CHAPTER 66

Best Practices for Designing and Developing School-Based Health Centers

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Getting Started

Call them school-based health centers, school clinics, or expanded school health services, they represent a relatively recent development in health care at school. In the past 30 years, in almost every state, a handful or more of communities have decided that their children and youth could benefit from the delivery of basic health care at or near school, and frequently the definition of basic care includes emotional and behavioral health services. Because school social workers often have a broad net of connections inside and outside the school, community, social workers may be asked to help plan or lead efforts to create new school-based health centers. This chapter describes important factors to consider during the planning and early implementation phases of such an initiative and suggests key issues to keep in mind as the project moves forward.

What We Know

Some Background

According to the most recent survey, there were about 1909 school clinics and programs across the country in 2007–2008. The centers were found in 46 states plus the District of Columbia, Puerto Rico, and the Virgin Islands (Figure 66.1). Four states did not have school-based health centers: Hawaii, Idaho, North Dakota, and Wyoming.

The centers are located in elementary schools (9.6%), elementary-middle schools (6.8%), middle schools (7.8%), high schools (33%), middle-high schools (4.9%), K–12 schools (17.3%%), and all other schools 20.3%. While the majority of centers are located in urban areas (56.7%), 16.1% are found in suburban areas, and 27.2% in rural communities (Strozer, Juszczak, & Ammerman, 2010).

What Is a School-Based Health Center?

School-based health centers share the following characteristics:

*They are located inside the school building or on the school campu*s. The 2007–2008 National Assembly census reported that 96% are located in the school building, while an additional 3% are located in a separate building on the school campus. As an early architect of school-based health centers, Philip J. Porter once said, "Health services need to be where students can trip over them. Adolescents do not carry appointment books, and school is the only place where they are required to spend time" (Center for Health and Health Care in Schools, 1993).

In most instances, the centers are sponsored by mainstream health organizations. Twenty-eight percent of the school-based centers are sponsored by community health centers, 25% by hospitals, and 15% by local health departments. School districts sponsor 12% of the centers, and the remaining 20% are supported by a mix of other local organizations including universities, mental health agencies, and nonprofits with a variety of purposes (Strozer et al., 2010).

The centers are staffed by licensed health professionals. Students receive care from multidisciplinary teams of professionals, each of whom can address a broad range of problems. A medical assistant supports a nurse practitioner or physician assistant. Mental health services are typically provided by a master's-level social worker. A part-time pediatrician or family practitioner

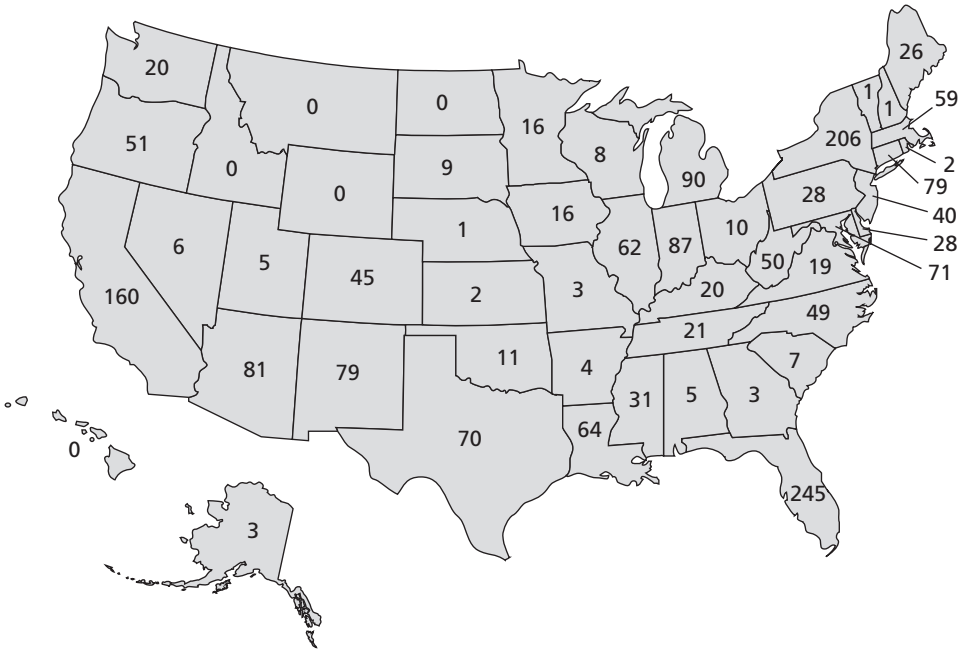

Figure 66.1 National Census School Year 2007–2008

Source: Strozer, J., Juszczak, L., & Ammerman, A. (2010). 2007 – 2008 National School-Based Health Care Census. Washington, DC: National Assembly on School-Based Health Care

and health educator may round out the core staff. Centers also may have a part-time nutritionist, dental hygienist, and substance abuse counselor, depending on the needs of students and the resources available in the community.

