



**Biennial Report on School-Based Health Centers
Fiscal Year 2008 and 2009**

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Commissioner**

Biennial Report on School-Based Health Centers – Fiscal Year 2008 and 2009
Executive Summary

Key Findings

- Six school districts received funding from the Texas Department of State Health Services (DSHS) to support seven school-based health centers (SBHCs).
- Over 85,000 students at 104 campuses had access to DSHS-funded SBHCs. The centers reported a total of 15,435 visits. An additional 1,453 non-students, including siblings and community members, were enrolled in SBHC services.
- Minor illnesses and preventive health services were the most frequently cited reasons for visits to the funded SBHCs. Asthma was the most frequently treated chronic condition.
- One SBHC in its final year of funding continued to implement a model that includes dental services. These services were provided one day a week by a volunteer dentist and other dental providers. A total of 784 dental visits were reported in FY08 at this one SBHC.
- SBHC directors reported billing Medicaid \$599,672. Of this amount, the centers received \$348,604 or 58 percent in reimbursements.

Future Activities

- Evaluate and report on the implementation of House Bill 281 including the number of applications received per fiscal year, the types of organizations that apply for SBHC funding, and the effectiveness of the newly instituted five-year funding stream.
- SBHCs will continue to track the attendance of students with chronic conditions such as asthma and diabetes.
- DSHS program staff will continue to provide technical assistance to funded sites. Technical assistance will include sustaining a SBHC program, developing a strong school partnership, and engaging parents to become supporters of SBHCs.
- DSHS will continue to:
 - Serve as a resource for SBHCs in Texas through its website;
 - Partner with the Texas Association of School-Based Health Centers (TASBHC); and
 - Initiate relationships with non-funded SBHCs to create an awareness of the SBHC grant program and funding opportunities for established SBHCs.
- DSHS will reach out to new stakeholders to increase awareness of DSHS funding for SBHCs. Outreach activities will include surveying stakeholders on barriers to the application process and developing an extensive email distribution list for announcing the release of the competitive grant application.

Table of Contents

Background	3
Funded School Districts	4
Evaluation Methods	6
Demographics	6
Access to Care.....	6
Enrollment.....	6
Staffing.....	8
Overview of Services - DSHS-Funded School-Based Health Centers	8
Total Visits.....	9
Chronic Conditions	10
Immunizations.....	11
Dental Services	11
Referrals.....	12
Measuring Educational Outcomes	12
Attendance Rates	14
Texas Assessment of Knowledge and Skills (TAKS)	14
Dropout and Graduation Rates.....	15
Difficulties Faced By SBHCs	15
Funding Application Issues.....	16
Implementation Issues	16
Billing and Reimbursements.....	16
Sustainability Issues.....	17
Technical Assistance Issues.....	17
Conclusion	18
Appendix A	22
Appendix B.....	24

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Texas Education Code (TEC), Chapter 38, §38.064, requires the Commissioner of DSHS to issue a biennial report to the legislature about the efficacy of SBHCs that receive funds from DSHS. This report focuses on SBHCs that received funding from DSHS in Fiscal Year 2008 (FY08) and Fiscal Year 2009 (FY09).

Background

According to the United States (U.S.) Census Bureau, in 2007 21.4 percent of children in Texas younger than 18 years of age were uninsured. Uninsured children are less likely to receive health care.ⁱ School personnel see a large number of students with physical and mental health conditions. Left untreated, these conditions may negatively affect a child's school attendance, academic performance, attention span, impulse control, and ability to refrain from self-destructive behavior. In order to address these issues, DSHS provides start-up funding for SBHCs in areas where students are in most need of health care.

Since the first SBHC in the US opened in Dallas in 1970, SBHCs have been a means of providing basic health care to medically underserved children and adolescents. Today, there are nearly 90 SBHCs serving Texas children.ⁱⁱ The centers use a comprehensive, affordable, multi-disciplinary approach to address the health care needs of school children, many of whom do not receive health care elsewhere. Often an array of services are provided, including but not limited to:

- Immunizations;
- Well-child exams;
- Sports physicals;
- Acute care for minor illness and injury;
- Management of chronic illness;
- Dental screenings, treatment and referral;
- Mental health services; and
- Basic health education.

SBHCs are usually located on school campuses, although some are located in easily accessible sites off campus or through mobile clinics. In some communities, the SBHC is located on one campus and only serves the students at that school. In other communities, a SBHC located on one campus may also serve other nearby schools. Each center is tailored to meet the needs of the school community.

SBHCs typically operate independently with the school nurse serving as the linkage for referring students for more advanced services. Before rendering services in the SBHC, students must have a signed parental consent form on file indicating all services that will be provided to the student. In many instances, family members, such as siblings or children of parenting teens, are also eligible to use SBHC services.

In 1993, the Texas Department of Health, now DSHS, began providing competitive grant funding to assist Texas communities in establishing SBHCs. In 1999, the 76th Legislature passed House Bill 2202, which amended TEC Chapter 38, and required the Commissioner of State Health Services to administer a grant program to assist school districts with the costs of operating SBHCs.

In FY 08-09 the program allowed a maximum of three years of funding per funded school district. A step-down funding formula provided a maximum of \$125,000 in year one to a maximum of \$62,500 in year three.

In 2009, the 81st Legislature passed House Bill 281 which changed the requirements for the SBHC grant program. House Bill 281 opens the eligible applicants to include local health departments, hospitals, health care systems, non profit organizations, and universities and upon availability of funds, extends the contract period to five years. House Bill 281 stipulates that funding under the grant program can be used to establish a SBHC, to expand services within existing SBHCs, and to operate a SBHC.

Since fiscal year 1994, 45 SBHCs have been funded and of those, 30 were still in operation in FY09 (See map on page 5 and Appendix A).

Funded School Districts

During the biennium, DSHS funded the following six school districts. These six school districts supported seven SBHCs:

- Frenship Independent School District (ISD) – First year of funding in FY08
- Mathis ISD – First year of funding in FY08
- Socorro ISD – Second year of funding in FY08
- Bangs ISD – Third year of funding in FY08
- Lufkin ISD – First year of funding in FY09
- Arlington ISD (two SBHCs) – First year of funding in FY09

Each of the six funded school districts established or continued to operate a SBHC that met the needs of its respective school population.

