

Report to:



School-Based Health Centers: *Expanding the Knowledge and Vision*

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Centers

July 2009

School-Based Health Centers: *Expanding the Knowledge and Vision*

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The New York State Coalition for School-Based Health Centers' works to create access to comprehensive, high-quality primary care, including medical, mental, oral, and community health services, for all children and youth statewide through school-based health centers by advocating for policies that promote the sustainability of school-based health centers; promoting the delivery of high-quality services; raising awareness of the school-based health care model; and promoting the growth and expansion of school-based health centers.

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Table of Contents

Executive Summary 5

Introduction 7

Section 1. School-Based Health Center Basics 8

 1.1 Services 11

 1.2 Benefits 13

 1.3 Assessing Need 17

 1.4 Staffing, Facility Requirements, and Data Collection 19

Section 2. Stakeholder Collaboration and On-going Support 21

 2.1 The Sponsoring Agency 21

 2.2 School Nurse(s), Social Worker(s), and Psychologist(s) 23

 2.3 Youth 25

 2.4 Parents 25

 2.5 Community 26

Section 3. Enhancements to the Model 27

 3.1 Dental Services 27

 3.2 Health Education, Promotion and Nutrition Counseling 28

 3.3 Facilitated Enrollment 30

 3.4 Family Services 30

 3.5 Community Agency Referrals 31

 3.6 Community Schools: A Unique Approach to Expanding School-Based
 Health Centers 31

 3.7 Miscellaneous Enhanced Services 32

Section 4. Resource Needs 33

 4.1 Start-up and Annual Costs 33

 4.2 Memorandum of Understanding 33

 4.3 Third-Party Billing 34

Section 5. Limitations and Challenges 36

 5.1 Limitations 36

 5.2 Challenges 37

Section 6. Other Options for Providing Health Care in Schools 40

 6.1 Integrated Resources In Schools (IRIS) 40

 6.2 Health Care Provided in Charter Schools 41

 6.3 School-Linked or Mobile Programs 42

Section 7. Advocacy	44
7.1 State Level School-Based Health Center Advocacy	44
7.2 Federal School-Based Health Center Advocacy	45
Conclusion	47
Appendices	48
School-Based Health Center Resources.....	63
Abbreviation Guide	64
References.....	65

Executive Summary

Students and families across New York State face significant barriers to accessing quality, comprehensive health care. School-based health centers (SBHCs) offer a unique opportunity for school districts to meet the health and mental health care needs of underserved students. SBHCs provide comprehensive primary and preventive health care. Enhancements to the basic school-based health model include on-site dental services, health education, promotion, and nutrition counseling, facilitated health insurance enrollment, family services, and community referrals. In addition, community schools offer a unique model of expanded SBHC services. SBHCs are defined by the New York State Department of Health (NYSDOH), School Health Program. However, alternative options of providing health care in schools are available in New York state include school-linked, part-time, or limited service programs, pilot projects utilizing nurse practitioner and social work students, the health care services provided in some charter schools, and mobile programs.

SBHC services are provided at no out-of-pocket cost to students/families that are enrolled. To enroll in the services offered at a SBHC, parents/guardians must sign an enrollment form which acknowledges their consent for the SBHC to treat their child. SBHCs are staffed by a multi-disciplinary team of licensed health care professionals and support staff. Currently, there are 216 approved, operating SBHCs in New York state, serving nearly 200,000 students. Approved SBHCs in New York state are located in areas with a high prevalence of unmet medical and psychological needs.

SBHCs offer numerous health, mental health, academic and economic/financial benefits. A student's health status plays an essential role in their ability to learn. SBHCs are on the front line – in schools – ensuring that students are healthy and ready to learn, allowing educators to focus their energy on education. Schools with SBHCs have been found to experience reduced absenteeism and improvements in graduation rates. SBHCs form an integral part of the safety net designed to support children living in underserved communities. SBHCs work in collaboration with school nurses, social workers, and psychologists. Instead of a duplication of services, SBHCs supplement the work of school health providers by offering a broad range of health care services.

The SBHC model is a marriage between a school district and a health care facility interested in providing easily accessible health care to underserved students. Each partner has a role in planning, organizing, operating, evaluating and supporting the SBHC. The SBHC sponsoring health care agency has the overall responsibility for the center's administration, operations, and oversight. School districts assist the SBHC by providing school space for the center at no cost to the sponsoring agency. SBHCs are traditionally located as close to the school nurse's office as possible as this helps with communication and coordination of care. It is strongly suggested that a school district sign a memorandum of understanding with the SBHC sponsoring agency. This shared use agreement is typically used to outline and formalize the relationship between the sponsoring agency and the host school.

Youth are SBHCs' most important stakeholders. Many SBHCs organize peer health education programs and youth advisory boards for the youth in their schools to promote the development of leadership and health advocacy skills. SBHCs depend greatly on a collaborative relationship with parents, guardians, and families of enrolled students. On-going communication between providers and parents allows providers to understand the broader context of the child's life.

SBHCs do face limitations and challenges. SBHCs greatest limitation is their lack of financial sustainability. SBHCs' mission is to serve uninsured and medically underserved children and teens throughout the state. As a result a great deal of health and mental health care services are provided without reimbursement. In addition, school districts, in collaboration with sponsoring agencies, often have to make difficult decisions in determining which school building is most in need; limited resources make it unlikely that every building in need will get a SBHC. Additionally, school districts interested in collaborating with a sponsoring agency to open a new SBHC must gain overwhelming faculty, parent, and community support. Lastly, numerous SBHCs across the state are in need of significant contributions from foundations, individuals, and corporations to establish a SBHC given high start-up costs and limited revenue generation. Without adequate start-up costs a center will not be able to open its doors.

Advocacy has been the driving force behind SBHCs for over twenty years. SBHCs engage in advocacy to increase awareness of the SBHC model and its benefits. SBHC funding is intimately tied to community and political awareness of the SBHC model. As an effective intervention, SBHCs not only provide direct health services but also empower children, adolescents and families to overcome challenges that threaten their basic human right: quality, accessible health care. Districts can play a pivotal role in SBHC advocacy by encouraging and cultivating opportunities for youth, parents, faculty, and the community to advocate on behalf of SBHCs.

In conclusion, **SBHCs offer a unique option for school districts interested in meeting the health and mental health needs of underserved students.** SBHCs offer countless benefits to students, families, the school district, and the community at large. Successful SBHCs are a partnership between sponsoring agencies and school districts who share the same common vision –all children will be healthy and ready to learn.

Introduction

The New York State Coalition for School-Based Health Centers (the Coalition) is the leading expert on school-based health centers (SBHCs) in New York State and is the only organization in the state that advocates exclusively on behalf of the state's 216 SBHCs. **This report was commissioned by the Community Health Foundation of Western and Central New York (CHF) to educate school districts and charter school administrators in western and central New York on the school-based health care model in New York State. This report may be used as a model to expand SBHC awareness and knowledge in other regions of the state or country as well.**

This report compiles knowledge on SBHCs including SBHC services, guidelines, staffing, enrollment, benefits, challenges of operation, limitations and enhancements of the model, and fiscal operation. In addition, the report includes a section on alternative options to provide health care in a school setting and options for stakeholder collaboration and on-going support. Lastly, the report includes an overview of school-based health advocacy and SBHC funding history in the state is detailed in *Appendix A7*.

Section 1. School-Based Health Center Basics

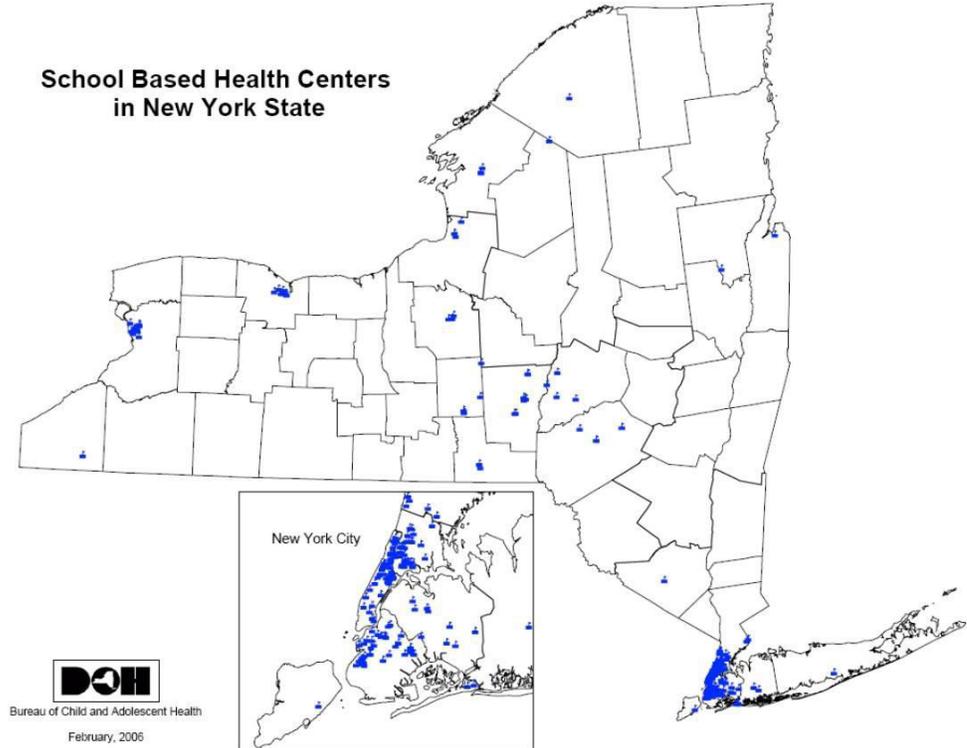
Students and families across New York State face significant barriers to accessing quality, comprehensive health care. Typical barriers faced by students in western and central New York that prevent them from receiving timely health care include financial barriers, including a lack of health insurance coverage, problems with transportation, problems with parents and students taking time off of work to attend appointments, inconvenient office hours, language and cultural barriers, and confidentiality issues.

SBHCs offer a unique opportunity for school districts to meet the health and mental health care needs of underserved students. SBHCs provide comprehensive medical and mental health care to school-aged children who have limited access to such services due to financial, geographical, and/or other significant barriers to care. SBHCs were founded on the belief that all school-aged children should have access to quality, comprehensive health care regardless of ability to pay. SBHCs reduce barriers to care by being located directly where students spend the majority of their time – in school. “Placing services in schools assures more immediate access for students and their families and allows for ongoing communication and coordination with school personnel regarding educational goals, student achievement, and overall school and student wellness (NYSDOH, 2008). SBHCs are open during normal school hours and must provide 24-hour/7-day a week access to services.

In 1989, the New York State Legislature passed regulations establishing SBHCs as a demonstration project in the state. However, some SBHCs appeared in the early 1980s, including a center in Rochester, New York at Franklin High that opened during the 1981-1982 school year. In 1993, the New York State Department of Health (NYSDOH), School Health Program established guidelines for the operation of SBHCs. The NYSDOH, School Health Program’s guidelines focus on services, staffing, relationships, organizational function, fiscal operation, data management, facility requirements, and quality management and improvement.

Currently, there are 216 approved, operating SBHCs in New York state, serving nearly 200,000 students. Last year, students enrolled in New York’s SBHCs made nearly 700,000 visits, with the top visits for health supervision, emotional problems, respiratory problems, injuries/poisonings, and diffuse symptoms. According to the NYSDOH (2009) 78% of New York’s SBHCs are located in urban areas of the state, of which 61% are located in New York City, and 14% are located in rural areas of the state.

Figure 1. School Based Health Centers in New York State



Location	# of Sponsoring Agencies	Location	# of Sponsoring Agencies
Albany	1	Mineola	1
Binghamton	1	Mt Vernon	1
Bronx	7	New Hyde Park	1
Brooklyn	8	New York	11
Buffalo	2	Norwich	1
Carthage	1	Patchogue	1
Clifton Fine	1	Port Chester	1
Cooperstown	1	Pulaski	1
Cortland	1	Rochester	3
East Meadow	1	St Albans	1
Elmhurst	1	Syracuse	1
Glens Falls	1	Utica	2
Gouverneur	1	Watertown	1
Hogansburg	1	Yonkers	1
Jamestown	1		
Middletown	1		

See Figures 2, 3, and 4 below for New York State data on SBHC grade configuration, enrollee ethnicity, and visit, enrollment, and center trends.

