Governor's Advisory Workgroup on School-Based Health Centers

EXECUTIVE SUMMARY

FULL REPORT AND RECOMMENDATIONS

Funded by
The California HealthCare Foundation,
The California Endowment and
The California Wellness Foundation

Workgroup Report and Process Facilitated and Prepared by
Bobbie Wunsch, Pacific Health Consulting Group
and Catherine Teare
July 2007

GOVERNOR'S ADVISORY WORKGROUP ON SCHOOL-BASED HEALTH CENTERS

MEMBERS

Lupe Alonzo-Diaz	Latino Coalition for a Healthy California
Roberta Bavin	Clovis Unified School District
Suzanne Bostwick	Los Angeles County Health Department
Charity Bracy	California Children's Hospital Association
Cathy Bray	Los Angeles County Office of Education
Alex Briscoe	Alameda County Health Care Services Agency
Kerry Brown	Blue Cross of California
Elisabeth Chicoine	Roseland Children's Health Center
Serena Clayton	California School Health Centers Association
John DiCecco	Los Angeles Unified School District
Lisa Folberg	California Medical Association
Harold Goldstein	Center for Public Health Advocacy
Martin Gonzalez	California School Boards Association
Margaret Hoyos	California Teachers Association
Adama Iwu	California Association of Physician Groups
Laura Jeffries	Association of California School Administrators
Abbe Land	The Los Angeles Free Clinic
Ted Lempert	Children Now
Christine Noguera	Golden Valley Health Centers
Susie Phillips	California Association of Nurse Practitioners
Cory Sanfilippo	California State Parent Teacher Association
Richard Seidman, MD	LA Care Health Plan
Vergia Slade	Health Net of California
Liz Snow	California Dental Association
Nancy Spradling	California School Nurses Organization
Kristen Golden Testa	The Children’s Partnership
Francesca Wright	Cities Counties and Schools Partnership
Kimberly Wyard	Northeast Valley Health Corporation

FUNDERS

Cecilia Echeverria	The California Endowment
Leonard Finocchio	California HealthCare Foundation
Ruth Holton-Hodson	The California Wellness Foundation
Robert Phillips	The California Endowment

STATE AND LEGISLATIVE STAFF

Peggy Agron	California Department of Health Services
Denise Arend	Managed Risk Medical Insurance Board
Qiana Charles	Office of Senator Mark Ridley-Thomas
Ken DaRosa	California Department of Finance, Health and Human Services Unit
Linda Davis-Alldritt	California Department of Education, School Health Connections/Healthy Start Office
Lara Flynn	Office of Assembly Member Mary Hayashi
Ed Hanson	California Department of Finance, Education Services Unit
Bruce Lee	California Department of Finance
Camile Maben	Office of the Secretary for Education
Vincent Marchand	Office of Senator Mark Ridley-Thomas
Amanda Martin	California Department of Finance, Health and Human Services Unit
Cathy McBride	California Department of Education
Rene Mollow	California Department of Health Care Services
David Monti	California Department of Alcohol & Drug Programs
Jeannie Oropeza	California Department of Finance, Education Services Unit
Jennifer Rousseve	California Department of Education
Bob Sands	California Health and Human Services Agency

Governor's Advisory Workgroup on School-Based Health Centers

REPORT AND RECOMMENDATIONS

Executive Summary

Governor Arnold Schwarzenegger, at his Summit on Health Care Affordability in July 2006, announced his intention to develop a plan to establish 500 new school-based health centers (SBHCs) at elementary schools. The proposal reflects the Governor's interest in using California's public schools as community centers, and the recognition of SBHCs as an "efficient and effective way to provide critical health services."

The proposed expansion of elementary SBHCs is closely linked to the Governor's Health Care Reform proposal. That proposal has three "essential building blocks:" 1) prevention, health promotion and wellness; 2) coverage for all Californians; and 3) affordability and cost containment.

School-based health centers, which pride themselves on working with children in the contexts of their schools, families and neighborhoods, fit squarely into the Governor's prevention and wellness efforts. SBHCs will be affected by the health care reform proposal to insure all children in California. Elementary SBHCs can play a key role in enrolling children in health insurance and linking them to care. Universal coverage will also mean significant change for SBHCs, some of which have been developed specifically to serve children *without* private or public health insurance.

Historically, the state of California has not played a significant role in the development or sustenance of SBHCs. They are most often local creations, initiated by individual schools, school districts, community health centers, counties or groups of dedicated parents and community members. California currently has approximately 150 SBHCs, and about one third of these are at elementary schools, according to the California School Health Centers Association. The approximately 50 elementary SBHCs in California are located in just 25 of the state's 1,000 school districts, which in total have more than 5,600 elementary schools. Half of all elementary SBHCs are located in Los Angeles County. The Governor's Advisory Workgroup defined SBHCs as health centers that provide health services to students directly on school campuses, at off-site facilities that are linked to one or more schools, or in mobile vans that serve multiple campuses. As the breadth of that definition suggests, SBHCs in California are notable for their diversity.

In late May 2007, key stakeholders were invited by the Governor's Office, the California Health and Human Services Agency, and the Office of the Secretary of

Education to serve on the Advisory Workgroup to the Governor's School-Based Health Center Initiative. Advisory Workgroup members were chosen to reflect a wide variety of experiences and points of view. Some work directly with SBHCs as administrators, providers, or advocates, while others represent providers (community clinics, children's hospitals, nurse practitioners, dentists), county health departments, the education community (school districts, county offices of education, school boards, teachers, school nurses, PTAs), insurers and health plans, children's health advocates, state agencies and departments, legislative offices, and philanthropy.

The Advisory Workgroup process received generous support from the California HealthCare Foundation, The California Endowment, and The California Wellness Foundation. Bobbie Wunsch of Pacific Health Consulting Group and Catherine Teare were engaged to facilitate the process and prepare a report on its outcomes, in conjunction with staff from the Governor's Office, the California Health and Human Services Agency and the Office of the Secretary of Education.

The Advisory Workgroup was charged with developing recommendations for the expansion of elementary SBHCs in California, in the context of health care reform and its three main goals: prevention, health promotion, and wellness; coverage for all California children; and affordability and cost containment. Specifically, the Advisory Workgroup was asked to focus on five areas of key importance to the Governor's Initiative:

- Roles - What are the roles of elementary school-based health centers in the context of universal health coverage?

- Outcomes - What do we want elementary school centers to achieve? What data do we need to ensure that they meet those outcomes?

- Program standards - How do we want these centers to operate?

- Partnerships - How can we ensure participation and support from parents, schools and local communities?

- Financing - How can we build funding models that are realistic and sustainable?

Recommendations of the Advisory Workgroup

These recommendations were developed collaboratively by the Governor's Advisory Workgroup on School-Based Health Centers on June 25 and 26, 2007 and express the agreement of the group.

The Governor's Advisory Workgroup on School-Based Health Centers finds that school-based health centers (SBHCs) provide a variety of health services to students directly on school campuses, at off-site facilities that are linked to one or more schools, or in mobile vans that serve multiple campuses; that SBHCs should be collaborations of community and school stakeholders in order to best meet the health, health care, cultural and linguistic needs of local communities; and that SBHCs will vary in their design and function from community to community and school to school.

In order to expand and sustain elementary SBHCs in the context of health care reform and universal coverage for children, the Governor's Advisory Workgroup on School-Based Health Centers recommends consideration of the following strategies:

1. The Advisory Workgroup recommends that elementary SBHCs fulfill the following roles:

    - provide medical, dental, vision and mental health education, anticipatory guidance, screening and assessment, referral, and case management.

    - increase access to primary care by serving as a primary care or medical home, or providing services that extend and complement a student's primary care home, including promoting communication with the child's primary care provider in order to avoid duplication and lack of continuity.

    - facilitate outreach, enrollment and retention in health insurance coverage programs for the school community.