While all SBHCs provide primary and preventive health care services and share other common characteristics, the model for providing services, types of services, and whether the center will serve families and community members is decided at the local level. School districts receive input from school and community stakeholders, including the school health advisory council (SHAC). Required by law, SHACs are comprised of community members including parents. The SHAC makes recommendations to the district regarding services and policies for the SBHC, ensuring that community values are reflected in the operation of each center.

There are three recognized SBHC models which include the mobile program model, the school-linked program model and the school-based program model (Appendix B). The funded school districts implemented two of the three recognized SBHC models that best served the demographics of their school population. One school district implemented a mobile program model and five school districts implemented the school-based program modelⁱⁱⁱ.

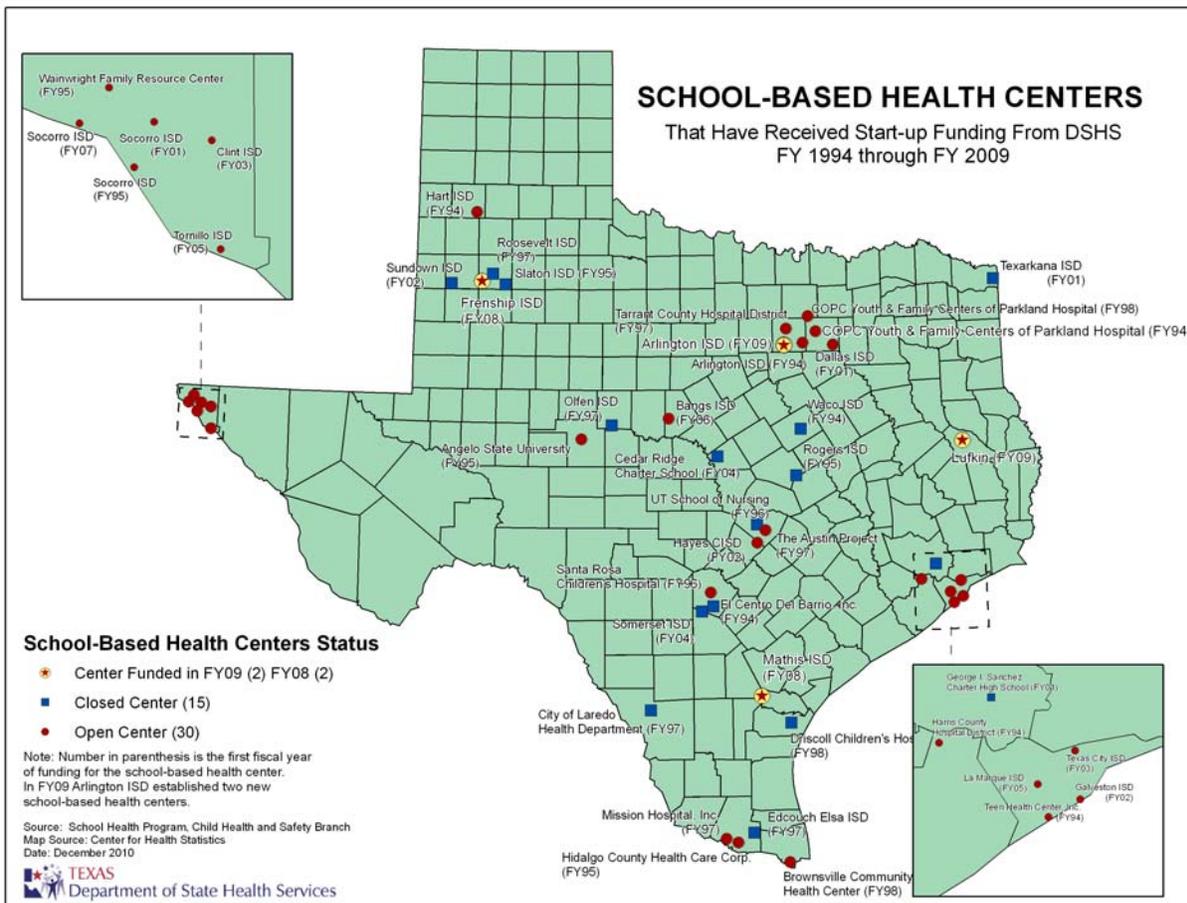
Socorro ISD, which covers 136 square miles in El Paso County, administers the “mobile” SBHC model. This model meets the needs of a large, rural district where nearly 80 percent of the students are economically disadvantaged and more than half have no primary care provider. Staffed by resident pediatricians from Texas Tech University Health Sciences Center, the mobile

unit travels to nine schools on a rotating schedule providing primary and preventive health care services.

Bangs ISD is located in a rural area near Brownwood and serves three campuses with a total of more than 1,000 students. Bangs ISD administers a SBHC model that includes dental services in addition to preventive and primary health care services. Staffed by a volunteer dentist and other dental providers one day a week, Bangs reported 784 dental visits in FY08.

Lufkin ISD located in a rural area in East Texas, serves over 8,500 students and is comprised of 11 elementary schools, one middle school, one high school, and one alternative school. The middle school campus with an enrollment of 1,796 is the largest middle school in the state of Texas.^{iv} Lufkin SBHC is only opened to students enrolled in the middle school.

The other three school districts, Arlington ISD, Frenship ISD, and Mathis ISD, have a more traditional SBHC model housing the center at one campus and making it accessible to other schools within the district. In Arlington ISD, DSHS funding supports two SBHCs both located on junior high school campuses. These two centers are open to any student in the district. In Frenship ISD, the SBHC is located at the elementary school and serves the other eight schools in the district.^v In Mathis ISD, the SBHC is located at the elementary school and serves three other campuses in the district.



Evaluation Methods

Evaluating whether SBHCs have an impact on educational outcomes is a key area of interest for DSHS. Multiple sources of quantitative and qualitative data were analyzed for this report, including academic achievement, attendance rates, graduation rates, and dropout rates. In addition, the report highlights utilization rate data identified in DSHS SBHC quarterly reports and Texas Education Agency (TEA) Academic Excellence Indicator System data. The data available for district outcomes are only a snapshot and cannot be causally linked to the impact of the SBHC. For the purpose of this report, SBHC district measures were compared to available state measures.

Demographics

Access to Care

During the biennium, DSHS-funded SBHCs experienced high usage by students.

- Over 85,000 students on 104 campuses had access to services.
- Among the six districts that received funding during the biennium, four are located in rural areas, one in an urban area and one is located in a suburban area:
 - Socorro ISD is located in a rural area near El Paso.
 - Bangs ISD is located in a rural area near Brownwood.
 - Lufkin ISD is located in a rural area in East Texas.
 - Mathis ISD is located in a rural area in the Coastal Bend Region.
 - Arlington ISD is located in an urban area in Tarrant County.
 - Frenship ISD is located in a suburban area near Lubbock.