Figure 2. **SBHCs in NYS, Grade Configuration** (NYSDOH, 2009)

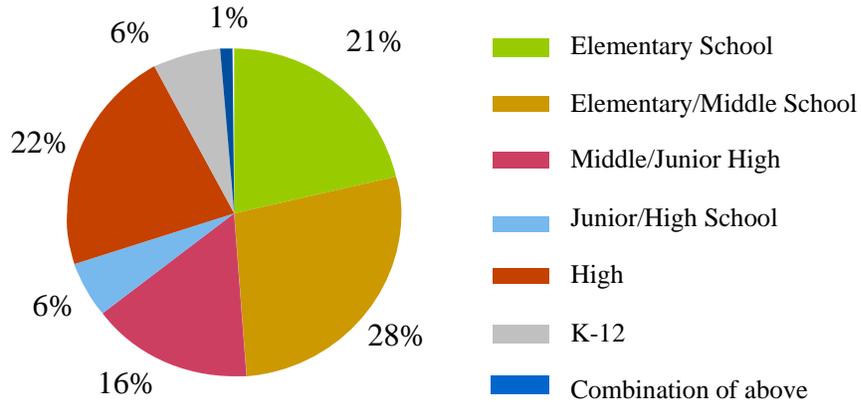


Figure 3. **SBHCs in NYS, Enrollees' Ethnicity** (NYSDOH, 2009)

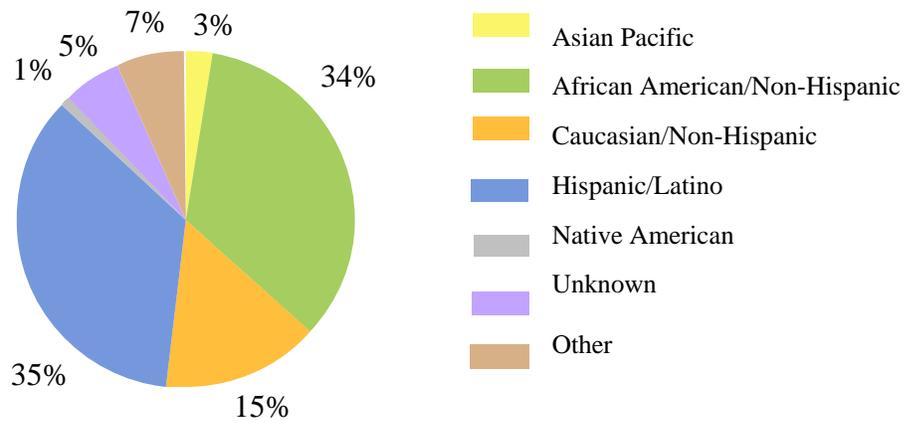
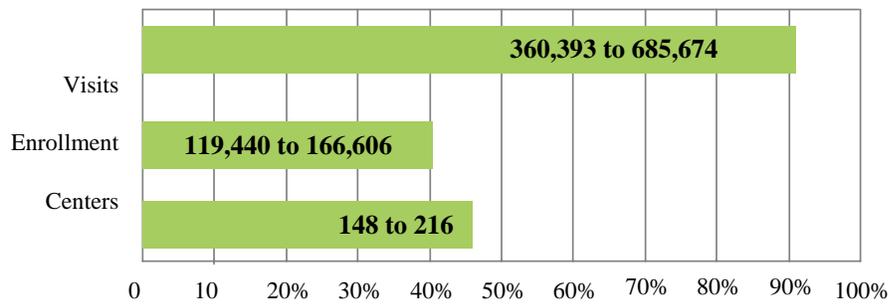


Figure 4. **SBHCs in NYS, Ten Year Percentage of Change Trends 1998 – 2008**



According to the National Assembly on School-Based Health Care's (NASBHC) 2004-2005 national SBHC census, there are approximately 1,700 SBHCs throughout the United States. According to the Center for Health & Health Care in Schools, there were at most 50 SBHCs across the country in 1985, representing a 3300% increase in SBHCs across the country in the last 20 years (as cited in 21st Century School Fund, 2004). Eight percent of the centers nationally serve at least one grade of adolescents and approximately 40% are located in Title I schools. "The majority of students served across the country are from minority and ethnic populations, which have historically experienced health care access disparities" (Juszczak, Schlitt, & Moore, 2007)."

1.1 Services

SBHCs are required to provide primary and preventive health care, diagnosis and treatment of acute illnesses, and management of chronic diseases. Services are provided under a sponsoring health care agency, referred to hereafter as the sponsoring agency. Specific services offered at a SBHC may include, but are not limited to: age appropriate well-child exams, immunizations, diagnosis and treatment of acute illness and injury, management and monitoring of chronic conditions, basic laboratory services, capability to prescribe commonly used medications, health education and anticipatory guidance, basic mental health services (by referral or on-site), substance abuse services, reproductive health care, and violence prevention education and intervention counseling. SBHC services are provided at no out-of-pocket cost to students/families that are enrolled in the service.

To enroll in the services offered at a SBHC, parents/guardians must sign an enrollment form which acknowledges their consent for the SBHC to treat their child. Students who are 18 years or older or are qualified to give consent under Section 2504 of the Public Health Law and are competent to give such consent, may enroll themselves in the SBHC. Enrollment forms, which are provided by the sponsoring agency, assess basic identification information, health insurance status, medical history, information on the student's primary care practitioner, and provide a medical release form. As indicated by the NYSDOH, School Health Program SBHC services are made available only to the students enrolled in the school building which houses the SBHC. SBHC staff maintains continual communication with a student's primary care provider during their enrollment in the center.

Achieving high levels of school-based health enrollment is critical to the success of the SBHC. In order to achieve success in this area, collaboration between students, parents, school nurses, teachers, school administrators, and local providers is essential. The target enrollment for a high school SBHC is 70% of the school's population by the end of the first full year of operation. If enrollment numbers are not met, the NYSDOH, School Health Program determines that the need for the SBHC was inappropriately assessed. Average New York State SBHC enrollment is 87% (NYSDOH, 2009).

In addition to students and parents making appointments at the SBHC to address health care needs, student referrals are a common occurrence. Student referrals to the center can come in various forms. Often teachers, administrators, school counselors, and the school nurse refer students/parents to the SBHC. Each school with a SBHC, in collaboration with the sponsoring agency, develops their own procedures for handling referrals.

Laboratory Testing

SBHCs may perform on-site, basic laboratory testing if registered with the NYSDOH, Clinical Laboratory Evaluation Program.

Mental Health

Mental health counseling is frequently identified as the primary reason for student visits at SBHCs throughout the country (Smith, 2002). In New York State approximately 15% of all school-based health diagnoses are related to emotional problems (NYSDOH, 2009). SBHCs in New York State are required to provide mental health services on-site or by referral. Some sponsoring agencies in western and central New York contract out their mental health services to local mental health providers. This arrangement allows sponsoring agencies that do not have enough staff to provide the services or that do not offer mental health services to provide mental health services on-site at the SBHC. For example, The Resource Center in Jamestown contracts with Family Services of Jamestown to provide mental health services to its SBHC enrollees. In addition, in central New York, the Syracuse Community Health Center contracts with Arise Child & Family Service to provide mental health services to SBHC enrollees in three of its centers. Both contracted mental health providers offer the added benefit of providing families services as well.

Reproductive Health

NYSDOH School Health Program guidelines require that reproductive health care must be offered at SBHCs in a high school setting on-site or by referral (NYSDOH, 2006). SBHCs that provide reproductive health care services by referral often collaborate with county public health agencies. Reproductive health care services include pelvic exams, STI testing and education, and HIV (oral) testing and counseling. Pregnancy prevention education is also provided, including an abstinence only program, if desired. The school should assess whether or not they anticipate issues/concerns about reproductive health services being offered at their SBHC(s). The school, in collaboration with the SBHC sponsoring agency, should develop a plan on how these issues/concerns will be addressed. *See Section 5.2 Challenges for more information on opening a SBHC.*

Expanded Services

Sponsoring agencies can determine the need and feasibility of providing expanded services through their SBHCs. Beyond the basic health and mental health services that are offered some SBHCs also offer health education and promotion services, social services, age-appropriate tobacco-use prevention, assessments and referrals, dental care, nutrition education and counseling, and well-child care of student's children. *See Section 3. Enhancements to the Model for more information on expanded services.*

1.2 Benefits

SBHCs offer numerous health, mental health, academic and economic/financial benefits. The amount of research conducted on SBHCs has grown substantially over the last ten years. Research data has proven to be extremely important in the ability of SBHCs to advocate for continued funding and support.

Academic Benefits

Research has confirmed that health and educational inequities are strongly linked. According to Fiscella and Kitzman (2009, p. 1073) “academic achievements and education are critical determinants of health across an individual’s life span and disparities in one contribute to disparities in the other.” Specifically, as educational achievement increases, health inequities decrease and vice versa. In addition, a student’s health status plays an essential role in their ability to learn. SBHCs are on the front line – in schools – ensuring that students are healthy and ready to learn, allowing educators to focus their energy on education. *See Appendix A3 for a list of programs and services SBHCs can provide as a partner in the educational process.*

Academic achievement is negatively affected by poor health status and risky behaviors, such as poor diet, physical illness, alcohol, tobacco, and other drug use, intentional injuries, and self esteem and emotional problems. If

SBHCs can directly impact these factors SBHCs can have an indirect impact on academic achievement (Geierstanger & Amaral, 2004). Additionally, academic achievement is affected by individual student factors, such as resiliency, developmental assets, and sense of school connectedness (Scales, Roehlkepartain, 2003; Symons et al., 1997; McKenzie & Richmond, 1998; Hanson & Austin, 2003). The aforementioned individual factors have been found to be directly influenced by the services provided in a SBHC (NASBHC, 2005b).

SBHCs promote good health while strategically targeting underserved populations (NASBHC, 2007). Satisfying the social and emotional needs of students prepares them to learn, increases their capacity to learn, and increases their motivation to learn. In addition, SBHCs reduce suspension, expulsion, and improve grade retention (Collaborative for Academic, Social, and Emotional Learning, 2003). Hall (2001) found that students at a Dallas SBHC who received mental health services had an 85% decline in school discipline referrals. *See Figure 5. The Education – Health Connection, for a description of SBHC tactics and academic outcomes.*

Figure 5. **The Education – Health Connection** (NASBHC, 2007)

SBHC Academic Outcomes	Reduce Barriers to Learning	Improve School Attendance	Improve Student Health	Meet Govt. Regulations
SBHC Tactics	Identify students at-risk for health and behavioral problems	Provide preventive health services	Refer students to services not provided in the SBHC	Immunize students
	Assist in IEP development	Treat acute conditions	Provide preventive health services	Participate in community initiatives on public health such as obesity and emergency planning
	Provide mental health services	Administer medication to students with chronic conditions	Treat acute conditions	Maintain health records for migratory students
	Treat acute conditions	May enroll students in health insurance	Manage chronic conditions	
	Manage chronic conditions	Provide mental health services	Conduct sports physicals	
			Provide mental health services	

Mental Health Benefits

Multiple studies throughout the country have established the effectiveness and quality of mental health care received at SBHCs. For example, a study comparing school-aged children receiving mental health care at a SBHC and school-aged children receiving mental health care at urban clinics, conducted by Armbruster and Lichtman (1999), found that school-based services showed improvements comparable to clinic-based services. Armbruster and Lichtman (1999) conclude, “school-based mental health services offer promise in the effort to bridge the gap between service need and service utilization” (p. 493). Additionally, in a New York based study by Klein and colleagues (2007), it was found that students using mental health services provided by SBHCs were significantly more likely than students not enrolled in a SBHC to receive critical mental health screening and counseling. In addition, Klein and colleagues (2007) found that SBHC users are more likely than those enrolled in Medicaid or

commercial insurance plans to receive critical screening and counseling and they are more likely to state that they trust their centers as a confidential place to go for care.

Webber and colleagues (2003) found that students who used SBHCs showed significant declines in depression and improvements in self-concept. In addition, adolescents who received counseling services at their SBHC significantly decreased their absenteeism and tardiness (Gail et al., 2000). Lastly, Juszczak, Melinkovich, and Kaplan (2003) found that visits by adolescents were 21 times more likely to be initiated for mental health reasons at SBHCs than at community health network facilities.

Health Care Access

SBHCs reduce significant barriers to accessing health care. As previously mentioned the typical barriers that prevent students from accessing needed health care include: transportation, financial barriers including lack of health insurance, confidentiality, inability for students or parents to take time off of work, and geography. Juszczak and colleagues (2003) found that average visit rates for Hispanic and African American youth who used their SBHC were higher than those who did not have access to a SBHC. In addition, a national multi-site study of SBHCs conducted by Mathematica Policy Research found a significant increase in health care access by students who used SBHCs: 71% of SBHC users reported having a health care visit in past year compared to 59% of students who did not have access to a SBHC (Kisker & Brown, 1996). Lastly, Ricketts and Guernsey (2006) found that improved access to reproductive health care at SBHCs in the Denver area helped to reduce African American teen pregnancy rates from 165/1000 to 38/1000.

Economic/Financial Benefits

SBHCs offer various financial benefits to families and to the state. Families are able to utilize the services of a SBHC at no out-of-pocket cost, thus reducing a significant barrier to accessing primary and preventive health care. Research has proven that individuals are more likely to receive health care when out-of-pocket costs are reduced (Feldstein, 2005). Secondly, by providing easily accessible and affordable care to children with asthma, in one year alone, SBHCs in New York State were able to save approximately \$3 million in hospital inpatient costs. In addition, SBHCs in the Bronx were found to significantly reduce expensive emergency department visits for students enrolled in the center. Specifically, emergency department visits were double for children in schools without a SBHC compared to children in schools with a SBHC (Webber et al., 2003). Additionally, Webber and colleagues (2003) found that asthmatic children in schools without a SBHC were 50% more likely to be hospitalized than those who attended a school with a SBHC.

In addition, citing improvements in graduation rates alone can effectively depict the cost-effectiveness of SBHCs. Numerous studies have indicated that students enrolled in SBHCs are significantly more likely to graduate from high school than students who did not use these centers (as cited in Visher, 2007). The improvements in graduation rates have long term effects which help illustrate the economic efficiency of SBHCs. For example, research has concluded that worker productivity is linked to an individual's level of education (DeLong, Goldin, & Katz, 2003). In addition, research has concluded that education is one of the strongest predictors of lifelong health (Freudenberg & Ruglis, 2007). "The less schooling people have, the higher their levels of risky health behaviors such as smoking, being overweight, or having a low level of physical activity" (Freudenberg & Ruglis, 2007, p2).