    - respond to identified school and community needs by integrating the direct services of the SBHC with school-wide and community-wide prevention and youth development activities.

    - provide all services in coordination with other school and school district personnel and parents.

    - support schools in improving academic outcomes for students by facilitating school attendance and full access to the educational program.

2. The Advisory Workgroup recommends that the California Health and Human Services Agency, in collaboration the California Department of Education, create a grant program to expand the number of elementary SBHCs. The program should begin with planning grants for new SBHCs or expansion of existing SBHCs, and should phase in support for ongoing operations.

    - The Advisory Workgroup recommends that funding target communities that demonstrate high levels of health disparities as well as unmet medical, mental health, dental and vision needs.

    - The Advisory Workgroup recommends that funding be contingent upon a community-based planning process that 1) involves school administrators, school district personnel, school board members, school health providers, parents, teachers, students, county and/or city health officials, community organizations, community clinics and SBHCs in the target area, and local community providers and health plans; 2) includes an assessment of local health data, community assets and barriers; and 3) coordinates with other local, county and regional children's health improvement efforts.

3. The Advisory Workgroup recommends that the California Health and Human Services Agency, in collaboration with the California Department of Education, establish program standards for elementary SBHCs:

    - requiring the SBHC, the school district and the school site to execute a contract or memorandum of understanding describing the relationship, roles and responsibilities of all parties to ensure, promote and sustain the health and wellness of students in the school community.

    - defining a minimum level of service that addresses medical, dental, vision, and mental health education, screening and assessment, and referral and other prevention and health promotion activities.

    - describing additional primary care service components, including medical, dental, vision, and mental health services.

    - governing elementary SBHCs in the areas of decision-making authority, relationships with the school administration and school board, privacy and confidentiality, and data collection, reporting and exchange, among others.

4. The Advisory Workgroup recommends that the California Health and Human Services Agency explore how non-clinical prevention and wellness services provided by SBHCs and other school health providers can be funded in keeping with the goals of the Governor's Health Care Reform Proposal.

5. The Advisory Workgroup recommends that the California Health and Human Services Agency assist SBHCs in 1) participating in electronic enrollment gateways for the purpose of ensuring that children enroll and retain health coverage in the most efficient manner possible and 2) exchanging health information electronically for the purposes of improving access to coordinated care and reducing duplication, while ensuring individual and family privacy.

6. The Advisory Workgroup recommends that the California Health and Human Services Agency and the Managed Risk Medical Insurance Board promote coordination and communication between elementary SBHCs and managed care plans and primary care providers in order to promote comprehensive, coordinated care, facilitate provider collaboration, assure appropriate utilization of health resources and avoid duplication of services.

7. The Advisory Workgroup recommends that the California Health and Human Services Agency and the Managed Risk Medical Insurance Board develop incentives for managed care organizations and insurers to contract with and reimburse SBHCs, as primary care providers or as convenient, family-friendly providers for certain essential covered services.

8. The Advisory Workgroup recommends that the California Health and Human Services Agency, in collaboration with the California Department of Education, develop outcome measures for elementary SBHCs that follow the program standards and align with the roles of elementary SBHCs. These measures should, at minimum, address the areas of health insurance coverage, preventive health care, wellness, and chronic disease.

9. The Advisory Workgroup recommends that the California Health and Human Services Agency and the California Department of Education implement the Public School Health Center Support Program created by AB 2560 in order to ensure the continued operation of elementary SBHCs and assure alignment with the goals of health care reform.

10. The Advisory Workgroup recommends that there be ongoing stakeholder involvement in all aspects of the development and implementation of the Governor's SBHC Initiative.

Governor's Advisory Workgroup on School-Based Health Centers

REPORT AND RECOMMENDATIONS

Introduction

Governor Arnold Schwarzenegger, at his Summit on Health Care Affordability in July 2006, announced his intention to develop a plan to establish 500 new school-based health centers (SBHCs) at elementary schools. The proposal reflects the Governor's interest in using California's public schools as community centers, and the recognition of SBHCs as an "efficient and effective way to provide critical health services."[1]

In October 2006, as a follow-up to the Summit, approximately 30 stakeholders joined a strategy meeting convened by the Governor's Office and the California Health and Human Services Agency. Participants in that meeting heard presentations on elementary SBHCs in California and on SBHC activities in other states, and discussed barriers to SBHC expansion. In the months that followed, the Governor's Health Care Reform Team held individual discussions to receive input on the SBHC proposal. These efforts culminated in the formation of the Governor's Advisory Workgroup on School-Based Health Centers.

The Advisory Workgroup process received generous support from the California HealthCare Foundation, The California Endowment, and The California Wellness Foundation. The California HealthCare Foundation also commissioned a paper on elementary SBHCs in California from Julia Graham Lear, Director of The Center for Health and Health Care in Schools at The George Washington University, a draft of which was made available to the Advisory Workgroup in June 2007. Bobbie Wunsch of Pacific Health Consulting Group and Catherine Teare were engaged to facilitate the process and prepare a report on its outcomes, in conjunction with staff from the Governor's Office, the California Health and Human Services Agency and the Office of the Secretary of Education.

Elementary School-Based Health Centers and Health Care Reform

The proposed expansion of elementary SBHCs is closely linked to the Governor's Health Care Reform proposal. That proposal has three "essential building blocks:" 1) prevention, health promotion and wellness; 2) coverage for all Californians; and 3) affordability and cost containment.

[1] Office of the Governor, State of California, *White Paper: School-Based Health Centers* (n.d., distributed in July 2006)

According to the White Paper on School-Based Health Centers released in conjunction with the Summit on Health Care Affordability, SBHCs' goals are "to prevent children from getting sick, promote overall health and well-being, enhance the delivery of primary and preventative services and improve attendance and performance at school."[2] SBHCs, which pride themselves on working with children in the contexts of their schools, families and neighborhoods, fit squarely into the Governor's prevention and wellness efforts.

The Governor's health care reform proposal would provide comprehensive health care insurance – including coverage for medical, mental health, and dental needs – for all children in the state with incomes up to 300% FPL, regardless of residency status. Children in families with higher income would have access to insurance under the proposal's guaranteed issue policy. Under the Governor's proposal, children from families with income under 100% of the Federal Poverty Level (FPL) will be entitled to insurance through Medi-Cal, while children with incomes between 100 and 300% FPL will be insured through the Healthy Families Program. The majority, but not all, of newly-insured children will be enrolled in managed care plans (all children in Healthy Families and children in Medi-Cal in counties with Medi-Cal managed care). Health care reform proposals from California's legislative leadership also include major coverage expansions for children.

SBHCs will be affected by the health care reform proposal to insure all children in California. Elementary SBHCs can play a key role in enrolling children in health insurance and linking them to care. Universal coverage will also mean significant change for SBHCs, some of which have been developed specifically to serve children *without* private or public health insurance.

Historically, California has not played a significant role in the development or sustenance of SBHCs. They are most often local creations, initiated by individual schools, school districts, community health centers, counties or groups of dedicated parents and community members. The passage of AB 2560 (Ridley-Thomas) in 2006, in combination with the Governor's Initiative, marks a change in the environment for SBHCs in California. AB 2560 creates a Public School Health Center Support Program to be administered jointly by the California Department of Public Health and the California Department of Education. The Support Program is charged with helping SBHCs conduct Medi-Cal and Healthy Families outreach; providing technical assistance to the centers; identifying funding sources; convening a public advisory committee, and reporting to the legislature on the program's progress. The legislation did not include funding for the Support Program.

In 2007, Senator Ridley-Thomas has introduced SB 564, which establishes a school health center grant program to be administered by the Public School Health Center Support Program; outlines eligibility criteria for those seeking funds; creates grants to support planning, facilities and start-up operations,

[2] Id.

and/or the expansion of school health center services; and provides resources for technical assistance and evaluation to support the expansion.