Enrollment

During the biennium, over 5,000 students were enrolled for SBHC services as evidenced by a signed parental consent form. In addition, 1,453 non-students, including siblings and other family/community members, were also enrolled for SBHC services. Table 1 illustrates the student population for each school district with the number and percent of students enrolled in the SBHC.

School District Served	Total Student Population^{vi}	Number of Students Enrolled* in SBHC	Percent of Student Population Enrolled* in SBHC	Number of Students Seen^{vii}
Frenship ISD	6,934	844	12.17	1,848
Mathis ISD	1,881	644	34.24	1,178
Socorro ISD ^{viii}	12,059	917	7.6	1,791
Bangs ISD	1,125	356	31.6	1,685
Lufkin ISD	1,796	1,429	79.56	801
Arlington ISD ^{ix}	63,268	854	1.35	2,108
Totals	87,063	5,044	17.26	9,411

*With completed and signed parental consent form on file.

According to SBHC data submitted to DSHS, the seven SBHCs serving over 100 campuses enrolled a total of 5,044 students, which represents 17 percent of the student population. Lufkin ISD had the largest percent of enrolled students and Arlington ISD had the smallest percent of enrolled students.

Several factors explain the variation in SBHC enrollment numbers, including the length of time the SBHC has been open, the size of the school district, and the number of campuses within the district that are permitted to use the SBHC. For example, Lufkin ISD established a policy that the SBHC would only be available to the middle school campus while Arlington ISD, consisting of 74 campuses, established a policy that allowed any student in the district with parental consent to access health care services at the two funded SBHCs.

“In one particular case a parent came in and thanked the SBHC staff for informing her of the services available to her and her uninsured children. This single mother of three has insurance through her employer but could not afford the family coverage. Ineligible for Medicaid services and unable to afford a doctor visit, school nursing staff referred the mother to the school based health center. Once there, the mother was informed of available programs that would assist her children not only with medical services but also dental services. Temporary medical services were established at the SBHC while CHIP application assistance was provided to the mother. Today the mother has CHIP insurance for all three children and calls the SBHC her children’s medical home.”

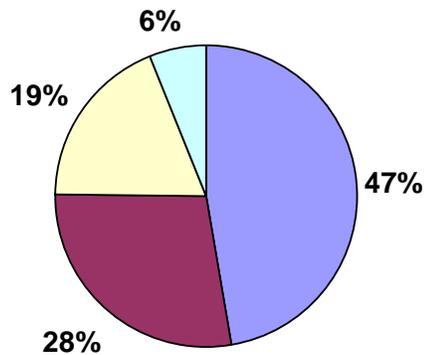
Mathis ISD

In FY06, nearly 70 percent of the students were enrolled in the SBHCs compared to 10 percent in FY07. The difference in the enrollment can be attributed to the total student enrollment of the funded school districts.

Figure 1 illustrates the racial/ethnic make-up of the student population of the six school districts combined: 47 percent were Hispanic; 28 percent were white, non-Hispanic; 19 percent were black, non-Hispanic; and six percent were classified as other. While data were not collected on the race/ethnicity of the actual

enrollees and users of school-based health centers, studies have shown that the demographic makeup of SBHC users reflects the school population.^x DSHS will make efforts to document the number of SBHC users in future reports. As SBHCs migrate to the use of electronic health records, user information will become easier to collect.

Figure 1. Total Student Population by Race/Ethnicity



■ Hispanic ■ White ■ Black ■ Other

Staffing

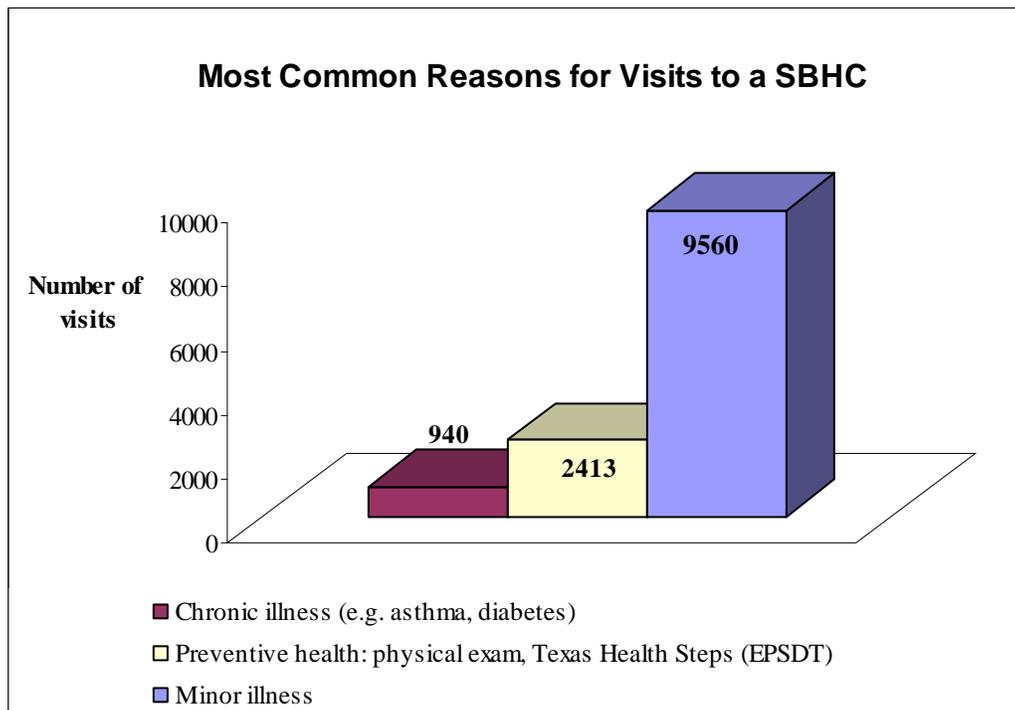
SBHCs are staffed by a team of health care providers. The grant requires the staffing to include a physician serving as the medical director and may include a nurse practitioner or physician's assistant, registered nurse, licensed vocational nurse, social worker, psychologist, and a licensed professional counselor. All SBHCs had a primary care provider on staff with six centers staffed with full-time providers. Four of the seven SBHCs had a mental health provider on staff and the other three SBHCs were associated to community mental health providers. One SBHC had dental providers on-site including a dentist, dental hygienist, and dental assistant and another SBHC site had access to dental providers through a dental mobile clinic. The variation of staffing patterns among contractors is the result of available resources, service delivery models, and established policies at the local level. SBHCs are established at the local level based on input from community stakeholders including the school health advisory committee.