Schools with SBHCs experience reduced absenteeism. Reducing absenteeism may lead to an economic/financial benefit for school districts as absences often translate into lost finances for schools. Asthmatic children in elementary schools without SBHCs missed 3 more days on average compared to those in a school with a SBHCs (McCord et al., 1993). Adolescents who received counseling services in a SBHC significantly decreased their absenteeism and tardiness, while those not receiving counseling slightly increased their absence and tardiness rates (Gail et al., 2000). Lastly, Hall (2000) found that medical services provided at Dallas SBHCs helped decrease absences by 50% among students who had three or more absences in a six-week period (Hall, 2000).

1.3 Assessing Need

The NYSDOH, School Health Program is responsible for approving the establishment of SBHCs in New York State. In order for a SBHC to be approved in New York, a sponsoring agency must demonstrate that the SBHC will be located in an area with a high prevalence of unmet medical and psychological needs. In order for a sponsoring agency to demonstrate this need, the School Health Program asks the sponsoring organization to describe the public health issues of the student population who will be served by the SBHC, including prevalent health problems and cultural, social, geographical, and financial barriers to health care.

In addition, a sponsoring agency must state the health and human service resources that are currently available to the student population, including those that are provided by the school and must address whether there are gaps or barriers to accessing these services. Additional indicators of high need recognized by the School Health Program include schools located in "High Need Districts", as identified by the New York State Education Department; a high percentage of free or reduced lunches; and schools that serve youth with significant chronic health needs. According to Juszczak and colleagues (2007) 69% of all SBHCs in the country report that more than half of their students receive free or reduced lunches.

Conducting student, faculty, and parent focus groups and/or surveys is a beneficial way to ascertain the needs and concerns of your school community. Collaborating with the sponsoring agency to collect data on school need will ensure that the sponsoring agency's application to the School Health Program will be as accurate as possible. Additionally, data collection will assist sponsoring agencies in deciding which services to provide at the SBHC.

To improve survey completion rates schools may utilize marketing techniques and incentives. Students, faculty, and parents are more likely to fill out a survey if they are familiar with the services that a SBHC provides or understand how the center would function if it was placed in the school building. Schools may be able to place SBHC information on their website or in their school newsletter along with survey information. In addition, utilizing incentives, especially for focus group meetings, and allowing the survey to be completed on-line as well as in a paper form may help increase your school's completion rate. A letter may be sent home to determine parents' interest in participating in focus group meetings. Parental permission should be received for students under age 18 to participate in focus groups. *See Appendix A1 for a sample parent survey and A2 for sample focus group questions.*

Once survey results are compiled the school district and/or the sponsoring agency should evaluate the results. If multiple school buildings were surveyed, the needs of each school should be compared. If multiple schools are eligible, or in need of the services provided by a SBHC within a district, a full needs and feasibility assessment should be conducted in each school. This assessment should be completed with the sponsoring agency to ensure that the SBHC is placed in the appropriate building. The determination of whether a SBHC will be a feasible option in a school building will be determined based on numerous factors including the students' needs, school space, resource limitations, the sponsoring agency's potential for success (i.e., need vs. size of the school population), and parental and community support.

1.4 Staffing, Facility Requirements, and Data Collection

Staffing

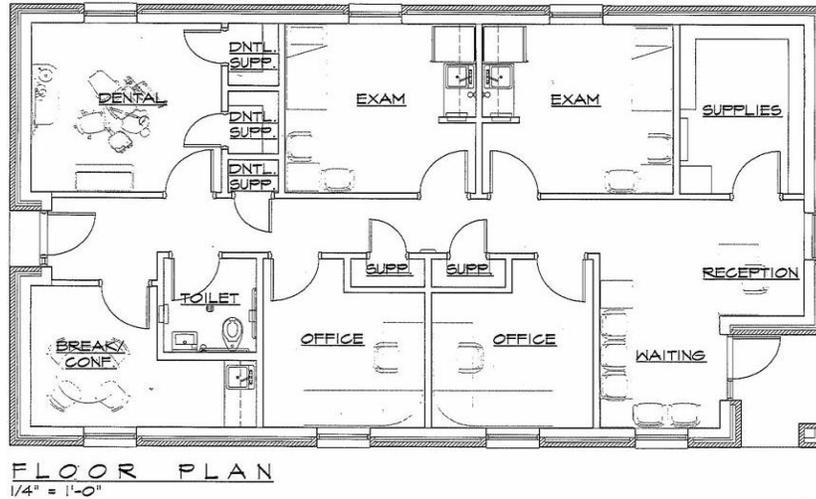
SBHCs are staffed by a multi-disciplinary team of licensed health care professionals and support staff. “All staff are required to be trained in child abuse, infection control, emergency care, including general first aid, basic life support, and in the use of a automated external defibrillator” (NYSDOH, 2006). SBHCs are required to have a presence during all normal school hours; this requirement may be fulfilled by the school nurse if the school and the SBHC sponsoring agency have an agreement for school nurse coverage of the SBHC during times when providers or health assistants are not on-site.

SBHCs are typically staffed by Nurse Practitioners (NPs) or Physician Assistants (PAs). One full-time NP or PA should be available for every 700-1,500 SBHC enrollees. A supervising physician from the center’s sponsoring agency is required to be accessible to the NP or PA at all times during center operation. Mental health needs must be addressed at the SBHC on-site or by referral. If services are provided on-site, one full-time licensed mental health provider should be available for every 700-1,500 students enrolled in the program. Lastly, all SBHCs have a medical or health assistant on site who schedules appointments, conducts data entry, and assists the NP and PA in preparation for appointments. SBHCs that offer expanded services may have additional staff on-site which may include a health educator, a community outreach worker, RNs or LPNs, or a nutritionist. If dental services are provided on-site, a dental assistant, a dental hygienist, and a supervising dentist will be part of the center’s staff. One full time dental hygienist can provide services for approximately 2,500 enrollees.

Facility Requirements

The school space designated to the SBHC must include adequate space to provide services. Space is needed for exam room(s), counseling room(s), a reception area, professional office space, a storage area, which includes a locked space for medical records and pharmaceuticals, bathroom(s), an infirmary area, clean and dirty prep areas, hand washing sinks, and a laboratory area. Approximately 1,500 to 2,000 square feet is recommended by the NYSDOH, School Health Program for a SBHC with an enrollment of 700 students. However, a typical SBHC is determined by available space and resources within the school building. “SBHCs are required to be equipped with a private telephone and fax line to ensure confidentiality and adequate access to the community and back-up providers (NYSDOH, 2006).”

Figure 6. **Sample SBHC floor plan** (Louisiana Assembly on School-Based Health Care, personal communications, 2009).



Data Management & Quality Improvement

SBHCs are required to submit quarterly reports to the NYSDOH, School Health Program within thirty days of the end of each quarter. Data management systems, whether they are hand-written or computerized, are utilized to collect data for the quarterly report. The current school-based health quarterly report evaluates information on SBHC enrollment, student's identification of a primary care provider, visit data, and required quality indicators including data on comprehensive physical exams, body mass index, immunizations, and age-appropriate anticipatory guidance. Similar to other health care providers, SBHCs develop quality management and improvement policies and procedures to ensure that they are providing the highest level of care possible.

Section 2. Stakeholder Collaboration and On-going Support

The SBHC model is a marriage between a school district and a health care facility interested in providing easily accessible health care to underserved students. Each partner has a role in planning, organizing, operating, evaluating and supporting the SBHC. These collaborative relationships are integral to the existence of the SBHC and its mission to provide quality health services to school aged children.

2.1 The Sponsoring Agency

SBHCs in New York State are defined by the NYSDOH (2006), School Health Program, as a “delivery system for comprehensive primary and preventive health and mental health care located in a school.” As previously mentioned, services are provided under a sponsoring health care agency, referred to hereafter as the sponsoring agency. All sponsoring agencies in New York State are defined under Article 28 of the Public Health Law.

Sponsoring agencies come in several forms including diagnostic and treatment centers, which include Federally Qualified Health Centers (FQHCs), and hospitals. Fifty-seven sponsoring agencies, (29 hospitals and 28 diagnostic and treatment centers, which include FQHCs) operate the state’s 216 centers. Figure 7 provides a general description of benefits and limitations of each type of sponsoring agency. SBHCs are considered an extension or an off-site clinic of the sponsoring agency. Sponsoring agencies are responsible for operating the SBHC. However, school districts are responsible for providing a space within the school building for the SBHC. *See Appendix A4 for a list of sponsoring agencies and SBHCs in western and central New York.*

Figure 7. **General Comparison of Benefits and Limitations of Sponsoring Agencies in New York State**

Sponsoring Agency	Benefits	Limitations
Hospitals	<ul style="list-style-type: none"> ▪ More likely to offer expanded clinical services, including lab work ▪ More likely to combat staff shortages due to greater financial sustainability ▪ Greater marketing potential. Hospitals tend to have a well known name in the community ▪ Larger network of providers, including specialist, that enrolled students may have access to 	<ul style="list-style-type: none"> ▪ School-based health program/division may not be autonomous in operation ▪ Given hospitals size, school-based health program directors may have to advocate for their program
Federally Qualified Health Centers	<ul style="list-style-type: none"> ▪ Eligible for federal funding including grant opportunities, greater financial sustainability ▪ The center could provide a medical home for the entire family 	<ul style="list-style-type: none"> ▪ Not available in every community
Diagnostic & Treatment Centers	<ul style="list-style-type: none"> ▪ May be smaller facilities ▪ School-based health program may have more operational flexibility ▪ Traditionally centers are community-centered 	<ul style="list-style-type: none"> ▪ Less likely to offer expanded services due to financial limitations

School districts interested in opening a SBHC must determine whether sponsoring agencies in their region of the state are interested in collaborating with the district to open a school-based health program. School districts should evaluate a sponsoring agency’s location, financial security, experience in delivering school-based health care, leadership, administrative support within the organization, and alignment of mission to the SBHC model. In addition, the array of services offered by the sponsoring agency should be evaluated along with the organization’s history of collaboration with school districts. Successful SBHCs are a joint collaboration between a school district and sponsoring agency interested in improving the health and mental health status of students in need.

The SBHC sponsoring agency has the overall responsibility for the center’s administration, operations, and oversight. Sponsoring agencies provide administrative support in various areas such as maintenance of confidential medical records, fiscal and billing procedures, quality improvement, coordination of services with backup health providers (to provide services when the SBHC is closed), and staffing. In addition, the sponsoring agency ensures the SBHC follows health policies and procedures and remains

current with NYSDOH, School Health Program guidelines and principles. It is recommended that school districts meet with the SBHC sponsoring agency on a regular basis to maintain open lines of communication and to ensure that concerns are addressed in a timely manner. *See Appendix A5 for a visual overview of sponsoring agency and school district responsibilities and options for collaboration.*

According to the NYSDOH, School Health Program (2006) the school district assists the SBHC by:

- Marketing the SBHC
Examples: include articles about the services offered at the SBHC in the school newsletter or on the school district's website
- Assisting in the SBHC enrollment process
Examples: inviting the sponsoring agency to kindergarten registration to assist parents in enrolling their children in the program or sending home enrollment packets via teachers each school year
- Assisting the SBHC in obtaining information on insurance status, including Medicaid and Child Health Plus
Example: sharing parental contact information with SBHC staff to ensure they have up-to-date information
- Providing appropriate access to school health records
Example: the school nurse and the SBHC staff work together to ensure that all students are up-to-date on their immunizations
- Maintaining the SBHC facility
Example: school district janitorial staff clean the center and empty the trash as they do teacher's classrooms

2.2 School Nurse(s), Social Worker(s), and Psychologist(s)

SBHCs form an integral part of a safety network designed to support children living in underserved communities. The other parts of that safety net include school nurses, school social workers, and school psychologists. Instead of a duplication of services, SBHCs supplement the work of school health providers by offering a broad range of health care services.

Developing an open line of communication between the school nurse and the SBHC staff is essential to the success of the center. School nurses can help greatly in the enrollment process and the referral process. Immunizations, sports physicals, work physicals, and health emergencies can be collaboratively handled by the SBHC and the school nurse to ensure students receive coordinated school health care. For example, a school nurse can track the immunization records of all students and identify the students missing key immunizations. The nurse can then refer students/families to the SBHC to receive the required immunization. Once enrolled, the student can receive their immunization at the SBHC and return promptly to their class with minimal to no interruption to their school attendance. A partnership between

the SBHC staff and the school nurse will improve students' quality of care; however, it is essential that confidentiality be maintained. Enrolled students' medical and mental health records are never shared with school nurses, social workers or psychologists without consent.

The SBHC may be the only health care provider in the school building in some cities across New York. Cities that are not required to have a school nurse on-site include New York City, Rochester, Buffalo, Syracuse, and Yonkers (New York State Education Department, 2009). However, school districts may contract with health care facilities to provide the health services traditionally provided by a school nurse. In schools with SBHCs in Rochester, Buffalo, and Syracuse the school district and sponsoring agency should evaluate whether the SBHC provider will provide the health services traditionally provided by a school nurse in addition to the services provided by the SBHC.