Elementary School-Based Health Centers in California

California currently has approximately 150 SBHCs, and about one third of these are at elementary schools, according to the California School Health Centers Association. This count is approximate, as there is neither a formal definition of an SBHC nor a central registry. The approximately 50 elementary SBHCs in California are located in just 25 of the state's 1,000 school districts, which in total have more than 5,600 elementary schools. Half of all elementary SBHCs are located in Los Angeles County.

The Governor's Advisory Workgroup defined SBHCs as health centers that provide health services to students directly on school campuses, at off-site facilities that are linked to one or more schools, or in mobile vans that serve multiple campuses. As the breadth of that definition suggests, SBHCs in California are notable for their diversity.

Elementary SBHCs have in common a focus on accessibility and reaching children where they are. Their services strive to be family-friendly and convenient, and emphasize cultural and linguistic competency. California's elementary SBHCs are available to all students in the school regardless of their ability to pay, though in most cases these SBHCs provide direct services to only some of the student population. Typically, elementary SBHCs have multi-disciplinary staffing and provide their services through direct one-on-one encounters with patients, but also through contact with parents, activities in the classroom, and work with the entire school community.

California's elementary SBHCs vary in their sponsorship, staffing, and services. Approximately one-half of all elementary SBHCs in California are sponsored by school districts, and another 25% are sponsored by community clinics that are designated as Federally Qualified Health Centers (FQHCs). Hospitals and medical centers sponsor about 15% of the state's elementary SBHCs, and a smaller number are linked to non-profit organizations, non-FQHC community clinics, physicians' groups and county health departments.[3]

Elementary SBHCs in California range from large clinics that treat students, their siblings and their parents and can provide comprehensive primary care and act as medical homes, to mobile vans that visit schools on a rotating basis to provide specialized services like dental screenings and treatment. Some SBHCs see themselves as comprehensive care providers; others provide more limited services, such as immunizations and well-child care. Data are not available for California elementary SBHCs in particular, but among all SBHCs in California 86% provide primary care, while nearly half (47%) offer mental health services

[3] Unpublished data from California School Health Centers Association.

and 18% provide dental care.[4] On a national level, 60% of elementary SBHCs provide primary care and mental health services, and 40% provide only primary care.

The services provided at California elementary SBHCs often include:

- prevention, health promotion and wellness services, including outreach, enrollment, and retention of students into health insurance programs; health education in the classroom or on campus; nutrition and fitness programs; parent education; violence and injury prevention programs; health assessments and screening; and public health surveillance and crisis response;
- primary health care, including physical examinations, immunizations, and other preventive medical services; diagnosis and treatment of minor injuries and acute medical conditions; management of chronic medical conditions; basic laboratory tests; referrals to and follow-up for specialty care; vision and hearing screening; and nutrition services;
- mental health services, including coordination with school personnel and other community providers at the school site to conduct outreach, identify students with potential mental health concerns, and provide advocacy, referrals and case management; supporting medical providers in screening for mental health needs; providing mental health assessments, crisis intervention, counseling, treatment, and referral; and coordinating services with county mental health departments and other agencies that provide mental health or related services in the school; and
- oral health services, including school-wide oral health education; supporting medical providers in screening for oral health needs, providing oral health education, providing fluoride varnish, and making referrals to community dentists; bringing dental providers to the school health center to provide oral health education, assessments, fluoride varnish and sealants; establishing dental facilities, including mobile and portable operations, at the school health center and offering preventive and treatment services provided by dentists.

[4] California School Health Centers Association, *An Overview of California's School Health Centers* (n.d.)

The Governor's Advisory Workgroup on School-Based Health Centers

In late May 2007, key stakeholders were invited by the Governor's Office, the California Health and Human Services Agency, and the Office of the Secretary of Education to serve on the Advisory Workgroup to the Governor's School-Based Health Center Initiative. Advisory Workgroup members were chosen to reflect a wide variety of experiences and points of view. Some work directly with SBHCs as administrators, providers, or advocates, while others represent providers (community clinics, children's hospitals, nurse practitioners, dentists), county health departments, the education community (school districts, county offices of education, school boards, teachers, school nurses, PTAs), insurers and health plans, children's health advocates, state agencies and departments, legislative offices, and philanthropy.

The Advisory Workgroup was charged with developing recommendations for the expansion of elementary SBHCs in California, in the context of health care reform and its three main goals: prevention, health promotion, and wellness; coverage for all California children; and affordability and cost containment. Specifically, the Advisory Workgroup was asked to focus on five areas of key importance to the Governor's Initiative:

- Roles - What are the roles of elementary school-based health centers in the context of universal health coverage?

- Outcomes - What do we want elementary school centers to achieve? What data do we need to ensure that they meet those outcomes?

- Program standards - How do we want these centers to operate?

- Partnerships - How can we ensure participation and support from parents, schools and local communities?

- Financing - How can we build funding models that are realistic and sustainable?

The Governor's Advisory Workgroup met over the course of three days in June 2007. An introductory meeting of the Advisory Workgroup was held on June 5, 2007 in Sacramento to introduce the Workgroup's process and explain its context and goals. In addition, Elisabeth Chicoine, MS, PNP, Director, Roseland Children's Health Center, Santa Rosa and Kimberly Uyeda, MD, MPH, Director, Student Medical Services, Los Angeles Unified School District gave presentations on their elementary school-based health centers.

The majority of the Advisory Workgroup's efforts took place in an intensive two-day session on June 25 and 26, 2007, also in Sacramento. That meeting, attended by approximately 40 individuals, included large-group discussions of elementary SBHCs' roles and outcomes, and smaller-group discussions of

program standards, partnerships, and financing on the first day. On the second day, participants worked in small and large groups to draft and discuss recommendations in the five issue areas. The Governor's Office was represented at the two-day meeting by Herb Schultz, Senior Health Policy Advisor to the Governor; the California Health and Human Services Agency by Secretary Kim Belshé and Assistant Secretary Bob Sands, and the Office of the Secretary of Education by Secretary David Long, Ph.D. and Chief of Staff Camille Maben. Staff from the office of Senator Mark Ridley-Thomas also participated.

This report represents the discussion of the Advisory Workgroup at the meetings on June 25 and 26 and the recommendations that resulted from that discussion. Each of the five discussion sections that follow – roles, outcomes, program standards, partnerships, and financing – gives some factual background on the current state of California's elementary SBHCs related to the issue, and then summarizes key points of discussion on the topic. Significant differences of opinion that arose in Advisory Workgroup discussions are also noted. The discussion sections are followed by recommendations that emerged from the meeting. The process was designed to achieve general agreement and the recommendations reflect the overall view of the Advisory Workgroup. Following the two-day meeting, the draft report and recommendations were sent to all Advisory Workgroup members for review and feedback. Almost all (95%) of the Advisory Workgroup members submitted comments on the draft report and recommendations, and those comments are reflected here.

Discussion of Key Issues for Elementary School-Based Health Centers in Health Care Reform

1. Roles of School-Based Health Centers in Context of Health Reform and Universal Coverage

Elementary SBHCs play unique and critical roles in providing health care to California children. Those roles vary from site to site, driven by the needs of the school community. Health care reform, including universal coverage for children, offers elementary SBHCs the opportunity to expand their roles.

Prevention, Health Promotion and Wellness

Prevention, health promotion and wellness are centerpieces of the Governor's Health Care Reform plan. By structuring benefits and providing incentives, the Governor hopes to encourage the adoption of healthy behaviors by all Californians. The prevention plan also includes a focus on the prevention and treatment of diabetes, and reversing current obesity trends. Elementary SBHCs have an opportunity to expand their role in individual, school- and community-wide prevention and health promotion activities in the service of these goals. Elementary SBHCs are well-positioned to identify and respond to health problems that are prevalent in their school communities, including asthma and obesity, in collaboration with other entities such as school district wellness committees and community collaboratives.