Overview of Services - DSHS-Funded School-Based Health Centers

The following is a summary of information from SBHC quarterly reports submitted to the DSHS School Health Program in FY08 and FY09. The reports quantify SBHC activities such as the number and type of clinic visits, Medicaid visits, immunizations, referrals, educational outcomes and anecdotal information. Data from SBHCs funded by DSHS during FY06 and FY07 are presented for comparison.

Total Visits

- Project directors reported 15,435 visits to SBHCs.
- Two sites reported dental visits. One site reported 784 dental visits and the other site reported 50 visits from June through August 2009.
- SBHC program directors reported 5,687 Medicaid visits and billed Medicaid \$599,672. Of the \$599,672 billed to Medicaid, the SBHCs received \$348,604 or 58 percent of their claims for an average reimbursement of \$105 per visit. Factors affecting reimbursement rates are addressed under the billing and reimbursement section on page 15.



Chronic Conditions

SBHCs treat and manage students with chronic conditions. Chronic conditions were reported as the third highest category of SBHC visits accounting for six percent of all visits. Among the chronic conditions, the seven sites reported asthma as the most common chronic condition accounting for 437 visits or 65 percent of all visits for chronic conditions (See Table 2). Asthma is one of the most common chronic conditions in the U.S. affecting 6.8 million children and is the leading cause of school absences.^{xi} In 2005, there were 728,000 (11.6%) and 458,000 (7.3%) children in Texas with self-reported lifetime and current asthma, respectively.^{xii}

While there is no cure for asthma, it can be controlled. SBHCs play an important role in helping students manage their asthma and in reducing emergency room visits and absentee rates.^{xiii} SBHC providers may develop an individualized asthma plan, identify asthma triggers, and prescribe appropriate medications. The SBHC provider works with the student's primary care provider to support continuity of care, provide for follow-up visits and prevent duplication of services.

Most common diagnoses at the SBHCs were:

- Allergic rhinitis
- Upper respiratory infection
- Pharyngitis (sore throat)
- Otitis media

Most common labs tests completed in SBHCs were:

- Urinalysis
- Streptococcus screening test
- Hemoglobin
- Glucose

Most common reasons for referral to services outside the SBHC were:

- Mental health problems
- Ear, nose, and throat problems
- Fractures
- Dental problems

Chronic condition	Total visits	Percent of visits
Asthma	437	65
Diabetes	92	14
Seasonal allergies	43	6
Mental health	27	4
Acanthosis	24	4
Other ^{xiv}	48	7
Total	671	100

Immunizations

Immunizations are among the most common health care service provided in SBHCs. Eighty-five percent of all SBHCs provide immunizations.^{xv} SBHCs help students receive the required immunizations for school. Mandated school immunizations for Texas are outlined in the Texas Administrative Code - Title 25 Health Services, §§97.61-97.72. Required vaccines include diphtheria, tetanus, pertussis, measles, mumps, and rubella, hepatitis A and B, varicella, polio and meningococcal.

The total number of immunizations administered in DSHS-funded SBHCs from FY06 through FY09 was 9,228 (Table 3). The largest number of immunizations occurred in FY07, with nearly 3,000 immunizations administered. During the biennium, the number of immunizations decreased by 814 in FY08 and by 533 in FY09. Several factors explain the decrease including the difference in total student population served by the SBHCs and the number of students who were up-to-date with their immunizations.

Temporal variations occur with regard to immunizations, with the highest number of immunizations typically occurring in the first quarter with the fewest occurring in the third and fourth quarters. The first quarter coincides with the beginning of school when students need their immunizations for admission^{xvi}. The third and fourth quarters cover the end of the school year and the summer months. For FY09, the increase in immunizations in the third and fourth quarters can be attributed to the fact that two SBHCs opened during the second quarter with increased immunizations administered during the third and fourth quarters.

Fiscal Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
2006 (4 SBHCs)	745	650	663	0	2,058
2007 (4 SBHCs)	1,027	899	771	142	2,839
2008 (4 SBHCs)	694	529	381	421	2,025
2009 (5 SBHCs)	379	449	717	761	2,306
Total	2,845	2,527	2,532	1,324	9,228

Dental Services

Tooth decay is the most common chronic childhood disease affecting children and adolescents. This disease is five times more common than asthma and seven times more common than hay fever.^{xvii} It is estimated that over 51 million school hours are lost each year to dental related activities. Children living in poverty suffer nearly 12 times more restricted activity days than children from higher-income families. Untreated dental problems can cause pain that interferes with a child's ability to learn or to be present in the classroom.^{xviii}

While all DSHS-funded sites screened students for dental problems and referred students to community dental providers, two of the funded sites had mechanisms in place to provide preventive and restorative services. One site had dental services on site staffed with rotating

volunteer dentists and dental hygienists. This site reported 784 dental visits in FY08. The second site was linked to a mobile dental unit and reported 50 dental visits from June to August 2009.

Referrals

In addition to basic services, referrals were made to community providers for specialty services and treatment for mental health problems, fractures, dental care, and ear, nose, and throat conditions. Table 4 lists the top three reasons for referrals by site. The seven SBHCs referred 640 students to community providers. Of the 640 students, 352 students were seen by outside providers for a referral completion rate of 55 percent. A referral completion rate is the percent of students that followed up with a community provider. The referral completion rate for the seven sites ranged from a high of 97 percent to a low of 20 percent. The SBHC with a completion rate of 20 percent served a school district in the El Paso area where providers are limited and travel distances to providers are vast.