SBHCs may collaborate with social workers and psychologist to identify children with high risk behavior problems or symptoms. The school social worker(s) and psychologist(s) can refer enrolled students to the SBHC for comprehensive individual and/or family counseling treatment. An example of a successful partnership between a SBHC and school mental health providers can be found at a Bronx high school where all school mental health providers meet regularly with SBHC staff to identify high risk students, make referrals, and coordinate the services for the enrolled students in treatment. In addition, school-based health staff support teachers and school administrators by providing individual, group, and classroom health education consistent with school curriculum, supporting teachers concerned about students' physical and mental health, and addressing the health needs of specific, high-risk populations.

2.3 Youth

Youth are SBHCs' most important stakeholders. To optimize the benefits SBHCs provide to students, many centers participate in activities that will increase school connectedness, such as encouraging student involvement in school-based health activities, providing opportunities for student leadership development, and encouraging school-based staff to act as mentors and role models (NASBHC, 2007).

Many SBHCs organize peer health education programs and youth advisory boards for the youth in their schools to promote the development of leadership and health advocacy skills. For example, Northern Oswego County Health Services, Inc. engaged youth served by one of their centers to become youth school-based health advocates. The youth from Sandy Creek Central School participated in advocacy training and traveled to the state capitol to educate legislators on the importance of SBHCs.

As part of addressing the barriers to accessible health care, SBHCs encourage youth to learn about their health, nutrition, physical activity, and disease prevention. Through health education, SBHCs hope to empower youth and their families to take active roles in their health maintenance as well as shaping policies that influence the health of their environment. SBHC staff may work with health and classroom teachers to assist their work in engaging youth. Successful work with youth is achieved when school administrations and faculty actively collaborate with SBHC staff to find and develop innovative strategies to engage youth.

2.4 Parents

SBHCs depend greatly on a collaborative relationship with parents, guardians, and families of enrolled students. On-going communication between providers and parents allows providers to understand the broader context of the child's life. SBHCs may structure their services according to the priority of needs and health concerns of the student population. Parents or guardians together with SBHC staff can plan and help execute the child's medical and/or mental health treatment plan.

As previously mentioned, SBHCs require the consent of parents or guardians to provide services. The parents receive notification by the SBHC when medical or mental health attention is needed for the enrolled child. For adolescent visits, the parents are notified about the confidentiality guidelines of reproductive health services. In New York State, adolescents have the right to consent for confidential reproductive health services. SBHC staff work with the enrolled adolescents on how to communicate to their parents and families about delicate issues. A successful SBHC recognizes the strength of developing a collaborative, working relationship with parents to address their child's needs. School districts can play an important role in cultivating this relationship by encouraging parents to use the SBHC as an ally.

2.5 Community

The NYSDOH, School Health Program requires each SBHC in the state to organize and coordinate a community advisory council (CAC) to ensure input from community members is considered in the development and operation of the SBHC (NYSDOH, 2006). Members of the advisory council should include school staff, community members, health providers, parents and youth. The establishment of the CAC is the responsibility of the SBHC sponsoring agency. The sponsoring agency is responsible for sending meeting notices and conducting the CAC meetings. However, school districts can assist sponsoring agencies in the process by sharing contact information of interested parties. SBHCs across the state have found that CACs optimize the center's benefits and impact and ensure that community needs are effectively met.

Section 3. Enhancements to the Model

3.1 Dental Services

Dental problems are among the top unmet needs of children across the country with a higher incidence experienced by low-income populations. According to Kumar and colleagues (2005) the prevalence of dental caries experienced and untreated dental caries were more prevalent in a low-income group of New York's third graders as compared to upper income group. In addition, a lower proportion of low-income children had visited a dentist in the last one-year compared to upper-income children (60.9% vs. 86.9%).

According to the 2004-2005 NASBHC Census, only 8.2% of SBHCs provide comprehensive dental care (NASBHC, 2005). However, according to NASBHC, 35% of SBHCs in New York provide preventive dental care (i.e., sealants, fluorides, and cleaning). School-based dental programs may be fixed or mobile. Fixed dental programs are permanent units that are placed within or adjacent to the SBHC. Mobile dental programs can be transported from location to location to meet the needs of various school populations. Mobile dental programs refer to either mobile equipment that is transported to each school and is setup for a limited time within a designated area of the school or mobile dental vans that are driven from school to school. Services are provided inside the mobile dental van. The extent of dental services offered is dependent upon the resources, financial and staff, of the SBHC sponsoring agency. Some SBHCs offer comprehensive dental services in which preventive and restorative dental care is provided by both a dental hygienist and a dentist. If dental services are not provided on-site, the NYSDOH (2006), School Health Program requires that services must be offered via referral.

For example, the North Country Children's Clinic in Watertown, NY opened one of the first permanent school-based dental clinics in New York State. The permanent dental clinic is located adjacent to the SBHC. Dental services are provided by a dentist and a dental hygienist; a dental aide schedules student appointments and assists in preparation for appointments. The North Country Children's Clinic bills health insurance providers for all billable dental services. Families who do not have dental insurance are placed on a sliding fee scale. Given its proximity to the SBHC, dental providers work collaboratively with the SBHC nurse practitioner to ensure that students' health and dental needs are adequately met. In western New York, SBHCs sponsored by Kaleida Health refer enrollees to their Women and Children's Hospital for dental services. In addition, the organization is currently preparing for a collaboration with University Pediatric Dental through SUNY Buffalo to provide dental services to SBHC enrollees through a mobile

program. A collaborating dentist and a dental hygienist will provide the dental services.

School-based dental programs operate under the NYSDOH, Bureau of Dental Health. Article 28 health care facilities interested in establishing a SBHC dental program (SBHC-D) must complete an application and receive approval by the NYSDOH (NYSDOH, 2007). As with SBHCs, school-based dental programs must meet various space, record, and management requirements. Albert and colleagues (2005) recommend that schools and/or sponsoring agencies thoroughly examine the dental health care needs and resources available to the student population along with the health and mental health care needs of the students. However, school-based dental programs may operate in schools without a SBHC. For schools with a SBHC or those interested in developing one it is recommended that school districts contract with a sponsoring agency that provides both health and mental health care services. Contracting with one sponsoring agency reduces the possibility of problems arising between two different health care facilities operating within the same school building. *See Section 6.3 School-Linked or Mobile Programs for an example of dental services offered at schools without a SBHC.*

3.2 Health Education, Promotion and Nutrition Counseling

According to the NYSDOH, SBHCs may provide health education to enrolled students through individual sessions, organized groups, school community-wide campaigns, and classroom workshops (NYSDOH, 2006). SBHCs have the ability to be a resource for enrolled students and the school community on topics such as tobacco prevention and cessation, chronic disease management such as asthma and diabetes, and reproductive health which includes abstinence, teen pregnancy prevention, and HIV/STI prevention. The provision of health education largely depends on funding support and the need of the school community. Diabetes and asthma self management education recently became a covered service under New York State's Medicaid program as long as the service is rendered by a certified educator (NYSDOH, 2008b). In addition, health education and promotion services could be supported through public and private grants.

Columbia University Mailman School of Public Health, Center for Community Health and Education sponsors a successful school-based health education component. The program staffs each SBHC site with a health educator. In 2004, the program provided health education interventions to nearly 20,000 teens and adults in the upper Manhattan area of New York City. On site health educators have the capacity to address the issues that affect the local community. The program has successfully carried out health education and promotion campaigns in the SBHCs, school classrooms and in the community. For example, a reproductive health care campaign included pregnancy prevention initiatives to promote abstinence, delay initiation of intercourse, and counsel sexually active and high risk young adolescents on

healthy decision-making. The health educator works collaboratively with the SBHC medical and mental health providers to address barriers to behavior change (Columbia University, 2009).

Many SBHC sponsoring agencies offer nutrition education and counseling as part of their individual medical services. As an enhancement to the SBHC model, nutrition education and counseling may be widely offered to enrolled students, groups, classrooms, and the school community. Some SBHC programs host nutritionist interns from local universities and colleges to provide this service in a cost effective manner. The interns provide one-on-one nutrition education and counseling to high-risk enrolled students. SBHCs can also assist schools in adopting school policies that promote student and faculty health and wellness.

The Montefiore School Health Program in the Bronx, New York has been successful in collaborating with students and faculty to advocate for nutritional changes in the school such as eliminating junk food and sugary drink options in school vending machines, changing school food policies to only distribute fat-free milk, and the establishment of cooking classes and additional physical activities for children and their families (Montefiore School Health Program, 2008).

In western New York, Kaleida Health's school-based health program sponsors health fairs and health promotion activities at their thirteen SBHC sites (G. Meeks, personal communication, June 4th 2009). Kaleida also staffs a registered dietician who provides individual nutrition counseling and community-based health promotion. According to the 2004 census by NASBHC, 68% of SBHCs offer some kind of nutrition, weight, or fitness management (Juszczak, Schlitt, & Moore, 2007). Even though health educators are an additional SBHC expense health education, promotion, and nutrition counseling are an integral part of creating a healthy school environment.

3.3 Facilitated Enrollment

In the late nineties, Governor Pataki and the New York legislature created New York's facilitated enrollment program. The program was an innovative initiative to enroll uninsured children and teens in public health insurance. "Launched in 2000, the facilitated enrollment program uses community-based organizations and health plans to find and enroll 'hard-to-reach' New Yorkers who have historically been left out of public health insurance (Lawler & Costello, 2005)." Since its inception, 250,000 children have been enrolled in public health insurance programs available within the state (Lawler & Costello, 2005).

The current public health insurance programs offered in New York State are Medicaid, Child Health Plus, and Family Health Plus. Facilitated enrollers assist families in determining which state offered health insurance plan is right for them. Facilitated enrollers can answer questions about these health insurance programs and can assist families in enrolling in the program. Facilitated enrollment is especially beneficial in areas with a high immigrant population as language and cultural barriers often prevent families from enrolling in health insurance programs on their own.

In western New York, Kaleida Health care recently commenced a facilitated enrollment program offered throughout their SBHCs. The program employs social workers and facilitated enrollers who ensure that uninsured adults and children who are eligible for government-funded health insurance programs are enrolled in such programs. In addition to health insurance programs offered by New York State, Kaleida's facilitated enrollers screen patients to determine whether they qualify for Kaleida Health's Charity Care Assistance Program. Translation services are available if needed as well. In addition, the Resource Center, in Jamestown, collaborates with Chautauqua Opportunities, Inc., to serve the families of SBHC enrollees who need the assistance of a facilitated enroller.

Access to health insurance reduces the out-of-pocket costs children/families spend on health care (Brealey, Myers, Marcus, 2007). Without a facilitated enrollment program families would be responsible for trying to obtain coverage on their own which results in poor insurance enrollment success and increased out-of-pocket costs spent on health care.

3.4 Family Services

Many SBHCs across the state actively reach out to parents and guardians to raise awareness about the services offered at the center, encourage them to enroll their child in the program and educate them on topics that assist in family communication, cohesiveness, and overall healthy lifestyles. Columbia University Mailman School of Public Health, Center for Community Health and Education and the Children's Aid Society, both SBHC sponsoring agencies in NYC, offer enhanced family services in an effort to empower parents to be effective advocates for their children's health

(Columbia University, 2009). These agencies believe that parents who receive assistance with legal, financial, emotional and health issues are able to focus on the needs of their children (Children's Aid Society, 2009). Enhanced services for parents may include: workshops on family development, adolescent growth and development, stress management, and assistance on domestic violence, housing, and job skill development. SBHCs also provide assistance to teen parents and their children.

3.5 Community Agency Referrals

SBHC staff is intimately aware of the needs of enrolled students and their families given their placement within the school building. As a result centers may often collaborate with other child-centered community agencies to manage needs that arise. SBHCs often refer students and families to food, housing, clothing, and prescription assistance, family counseling, and social service agencies. In addition, adolescents and parents are often referred to free or low-cost programs offered by the state. For example, adolescent patients who are interested in tobacco cessation are often referred to the New York State Smokers' Quitline. School districts can assist SBHCs in referring enrollees to local community agencies by providing SBHC staff with a list of community agencies that the district has collaborated with in the past.

3.6 Community Schools: A Unique Approach to Expanding School-Based Health Centers

An enhancement to the SBHC model also includes community schools. A community school is a public school that is a partnership between school administrators and a community-based health care organization that offers a wide range of health and social services to ensure that children are physically, emotionally and socially prepared to learn (Children's Aid Society, 2009). The Children's Aid Society offers a superior example of a community school. Currently the agency operates 21 community schools in New York City, in partnership with the Department of Education (Children's Aid Society, 2009). Since 1989, the Children's Aid Society has offered after-school programs that focus on academic, social, cultural and recreational objectives, parent education, child health insurance enrollment, medical and dental services, mental health services, immigration and legal assistance, summer camp, community events and economic development (Quinn, 2005). The community school is open early mornings, evenings, weekends and summers (Children's Aid Society, 2009).

This enhanced model offers accessible health, mental health, and social services for children and their families. However, this enhanced model is expensive to operate. Traditionally, its financing is dependent on a patchwork of public and private grants as well as donations. Despite its cost, this model is increasing in recognition with a recent mention by the United States Secretary of Education, Arne Duncan, in which he spoke in depth

about the vision of the community school model becoming a standard for American public schools (Coalition for Community Schools, 2009).