School-based health centers provide comprehensive services. From diagnosis and treatment of diseases to counseling for students and families, school-based health centers address a broad spectrum of health problems. The 2007–2008 NASBHC survey of 1226 centers found that leading physical health services included comprehensive health assessments (96.6%), treatment for acute illness (96.1%), prescriptions for medications (96.0%), screenings such as vision and hearing (92.7%), asthma treatment (94.6%), nutrition counseling (90.6%), and immunizations (85%). Mental health providers were employed at 74.6% of the school-based centers. Leading services included crisis intervention (96.2%), referrals (96.1%), mental health assessments (95.9%), screenings (95.4%), grief and loss therapy (94.9%), and brief therapeutic interventions (91.6%). Most centers also provide health promotion and risk reduction strategies and programs. In elementary schools these services include nutrition and fitness counseling (85.2%), injury prevention (78.9%), violence prevention (78.1%), resiliency and social skills building (71.9%), and tobacco prevention (58.6%) (Strozer et al., 2010).

School-based health centers build partnerships with parents. Typically, school-based health centers require written parental consent prior to accepting students as patients. School-based health centers also strive to get parents involved through parent newsletters, family communication seminars, and satisfaction surveys. Centers communicate with parents without compromising the confidential patient–provider relationship that teens desire and expect. Parents are immediately informed about their children's condition and treatment in life-threatening situations. While protecting teens' privacy, staff members also strongly encourage family communication.

School-based health centers build partnerships within their schools. Health centers organize open houses, attend faculty conferences, and conduct school-wide immunization campaigns. Health center staff members meet with principals, assistant principals, teachers, coaches, guidance,

and other pupil support personnel, as well as front-office staff. Health center personnel, who frequently are not school district employees, team up with the school's own health staff and with the academic and administrative staff to lead staff workshops on child and adolescent health, organize health fairs, and work in multiple ways to support the school community.

School-based health centers build partnerships with the community. To organize community support, health centers establish advisory councils of parents, students, health care providers, legislators, clergy, and community and business leaders. The councils advise on local needs, help develop health center policies, educate the community about child and adolescent health concerns, and educate local and state officials about the important role health centers have in working with families and communities to support healthy children and teens.

What We Can Do

First Steps

The starting point for a school-based health center may vary considerably from place to place. In some cases, it could be a response to a school crisis; in another, an opportunity may present itself in the form of a new grant program. A center may also be identified as the right response to a long-felt need, or result from the work of a community advocate who puts together the research, political, and funding pieces essential to launch a center. The remarkable thing is that those centers that do get started have a very good chance of surviving—despite ongoing financial and other challenges.

Centers that are well designed and that succeed address the following four questions.

1. *Is there an unmet need?* Documenting unmet need is essential to assure that the center will be busy, demonstrate its use to the community, and generate the funds required to sustain the center in the future. Information about student needs also provides a critical platform on which to build the service program. Limited budgets and space will require that choices be made among the types of providers to be hired, the services to be offered, and the skills or perspectives to be reflected in the staff. A solid needs analysis provides the information necessary to determine whether to move forward with a project and, if so, how to move forward. Needs assessment tools are available for use during this process (Center for Health and Health Care in Schools, 2009).
2. *What do key stakeholders think and how will they be involved in the program?* Establishing a school-based health center is a challenging task. As with other physical and mental health programs in schools, the health center bridges two complex worlds—education and health. Key figures from both must support the initiative. Conversations with school board members, parents, the superintendent, affected principals, influential school staff, and community-based health professionals are essential for understanding their interests and involving them in the ongoing development of the program. Both during the planning phase and after the new center is launched, some of the stakeholders will serve on the health center advisory committee. The advisory committee will be the ongoing political firewall for the health center. Because members will include representatives of elected officials, parents, teachers, and recognized children's advocates, the advisory committee will reflect the community in supporting the centers.
3. *Is space available?* Finding adequate space for a school-based health center can be both a practical and political challenge. Some communities are experiencing rapid growth, and the schools are crowded. A separate facility located on the school campus may be a necessary direction. As a matter of convenience and student safety, many health center veterans argue that the center should be centrally located inside the school—across from the cafeteria or positioned off another well-traveled corridor. First floor space is generally more desirable than upper floors. If a center is to be used by community members or at times when the school is not open, ideally the center will be directly accessible from the outside. In a school with space constraints, it may be difficult to find space not already occupied by others. While principals typically determine space arrangements, health center planners will want to do what they can to assure that their new space does not generate hostility among their school colleagues. That said, securing the school principal's commitment to specific space before a final selection is announced may be a wise course of action.