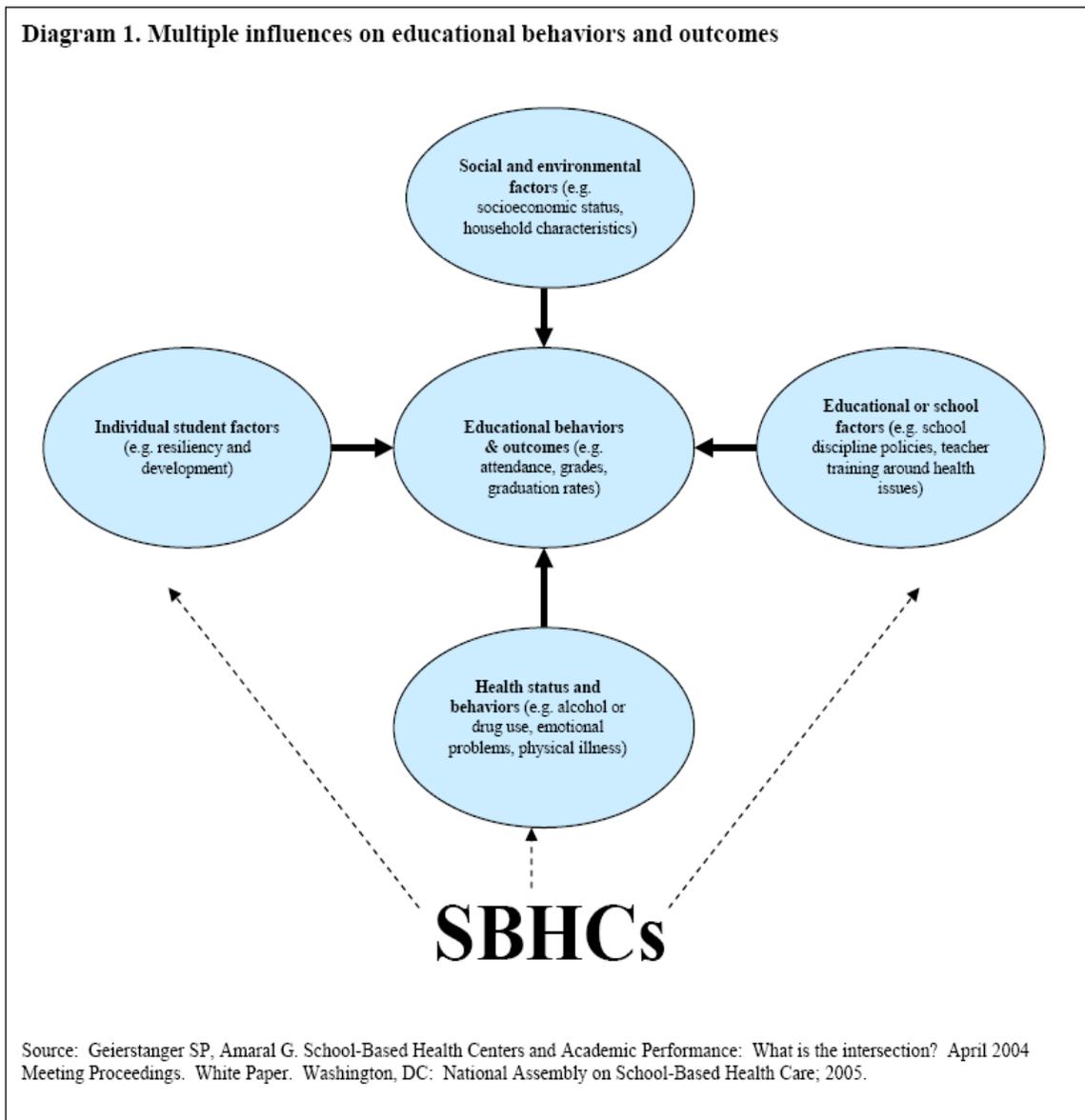
Table 4. Top Three Reasons for Referrals by Site	
Site	Reasons for referral
Arlington	1. Mental health 2. Nutrition 3. Early childhood intervention
Bangs	1. Dental problems 2. Hearing loss 3. Fractures
Mathis	1. Fractures 2. ENT 3. Cardiologist
Frenship	1. Mental health 2. Recurrent otitis media 3. Heart murmur
Socorro	1. Ophthalmology - vision problems 2. Orthopedics - injuries 3. Developmental delays/early childhood intervention
Lufkin	1. Fractures 2. Dental 3. Mental health

Measuring Educational Outcomes

One of the goals of the SBHC efficacy report is to examine the extent to which SBHCs have had an effect on attendance rates, academic achievement, graduation and dropout rates. As national research indicates, there is not a direct relationship between SBHCs and improved academic performance. To assess the true impact of SBHCs on academic performance, rigorous research and evaluation methods will need to be developed. Factors that hamper such research include

turnover in school population, the inability to randomize groups into clinic users and non-users, difficulties in selecting comparison groups, controlling for external factors such as increased resources to school districts to improve test scores, and the high cost of research.^{xix}

Assessing the impact of SBHCs on academic performance also requires a clear understanding of the relationships between SBHCs, academic performance, and other educational, social and environmental influences. A framework for understanding how multiple factors influence academic performance and educational behaviors is important. These factors include health status and behaviors, individual student factors, educational or school factors, and social and environmental factors. Diagram 1 illustrates the four areas of influence on educational behaviors and outcomes and the potential impact of SBHCs.



As indicated in Diagram 1, SBHCs can influence factors that impact the educational and behavioral outcomes of students. Table 5 lists these factors, provides examples of each factor, and describes the potential impact of a SBHC on each factor.

Table 5. Factors Influenced by SBHCs		
Factors	Examples	Impact by SBHCs
Health Status and Behaviors	Alcohol or drug use, emotional problems, and physical illness	Interventions such as counseling for alcohol or drug use
Individual Student Factors	Resiliency and developmental assets	Supporting and treating students with chronic and behavioral illness
Educational or School Factors	School discipline policies and teacher training around health issues	Provide health education in the classroom on health topics

Attendance Rates

There was no significant difference in attendance rates in the six school districts.^{xx} While there is not a direct link between SBHCs and district level attendance rates, a review of the research compiled by the National Assembly on School-Based Health Care (NASBHC) indicates that a substantial positive change in attendance rates does occur among students with chronic conditions such as asthma when a SBHC is present.^{xxi}

In November 2008 a Behavioral Health Clinic (BHC) was begun, with a pediatrician and psychologist meeting with students referred for behavioral issues (by teachers, parents, nurse practitioner). A student utilizing the BHC has been previously retained and was having consistent behavioral problems in class. The teacher noted that the child was 1 grade level behind in academics and was having difficulty focusing, and there were numerous referrals to the office for discipline issues. His parents requested help and he was referred to the BHC and was eventually diagnosed with ADHD. He received treatment, and continued to meet with the psychologist and school counselor. The counselor also involved the father in doing small projects at the school with his son. Discipline referrals decreased significantly, and the student passed his TAKS test.

