feedback to the centers and nearly half (49.9%, n=1019) of SBHCs have adolescents serving as members of health center committees, advisory councils, or boards.



School-Based Health Centers • School Year 2010-2011

Locations of SBHCs Nationwide



State	Count	State	Count
Alabama	7	Missouri	4
Alaska	3	Nebraska	1
Arizona	47	Nevada	5
Arkansas	7	New Hampshire	1
California	172	New Jersey	24
Colorado	54	New Mexico	74
Connecticut	86	New York	231
Delaware	28	North Carolina	57
District of Columbia	6	Ohio	27
Florida	224	Oklahoma	3
Georgia	7	Oregon	61
Hawaii	3	Pennsylvania	31
Illinois	67	Puerto Rico	3
Indiana	31	Rhode Island	9
Iowa	18	South Carolina	1
Kansas	5	South Dakota	6
Kentucky	24	Tennessee	26
Louisiana	87	Texas	87
Maine	27	Utah	7
Marshall Islands	1	Vermont	5
Maryland	67	Virgin Islands	1
Massachusetts	56	Virginia	18
Michigan	90	Washington	19
Minnesota	20	West Virginia	64
Mississippi	27	Wisconsin	1

n=1930

***OUR MISSION* - To improve the health status of children and youth by advancing and advocating for school-based health care.**

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