3.7 Miscellaneous Enhanced Services

Some SBHCs hire community outreach workers to establish a concrete link between the center and the local community. Community outreach workers continually assess the needs of students served by the SBHC and available services offered within the community. Students are then connected with applicable community-based services. In addition, community outreach workers engage other youth-serving community agencies to develop a connection between the SBHC and the local community.

SBHCs may also serve as a site for the training of medical, mental health, and other health providers. SBHCs have the potential to provide enhanced services by collaborating with universities and medical schools. Interns or medical students then complete a portion of their rotations at a SBHC. The establishment of enhanced services should be planned and developed jointly between the school district and the SBHC sponsoring agency.

Section 4. Resource Needs

4.1 Start-up and Annual Costs

SBHCs in New York State are required to be located within a school building. The NYSDOH, School Health Program states that school districts assist the SBHC by “providing space at no cost to the sponsoring agency (NYSDOH, 2006).” However, school renovation, which is typically needed to open a SBHC, is not necessarily provided at “no cost” to the sponsoring agency. It is recommended that the SBHC be located as close to the school nurse’s office as possible as this helps with communication and coordination of care. Start-up costs include the actual renovation of the center’s space, as well as the purchase of office and medical equipment. In addition, some sponsoring agencies factor in the cost of administrative and provider staff salary and benefits during the planning and initial implementation phase of the center. Approximate start-up costs in western and central New York range from \$200,000 to \$350,000 with higher costs attributed to larger centers, typically located in high schools. This estimate includes the cost of construction/renovation of the school space.

Staffing costs, including benefits, equate to the largest annual expenditure for SBHCs. Additional annual costs include medical supplies and medications/immunizations, insurance, utilities and cleaning expenses, and indirect costs such as staff continuing education and travel expenses. Several school districts throughout the state provide the school renovation as an in-kind contribution as well as utilities, phone and internet usage, and custodial support.

4.2 Memorandum of Understanding

It is strongly suggested that a school district sign a Memorandum of Understanding (MOU) with the SBHC sponsoring agency. This shared use agreement is typically used to outline and formalize the relationship between the sponsoring agency and the host school, and the responsibilities of each member of the agreement (21st Century School Fund, 2004). The MOU should clearly spell out the contributions of each party. *See Appendix A6 for a sample MOU between a school district and a sponsoring agency.*

According to the NYSDOH, School Health Program the MOU between the school district and/or the school building administration and the SBHC sponsoring agency should be updated every five years and should include:

- Methods for addressing priorities and resolving differences.
- Assurances that there will be a collaborative relationship between the SBHC staff and school personnel.
- A description of how the SBHC sponsoring organization will provide 24-hour access to services when the SBHC is closed.

Other factors that may need to be considered before developing and signing the MOU include:

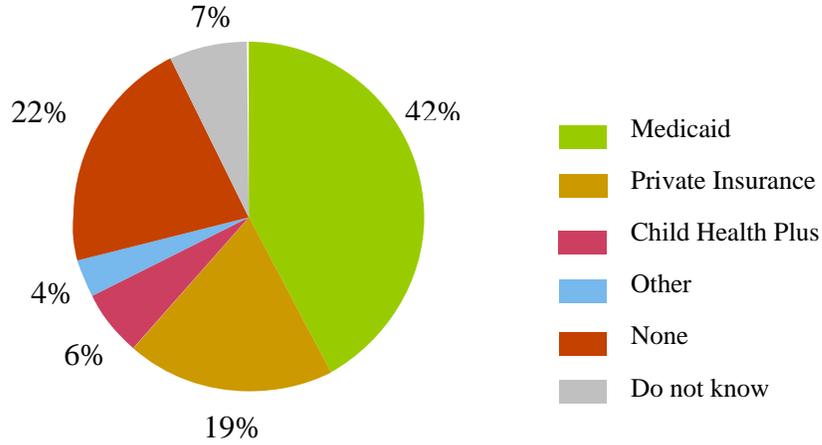
- What are your needs and expectations with respect to ongoing communication, dialogue, joint planning, and problem solving? Confidentiality requirements should be clearly detailed.
- Will the school nurse cover the SBHC during times when providers or health assistants are not on-site?
- Which party will pay for utilities, phone, and internet usage costs? If the sponsoring agency is to pay the school district for these services, how will the services be billed and paid?
- Which party will provide or pay for school building renovations if necessary to open the SBHC?

4.3 Third-Party Billing

As previously stated, SBHCs provide care to all enrolled students who enter the center at no out of pocket cost. In addition, SBHCs are mandated, by the NYSDOH, School Health Program to provide services to all enrolled children regardless of health insurance coverage (NYSDOH, 2006). SBHC funding has been directly tied to statewide advocacy campaigns that have supported the use of public monies to fund SBHCs across the state and advocacy campaigns that have supported changes in public health insurance policies that ensure SBHCs are reimbursed equitably for the services that they provide. *See Appendix A7 for an overview of SBHC funding history in New York State.*

According to Brindis and colleagues (2003), 73% of all SBHCs throughout the country bill Medicaid and other third-party insurers for services rendered. The NYSDOH, School Health Program encourages SBHCs to establish procedures for obtaining and confirming health insurance coverage information. Figure 8 provides a breakdown of SBHC enrollees by type of coverage. SBHCs generate encounter forms for billable visits and establish procedures to ensure Medicaid and other third-party insurances are billed for services rendered. “Revenues received from billing insurance companies must be returned to the SBHC program for the support and development of the program” (NYSDOH, 2006).

Figure 8. New York State SBHC Enrollees by Health Insurance Coverage (NYSDOH, 2009).



However, “insurance revenues are well below what might be expected, given the insurance status of children and adolescents” (Brindis et al., 2003, p99). For example, NASBHC indicates “only half of the SBHCs that bill Medicaid are able to collect any payment at all (NASBHC member letter, *personal communications*, March 2007).” Additionally, Harvey and colleagues (2002) indicate that Medicaid revenue has traditionally covered fewer than 10% of all operating costs for most SBHCs throughout the country. Some public health insurance programs’ reimbursement stipulations contribute to SBHCs’ minimal amount of insurance revenue.

Section 5. Limitations and Challenges

5.1 Limitations

Lack of financial sustainability. SBHCs are supported with public and private grant dollars. However, in recent years “public and private grant dollars from federal, state, and local levels have become more and more competitive and in shorter supply” (NASBHC, 2000, p1). In addition, the mission of SBHCs is to serve uninsured and medically-underserved children and teens throughout the state. As a result a great deal of health and mental health care services are provided without reimbursement; the cost of these services must then be absorbed by the sponsoring agency. *See Section 4. Resource Needs for more information on the financial sustainability of SBHCs throughout New York State.*

Treatment restricted to students enrolled in a specific building – when needs exist across multiple buildings. School districts, in collaboration with sponsoring agencies, often have to make difficult decisions in determining which school building is of most need knowing that resource limitations will most likely prevent the school district or sponsoring agency from placing a SBHC in every building in need. Additionally, as students age out of elementary and middle schools they can no longer access the services offered at their former SBHC. Lastly, SBHCs are not permitted to treat school faculty, which is often desired by school personnel.

Inability to provide expanded clinical and ancillary services. SBHCs are off-site locations of larger sponsoring agencies, and often have to refer students for laboratory testing because the financial and staff resources to provide the testing is often too great for the SBHC to absorb. In addition, since SBHCs are off-site locations of sponsoring agencies, centers are often the last to receive resources, in particular updated technology equipment. SBHC staff must continually advocate for resources to be equitably spent within the school-based health program. In addition, since SBHCs are located within school buildings, centers are often provided limited space to operate. This limitation can be narrowed if school districts and sponsoring agencies collaborate during the construction and renovation of the SBHC space to ensure the center receives adequate space to operate.

SBHCs are not the traditional medical home or primary care provider for enrolled students. SBHCs traditionally offer services only when the school is in session. Therefore, parents often maintain their child’s former primary care provider to provide services when the SBHCs is closed. Continuity of care is an essential aspect of providing high quality, comprehensive health care. In an effort to maintain continuity of care with student’s primary care providers SBHCs maintain open lines of communication with enrolled students’ primary care provider. Copies of

students' medical records are sent to their primary care provider after each appointment to improve continuity of care, reduce fragmentation, and prevent duplication. In addition, SBHCs are required by the School Health Program to provide 24-hour/7-day a week access to services. This requirement is traditionally met by utilizing the sponsoring agency's on-call service. However, a limitation of many SBHCs is that services are not provided at the center during holidays and summer vacation. If services are provided they are usually provided on a limited basis only. If students need to access health and mental health services during holidays and summer vacation students/parents must visit the SBHC's sponsoring agency or their primary care provider.

5.2 Challenges

Need for broad support. School districts interested in collaborating with a sponsoring agency to open a new SBHC must achieve overwhelming faculty, parent, and community support. "Parent and community member opposition is detrimental to the establishment and functioning of a viable school-based model" (Albert, McManus, & Mitchell, 2005, p157). It is imperative that faculty, parents, and community members be engaged in dialogue regarding the need for and their opinions of establishing a SBHC. Faculty, parents, and community members should be provided with an opportunity to ask questions and provide their feedback on the possibility of opening a new center. Typical faculty concerns center around the impact the SBHC will have on changing the dynamic within the building, including changing the roles and responsibilities of the school nurse and school counselor(s). Typical parental concerns center around the type of services provided, including parental opinion of offering reproductive health care services in high school settings and confidential mental health care services, the impact the SBHC may have on school district resources and/or the tax rate, and the potential impact on the school nurse. Community member apprehension typically centers around concerns over the impact the SBHC will have on district resources and/or the tax rate, concerns over how one school building was chosen as opposed to another needy building, and local pediatrician and family physician opposition. Opposition from local pediatricians and family physicians typically focuses on the idea that the SBHC will reduce local physicians' patient load thus removing patient revenue from their practice.

Concerns about continuity of care and duplication of services. It is imperative that local pediatricians and physicians be included in the SBHC dialogue from the very beginning. In addition, it should be explained to local pediatricians and physicians the desire of the center to collaborate with them to ensure continuity of care is maintained and duplication of services are prevented.

Gaining full support. Gaining the full support of all stakeholders is unlikely; however, it is imperative that lines of communication remain open between the school district, the SBHC sponsoring agency, parents, faculty, and community members, including local pediatricians and physicians. Sponsoring agencies may assist districts in educating faculty, parents, and community members on the SBHC model to ensure that questions are clearly answered and misconceptions are cleared. Significant areas of concerns raised by these important stakeholders must be addressed before a district can move forward with opening a SBHC.

To address stakeholder concerns, it is recommended that school districts (Kaleida Health, 2006):

1. **Engage all school faculty in the SBHC planning and implementation process.** Faculty should be given an opportunity to freely express their concerns. Faculty interested in becoming more intimately involved in the planning and implementation of the SBHC should be given an opportunity to join a faculty planning and implementation team. It is strongly recommended that school nursing and counseling staff be included on this team.
2. **Include local pediatricians and family physicians in the SBHC dialogue from the very beginning.** Ensure that open lines of communication are maintained so that both parties are able to express their concerns and desires for collaboration in the future.
3. **Assist the sponsoring agency in creating a Community Advisory Council (CAC) to engage parents and community members in the planning and implementation of the SBHC.** The group can assist the school district and sponsoring agency in determining the scope of services offered, by providing feedback on SBHC operation, and by providing ideas on marketing the SBHC.

Adequate space and facilities are critical factors in sustaining a SBHC. Albert and colleagues (2005) indicate that adequate space and facilities are critical factors in sustaining a SBHC since inadequate space may reduce the center's productivity and may limit its ability to meet the needs of underserved students. It is essential that schools adequately plan for the facility requirements of a SBHC. Centers that are haphazardly placed in closets or storage areas will not be able to achieve adequate productivity and will not be as successful as centers that are given the appropriate facilities and space. It is recommended that school districts consult with the SBHC sponsoring agency before any renovations are made. Each party is obligated

to comply with state regulations which govern facility requirements of schools and health centers. School districts and sponsoring agencies must respect each other's obligations and regulations and should begin working together in the early planning and developing stages.

High start-up costs and limited ability to generate revenue. Lastly, numerous SBHCs across the state are in need of significant contributions from foundations, individuals, and corporations to establish a SBHC given high start-up costs and limited revenue generation. Without adequate start-up funds a center will not be able to open its doors. School districts should collaborate with sponsoring agencies to find innovative funding sources to open the SBHC. *See Section 4.1 Start-up and Annual Costs for more information on start-up costs.*

Section 6. Other Options for Providing Health Care in Schools

Options for providing health care in schools include school-linked, part-time, or limited service programs. There are approximately 221 alternative school health centers throughout the United States providing health care services in schools, with 187 being school-linked and 34 operating as mobile programs (Juszczak et al., 2007). Listed below are examples of alternative options for providing health care in schools. Each example includes an overview of the alternative model, including benefits and limitations.