Frenship ISD

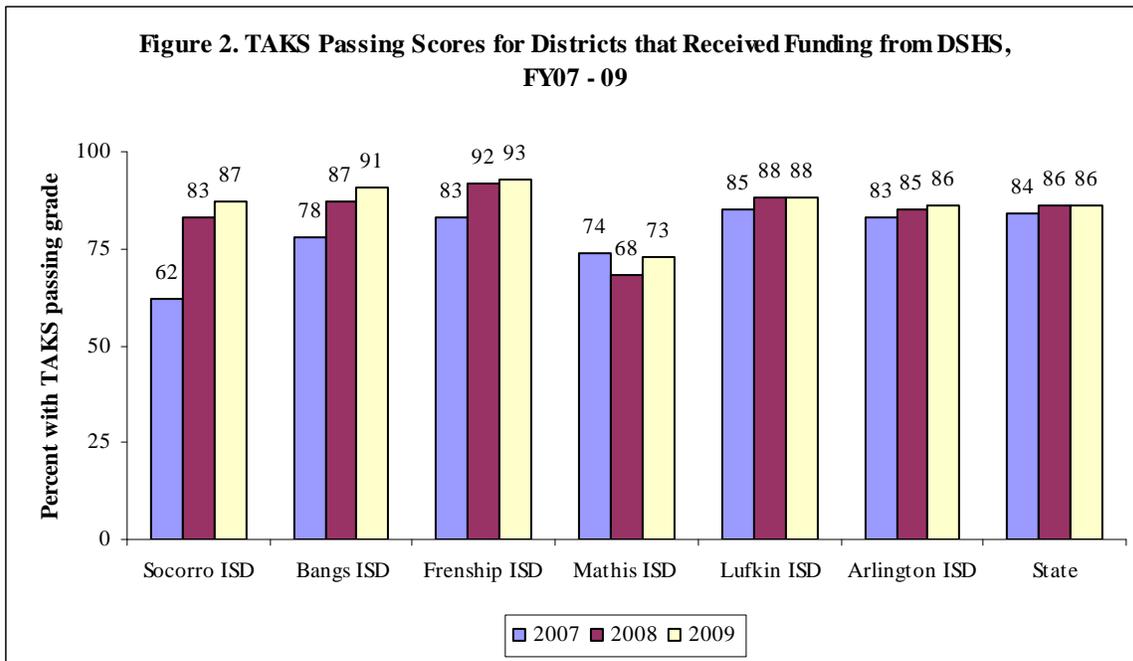
DSHS-funded SBHCs track and report the attendance of students with certain chronic conditions. Revisions to the reporting and monitoring systems have helped improve tracking and reporting attendance for students with chronic conditions. One site that tracked attendance rates for students with asthma found a 24 percent decrease in absences among those asthmatic students reporting upper respiratory symptoms. One student reduced his absences by 46 percent in one year. The decrease cannot solely be attributed to the presence of the SBHC; however, the site did report an increase in the identification of asthmatic students and a 24 percent increase in the number of inhalers kept at school.^{xxii} Future reports will continue to include analysis of attendance rates for students with chronic conditions such as asthma and diabetes.

Texas Assessment of Knowledge and Skills (TAKS)

Texas began administering the TAKS test to students in grades 3 through 11 during the 2002–2003 school year. TAKS data were obtained from TEA for FY06 through FY08 to measure “pass rates”

among students in districts with SBHCs funded by DSHS. While the four school districts with SBHCs operating in FY08 improved their TAKS scores between 2007 and 2008 (Figure 2)^{xxiii} this cannot be directly attributed to the SBHC. Data were not available for the school year covering FY09 and therefore attendance rates for two districts could not be assessed. The following factors must be considered in examining the impact of a SBHC on TAKS scores.

- **Reporting.** TEA reports TAKS scores at the campus and district levels. While six of the seven SBHCs served multiple campuses within the district, not all campuses within each district had access to the SBHC. Even at the campus level, the percentage of students enrolled in the SBHC may be too low to affect TAKS scores.
- **External variables.** External variables may impact scores. A school with low TAKS scores may provide increased instruction time to improve TAKS scores. The influence of this variable alone could potentially outweigh any increase in TAKS scores that may have resulted from a SBHC.



Dropout and Graduation Rates

Two school districts showed an increase in students graduating and a reduction in those dropping out from FY07 to FY08. Due to reporting and external variables as previously mentioned, the improvement in dropout and graduation rates cannot be attributed solely to the SBHCs.

Difficulties Faced By SBHCs

Districts often face challenges when trying to establish a SBHC. These issues include funding application issues, implementation issues, sustainability issues, and technical assistance issues.

Funding Application Issues

Historically, there has been a decline in the number of school districts applying for DSHS funding. Stakeholders indicate that the DSHS application process is difficult for school districts that often do not have expertise in grant writing. The table below lists the number of applications received from FY06 – FY09.

Fiscal Year	Number of applications received
2006	2
2007	3
2008	3
2009	2

While the number of applications received from 1994-1998 (Appendix A) is unknown, the number of DSHS funded contracts for SBHCs suggests an increased number of applications from several entities such as hospitals and universities.

It is anticipated that the number of applications will increase as HB 281 (81st Legislative Session) expanded the applicant pool to include local health departments, hospitals, health care systems, non profit organizations, and universities.

Implementation Issues

Billing and Reimbursements

Billing issues, especially related to Medicaid, continue to create challenges for SBHC management. A report conducted by NASBHC in 2000^{xxiv} suggested that SBHCs throughout the nation are challenged by Medicaid billing. Complexity of the system and the variability among states' policies in terms of what types of services can be fully reimbursed under Medicaid contribute to problems on reimbursement. According to the report, the majority of states indicated that of all services billed, only a small proportion was reimbursed, and only two states reported reimbursement rates greater than 50 percent.

This is consistent with feedback from the DSHS-funded SBHCs. The six districts billed Medicaid \$599,672. Of this amount, the centers received \$348,604 or 58 percent in reimbursements for an average reimbursement of \$105 per visit.

There are many variables that affect the amount that SBHCs are able to bill third-party payors and the amount they are reimbursed for services. The site that billed the largest amount is part of a federally qualified health center (FQHC). FQHCs receive a higher reimbursement rate from Medicaid than other Medicaid providers. Another site that received reimbursement of 90 percent of its claims is affiliated with an academic medical institution with a well-established billing system.