Elementary SBHCs currently engage in a range of prevention and wellness activities. Many of these efforts are with individual patients: screenings, immunizations, health education and guidance for children and families, and asthma and diabetes management. A smaller number of elementary SBHCs are involved in or lead school- or community-wide prevention and wellness activities, for example by providing classroom health education, offering parenting education classes, or coordinating efforts with the school food programs, or working with community efforts such as diabetes prevention and treatment programs or environmental coalitions. The Roseland Children's Center in Santa Rosa described how that SBHC had discovered that a large number of its patients suffered from iron deficiency anemia, and in response initiated a primary anemia prevention project in partnership with the local food bank, WIC program and county health department. The rate of young children with iron deficiency anemia has declined from nearly 30% in 2000 to less than 10% today.

Some Advisory Workgroup participants expressed concern about adopting a broad definition of elementary SBHCs' role in prevention, health promotion and wellness, given the lack of funding to support this role. Since many prevention and wellness activities are not currently reimbursable by third-party payors, an expanded prevention role for elementary SBHCs would require new sources of funding.

Coverage for all California Children

The Governor's proposal to make health insurance coverage available to all children in the state, regardless of income or residency status, both creates opportunities for elementary SBHCs to expand their role in linking children to insurance, and changes the context in which elementary SBHCs work.

Elementary SBHCs' Role in Linking Children to Insurance

Most elementary SBHCs in California are located in schools and communities with many low-income families and high rates of uninsurance – 84% of children in elementary schools with SBHCs are eligible for the free and reduced price lunch program. SBHCs provide outreach activities to identify uninsured students and educate their families about health coverage options. Some of these outreach activities include:

- Educating students and their families on health insurance options, the healthcare system, the importance of preventive care, and health issues and risks through one-on-one education, classroom presentations, and at school events such as assemblies or health fairs.
- Informing teachers and other school staff about health insurance options so they can educate and refer students and their families.
- Determining student insurance status and health care needs.
- Implementing Express Lane Eligibility through the school lunch program.
- Training parents or students to conduct outreach and education.

Some elementary SBHCs provide direct, individualized enrollment assistance in conjunction with Certified Application Assistants (CAAs) or county eligibility workers. Those SBHCs that are Child Health and Disability Prevention program (CHDP) providers can enroll low-income uninsured children directly in temporary Medi-Cal through the CHDP Gateway at the time of health screening visits.

Universal coverage for children will open up new options for insurance for many SBHC clients and other students. SBHCs are uniquely positioned to conduct outreach and enrollment because they are located at schools and often have contact with families when they are actively seeking health care. However, outreach and enrollment entail complex and time-consuming tasks that are often not eligible for reimbursement, though CAAs are paid for direct enrollment services. If SBHCs are to be central players in outreach and enrollment efforts at a school, they will need to maximize these direct enrollment fees, but may also need additional funds to support their work. Currently, the state provides outreach and enrollment funds through Outreach, Enrollment, Retention and Utilization (OERU) grants to counties, and in some counties school enrollment campaigns are part of these efforts. SBHCs could expand their outreach and enrollment work by joining these efforts at a county level.

Elementary SBHCs' Role in Linking Children to Primary Care Providers

The Advisory Group agreed that children should have care from a medical home, defined by the American Academy of Pediatrics as care that is accessible, continuous, comprehensive, family centered, coordinated, compassionate, and culturally competent, and delivered or directed by well-trained physicians who provide primary care and help to manage and facilitate all aspects of pediatric care.[5]

Some elementary SBHCs can serve as a medical home, providing 24-hour coverage for comprehensive medical services on a year-round basis, even when the school or health center is closed. Many, though not all, of these SBHCs are sponsored by community clinics or hospitals, and may qualify to participate as primary care providers (PCPs) in public and private managed care plans. Some families may choose the SBHC as their child's PCP; others may not.

Other SBHCs, however, do not qualify as PCPs and cannot fulfill the requirements of the medical home concept, because their hours, staffing, or services are too limited. The services of these SBHCs supplement those provided by the medical home, and linkage to the medical home or PCP is a critical part of their work. In all cases, the goal is that patient care be coordinated and not duplicative.

Linkage activities may include:

- Educating families about the managed care system including the role of the PCP and the need for referrals to specialists.
- Assisting families in selecting a PCP (if enrolling in managed care).
- Scheduling a first appointment. Families who speak limited English or have not had experience with the health care system may need assistance navigating voice mail systems and scheduling procedures.
- Resolving access barriers such as transportation, language, fear, or confidentiality.
- Providing referral and case management to ensure that students and families are connected to health care and other services in the community.
- Transferring information or medical records to the PCP or other provider, either as matter of information or when follow-up care is needed.

Elementary SBHCs often experience significant barriers in referring and connecting patients to their PCPs in the community. Linkage activities are unpaid, and can be extremely labor-intensive. Many students, and their parents, may not know who their PCP is, or even that they have one. Some elementary SBHCs reported that communication with their patients' community-based providers is difficult to achieve, limiting their ability to coordinate care. Community

[5] American Academy of Pediatrics, Medical Home Initiatives for Children With Special Needs Project Advisory Committee, "Policy Statement: The Medical Home," *Pediatrics* 110(1), pp. 184-186 (2002).

providers likewise express frustration, saying that they often have no information about the care that their patients receive from SBHCs, and are also concerned about duplication of care.

As a practical matter, some children are enrolled with PCPs who do not meet the definition of a medical home. They may, for example, be located far from the family's home and thus not be accessible, or may not be linguistically or culturally competent or family-friendly. Elementary SBHCs often report that even though their own care is not comprehensive, they are the closest thing to a medical home that some children have. While the SBHCs still work to contact children's PCPs and keep them informed of care provided, they may never succeed in communicating directly with the PCP. Even when they do, the child's family may be unable to access these providers.

Despite these barriers, members of the Advisory Workgroup voiced the importance of elementary SBHCs' roles in linking children to insurance and to their PCPs and supported the concept of the medical home, particularly in a context in which every child is eligible for insurance. Telemedicine applications were mentioned as a potential strategy for SBHCs to connect with children's community providers, as well as with other resources. Elementary SBHCs will require support – financial, technical, and policy – to expand their roles in this sphere and connect children to coverage and to necessary and appropriate services in the community.

Elementary SBHCs' Role in Direct Services in the Context of Universal Coverage for Children

Currently, many SBHCs define their roles primarily as the delivery of direct health care services to individual children and, sometimes, families. Under health care reform, SBHCs' role in the direct provision of health care services could take many forms. In addition to the school- and community-wide prevention, health promotion and wellness activities discussed above, the Advisory Workgroup was encouraged to define those services which could best be provided at schools, or for which the school setting provided a key advantage.

The Advisory Workgroup was in agreement that the exact package of health services provided at an elementary SBHC will and should vary depending on characteristics of the elementary SBHC itself, the school community and the surrounding community. For example:

- Community clinic-operated SBHCs might serve as the PCP for all children in a family, contract with managed care plans and provide comprehensive services in a medical home model.
- Mobile dental vans, though they provide only limited services, might be able to ameliorate a shortage of dental providers who accept Denti-Cal in a community.

- A school-district sponsored SBHC that does not provide comprehensive services might do school-wide asthma screenings and provide education and referral to children at high risk.