4. *Are there sufficient funds to support the center, for an initial 4-year time period?* Across the country, community leaders and health professionals have launched school-based health centers with funding from a variety of sources—public funds from city or county budgets, state grant dollars, private foundation grants, and in limited instances, funding from the federal community health center grant program. It is also possible for community organizations to pool resources, blending donated dollars, staffing, and other resources to provide the components of a school-based health center. While there is variety in the sources of funding, it is generally true that it requires several years to complete program design, start up initial operations, and get the center functioning on an even keel. The initial financial plan should ideally provide for 4 years of funding (Center for Health and Health Care in Schools, 2008).

School-Based Health Center Nuts and Bolts

Whether a school-based health center is just starting up or fine-tuning a long-established program, the core components of a successful program include a memorandum of understanding (or memorandum of agreement) between the school district and sponsor of the school-based health center, alignment of health services with students' unmet health needs, staffing to provide the services, a management and training structure, and a realistic budget.

A *memorandum of understanding (MOU)* helps define the mutual responsibilities of the school-based health center and the school or school district. From the perspective of the center, it is important that the school commit to providing space, heat, light, and power as an in-kind contribution. The school may also provide the Internet connection, telephone lines, janitorial services, and/or support for some staff members. For its part, the school may want to clarify the operating hours of the center, who will use the center, and the conditions under which the center may be used. Questions the MOU could answer include: Will teachers be served at the center? Will all students be permitted to use the center? What will be the hours of service, and under what conditions may a student be excused from class to visit the center? Procedures to be used in working out day-to-day problems can also be established in an MOU.

Health services and staffing are central to the success of a school-based health center. The initial determination of student problems that have not been addressed by services in the community lays the groundwork for setting service priorities. If the primary concerns of students attending a local high school are mental health and substance abuse, then it makes sense that the initial hires or service contracts would be in those two arenas. If an elementary school serves a significant number of recent immigrant families, it would be likely that service and staffing decisions would reflect this important aspect of the community. In the main, school-based health centers are staffed with nurse practitioners who can diagnose and treat diseases and clinically trained social workers to screen, assess for, and treat mental and behavioral health problems. A mix of other full- or part-time staff completes the clinic team. They include physicians, nutritionists, nurses, health educators, and health aides. Many schools host at least some health professionals and health educators—either on staff, under contract, or available through volunteer arrangements full- or part-time. Schools, particularly those in large urban school districts, may have an array of health providers. These include school nurses, mental health professionals, substance abuse counselors, and health educators. Who these people are and whether their services are full-time or part-time will have been established during the planning process. Making certain that the school-based health center complements rather than duplicates existing services is vital.

The management and training structure for a school-based health center should take into account that the center is located off-site from its institutional home. From a management perspective, a school-based health center is generally too small to justify a full-time management position. Even if a center operates within a multisite program of four or more centers, the manager will split her or his time among the sites, often maintaining an office at the sponsoring institution. Typically this means that at any one location, day-to-day center management is handled by a senior clinician, either the nurse practitioner or the mental health professional. In addition to providing clinical services, this person assures that clinic policies and protocols are observed, that records are maintained in accord with sponsor policies, and that relationships with school staff and the center advisory committee are attended to. The school-based health center program manager, who provides the interface between the

sponsoring institution and the health center, is typically responsible for preparation of annual budgets, tracking revenues and expenses, and conducting long-term planning for the financial future of the organization. This person also tends to the center's important external relationships with parents, the advisory committee, the school board, and any other community leaders with a particular interest in the center.