6.1 Integrated Resources In Schools (IRIS): A Program of Binghamton University Initiative for Best Practices in Full Service Community Schools

Program Overview

With support from the Stewart W. and Willma C. Hoyt Foundation, the IRIS program is a pilot project that develops, implements and evaluates an integrated system of health and social services in two Binghamton City School District elementary schools. The pilot sites for the IRIS program serve over 1,000 children between them, from pre-K through grade 5. The schools have extremely high poverty rates and the vast majority of students receive public assistance. Two Binghamton University Decker School of Nursing nurse practitioner students work closely with the school nurses (4hours/week each) to provide direct and indirect nursing services. Direct nursing services include health screenings and assessments for all of the students enrolled in the IRIS program. In addition, two Binghamton University Social Work graduate students (15 hours/week each) work closely with the school social workers/counselors to expand the direct and indirect social work services provided to students and their families. Social work services include counseling, referrals, consultation and collaboration with school staff, especially classroom teachers and community agency providers. Graduate social work students also actively participate in SBIT (School-Based Intervention Team) meetings for “at risk” students and wraparound meetings for students receiving special education services.

In collaboration with school principals, Binghamton University graduate nursing, education and social work faculty and graduate students execute a clearly defined protocol for identifying and serving children and families in the most need of IRIS services. A research proposal to evaluate the IRIS program has been approved by Binghamton University’s Human Subjects Research Review Committee.

Benefits and Limitations

The fundamental benefit of the IRIS program is the importance it places on evaluation. The program was developed by practitioners and educators interested in studying the effectiveness of an integrated system of health and human services in needy school populations. The results of this pilot project will have an important impact on how care is delivered in future alternative school-based models. In addition, the program utilizes low-cost graduate students to provide services to populations in need. This is of great importance given the current shortage of nurse practitioners and social workers across western and central New York and ensures that students new to the nurse practitioner and social work field understand the unmet needs faced by students and families in their communities.

As with all alternative SBHC models the IRIS program is not regulated by the NYSDOH, School Health Program. The School Health Program has spent years devising best practices and operating guidelines to ensure that the provision of school-based health care is of the highest quality achievable. Secondly, the IRIS program is a pilot study. Therefore, this model should not be replicated until research validates its effectiveness. Lastly, the IRIS program was funded through a grant from a private foundation and does not currently have a means of financially supporting itself. Therefore, the long-term sustainability of this type of program would be dependent upon future foundation or private grants and/or donations.

(Section 6.1 adapted from Elizabeth Anderson and Laura Bronstein, June 1, 2009, personal communications).

6.2 Health Care Provided in Charter Schools

Overview

According to the State University of New York, Charter Schools Institute (2009) there are currently 115 charter schools operating in New York, 78 of which are located in New York City. These charter schools serve nearly 35,000 students, representing less than 2% of all public schools in the state. Charter schools must comply with laws regarding the provision of health services, as defined in Article 19 of the Education Law. It is possible for charter schools to comply with Article 19 regulations by hiring licensed health professionals (i.e., nurse practitioners or physician assistants) in addition to or in place of a professional registered nurse. Specifically, § 902 of Article 19 of the Education Law states, “Any such board or trustees may employ one or more school nurses, who shall be registered professional nurses, as well as other health professionals, as may be required (New York State Education Department, 2009).” The nurse practitioner or the physician assistant provides the typical services of a school nurse while providing expanded services as defined by their medical license.

Benefits and Limitations

The use of nurse practitioners or physician assistants to provide health services in charter schools is not regulated by the NYSDOH, School Health Program and is thus not considered a SBHC. The School Health Program has spent years devising best practices and operating guidelines to ensure school-based health services are of the highest quality of care achievable in a unique setting to a distinct population of patients. Hiring nurse practitioners or physician assistants to provide health services does not allow for the provision of comprehensive health and mental health services nor will students in need be able to access services 24-day/7 days a week. However, this option does expand the health care services that are traditionally offered in a school setting.

6.3 School-Linked or Mobile Programs

Overview

According to NASBHC (2009), school-linked health centers are an alternative option of providing health care in schools. In this model, schools or school districts become affiliated with community-based health centers that have a mission to serve uninsured and underserved children. School-linked health centers are located off school grounds and may serve more than one school. The operating hours are not limited to the school session schedule and may be available on weekends, holidays, and summer vacations. Since school-linked centers are community-based they may have access to an established referral network of medical, mental health and dental health providers. School-linked health centers may also have the capacity to offer a broader scope of services than typically found in SBHCs such as laboratory services, specialty care such as vision, and family services. Practical limitations to school-linked health center include the accessibility of the health centers, the lack of communication between the school and the health center located off grounds, and limitations on developing mutually supportive partnerships with youth, parents, and the school community.

Mobile programs provide services by traveling to those in need. The New York Children's Health Project, located in New York City and funded by the Children's Health Fund, launched its mobile clinic in 1987 (Children's Health Fund, 2009). Blue buses and vans provide comprehensive primary care, physical examinations and immunizations to children and families in need. These services are not school-based. However, they do provide services directly where families in need are located – in underserved communities. Schools located in communities with mobile programs may promote the services of the mobile program to children and families. However, as with school-linked programs, mobile programs have practical limitations including accessibility, the lack of communication between the school and the health center located off grounds, limitations on developing mutually supportive partnerships with youth, parents, and the school

community, and limitations on availability of services since services are only offered at specific times.

School-based mobile dental programs have become more common in recent years. For example, the Syracuse Community Health Center will be commencing the *Project Bright Smiles Initiative* this summer in five schools in the Syracuse School District in five schools in the Syracuse School District including: Blodgett, Seymour, Elmwood, Frazer, Franklin and McKinley-Brighton. The initiative is a dental screening program, which utilizes mobile dental equipment. A dentist will provide oral exams and will develop treatment plans for students and dental hygienists will provide cleanings and sealants/fluoride (if age appropriate). In addition, oral health education services will be provided to all students within the five schools. Syracuse Community Health Center will be sustaining the program by billing Medicaid for services rendered. The five schools served by this program do not currently have SBHCs. However, the schools have agreed to provide space for the mobile dental program in their school's nurse's office or in an adjacent room. The program will serve pre-K through 8th grades.

Benefits and Limitations

School-linked or mobile programs are traditionally developed to meet the needs of underserved children. School-linked or mobile programs do reduce some barriers to accessing health care, in particular transportation barriers. In addition, school-linked or mobile programs emphasize collaboration between partners to ensure those in need are being served. However, school-linked or mobile programs are not regulated by the NYSDOH, School Health Program. As a result, these programs may not follow the operating guidelines and best practices that SBHCs are required to follow. As previously mentioned, mobile dental programs are regulated under the NYSDOH, Bureau of Dental Health. However, mobile dental programs only provide one type of health care service. Therefore, students in need of medical and mental health services must access these services within the community.

Section 7. Advocacy

Advocacy has been the driving force behind SBHCs for over twenty years. SBHCs engage in advocacy to increase awareness of the SBHC model and its benefits. SBHC funding is intimately tied to community and political awareness of the SBHC model. As an effective intervention, SBHCs not only provide direct health services but also empower children, adolescent and families to overcome challenges that threaten their basic human right: quality, accessible health care. It is important for school districts to understand the power of SBHC advocacy. Districts can play a pivotal role in SBHC advocacy by encouraging and cultivating opportunities for youth, parents, faculty, and the community to advocate on behalf of SBHCs. SBHC advocacy not only provides increased understanding of the school-based health model but also improves the model's sustainability. Below is a description of SBHC advocacy that has been carried out on the state and federal level.

7.1 State Level School-Based Health Center Advocacy

SBHC staff routinely advocate for children's unimpeded access to health care. In collaboration with school staff, parents, youth and community members, SBHCs are able to provide critically needed services to underserved students. SBHC advocacy is needed to ensure children's access to health care is secured and stabilized. The New York State Coalition for School-Based Health Centers' (the Coalition's) long history of grassroots advocacy has contributed to an increase in the number of centers throughout the state. Persistent SBHC advocacy is needed to continue to raise awareness about disparities in health care access and to garner additional support of the school-based health movement.

SBHC advocacy is cultivated by utilizing existing partnerships with school staff, parents, youth, and community members. Each partner plays an important role in advocating on behalf of SBHCs at multiple levels of government, from local to federal. The Coalition has organized local and statewide activities as well as influenced federal policy by meeting with federal representatives in New York. All activities require the participation of SBHC community members to be truly effective in sharing the information of how the SBHC influences the lives of the enrolled youth, their families and the community.

Each year, the Coalition organizes a statewide SBHC Advocacy Day in Albany. Youth, parents, school staff, and SBHC staff from various communities across the state travel to the state capitol to rally support for SBHCs. The activity is a highlight of SBHC advocacy in New York and an opportunity for supporters to hear and share their stories about SBHCs. The event also involves meetings with state legislators to educate and partner with them on SBHC issues. Advocacy Day is not only an event that supports

SBHCs, the event also encourages youth, parents and school community members to become leaders and advocates for social justice.

Throughout the year, the Coalition continues to involve SBHC advocates through activities in local SBHC communities. The youth can be involved through *youth advisory councils* (YACs) and school health awareness projects. The YACs are organized by the local SBHC program to encourage youth to voice their opinions, concerns, and ideas about SBHC issues. School districts play a pivotal role in fostering an environment that values and supports YACs. School personnel should meet with youth and SBHC staff to evaluate the possibilities of collaborating to form a successful, active youth council. YACs, which are youth-led, organize activities that interactively educate their peers on SBHCs and health issues. Past YAC projects have included video documentaries, school newspaper articles, poetry and song writing, posters, and health fairs. The Coalition also organizes an annual statewide essay contest which recognizes youth winners from various regions of the state. *See Appendix A8 for excerpts from 2009 essay contest winners.*

The Coalition also encourages parent involvement in SBHC advocacy. Parents have been active supporters of SBHCs through participation in letter-writing campaigns, phone call drives to legislators, and participation in legislative meetings, budget hearings and rallies. SBHCs collaborate with parent associations to work on child health issues in their local communities and on statewide campaigns. School districts should encourage a linkage between parent teacher organizations and SBHC staff. Some SBHC programs foster parent leadership in the community through the development of projects focusing on specific health issues such as asthma, immunizations, obesity, and physical fitness.

In addition, SBHC advocacy is also supported by local community advisory councils (CACs) and community partners. CACs actively participate in SBHC advocacy campaigns to secure funding on a local and state level. The establishment of a CAC assists school districts and sponsoring agencies in raising awareness and support of SBHCs. Community partners such as local foundations, businesses, religious institutions, and social service organizations support SBHC advocacy through grants, donations and resource collaboration. The vision of healthy children, schools and communities is a shared value that includes many supporters. Successful SBHCs become active partners with supporters who share this vision. *See Section 2.5 Community for more information on CACs.*

7.2 Federal School-Based Health Center Advocacy

National Assembly on School-Based Health Care (NASBHC) is the leading voice on school-based health and children's health advocacy on the federal level. With recent federal administration changes and the discussion of health care reform NASBHC is actively working on multiple campaigns that are promising for the advancement of SBHCs. Currently, NASBHC is gathering

information about possible SBHC funding through the American Recovery and Reinvestment Act (a.k.a. the Economic Stimulus Package). Possible funding streams include Title 1, innovation funds, and health information technology. SBHCs affiliated with sponsoring agencies that are FQHCs have the opportunity to apply for stimulus package funding.

In addition, NASBHC has made progress in achieving recognition of SBHCs as a recognized provider of services under the State Children's Health Insurance Program (SCHIP). In February 2009, President Obama signed the SCHIP reauthorization legislation that included the definition of SBHCs as a recognized provider of children's health care. With this inclusion, SBHCs may advocate to change individual state policies to allow reimbursement for SBHC providers under the SCHIP program (NASBHC, 2009).

In May 2009, NASBHC achieved an additional accomplishment in SBHC advocacy with the introduction of the Healthy Schools Act of 2009 (S.1043) sponsored by U.S. Senator Stabenow (D-MI) and Snowe (R-ME). The act would mandate reimbursement for SBHCs who provide services under SCHIP and Medicaid nationwide. This accomplishment has spread into health care reform discussions. Currently, reimbursement language, similar to language included in the Healthily Schools Act of 2009, is included in the House Tri-Committee health care reform bill (NASBHC, 2009). In addition, federal authorization language for SBHCs is included in the Senate Committee and House Tri-Committee health care reform bills which are being debated in Congress this summer (NASBHC, 2009). Federal SBHC authorization would authorize the federal government to fund SBHCs across the country. It is an exciting time period for NASBHC and SBHC advocates across the country.

Conclusion

This report, which was commissioned by the Community Health Foundation of Western and Central New York, provides a wealth of information on the school-based health model. This report compiles knowledge on SBHCs including SBHC services, guidelines, staffing, enrollment, benefits, challenges of operation, limitations and enhancements of the model, and fiscal operation. In addition, the report includes a section on alternative options in providing health care in a school setting and options for stakeholder collaboration and on-going support. Lastly, the report includes an overview of school-based health advocacy and its importance in sustaining the school-based health model in New York State.

SBHCs offer a unique option for school districts interested in meeting the health and mental health needs of underserved students. SBHCs offer countless benefits to students, families, the school district, and the community at large. Successful SBHCs are a marriage between sponsoring agencies and school districts who share the same common vision –all children will be healthy and ready to learn.

Appendices

A1. Sample Parent Survey

1. Please choose the health insurance plan which covers your child currently.

- * My child does not have health insurance
- * Child HealthPlus
- * Empire
- * GHI
- * USFHP Martin's Point Health Care
- * Excellus BlueCross BlueShield
- * Medicaid
- * POMCO
- * Tricare
- * Other _____

2. If your child is covered under a health insurance plan, does the plan adequately cover the cost of your child's health care needs?