The precise impact of universal coverage of children in California was debated. Some Advisory Workgroup members believed that the elementary SBHCs' roles would be significantly changed when all children are covered, with referral to community resources becoming more important and direct provision of primary care services less relevant. In this view, to the extent that SBHCs provide individual health care services, these should supplement the care provided by the PCP or medical home. Other participants stated that even when every child has an insurance card, SBHCs will still be some children's only provider of health care, due to access barriers in the community. Concerns were also expressed about the existing system's capacity, in some geographic areas, to serve all the newly-insured children. This concern supports important roles for SBHCs in expanding provider capacity by serving as PCPs themselves, and through participation in training programs to increase the number and diversity of health professionals. The Advisory Workgroup agreed that elementary SBHCs' accessibility and convenience, family-friendliness and cultural competence will assure their continued importance in an environment of universal coverage, regardless of the exact scope of services offered and the nature of the relationship to community providers.

Affordability and Cost Containment

Research on elementary SBHCs' role in containing health care costs is limited. Several research studies have demonstrated SBHCs' ability to contain costs by reducing the use of high-cost services. In one study of an elementary SBHC, for example, children enrolled in the program had lower emergency department expenses and higher preventive care expenses than children with no access to an SBHC, for an overall savings that the authors deemed likely to accrue to the state's Medicaid program.[6]

The Advisory Workgroup spent less time discussing elementary SBHCs' role in affordability and cost containment than on the impact of other aspects of health care reform, but did cite the fact that the early intervention and preventive services that elementary SBHCs provide have repeatedly been shown to pay dividends. For example, school-wide wellness programs may lower the incidence of obesity and its related health consequences. Dental screening, education, varnish and sealant programs, alone or combined with remedial treatment programs, have been shown to arrest the progress of dental caries, thus saving money and provider time. SBHCs also have an important role to play in the early recognition of and intervention in mental illness.

[6] Adams EK and Johnson V, "An Elementary School-Based Health Clinic: Can It Reduce Medicaid Costs?" *Pediatrics* 2000; 105:780-788.

Academic Performance

The role of elementary SBHCs in promoting children's school readiness and academic performance was a major topic of discussion at the Advisory Workgroup meeting.

While much evidence does exist connecting children's health status and their academic performance, the research on SBHCs' influence on academic performance, like that on cost containment, is relatively limited. Some research studies have shown positive effects from SBHCs on children's school attendance, promotions to the next grade, and disciplinary problems. While most of these studies involved older children, some have been done at the elementary level, and the strongest findings from these studies concern SBHCs' impact on school attendance. For example, a New York City study comparing management of children with asthma at schools with SBHCs and schools without them found that not only were emergency room visits for asthma cut approximately in half at schools with SBHCs, school attendance was increased by 3 days for children at these schools.[7]

The Advisory Workgroup generally agreed that elementary SBHCs have a role in promoting children's readiness to learn, and that their interventions have an educational purpose as well as a health and wellness one. Vision, hearing and dental problems, asthma, poor nutrition and mental health difficulties all have direct and well-documented effects on school performance, and elementary SBHCs work to ameliorate these problems. Providing a convenient source of health care allows students to minimize the amount of class time missed for medical appointments or due to illness. Elementary SBHCs can also play an important role, in conjunction with school personnel, in managing students' chronic medical conditions, and in the development and implementation of Individualized Education Plans (IEPs) for students in special education.

The Advisory Workgroup discussed the difficulties inherent in demonstrating the positive impact of elementary SBHCs on academic outcomes. While no one in the Advisory Workgroup disputed the importance of a child's health status and readiness to learn and academic performance, the Workgroup raised concerns about how to demonstrate the impact of SBHCs on student academic performance on a local, school by school basis.

[7] Webber MP et al., "Burden of Asthma in Inner-city Elementary Schoolchildren," *Archives of Pediatric and Adolescent Medicine 2003; 157:125-129.*

2. Outcomes for Elementary School-Based Health Centers

If elementary SBHCs are going to play critical roles in children's health in the context of health care reform and universal coverage for children, then they will need to demonstrate that their activities result in positive outcomes for the children and families they serve. The Advisory Workgroup discussed outcomes and evaluation at length.

Over the 30-year history of SBHCs in the United States, numerous evaluations of their impact on child and adolescent health outcomes have been conducted. Broadly, SBHCs have been shown in a number of carefully designed studies to influence children's health status and use of health systems in a positive way. For example, research has demonstrated increases in health care visits by students who have access to SBHCs compared to those who do not, and has shown that students are more likely to go to a SBHC than to a community facility for mental health services. Studies have also shown reductions in inappropriate emergency utilization and hospitalization. As discussed in the previous section, several studies have attributed lower Medicaid expenditures to this reduced use of high-cost services by students who use SBHCs. Most research on SBHCs has been conducted in high-school settings, though a smaller number of studies have found these outcomes in elementary SBHCs.

Elementary SBHCs typically provide direct services to only some of the students in the schools where they are located. While some evaluations have looked at health outcomes of SBHC patients, others have evaluated impacts on the school community as a whole. Both types of evaluations may be relevant, though an expanded role for elementary SBHCs in school- and community-wide prevention and health promotion activities argues for evaluating at least some outcomes school-wide.

A related discussion focused on whether evaluation efforts should compare schools with SBHCs to schools without, looking, for example, at immunization or attendance rates. Some participants noted that the concentration of SBHCs in schools where students often begin with relatively lower health status may bias these evaluations against finding evidence of SBHCs' effectiveness, though this concern could perhaps be addressed through careful research design. Others said that outcomes measurement requires an evaluation of relative performance, and that evidence of a competitive advantage (against other schools, or against health plans) is critical to making the case for SBHCs.

Some participants suggested instead that outcomes be measured against numerical benchmarks: 90% of children in a school with an SBHC should receive a dental screening by the end of their first grade year, or 95% of children in a school should have health insurance and/or identify a medical home on their school registration card, for example. There was consensus that final decisions on outcome measures should be set in concert with the development of program standards.

The Advisory Workgroup noted a number of barriers to evaluating outcomes of SBHCs. True outcome-based research is typically very expensive, and it is difficult to rule out other causes for any particular health outcome. However, given the proven impact of certain preventive services on child health outcomes, it may in some cases be sufficient to measure delivery of those services, and Healthy People 2010 goals provide good benchmarks for preventive health outcomes. In addition, different SBHC models may require different forms of data collection and evaluation. The Advisory Workgroup suggested that core statewide outcome measures be kept simple, with individual communities given the latitude to evaluate additional outcomes.

Evaluation of SBHCs' impact on educational outcomes is controversial. While some stakeholders encourage more research into the relationship between SBHCs and academic outcomes, others argue that SBHCs are designed to affect health status, and should not be held responsible for academic performance.[8] Some Advisory Workgroup members held that isolating the impact of the SBHC among all other influences on an entire school was sufficiently difficult that it would leave SBHCs vulnerable to charges of not meeting their goals. These concerns notwithstanding, the Advisory Workgroup found that such outcomes as school attendance and vision, hearing and dental screening results were important in evaluating elementary SBHCs' success in preparing children to learn. By demonstrating a connection to the educational process, SBHCs potentially could mobilize additional support from teachers, school administrators, parents, and other community members.

On a practical level, participants favored using existing data sets to evaluate SBHC outcomes, where possible. For example, SBHCs that contract with managed health care plans will already be included in the plans' annual Healthcare Effectiveness Data and Information Set (HEDIS) surveys, which measure health plans' performance. When children enrolled in those plans receive services from non-contracted SBHCs, however, service data will not be available to the plan. Managed care organizations may be able to improve their HEDIS scores if they can access service data from all SBHCs. Immunization registries and first-grade physicals are valuable sources of data already in use, and California Student Information Services (CSIS), which includes important health information and uses a privacy-protected unique student identifier, might also be used to measure outcomes. Finally, qualitative evaluation methods such as student and parent surveys are important for program improvement and as a tool to demonstrate support for SBHCs.