SBHCs that are not affiliated with either an FQHC or an academic medical institution often face more challenges in billing third-party payors. These include delays in billing caused by a change

in provider which requires the new provider to apply and gain approval in becoming a Medicaid provider, learning to navigate the Medicaid system, and limited personnel to handle the billing. These challenges have the potential to impact the provision of services and future sustainability. However, as SBHCs become more familiar with establishing billing practices, it is likely that reimbursement rates will increase.

Sustainability Issues

Sustainability continues to be an issue for SBHCs. Similar to other states across the country, Texas provides startup money for the establishment of SBHCs.^{xxv} Additional local and private dollars and resources are needed to sustain a program. School districts also provide direct dollars and in-kind support to SBHCs. A majority of the school districts provide in-kind support in the form of staff time, space, utilities, and equipment.

“There are so many stories, but one that stands out is the story of a 2-year old twin boy. He had been kept away from other children because of aggressive behaviors and what the parents described as “animalistic” actions. The parents had no transportation or money for evaluation. They learned of our services from the school nurse of their older child. They were able to walk to our center for an evaluation and could afford the \$5 co-pay. We determined that the child was actually deaf and enrolled him in ECI services. He is now showing normal behaviors and communicates by signing. This has totally changed this family and normalized the child!”

Arlington ISD

The funded sites are required to report on their sustainability efforts at the end of each contract year. Funded sites reported the need to increase revenues through third-party payors. In order to help increase revenues, SBHCs activities have included outreach to parents to enroll their children in Medicaid or CHIP programs. Sites are also seeking additional funds from community organizations, private foundations, and other sources.

A strong school partnership is also critical in sustaining a SBHC. Schools can benefit from having a solid SBHC program. These benefits include improvements in attendance for students with chronic illnesses and reduced barriers to learning which may include less time out of class for health issues and early intervention for mental health issues which impact behaviors in the classroom. Developing a strong school partnership requires that the SBHC continuously participate in

school activities. Activities that help foster a strong school partnership include attending SHAC meetings, serving as a resource to school personnel, participating in individual education plan meetings, and providing health education in the classroom.

Engaging parents as SHAC members and supporters of SBHCs is a vital component in developing a strong school partnership. Parents can play a significant role in sharing the value of a SBHC with new school board members and school leadership.

Technical Assistance Issues

The DSHS School Health Program continued to provide technical assistance to funded sites. Technical assistance activities included two support meetings each fiscal year, regular conference calls, and individual monitoring of program activities. Technical assistance was also available

statewide through the annual TASBHC conference, resources provided through the DSHS School Health Program website, and participation in a national initiative to provide trainings to SBHCs in Texas.

Technical assistance activities	Number of participants
<ul style="list-style-type: none"> TASBHC annual conferences – DSHS presented information on DSHS funding 	120
<ul style="list-style-type: none"> Number of contacts as documented through emails regarding the RFP process and SBHC funding. 	20
<ul style="list-style-type: none"> Four DSHS contractors meeting – two at the start of fiscal year and two in conjunction with the TASBHC conference 	52
<ul style="list-style-type: none"> Seven trainings as part of the <i>Texas Partnership</i> project – a national initiative between the TASBHC, DSHS School Health Program, and NASBHC. Texas was one of four states selected to participate in the project. 	89
<ul style="list-style-type: none"> Texas School Health Network program – provided information about the SBHC program and funding information. 	20
<ul style="list-style-type: none"> DSHS internal meetings with other programs to share information about the Request for Proposal process and SBHC funding. Other programs include – FQHC, Quality Management Branch regional staff, two meetings, and Maternal and Child Health. 	35

In addition to the technical assistance activities, the DSHS program staff is working with both the national and state SBHC organizations in supporting SBHCs. These relationships allow DSHS access to the latest information in the field which is shared with contractors and stakeholders. These relationships also create an avenue for sharing ideas and solving challenges facing the SBHC field.

Conclusion

DSHS-funded SBHCs continue to provide preventive and primary care services to medically underserved students in Texas with positive results.

- During the biennium, over 85,000 students across 104 campuses had access to a DSHS-funded SBHC.
- Over 1,450 non-students including siblings and other family/community members were enrolled for services in the DSHS-funded SBHCs.
- Immunizations, well-child visits, and physical examinations were the most common preventive health care services provided by SBHCs.

- SBHC directors reported billing Medicaid \$599,672. Of this amount, the centers received \$348,604 or 58 percent in reimbursements for an average reimbursement cost of \$105 per visit.

One of the goals of this report is to examine the impact of SBHCs on academic performance. As shown by the analysis of funded sites and national research, SBHCs are more likely to impact educational behaviors such as attendance rates for asthmatic students rather than educational outcomes such as TAKS scores.^{xxvi} A true determination of the impact of SBHCs on academic achievement can only be measured by tracking student academic outcomes, exam scores, attendance rates, SBHC service utilization by individual students, along with numerous other social and behavioral variables in a controlled research project. A pilot project could be a reasonable, cost effective method to determine the true impact of SBHC on academic achievement.

Districts face challenges when trying to establish, implement, and sustain a SBHC. Stakeholders indicate that the DSHS application process is difficult for school districts that often do not have expertise in grant writing. While a few of the SBHCs show progress in billing Medicaid, the Medicaid billing process often requires more investment in staff time than can be recouped through reimbursement.

During the biennium, DSHS staff continued to provide technical assistance to funded programs. These activities included two annual meetings, regular conference calls, improved reporting and monitoring system, and assistance in identifying resources to help sustain programs. In addition to these activities, the DSHS School Health Program continued to develop a strong partnership with TASBHC. This partnership benefits all SBHCs in Texas that serve some of the children in most need in Texas.

In 2009, the 81st Legislature passed House Bill 281 which expanded the eligible applicants to include local health departments, hospitals, health care systems, non profit organizations, and universities. Expanding the applicant pool is likely to increase the number of applications, as most school-based health centers are sponsored by hospitals, health care systems, local health departments and non profit organizations^{xxvii}

DSHS School Health Program will reach out to new stakeholders to increase awareness of DSHS funding for SBHCs. Outreach activities will include surveying stakeholders on barriers to the application process and developing an extensive email distribution list for announcing the release of the funding application.

ⁱU.S. Census Bureau, Current Population Survey: 2008 Annual Social and Economic Supplement (2007 data) <http://pubdb3.census.gov/macro/032008/health/toc.htm>.

ⁱⁱ Texas Association of School-Based Health Centers, October 2008, accessed June 14, 2010.