- * Yes
- * No, co-pays are too high
- * No, deductible is too high
- * No, I can't find an approved provider
- * No, the plan does not include well-child visits

3. Why have you cancelled or rescheduled your child's medical appointments in the past? (Check all that apply)

- * Weather
- * Unable to miss time at work
- * Inconvenient office hours
- * Other _____
- * Problems with transportation or unavailable transportation
- * No health insurance coverage
- * Co-pay or deductible was too high

4. Is your child a patient at the North Country Children's Clinic's primary care facility in Watertown?

- * Yes
- * No

5. Does your child have special health care needs or concerns?

- * Yes
- * No

6. If yes, which of the following? (Check all that apply)

- * ADD/ADHD
- * Asthma
- * Chronic ear, nose, or throat infections
- * Gastrointestinal problems
- * Respiratory problems
- * Other _____
- * Allergies
- * Chronic bronchitis
- * Diabetes
- * Migraine headaches
- * Weight/Diet

7. During the past year, has your child experienced any of the following problems? (Check all that apply)

- * Academic difficulties in school
- * Coping with a divorce or separation
- * Coping with a loss
- * Difficulty with parents or family
- * Managing stress
- * Other _____
- * Behavior difficulties in school
- * Bullying
- * Coping with a parent's deployment
- * Feeling depressed
- * Outbursts of anger or violence

8. If the services of a school-based health center were available to your child at the Wilson Building which services would you use? (Check all that apply)

- * Treatment of illness or injury
- * Immunizations
- * Counseling for school/personal problems
- * Annual physical exam
- * Monitoring chronic conditions
- * None

9. What would most likely influence your decision to enroll your child at a school-based health center? Rank each item from 1 to 3 (1 being most likely and 3 being least likely).

- _____ Sponsoring agency reputation
- _____ My child does not have insurance coverage
- _____ My child is not currently assigned to a provider
- _____ No out-of-pocket costs
- _____ Services offered
- _____ Location

(North Country Children's Clinic. (2009). Personal communications.)

A2. Assessing the Need: Sample Focus Group Questions

Stakeholder	Questions
<i>Parents</i>	What services would you expect to be provided by the school-based health center in your child's school?
	Would you like to see any special services in the school-based health center?
	Does your child have any chronic (ongoing) health problems?
	Does your child have any periodic illnesses that cause absence from school?
	Does your child currently have a primary care physician? If yes, when was their last visit? If no, where do you seek care?
	The school-based health center is expected to offer a full range of medical services for adolescents, as outlined by the American Academy of Pediatrics. This includes reproductive health care services, which involves gynecology exams, treatment of sexually transmitted illnesses and HIV counseling and testing. Pregnancy prevention education is also taught. All of our services are provided in a safe, confidential environment. As a parent, do you have any concerns regarding the range of services that we plan to offer?
	Would you enroll your child in the school-based health center?
	Why is having a school-based health center important to you and your child?
<i>Students</i>	What services would you expect to be provided at the school-based health center in your school?
	Would you like to see any special services in the school-based health center?
	Do you have any chronic (ongoing) health problems?
	Do you have any periodic illnesses that cause absence from school?
	Do you currently have a primary care physician? If yes, when was your last visit? If no, where do you seek care?
	Would you come to the school-based health center for care?

(Kaleida Health/Women & Children's Hospital of Buffalo School Health Services. (2006, December). Personal communications.)

A2. Assessing the Need: School Data

To assist the sponsoring agency in determining level of need, school personnel should provide answers/data to the following questions:

- Basic Educational Data System (BEDS)
- What are the students' most prevalent health issues?
- What is the level of absenteeism?
- What health care service is missing from the community?
- What is the level of free and reduced lunches?
- What is the average percentage/number of students that are excluded from NFHS/Abate for non-compliance with mandated immunizations?
- What behavioral health/mental health issues are present in the student population, if any? How are these services addressed at present? Via referral to a primary care provider? Via referral to another agency? Other methods?
- How many parenting teens or pregnant teens are in school on a regular basis each year?
- What types of health education services (if any) are provided at the school? Are there regular classes or programs regarding healthy behaviors, risk reduction, etc. offered to students? Who provides these services?
- Does the district have a crisis intervention team available to address immediate needs of students? If so, who staffs such teams? What is their role (crisis intervention only, counseling, etc.)?
- What types of referrals does the school nursing staff make to community agencies and health providers? Do you provide follow up on referrals, including assessment of how many students keep referral appointments and the outcome of the referral service?

A3. School-Based Health Centers and Academics: Finding the Connection

	School-Based Health Center Service or Program	Benefit to School/Education System
Services for Students	Identify students at risk for health and behavioral problems	To reduce obstacles to the learning process
	Assist in IEP development	To ensure health factors are considered and addressed
	Immunize students	To ensure the school meets governmental requirements, to minimize school-wide outbreaks, and to reduce absenteeism (absences often translate into lost finances for schools)
	Administer medication to students with chronic illness	To reduce absences, as well as disciplinary action for students with behavioral health problems
	Provide mental health services	To help students concentrate in school and maintain healthy relationships with peers, teachers, and family
	Provide preventive health services	To improve student health and prevent or minimize future health and mental health problems
	Provide on-site management of acute health conditions	To improve attendance and student health
	Refer students to services not provided at the school-based health center	To address the full spectrum of health issues that can function as barriers to learning and to case manage students receiving services elsewhere
	Conduct sports physicals	To increase student participation in activities that connect them to the school and improve their physical, cognitive, and social well-being in a safe environment
	Encourage student participation and involvement in school-based health center activities	To increase student connection with their school
	Enroll students in health insurance	To help generate funds not only for school-based health center services but also for other school services
	Provide opportunities for leadership and involvement in peer programs	To help students develop leadership and problem solving skills and improve the overall school climate
	Employ staff that can serve as mentors and role models	To encourage students to stay in school and pursue their interest in health-oriented careers
	Provide individual, group, and classroom health education consistent with the school curriculum	To provide students with instruction on topics that teachers may not feel comfortable or qualified to teach (i.e. pubertal development/sex education)
Services for the School Community	Support teachers concerned about students physical or mental health	To allow teachers to focus on teaching
	Support principals by addressing health needs of specific high-risk populations	To allow students to be more successful in schools
	Participate in community initiatives on public health issues such as obesity and emergency planning	To improve school compliance with local, state, and federal regulations and provide a safe school environment
	Coordinate with other school and community service providers	To ensure that school staff can address the health and well-being of students in a coordinated and efficient manner
	Encourage parental involvement	To increase family participation in school and educationally oriented activities

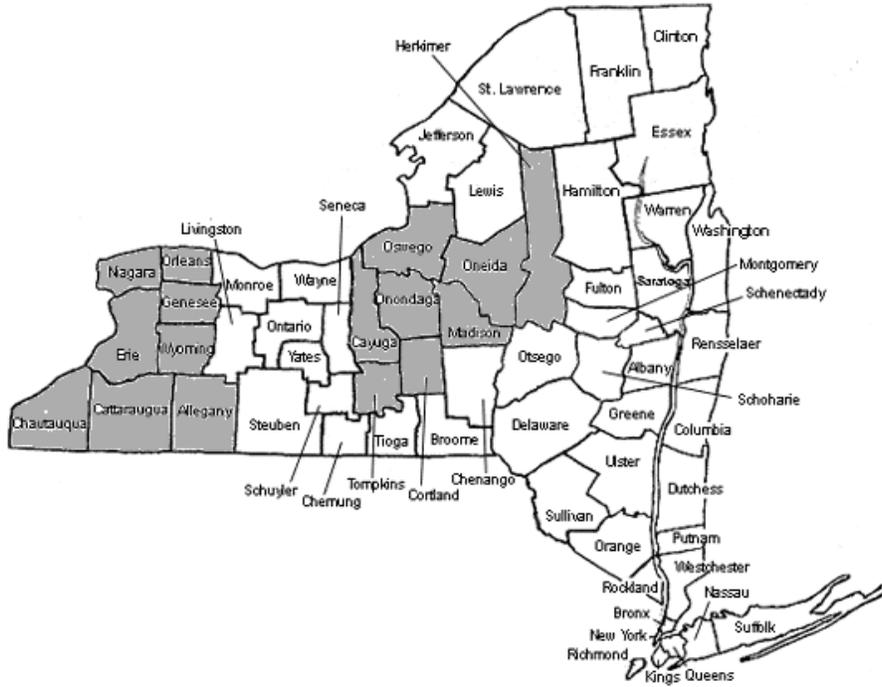
(NASBHC, 2005b)

A3. School-Based Health Centers and Academics: No Child Left Behind Act and School-Based Health Center Contributions

No Child Left Behind Act (NCLB) Titles	Criteria	School-Based Health Center Contribution
Title I	Part C –Education of Migratory Children	Immunization and health records of migrant children for national database.
	Part D –Prevention and Intervention Programs for Children and Youth Who are Neglected, Delinquent, or At-Risk	Information, prevention, and intervention services, screenings, and treatment of students
Title IV	21 st Century Schools	Drug and alcohol prevention education, screening, and counseling and treatment options
Title VII	Indian, Native Hawaiian and Alaskan Native Education	Health promotion activities to meet the “unique educational, cultural, and academic needs of American Indian and Alaskan Native students”
Title X	Repeals, Re-designations, and Amendments to Other Statutes.	Bring facilities into health compliance.

(NASBHC, 2005b)

A4. Counties Served by the Community Health Foundation of Western and Central NY

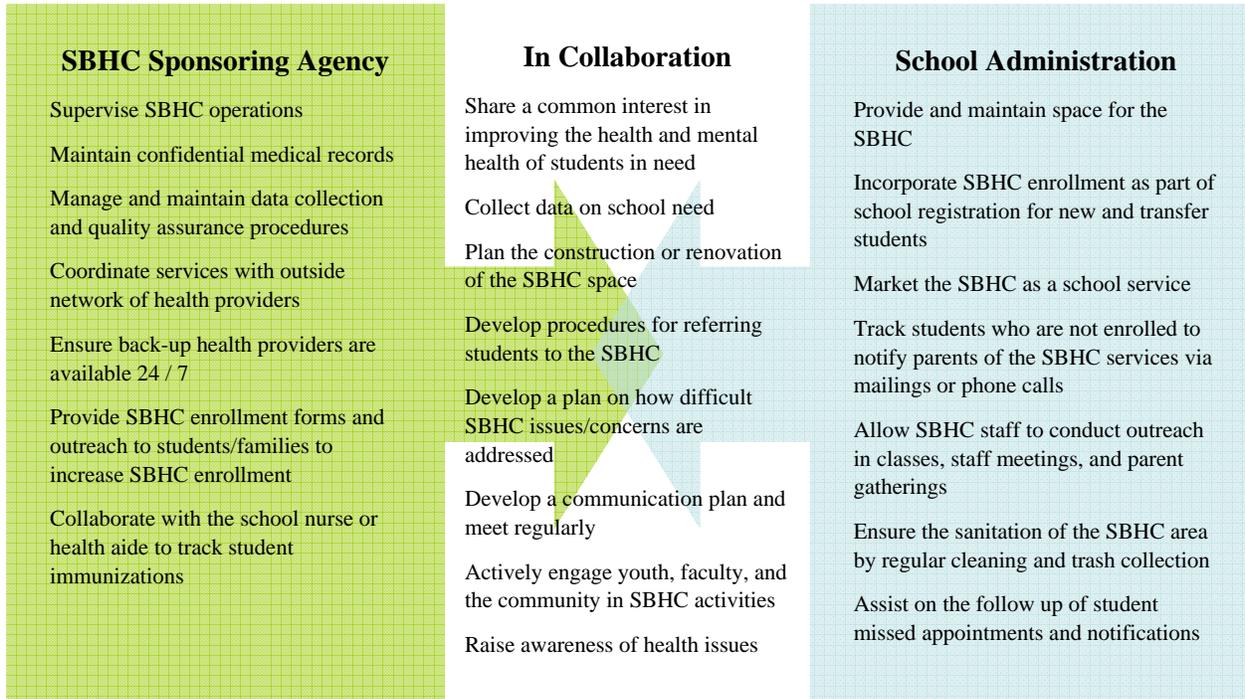


A4. Counties Served by the Community Health Foundation of Western and Central NY: School-Based Health Center Sponsoring Agencies