[8] National Assembly on School-Based Health Care, *School-Based Health Centers and Academic Performance: What is the Intersection? April 2004 Meeting Proceedings* (January 2005)

3. Program Standards for Elementary School-Based Health Centers

Unlike the majority of states with significant numbers of SBHCs, California currently has no statewide policy or program standards for SBHCs. Discussion at the Advisory Workgroup meeting returned several times to the question of program standards and formal definition of elementary SBHCs, with a strong consensus emerging that the scope of the Governor's Initiative on SBHCs required the state to develop program standards for elementary SBHCs, and that program standards should flow from identified roles and desired outcomes.

The states that have developed program standards to guide health center operations have often done so in conjunction with the development of direct state funding programs (which exist in 20 states and Washington, DC). Although in many states SBHCs were originally established on an *ad hoc* basis, a number of states have subsequently created formal standards for existing and new SBHCs that are used as a basis for funding decisions, as a benchmark for evaluation, and as a quality improvement tool. [9]

The Advisory Workgroup discussed the importance of establishing program standards in the following areas.

Target population: Whom should California's new elementary SBHCs serve?
Governance: Does the SBHC have a governance system that specifies decision-making authority and accountability structures, and defines the relationship with the school administration and school board?
Sponsoring agencies: What are the fiscal, legal and other requirements for sponsorship?
Facilities: What standards must facilities meet?
Scope of services: Should all SBHCs provide a core set of services? Should the state define different levels of SBHC services? How should community need be assessed in defining the scope of services for a given SBHC?
Staffing: What types of professional staff are necessary? What qualifications do SBHC staff have? What staffing ratios are necessary?
Access and referrals: What are the SBHC's hours? What happens when the SBHC is closed?
Cultural and linguistic competency: What are the requirements for services in different languages? How does the SBHC demonstrate cultural competency to serve the school community?
Medical home: How does the SBHC communicate with patients' medical homes and/or primary care providers? When is information exchanged and how is confidentiality maintained? What is the SBHC's role and what are the procedures when the SBHC identifies a need for a specialist referral?

[9] Julia Graham Lear, PhD, MA, *School Health Centers in California: Building on the Past; Learning from Experience* (commissioned by the California HealthCare Foundation, forthcoming July 2007)

Managed care: What contractual relationship is required, if any, between SBHCs and managed care organizations that contract with public insurance programs?
Consent and confidentiality: What legal guidelines regarding consent and confidentiality apply, and what policies must SBHCs have in place to conform to these laws? What processes for informing parents and seeking consent are used? How does the SBHC meet the requirements of HIPAA and FERPA?
Medical records: How are medical records collected, stored and accessed? Under what circumstances can medical information be shared with other providers?
Data collection and reporting: What patient information is collected, and how is it used? What access does the SBHC have to school databases?
Technological capacity: What role should health information technology and health information exchange play in SBHCs and what capacity for HIT should SBHCs demonstrate?
Fiscal management: What fiscal standards must SBHCs meet and what information must they report? How is oversight provided?
Evaluation: Who evaluates the SBHC, how often and what are the consequences? Are there statewide benchmarks for performance?
Relationship to other school services: How does the SBHC refer children to other school or school district services such as special education or language services? Is a protocol in place for referrals to the SBHC by school faculty and staff?

Program standards for elementary SBHCs might be created as part of a state funding program through, for example, a Request For Proposal (RFP) process that would require SBHCs to meet certain criteria in order to be eligible for state dollars. Alameda County, the one California county that runs a grant program for SBHCs, has program standards that its clinics must meet as a condition of funding. Program standards might also be developed independent of any funding program. The Advisory Workgroup discussed the potential value of program standards in SBHCs' efforts to seek reimbursement from third-party payors.

Development of program standards was distinguished from processes which would require separate SBHC licensure, certification or accreditation. On this point, there was disagreement: some participants felt that SBHCs are already subject to requirements of a variety of licensing organizations and public programs, that these are extremely burdensome for clinics and that a separate SBHC certification or accreditation would not add value. Others argued that some form of designation for SBHCs was necessary to enable them to participate fully in the health care system under health care reform. Any effort like this should build on other licensing processes and not duplicate those already in place.

As in the Advisory Workgroup's discussions on other topics, the tension between standardization and community variability was a major focus of the deliberations on program standards. Recognizing the diversity of existing SBHCs and the

diversity of school communities in which new SBHCs will be established, program standards will need to allow for variations in structure and community need. A number of states have built such flexibility into their standards: Maryland, for example, has a set of minimum requirements for all SBHCs, but certifies their centers as meeting different levels of service (basic, expanded or comprehensive) based on availability of services and staffing levels. New Mexico also defines three levels of service, and specifies that “[e]ach local community decides which services will be offered at its SBHC.”

While the Advisory Workgroup did not define these distinctions, they discussed having the state define a standardized minimum level of service focused on prevention and health promotion services, and allowing individual communities significant latitude in the amount and type of other services to be provided at the SBHC. Exceptions for single service providers, such as mobile dental vans, vision screening services, or SBHCs focused on mental health services, that might not meet the minimum service requirements but that respond to critical community needs, were also considered by the Advisory Workgroup.

4. Parent, School, and Community Partnerships

The Governor's White Paper on School-Based Health Centers opens with the Governor's belief "that California's public schools should serve as community centers," and that SBHCs are one way of fulfilling this mission.[10] From this perspective, the topic of SBHCs' partnerships – with parents, schools and the larger community – takes on particular importance. As in other areas, recommendations for standardization were balanced with concerns that elementary SBHCs have the latitude to respond to particular local school and community needs and circumstances.

In California, such partnerships have frequently been initiated and defined in the planning of a new SBHC, though there is no statewide requirement that any particular planning process be implemented or that any particular players be included. The Advisory Workgroup found that under the Governor's Initiative, planning processes should be required and standardized, citing Healthy Start projects as models of inclusive planning, noting that SBHC planning should be coordinated with other local and regional efforts.

Elementary-age children do not seek or receive health care independent of their parents, and the new elementary SBHCs envisioned by the Governor's Initiative will need solid strategies to engage parents both individually and in governance. Elementary SBHCs must continue their work to make their facilities and services friendly to families, easily accessible, and culturally appropriate. Parents are essential partners in outreach and enrollment, and will be the focus of some prevention efforts, for example those targeting obesity and diabetes, which require that parents make changes to the way they and their families shop and eat. SBHCs were encouraged to partner with parents through a variety of organizations, including PTAs, English language advisory committees, school site councils, and district wellness committees.

SBHCs' relationships with schools and school districts were the topic of extensive discussion. Individual schools and school districts have varying relationships with SBHCs. In some cases, school districts have established the SBHCs and staff them with district employees. Governance structures for the SBHCs may or may not include district or school personnel. Even where the district's involvement is more limited, schools typically contribute space and other in-kind services to the SBHCs, and SBHCs recognize the importance of strong relationships with the district, particularly where turnover among principals is high.

SBHCs exist as one part of larger school health systems. Other health and wellness efforts within school systems may include school nurses, other medical services including IEHPs and care for children with chronic illness, physical

[10] Office of the Governor, State of California, *White Paper: School-Based Health Centers* (n.d., distributed in July 2006)

education programs, food and nutrition services, after-school programs and health education curricula, among others. Currently, SBHCs are linked with these other efforts in a variety of ways. For example, some SBHCs have designed their consent forms to allow clinics to share immunization records with the school, ensuring school entry for young children and continuous enrollment for older students. SBHCs also work with schools to establish and carry out care plans for children with chronic illnesses. The Advisory Workgroup discussed the importance of having the SBHC work cooperatively with *all* school providers of health and wellness services in order to create a coordinated school health environment, but said that this is not always the case with existing elementary SBHCs.