From a clinical practice and training perspective, there are several implications for offering health services in a location other than within the sponsoring institution. First, the persons who are selected to be the school-based health professionals, whether they are nurse practitioners, nutritionists, clinical social workers, or nurses, will preferably have several years of experience in their own fields. To practice in a satellite facility means to be distant from seasoned professionals and less likely to have easy consults close at hand. Putting inexperienced providers in a school setting deprives them of the opportunity to practice their new skills with the guidance of easily accessible senior staff. A benefit of health center sponsorship by a mainstream health care organization is that these sponsoring organizations frequently maintain a rich array of clinical training opportunities that help the health center staff keep their skills sharp as well as build relationships within the sponsoring organization. Typically these organizations will require that health center staff participate in training on a regular basis.

Persistent Issues

Two issues that are critical in the development of school-based health centers are politics and financing. They must be carefully monitored by health center leaders and advisors.

Politics

When the term *politics* is raised in connection with school-based health centers, the first words likely to occur to the reader are "teen pregnancy" or some other hot-button issue. While proposed school-based health centers may trigger a debate on teen sexuality and whether or how the centers should respond to this matter, in many communities the questions may center on cost, who is in charge, and the role of parents. Whatever the questions raised, however, developing and maintaining a school-based health center requires ongoing attention to political issues at many levels.

At the local level, within the school building, there are critical relationships to be established and maintained with other health professionals, teachers, counselors, and the administrative staff. Long-time school building staff can be a resource for understanding the school's culture and the most effective way to work with students. Outside the school building, within the superintendent's office, the school board, the county commission, the mayor's office, or in the community at large, the health center must cultivate supporters who understand the work of the center and will advocate on its behalf. When seeking support, whether from voters or from local or national elected officials, the most important advocates for the health center will be the students, their parents, and representatives of the community, in that order. Professionals who draw their paycheck from the health center cannot be as persuasive as those who use and value the service.

Strategies to build relationships with state officials and federal representatives include assuring that local representatives have visited the center, have seen firsthand the support it has within the community, and understand what must be done in the state capital or in Washington to sustain the centers. In some states, school-based health centers have benefited from partnering with child advocacy organizations in the state capital. Currently, 19 states have active school-based health center associations (see Box 66.1). The National Assembly on School-Based Health Care is also a good place to learn how to pursue these relationships. Because relationships are built over a period of time, the time to begin is when the project begins.

Financing—Making Sure There Is a Tomorrow

There is no easy road to financing school-based health centers. The very reason they fill a critical need is that they care for children and adolescents who are uninsured, are enrolled in Medicaid or CHIP programs, or need services such as early mental health interventions that are not reimbursed or are reimbursed with difficulty. Thus, the justification for a school-based health center has within it the seeds of ongoing financial struggle. In some states, such as New York, the Medicaid program treats school-based health centers equitably, and the challenge is less. In other states, where

Box 66.1 State SBHC Associations

Arizona	Massachusetts
California	Michigan
Colorado	New Mexico
Connecticut	New York
Florida	North Carolina
Illinois	Ohio
Kentucky	Oregon
Louisiana	Texas
Maine	West Virginia
Maryland	

Medicaid reimbursement rates do not cover the cost of providing care, the challenge is profound.

Studies of school-based health center funding have found that there is a wide range of costs for individual school-based health centers depending on whether the host school is located in a high, medium, or low-cost community and whether the health center offers limited or a full range of services. A report from the state of Oregon reported that SBHC costs for a 9-month year during school year 2006–2007 ranged from $41,000 to $311,250 (Nystrom & Prata, 2008). While individual centers might be primarily funded by a state grant or by city or county resources, studies have found that most centers draw support from a wide range of both public and private resources, grants, and individual insurance reimbursements.

The past 25 years of rapid growth in school-based health centers suggest the following lessons about financing school-based health centers:

- It will always be hard work. Frequently the patients are uninsured or poorly insured. Moreover, the centers often provide important services such as family counseling or teacher consultations that are not covered by health insurance.
- In close-knit, smaller communities such as Wayne County (see below), it is possible to build an extraordinary school-based program using a combination of contributed resources and volunteer professionals. However, these contributions require continued outreach to build the relationships that are the foundation for community giving.
- In complex, urban environments, school-based health center resources may be more conventional: local tax dollars, state and federal grants, as well as United Ways and other private philanthropy.
- Private philanthropy and public dollars may be available to help support SBHCs even if they do not bear the specific title "school-based health center grant program." Funds targeted on children's health services, new immigrant communities, prevention programs, health care for the uninsured, programs to prevent alcohol and substance abuse and teen pregnancy, and initiatives to build school–community partnerships are all potential resources.