Western New York		Central New York	
The Resource Center <i>Chautauqua County</i>	Jamestown High School – Jamestown	Family Health Network of Central NY <i>Cortland County</i>	Randall Elementary – Cortland
			Parker Elementary – Cortland
			Cincinnatus Central School – Cincinnatus
			Marathon Elementary – Marathon
			Marathon JR/SR High School – Marathon
			Deruyter Central School – DeRuyter
Kaleida Health care <i>Erie County</i>	Stanley Makowski # 99 – Buffalo	St. Elizabeth’s Family Medical Center <i>Oneida County</i>	Kernan Elementary – Utica
	Westminster Charter School – Buffalo		
	Herman Badillo – Buffalo		
	BEST School # 6 – Buffalo		
	Build Academy – Buffalo		
	Community School # 53 – Buffalo		
	Futures Academy – Buffalo		
	Dr. Martin Luther King – Buffalo		
	Hillery Park – Buffalo		
	Dr. Lydia Wright – Buffalo		
	South Park High – Buffalo		
	Grover Cleveland High – Buffalo		
Bennett High – Buffalo			
Sisters of Charity Hospital <i>Erie County</i>	West Hertel Academy – Buffalo	Upstate Cerebral Palsy <i>Oneida County</i>	Donovan Middle School – Utica
	PS 44 Lincoln Academy – Buffalo		
	South Side Elementary – Buffalo		
		Syracuse Community Health Center <i>Onondaga County</i>	Bellevue Middle School – Syracuse
			Delaware Elementary – Syracuse
			Dr. King Elementary – Syracuse
			Dr. Weeks Elementary – Syracuse
			Fowler High School – Syracuse
			H.W. Smith Elementary – Syracuse
		Northern Oswego County Health Services, Inc. <i>Oswego County</i>	APW High School – Parish
			Sandy Creek School – Sandy Creek
			Pulaski JR/SR High – Pulaski
			Laura M. Sharp Elementary School – Pulaski

A5. Sponsoring Agency and School District Responsibilities

The School-Based Health Center Successful Partnership



A6. Sample Memorandum of Understanding (MOU) Between a School District and Sponsoring Agency

TEMPLATE FOR A MEMORANDUM OF UNDERSTANDING

BETWEEN

(PROVIDER NAME) _____

AND _____ (SCHOOL PRINCIPAL)

AND _____ (SCHOOL DISTRICT)

The purpose of this Memorandum of Understanding is to define and outline the responsibilities of

(Health Care Provider)

and _____
(School)

in order to provide comprehensive health care services through a school-based health center (SBHC) located at the school:

The School Principal agrees to provide the following support to the project staff at this site:

1. FACILITIES

Space for the SBHC that will include:

- a) Adequate office space for all SBHC staff
- b) Examining rooms with lavatory accessibility
- c) Private counseling room
- d) Waiting room/area for students and parents
- e) Adequate heat, lights and ventilation in all areas
- f) Locked storage closet for supplies and equipment
- g) Security for all areas of the SBHC
- h) Maintenance and cleaning of the health center area
- i) Safety instructions/guidelines for evacuation

2. EQUIPMENT AND SUPPLIES

- a) At least one dedicated telephone and telephone line
- b) Accessibility to a photocopier

3. PROGRAMMATIC COMPONENTS

Assistance with:

- a) Marketing the School Health Program and distribution of communication materials
- b) Obtaining informed parental consent
- c) Encouraging parental presence at the initial examination
- d) Assisting the SBHC in obtaining insurance and Medicaid information from students and parents
- e) Providing follow-up on broken appointments implementing joint health education workshops, when appropriate, in all project schools

The Health Care Provider (_____) will provide the following:

1. **ON-SITE SERVICES** (For enrolled students only - with parental consent)
Comprehensive primary and preventive health and mental health services for children according to the *New York State Guidelines for School-Based Health Centers* including referral and follow up for needed medical, dental, and psycho-social care
 - a) Ongoing care for chronic diseases such as asthma
 - b) Social service case work as needed
 - c) Health education activities for parents and teachers in cooperation with the school
 - d) First aid and emergency care (available to all students in the school)

2. **BY REFERRAL TO THE SPONSORING ARTICLE 28 FACILITY**
Continuity of care: 24 hours a day, 7 days a week, through

(Facility Name)

3. Assistance with enrollment in Child Health Plus and Medicaid Managed Care.

4. Referral and follow up as indicated for additional medical, mental, dental and social services.

.....
SIGNATURES:

_____ Chief Health Care Officer	_____ (Date)
_____ Superintendent of School District	_____ (Date)
_____ School Principal	_____ (Date)

*(Melva Visher. (June, 2009). Personal communications). *Note: This is MOU is for explanatory purposes only.*

A7. School-Based Health Center Funding History in New York State

SBHC staff and supporters have a long history of advocating for funding and policies that would stabilize and enhance the delivery of quality health care to children. On multiple levels, SBHC advocates have made great advancements in raising awareness of child health issues and initiating grassroots action to impact legislation that promotes the vision of accessible child health care. In New York and nationwide, advocates of children's health and SBHCs are actively working on funding and policy campaigns.

For over twenty years, SBHCs in New York State have advocated for stable funding to provide accessible health services to children in underserved communities. As previously noted, SBHCs were established as a demonstration project in 1989 by the New York State Legislature. Since that time, state budget funding for SBHCs has increased by 142% from 9 million to 24 million dollars annually. The Coalition and fellow child health advocates have been instrumental in securing and reinforcing SBHCs.

Soon after the establishment of the SBHC demonstration project, the Coalition (formally named the New York State Coalition for School-Based Primary Care) was organized by a core group of professionals concerned with the existing service delivery system of health care for children and adolescents. The Coalition began advocating to financially stabilize SBHCs and influence child health policies. In the same year it was organized, the Coalition successfully advocated for a regulatory change that would allow SBHCs to be reimbursed at an enhanced Medicaid rate. This policy change had an impact of an estimated \$7,000,000 per year in increased Medicaid revenues for SBHCs across the state (S. McNally, personal communication, June 4th, 2009).

With escalating Medicaid expenditures nationwide, a policy movement toward Medicaid managed care became popular in many states during the 1990's (Feldstein, 2005). It was introduced in NYS in 1996. This shift threatened SBHC Medicaid reimbursement as Medicaid managed care emphasized the utilization of PCPs. As a result, the Coalition immediately took action and advocated to legislators and health officials for a one year Medicaid "carve-out" which allowed SBHCs to continue to bill Medicaid on a fee-for-service basis for services provided to children enrolled in Medicaid Managed Care plans (S. McNally, personal communication, June 4th, 2009). Historically, carve-out arrangements have developed based upon the belief that certain services will not be attended to adequately in the standard managed care plan unless special provisions are made (Making the Grade National Program Office, 1995). The Making the Grade National Program Office indicates that carve-out arrangements have involved services such as family planning, mental health, and substance abuse counseling. In New York, the carve-out was extended for several years afterward by administrative decree until it became a permanent carve-out arrangement in 2004 (S. McNally, personal communication, June 4th, 2009). Currently, SBHCs in New York bill Medicaid directly for services delivered to children enrolled in Medicaid managed care plans on a fee-for-service basis (Harvey et al., 2002). This carve-out arrangement has contributed to improvements in SBHCs' ability to receive patient care revenue. Presently, there are over two million individuals in New York State enrolled in Medicaid Managed Care; approximately 700,000 of these individuals are from upstate New York (NYSDOH, 2009b).

Aside from the permanent Medicaid carve-out arrangement, the Coalition has been victorious in securing funding for SBHCs through special

funding projects. In 2000, the Coalition advocated for the allocation of a portion of tobacco settlement funds under the Health Care Reform Act (HCRA) resulting in \$7,000,000 a year for three years. SBHCs throughout the state continued to receive \$7,000,000 in HCRA I (HCRA was later defined by sub-categories. HCRA funds from the tobacco settlement are designated as HCRA I as of 2006) until 2008 when it was reduced to \$6,800,000 due to across the board state budget cuts. In 2002, the Coalition led a state-wide campaign to encourage the Legislature to allocate a portion of funding from Temporary Assistance for Needy Families (TANF) funds for SBHCs resulting in \$3,500,000 a year to be utilized for a range of non-reimbursable clinical and preventive services. After 2006, funding that was received from TANF funds were changed to HCRA funds within the state budget. HCRA funds help to financially stabilize SBHCs throughout the state.

Most recently, the Coalition successfully advocated for approval from the state government for Medicaid reimbursement for mental health services provided by certified social workers at SBHCs. Without this mechanism SBHC sponsoring agencies had to absorb the cost of this un-reimbursable care. As of 2009, social work services at SBHCs were included in a new methodology for reimbursement of primary health care by Medicaid within the Governor's budget and approved by the Legislature. This new payment methodology for Medicaid services— Ambulatory Patient Groups (APGs)—is based on diagnostic categories and is part of New York State's effort to emphasize comprehensive primary care services that will reduce both emergency room use and hospitalization. Psychotherapy services provided to pregnant women, children and adolescents is part of a program of targeted investments to improve primary care access. An additional service that is reimbursable under this new methodology is services provided by "certified health educators"

working with diabetes and asthma patients, as mentioned in *Section 3.2*.

In 2008, the Coalition campaigned to hold SBHCs harmless from state budget cuts as a result of the nationwide economic crisis and the state's deficit. New York Governor David Paterson initiated a series of budget negotiation meetings to cut state budget spending for fiscal year 2008-2009 and 2009-2010. The funding for SBHCs was in jeopardy of severe state budget cuts that would destabilize SBHCs in communities with the greatest need for quality health care. The Coalition led grassroots efforts to increase awareness of SBHCs and their significant benefits to countless numbers of students, families, and communities across the state. The Governor and Legislature reached a final agreement on the budgets for fiscal year 2008-2009 and fiscal year 2009-2010 that held SBHCs harmless from severe funding cuts. 2008-2009 funding for SBHCs was reduced by 6%, which was the standard reduction to primary care service programs across the state. The Governor did not include additional cuts to SBHCs in his proposed executive budget for fiscal year 2009-2010 and the Legislature successfully added \$507,600 for SBHCs to the final budget agreement amidst a grim fiscal climate.

Moving forward, the Coalition continues to strategize to increase the sustainability and expansion of SBHCs in the state. Through its history in legislative advocacy, the Coalition found success on policy and funding initiatives for SBHCs by collaborating with local communities to raise awareness of the health needs of children. As the state weathers the current economic crisis, SBHCs are struggling to meet the increased demand and needs for primary medical, mental health, health education, and dental care. The Coalition's focus for the upcoming year is to secure the existing funding streams for SBHCs in the state

budget despite the continued economic recession. ■

A8. Student Essay Excerpts

- “These SBHCs are important to me because I know there will come a time where I will have a stomach ache or a cold and maybe a need for a vaccination and having these services provided to me by the SBHC will avoid my mom from missing a day from work to take me to my primary doctor. My mom can depend on my school health center with some of these situations at the same time help me prevent the spread of disease or viruses that I may be at risk of now or in the future by educating us as a family.” – *11 year old female, Bronx, NY*
- “Coming to my school-based center has helped me keep up my grades. Falling behind used to be a problem for me, I would always fail a class because I had many problems at home and at school people would pick on me. Whenever I had a problem at home I would keep it to myself because I didn’t have anyone to talk to. When I started middle school and I wasn’t passing math, my friend told me about the SBHC. I went to the clinic and shortly after I started meeting with my counselor I started passing my classes. When I started seeing the counselor it help me to be more focus in class, because I would sit down and do my class work without having to think about my problems. I have achieved my goal of becoming a better student.” – *14 year old female, NYC*
- “Having SBHCs do not only help the students, but it helps our community. Think about it. If we are healthy, strong, and supported that means that we are better equipped to become positive role models to our community. When our SBHC educates us on how to protect ourselves, we are protecting our peers, our parents and our community.” – *17 year old female, NYC*
- “You could discuss economic, or political, or cultural aspects, and to some degree those all fit, but the true purpose of the SBHCs is to care for the children. If they can save one student from dropping out of school, or one child from being abused, or one young person from constant illness, they have proven their worth. Children are the future of this country, and they need to be looked after.” – *17 year old female, Watertown, NY*

School-Based Health Center Resources

National Assembly on School-Based Health Care

1100 G Street, NW, Suite 735
Washington, DC 20005
Tel: (202) 638-5872 Fax: (202)638-5879
Email: info@nasbhc.org
Website: www.nasbhc.org

New York State Coalition for School-Based Health Centers

c/o North Country Children's Clinic
238 Arsenal Street
Watertown, NY 13601
Tel: (315) 782-9450 Fax: (315) 782-2643
Email: jhorton@nystatesbhc.org or jlima@nystatesbhc.org
Website: www.nystatesbhc.org

New York State Department of Health, School-Based health Center Dental Programs

Website: http://www.health.state.ny.us/prevention/dental/school_based_hc_dental.htm

New York State Department of Health, School-Based Health Centers in NYS

Website: www.health.state.ny.us/nysdoh/school/

New York State Oral Health Technical Assistance Center

259 Monroe Ave.
Rochester, NY 14607
Tel: (585) 325-2280 Fax: (585) 325-9923
E-mail: oralhealthTAC@rpcn.org
Website: www.oralhealthtac.org

The Center for Health and Health care in Schools

c/o School of Public Health and Health Services
The George Washington University
2121 K Street NW, Suite 250, Washington DC 20037
Tel: (202) 466-3396 Fax: (202) 466-3467
E-mail: chhcs@gwu.edu
Website: www.healthinschools.org

W.K. Kellogg Foundation – School-Based Health Care Policy Program

One Michigan Avenue East
Battle Creek, Michigan 49017
Tel: 269-968-1611
Fax: 269-968-0413
Website: www.wkkf.org/default.aspx?tabid=75&CID=316&NID=61&LanguageID=0

Abbreviation Guide

Community Advisory Council (CAC)

Federally Qualified Health Centers (FQHCs)

Memorandum of Understanding (MOU)

National Assembly on School-Based Health Care (NASBHC)

New York State Department of Health (NYSDOH)

Nurse Practitioners (NPs)

Physician Assistants (PAs)

Primary care physician (PCP)

School-based health centers (SBHCs)

Youth Advisory Council (YAC)

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