The school nurse is traditionally the bridge between the educational setting and the medical establishment. School nurses perform health and developmental screenings, are responsible for any necessary care plan for students while they are in school, serve as a resource to teachers and administrators, and provide school-wide health education in and outside the classroom, among other services. Unfortunately, many schools in California do not have sufficient staffing to allow the school nurse to perform all these tasks, and some schools have no nurse at all. SBHCs, though they can perform some school nurse functions for some students, are not replacements for school nurses. SBHCs function best in coordination with a school nurse who, because of her role as gatekeeper to other school health services, status as a school employee, and access to all students can significantly advance the SBHC's work. Given the tremendous variability in access to school nurses, the Advisory Workgroup could not offer specific recommendations in this area, but emphasized that SBHCs should coordinate with and build on the role of the school nurse where one exists.

SBHCs also work with their county health departments, particularly in programs that counties administer such as CHDP, EPSDT Supplemental Services, California Children's Services (CCS) and the Children's System of Care through the county mental health department. Alameda County has established a county-wide effort to provide health and wellness services through SBHCs (at the high school level), but many other county health departments are also involved in sponsorship of or work with their SBHCs. Implementation of the Mental Health Services Act may present an opportunity for elementary SBHCs to strengthen their partnerships with counties in this area.

5. Financing and Sustainability

Financial sustainability has been a central concern of SBHCs since the first SBHC was founded. Principally located in communities and schools with large numbers of low-income children, SBHCs have learned to be inventive and determined in securing funding from year to year. Health care reform, and universal coverage for children in particular, offer new opportunities and challenges for elementary SBHCs. Expansion of elementary SBHCs in California as the Governor has proposed will require significant planning and preparation to ensure that new and existing SBHCs can finance their capital and ongoing operating costs.

Most SBHCs in California, as nationally, must each year cobble together funding from a variety of sources. Third-party reimbursements and categorical public funding, foundation grants, county and state contracts and private fundraising are among the most important sources of financing for elementary SBHCs. With the exception of third-party reimbursement, these are often one-year sources, increasing the SBHC's fundraising burden and inhibiting long-range planning. Philanthropic sources have a history of funding new models, start-up, research and evaluation, but are typically not interested in ongoing operations. Elementary SBHCs also receive significant in-kind donations from the schools that house them, parents that support them, and health care providers that operate them.

Direct State Funding

Unlike most states with large numbers of SBHCs, California has no state funding infrastructure that specifically supports SBHCs. By contrast, according to data from The National Assembly on School-Based Health Care, 20 states and the District of Columbia spent over $56 million to support SBHCs in 2004-2005. Most states allocated funds through competitive grant programs, while others allocated core funding to agencies that offered essential services to school populations. State general funds provided more than half the state dollars explicitly available to school health centers. States also used tobacco settlement dollars and Title V MCH block grant funds for the centers, among other sources.[11]

In California, Alameda County is the only county that has a formal grant program for its SBHCs, though several other counties sponsor SBHCs. The Alameda County School-Based Health Center (SBHC) Fund provides core operating support of $100,000 annually to each of the county's high school health centers, and also provides technical assistance and evaluation services. The Los Angeles Unified School District (LAUSD) has a major commitment to its elementary SBHCs and works closely with the LA Trust for Children's Health, which provides funding and strategic support to LAUSD's SBHCs.

[11] John Schlitt, National Assembly on School-Based Health Care, personal communication, July 26, 2007.

The Advisory Workgroup felt strongly that direct funding, distributed directly by the state through a grant program, was essential if the Governor's Initiative to expand elementary SBHCs is to succeed. Participants defined a number of ways that state funding could support elementary SBHCs. Grants for planning and start-up were a priority for the Advisory Workgroup. Core operating support was also considered important, particularly to the extent that elementary SBHCs focus on activities that are not reimbursable by third-party payors, such as outreach and enrollment, school-wide prevention education, coordination with school personnel and/or parent education. The Advisory Workgroup agreed that the Governor's Initiative should include a staged grant-making program to begin with planning grants for new or expanded SBHCs, and should phase in support for services provided by new and existing SBHCs that are not reimbursed by third-party payors.

Other areas in which direct state support is considered important include technical assistance to improve SBHCs' operations and administration, support for information technology infrastructure, and support for SBHCs' work to enroll children in health insurance. The Advisory Workgroup recommended that foundations, the California School Health Centers Association, counties and academic partners also be involved in this work.

The Advisory Workgroup was divided about the importance of state assistance with facilities acquisition and capital costs. While some felt that schools and school districts had successfully been able to supply these, others felt that it was difficult to support these costs through foundation grants, and thought the state should make capital and facilities funding a priority. To some extent, the discussion turned on local experiences: in some areas, school enrollment is continuing a long decline, and existing school district facilities may be available to be converted to SBHCs (though SBHCs may still be in competition with other interests, including preschools and charter schools). In other areas, enrollment is increasing rapidly and lack of space is a key barrier to the establishment of new facilities.

The Advisory Workgroup recommended that any grant program be administered jointly by CHHS and CDE, in recognition of SBHCs' benefits for both health and educational outcomes and the goal of aligning SBHCs more closely with school-wide health and wellness efforts. Several participants registered their opposition to looking to Proposition 98 education dollars as a partial source of funding for the Governor's SBHC initiative, considering the high expectations for California schools and the limited resources available to support the schools' core mission of providing an education program for all children. Some participants suggested that the state explore other existing resources, among them federal funds, Proposition 63 mental health funds, and Healthy Families Rural Health Demonstration Project funds, that could be leveraged to help support SBHCs.

Third-Party Reimbursement

Early SBHCs in California often did not seek reimbursement from third-party payors, instead relying on grant funding to support patient services. With the establishment of Healthy Families statewide and Children's Health Initiatives in 22 counties, the development of the CHDP Gateway and other policy changes, California's elementary SBHCs now regularly seek reimbursement from sources including CHDP, Medi-Cal, Healthy Families, Healthy Kids, EPSDT, and others. Still, third-party reimbursements are low: more than half of all SBHCs in the state recover less than 50% of their budget from all billing sources. While SBHCs that are sponsored by FQHCs have access to higher reimbursement rates for Medi-Cal patients, other SBHCs face low fee-for-service rates in Medi-Cal. Many services provided by SBHCs are not reimbursable by any third-party payors, and some SBHCs have said that the amount of reimbursement they recoup does not justify the administrative time spent on billing.

In a universal coverage environment, third-party reimbursements from insurance still would not cover SBHCs' budgets. Moreover, barring other policy changes, SBHCs likely will lose access to certain categorical programs that currently fund care for uninsured children and to certain discounts and services for which uninsured children are eligible, such as the federal Vaccines for Children (VFC) Program. Some SBHCs are already affected by their inability to use these lower-cost vaccines for children who enroll in Healthy Kids programs (locally funded insurance for children who do not qualify for public programs). SBHCs must instead purchase vaccines at market rates that are not fully reimbursed by health plans.

Managed Care

Access to managed care reimbursements will become even more important to SBHCs in a universal coverage scenario. Currently, managed care presents particular difficulties to SBHCs' efforts to gain third-party reimbursements. SBHCs' ability to participate as providers in these systems depends in part on who the sponsoring health care providers are, what services are offered by the SBHC, and the willingness of the managed care plans to work with SBHCs community by community, health plan by health plan. If the sponsor is an FQHC or other comprehensive care provider, the SBHC is more likely to be able to participate as a contracted primary care provider within the health plan's provider network. By contrast, SBHCs that cannot participate as PCPs need special contracts with managed care plans in order to bill for services to children enrolled in those plans, and at present few SBHCs and plans have reached such agreements. Even when a contract can be signed, concerns about duplication of services, sharing of medical records, and maintenance of medical homes may limit the services for which SBHCs can be paid.

Policy changes may be needed to address some of the barriers to SBHCs' coordination with managed care plans. Most elementary SBHCs are staffed by nurse practitioners, who are excluded by definition from serving as primary care

providers or being assigned patients on some managed care panels. The Governor's Health Care Reform plan includes proposals to make scope of practice changes for "physician extenders" such as nurse practitioners and physician assistants, and these changes might affect SBHCs' ability to participate in managed care.