Tools and Practice Examples

WISH—Wayne Initiative for School Health

Twenty years ago, Wayne County, North Carolina, had one school nurse to provide professional health services to the 20, 000 students enrolled in this rural school district some 60 miles east of Raleigh. David Tayloe, the head of the largest local pediatrics group in the county, noted that he and his colleagues rarely saw children after they entered the fourth or fifth grade. Concerned about this absence of care, as well as high rates of teen pregnancy and other problems among the community's adolescents, the pediatrician met with officials from a local hospital, the school system, and the health department to discuss how the community might organize an effective response. With the incentive of a grant program available from the Robert Wood Johnson Foundation, this group submitted an application, was successful, and opened centers in two county middle schools. Over the next 8 years, this group of community representatives became an independent nonprofit collaborative named the Wayne Initiative for School Health (WISH) and began building a school-based health center network for middle and high schools in the county. By 2012, the total number of clinics had grown to 12, four middle schools and two high schools.

In 1996 when the Wayne County school health collaboration was getting started, state data identified middle school children as having the least access to health care. Parent surveys told them that parents worried about getting basic care for their children, wanted more teen pregnancy

prevention, and needed greater access to children's mental health services. Barriers to care were identified as the difficulty the parents experienced in getting time off from work to take their children to the doctor and their lack of health insurance due to high cost. That parents of Wayne County truly wanted their children to have more access to health care has been demonstrated by ongoing high rates of student enrollment in the health centers. At each of the five schools, more than 85% of the children are enrolled in the centers. All students receiving services in the health centers must have a signed parental consent form on file, and parents must come to the center *in person* to enroll their child. These high enrollment rates have continued into 2011.

When the first two centers opened, they provided acute and chronic health services, mental health care, health education, nutrition education, immunizations, and physical examinations. This basic service package has been maintained. A clinic director and medical director oversee the operation of the centers. Each health center has a full-time registered nurse and aide. A group of health educators, mental health counselors, and dietitians rotate among the schools. Mental health professionals, including licensed clinical social workers, are private practice clinicians who sign MOUs with WISH and commit to a specific number of days at the health centers. These MOUs specify that the clinicians must see all students, regardless of insurance status. Clinicians are compensated by insurance payments for Medicaid and privately insured patients.

Funding for the centers remains a challenging but cooperative effort. The school system designed and built generous-sized health center offices that include a waiting room, an enclosed business and registration area, at least two exam rooms, and a room for group health education and other activities. School custodians help keep the clinic clean. The partner agencies contribute staffing and supplies. The students contribute pocket change to the "WISHing Well" and raise more than $1,000 annually to support the center. Reimbursement for patient services is received for students enrolled in public or private health insurance plans. The four health centers that meet stringent credentialing criteria established by the state are permitted to see Medicaid-enrolled children without securing prior approval from the children's medical homes. In 2010, Blue Cross Blue Shield of North Carolina (BCBSNC) began reimbursing school-based office visits, screenings, and vaccinations for students aged 5–17 who are covered by a BCBSNC plan. The insurer intends to evaluate additional school-based health centers for inclusion in its provider network (Komives, 2010).

Program performance from a community perspective is monitored through multiple satisfaction surveys. Parents, teachers, and students are all surveyed for their views on whether the school-based health centers are meeting their needs.

Denver Health School-Based Health Center Program

Denver Health's school-based health center program celebrates its 25th anniversary in 2012. Like the Wayne Initiative for School Health, Denver's first two school-based health centers also started with a grant from the Robert Wood Johnson Foundation—but 10 years earlier, in 1987. Under the leadership of the Denver Children's Hospital, the program launched clinics in Lincoln and East high schools with full-time nurse practitioners and master's-prepared mental health professionals at all sites. In contrast to Wayne County, many of these students had community-based health providers to whom they turned for annual physical exams and routine medical services. A study conducted after 10 years of operation, however, documented that when students were concerned about confidentiality, they were more likely to use the school-based health centers. As the study report noted, the school-based health centers were the students' primary source of mental health care and reproductive health services. The centers appeared to be the *only* source for substance abuse interventions and treatment. The Denver school-based health centers on average enroll 92% of the students at their schools.

As grant funds diminished, Denver Health, the city's safety-net provider that included a 400-bed hospital, the public health department, and a network of community health centers, assumed responsibility for the school-based health centers. Because Denver Health receives substantial state funding for care to uninsured and low-income people in Colorado and because Denver Health, as a federally qualified health center, is entitled to receive cost-based reimbursement for care provided to Medicaid beneficiaries, the organization

has a stronger financial base with which to support the school health centers.

With the transfer of program sponsorship, the network of centers began to expand. As of 2011, there were school-based health centers operating in four middle, two middle-high, and seven high schools. Almost 9,000 students receive services through the clinics annually. The health centers provide basic medical care, health education, and mental health care. School health center team members include advanced care providers (nurse practitioners, physician assistants, and physicians), medical assistants, mental health providers, health education specialists, insurance outreach workers, and Denver Public Schools school nurses (Denver Health, 2011).

In addition to routine clinical care, health center staffers organize a variety of programs for students, including immunization initiatives, insurance outreach and enrollment, vision and hearing screening, preventive oral health screening, asthma management, and case management of sexually active and pregnant teens.

Even with a solid financial base, Denver Health commits significant time to securing funding for its centers. Funding comes from diverse sources, including state and federal grants, patient care revenues, and key private funders such as the Colorado Health Foundation. Similarly critical in-kind contributions come from the Denver Public Schools, the Mental Health Corporation of Denver, St. Anthony's Hospital, and Arapahoe House substance abuse programs.

Key Points to Remember

The melding of primary care, mental health, and health education in one location within a school building has proven a powerful model for addressing the health needs of children but a challenging model to fund. The simplest part of starting a school-based health center will be organizing the clinical practice, arranging the staffing, and securing adequate space. The biggest job will be developing both a strong political base of support and building a network of potential donors. The first steps in that direction will include organizing stakeholders at the school building, school district, community, and state levels and making the personal connections and collaborative relationships that result in a team of people committed to the long-term success of the center.

Resources

Individuals and communities seeking to develop school-based health centers will find these organizations and Web sites of considerable help:

1. The National Assembly on School-Based Health Care (NASBHC), the national advocacy organization for school-based health centers, maintains a Web site, www.nasbhc.org, with how-to guides on starting a center. NASBHC is a critical resource for guidance in developing stakeholder networks and making the school-based health center case to local, state, and federal policymakers.
2. The 19 state school-based health center organizations (see the Box 66.1) have developed Web sites and resources that offer state-specific information.
3. The Center for Health and Health Care in Schools (CHHCS) located at the School of Public Health and Health Services at the George Washington University Medical Center also sponsors a Web site, www.healthinschools.org, with current information on funding resources, as well as extensive materials on school-based health services, school-based health centers, school-based mental health services, and school-based oral health care.

References

Center for Health and Health Care in Schools. (1993). *The answer is at school*. The George Washington University Medical Center.

Center for Health and Health Care in Schools (2008). *Financing options*. Retrieved July 15, 2011, from http://www.healthinschools.org/Consulting/Colorado-Health-Foundation-Consulting.aspx

Center for Health and Health Care in Schools. (2009). *Financing options for school-based health centers.* Retrieved July 15, 2011, from http://www.healthinschools.org/~/media/Colorado%20Health%20Foundation%20Final%20Products/TCHF_Final_Financing_Options_3_09.ashx

Center for Health and Health Care in Schools. (2009). *School-based health care initiative readiness assessment*. Retrieved July 14, 2011, from http://www.health-inschools.org/~/media/Colorado%20Health%20Foundation%20Final%20Products/Readiness_Assessment_100609_with_Appendix.ashx

Denver Health. (2011). *Denver school-based health centers annual report 2009–2010.* Retrieved July 17, 2011, from http://denverhealth.org/LinkClick.aspx?fileticket=H9a4H0jORDA%3d&tabid=178&mid=8081

Gomives, G. (2010). *Letter to the editor. N C Med J., 71*, 598.

Nystrom, R. J., & Prata, A. (2008). Planning and sustaining a school-based health center: Cost and revenue findings from Oregon. *Public Health Reports, 123*(6), 751–760.

Strozer, J., Juszczak, L., & Ammerman, A. (2010). *2007–2008 National school-based health care census.* Washington, DC: National Assembly on School-Based Health Care. Retrieved July 13, 2011, from http://www.nasbhc.org/site/c.jsJPKWPFJrH/b.2716675/k.9D3E/EQ_National_Data.htm

Video corresponding to this chapter can be found at http://www.oup.com/us/schoolsourcebook

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