Contracting and administrative requirements also pose steep hurdles to SBHCs' participation in managed care. In 2005, L.A. Care Health Plan recently conducted a pilot project to get information about services provided to L.A. Care members in SBHCs, and to model strategies for integrating SBHCs into managed care. Nine SBHCs in Los Angeles participated by submitting claims to L.A. Care. The project found that SBHCs experienced administrative barriers to establishing a relationship with the plan, including negotiating and executing the contract, identifying and verifying patients' insurance status, submitting claims, and communicating with the patient's PCP. Some SBHCs reported that their sponsoring organizations did not choose to invest in the necessary infrastructure to allow them to generate claims.

HealthNet is an example of a health plan that does contract successfully with SBHCs outside the PCP relationship. HealthNet pays SBHCs on a fee-for-service basis for certain services for its Medi-Cal and Healthy Families members statewide. The child's PCP continues to receive the full capitation. SBHCs in turn send billing forms to HealthNet so that the case coordination team there can close the referral loop with the PCP and ensure that records of the SBHC services are included in the child's medical record. This arrangement benefits both the SBHC, which is paid for the services it provides and has the information it needs to try and connect patients to their PCPs, and the health plan, which gains access to more complete information about their members' use of health services and can follow up on identified health needs.

Just as other states have established grant programs to direct state dollars to SBHCs, many have also intervened in policy to assist SBHCs in receiving third-party reimbursement, including from managed care plans. According to research by The Center for Health and Health Care in Schools at The George Washington University, as of 2002:

- Five states required Medicaid managed care plans to include school health centers in their provider networks and 11 more states encouraged Medicaid managed care to include school health centers in their networks. For SCHIP plans, five states required and nine states encouraged the inclusion of the centers.
- Thirty-eight states permitted school health centers to bill for services under fee-for-service (FFS) Medicaid and the State Child Health Insurance Program (SCHIP).
- Thirty-nine states reported that nurse practitioners are eligible to bill for their services under FFS Medicaid and in thirty-four states, nurse practitioners are eligible to bill for services under FFS SCHIP. In some

states, other providers such as psychologists and social workers are also eligible to bill for services provided within school health centers.

- Thirty-one states permitted nurse practitioners to participate as primary care providers in Medicaid managed care plans; 29 states permitted nurse practitioners to participate as primary care providers in SCHIP plans, and 24 states permitted nurse practitioners to participate as primary care providers in commercial plans.[12]

Advisory Workgroup members felt strongly that a critical role for the state is in driving policy changes that will increase SBHCs' access to third-party reimbursement, and particularly to payments from managed care plans. While the Advisory Workgroup was agreed that SBHCs cannot sustain themselves on reimbursements alone, there was equal agreement that third-party payments must be maximized to the extent possible. Recognizing that most managed care plans and insurers have not contracted with SBHCs for the provision of services, Advisory Workgroup members agreed that the state must create incentives for managed care plans and insurers to reimburse elementary SBHCs if the Governor's Initiative is to succeed.

[12] Lear at 13.

Recommendations of the Advisory Workgroup

These recommendations were developed collaboratively by the Governor's Advisory Workgroup on School-Based Health Centers on June 25 and 26, 2007 and express the agreement of the group.

The Governor's Advisory Workgroup on School-Based Health Centers finds that school-based health centers (SBHCs) provide a variety of health services to students directly on school campuses, at off-site facilities that are linked to one or more schools, or in mobile vans that serve multiple campuses; that SBHCs should be collaborations of community and school stakeholders in order to best meet the health, health care, cultural and linguistic needs of local communities; and that SBHCs will vary in their design and function from community to community and school to school.

In order to expand and sustain elementary SBHCs in the context of health care reform and universal coverage for children, the Governor's Advisory Workgroup on School-Based Health Centers recommends consideration of the following strategies:

1. The Advisory Workgroup recommends that elementary SBHCs fulfill the following roles:

    - provide medical, dental, vision and mental health education, anticipatory guidance, screening and assessment, referral, and case management.

    - increase access to primary care by serving as a primary care or medical home, or providing services that extend and complement a student's primary care home, including promoting communication with the child's primary care provider in order to avoid duplication and lack of continuity.

    - facilitate outreach, enrollment and retention in health insurance coverage programs for the school community.

    - respond to identified school and community needs by integrating the direct services of the SBHC with school-wide and community-wide prevention and youth development activities.

    - provide all services in coordination with other school and school district personnel and with parents.

    - support schools in improving academic outcomes for students by facilitating school attendance and full access to the educational program.

2. The Advisory Workgroup recommends that the California Health and Human Services Agency, in collaboration the California Department of Education, create a grant program to expand the number of elementary SBHCs. The program should begin with planning grants for new SBHCs or expansion of existing SBHCs, and should phase in support for ongoing operations.

    - The Advisory Workgroup recommends that funding target communities that demonstrate high levels of health disparities as well as unmet medical, mental health, dental and vision needs.

    - The Advisory Workgroup recommends that funding be contingent upon a community-based planning process that 1) involves school administrators, school district personnel, school board members, school health providers, parents, teachers, students, county and/or city health officials, community organizations, community clinics and SBHCs in the target area, and local community providers and health plans; 2) includes an assessment of local health data, community assets and barriers; and 3) coordinates with other local, county and regional children's health improvement efforts.

3. The Advisory Workgroup recommends that the California Health and Human Services Agency, in collaboration with the California Department of Education, establish program standards for elementary SBHCs:

    - requiring the SBHC, the school district and the school site to execute a contract or memorandum of understanding describing the relationship, roles and responsibilities of all parties to ensure, promote and sustain the health and wellness of students in the school community.

    - defining a minimum level of service that addresses medical, dental, vision, and mental health education, screening and assessment, and referral and other prevention and health promotion activities.

    - describing additional primary care service components, including medical, dental, vision, and mental health services.

    - governing elementary SBHCs in the areas of decision-making authority, relationships with the school administration and school board, privacy and confidentiality, and data collection, reporting and exchange, among others.

4. The Advisory Workgroup recommends that the California Health and Human Services Agency explore how non-clinical prevention and wellness services provided by SBHCs and other school health providers can be funded in keeping with the goals of the Governor's Health Care Reform Proposal.

5. The Advisory Workgroup recommends that the California Health and Human Services Agency assist SBHCs in 1) participate in electronic enrollment gateways for the purpose of ensuring that children enroll and retain health coverage in the most efficient manner possible and 2) exchange health information electronically for the purposes of improving access to coordinated care and reducing duplication, while ensuring individual and family privacy.

6. The Advisory Workgroup recommends that the California Health and Human Services Agency and the Managed Risk Medical Insurance Board promote coordination and communication between elementary SBHCs and managed care plans and primary care providers in order to promote comprehensive, coordinated care, facilitate provider collaboration, assure appropriate utilization of health resources and avoid duplication of services.

7. The Advisory Workgroup recommends that the California Health and Human Services Agency and the Managed Risk Medical Insurance Board develop incentives for managed care organizations and insurers to contract with and reimburse SBHCs, as primary care providers or as convenient, family-friendly providers for certain essential covered services.

8. The Advisory Workgroup recommends that the California Health and Human Services Agency, in collaboration with the California Department of Education, develop outcome measures for elementary SBHCs that follow the program standards and align with the roles of elementary SBHCs. These measures should, at minimum, address the areas of health insurance coverage, preventive health care, wellness, and chronic disease.

9. The Advisory Workgroup recommends that the California Health and Human Services Agency and the California Department of Education implement the Public School Health Center Support Program created by AB 2560 in order to ensure the continued operation of elementary SBHCs and assure alignment with the goals of health care reform.

10. The Advisory Workgroup recommends that there be ongoing stakeholder involvement in all aspects of the development and implementation of the Governor's SBHC Initiative.