ⁱⁱⁱ Strozer J., Juszczak L, Ammerman A. 2007-2008 National School-Based Health Care Census. Washington, DC: National Assembly on School-Based Health Care. Website: www.nasbhc.org. Accessed July 5, 2010.

^{iv} Lufkin ISD Fiscal Year 2009 Grant Application for School-Based Health Centers.

^v At the end of fiscal year 2008, Frenship ISD opened its school-based health center to all nine schools in the district.

^{vi} Enrollment table is based on quarterly data reports and verified by TEA's AEIS (2008-2009) report with a five percent variance. Enrollment for Socorro ISD is from AEIS Report (2007-2008). Lufkin SBHC only serves the middle school campus and student population represents the middle school campus.

^{vii} Number of students seen by provider. Duplicate numbers for all sites; three of the contractors (Frenship, Mathis, Socorro) received funding and reported data for both FY 2008 and FY 2009, two of the contractors (Arlington and

Lufkin) received funding and reported data for FY 2009, and one contractor (Socorro ISD) received funding and reported data for FY 2008.

^{viii} Socorro ISD – Student population is based on the population of the 13 campuses served by the mobile SBHC, fiscal year 2009 – 3rd quarter data report.

^{ix} The two DSHS-funded SBHCs for Arlington ISD are located on junior high campuses classified as Title 1 schools. From the submitted 3rd quarter data report, it is estimated that 60 percent of the students from these two campuses are enrolled in the SBHC.

^x Schlitt J, Santelli J, Juszczak L. and et al (2000). Creating access to care: school-based health center census 1998-99. National Assembly on School-Based Health Care: Washington, DC.

^{xi} American Lung Association. Childhood Asthma Overview. Website: <http://www.lungusa.org>. Accessed December 9, 2008.

^{xii} Texas Asthma Controlled and Prevention Program. The Burden of Asthma in Texas 2000-2005 Report.

<http://www.dshs.state.tx.us/chronic/pdf/asthbur.pdf> Accessed December 9, 2009.

^{xiii} Webber MP, Carpiello KE, Oruwariye T, et al. Burden of Asthma in Inner-City Elementary School Children: do School-Based Health Centers Make a Difference? Arch Pediatr Adolesc Med.2003;157:125-129.

^{xiv} The other category includes seizure disorders, hypertension, and heart murmur.

^{xv} Strozer J. Op cit.

^{xvi} Immunizations are required to enter public or private primary or secondary schools or institutions of higher education per Texas Administrative Code, Title 25, Part I, §§97.61-97.72.

^{xvii} US Department of Health and Human Services. Oral Health in America: A Report of the Surgeon General. Rockville, MD: US Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institute of Health, 2000.

^{xviii} Ibid.

^{xix} Geierstanger SP, Amaral G. School-Based Health Centers and Academic Performance: What is the intersection? April 2004 Meeting Proceedings. White Paper. Washington, DC: National Assembly on School-Based Health Care; 2005.

^{xx} Attendance rates were analyzed for fiscal year 2007 (school year 2006-2007) and fiscal year 2008 (school year 2007-2008) using the Texas Education Agency - Academic Excellence Indicator System (AEIS) report. Data were not available for fiscal year 2009 (school year 2008-2009).

^{xxi} Ibid.

^{xxii} Frenship ISD, FY 2008 Annual Report for DSHS School-Based Health Centers, August 30, 2008.

^{xxiii} Texas Education Agency. TAKS Standard Accountability Indicator. For 2006 and 2007, the standard accountability indicator excluded grade 8 science. For 2008, the standard accountability indicator included selected TAKS (accommodated).

^{xxiv} National Assembly on School-Based Health Care (2000). Medicaid Reimbursement in School-Based Health Centers: State Association and Provider Perspectives. NASBHC: Washington, DC.

^{xxv} State Policies that Support School-Based Health Centers, School Year 2004-2005. National Assembly on School-Based Health Care, Washington, DC. Website: www.nasbhc.org. Accessed March 5, 2008.

^{xxvi} Geierstanger SP. Op cit.

^{xxvii} Strozer J. Op cit.



Appendix A:
School-Based Health Centers – Fiscal Year 1994 through Fiscal Year 2009

FY	School districts/organizations ¹	CITY	STATE	STATUS
2009	Lufkin ISD	Lufkin	TX	Open
2009	Arlington ISD (Workman)	Arlington	TX	Open
2009	Arlington ISD (Nichols))	Arlington	TX	Open
2008	Mathis ISD	Mathis	TX	Open
2008	Frenship ISD	Wolfforth	TX	Open
2007	Socorro ISD	El Paso	TX	Open
2006	Bangs ISD	Bangs	TX	Open
2005	La Marque ISD	La Marque	TX	Open
2005	Tornillo ISD	Tornillo	TX	Open
2004	Cedar Ridge Charter School	Lometa	TX	Closed
2004	Somerset ISD	Somerset	TX	Closed
2003	Clint ISD	El Paso	TX	Open
2003	Texas City ISD	Texas City	TX	Open
2002	Galveston ISD	Galveston	TX	Open
2002	Hayes CISD	Buda	TX	Open
2002	Sundown ISD	Sundown	TX	Closed
2001	George I. Sanchez Charter High School	Houston	TX	Closed
2001	Dallas ISD	Dallas	TX	Open
1998	COPC Youth & Family Centers of Parkland Hospital	Dallas	TX	Open
2001	Socorro ISD	El Paso	TX	Open
2001	Texarkana ISD	Texarkana	TX	Closed
1998	Brownsville Community Health Center	Brownsville	TX	Open
1998	Driscoll Children's Hospital	Corpus Christi	TX	Closed
1997	The Austin Project	Austin	TX	Closed
1997	City of Laredo Health Department	Laredo	TX	Closed
1997	Edcouch Elsa ISD	Edcouch	TX	Closed
1997	Mission Hospital, Inc.	Mission	TX	Open
1997	Olfen ISD	Rowena	TX	Closed
1997	Roosevelt ISD	Lubbock	TX	Closed
1997	Tarrant County Hospital District	Fort Worth	TX	Open

¹ In 1999, the 76th Legislature passed House Bill 2202, which amended TEC Chapter 38, and required the Commissioner of State Health Services to administer a grant program to assist school districts with the costs of operating SBHCs. Prior to House Bill 2202, hospitals and other organization were eligible for funding for the establishment of SBHCs.

1996	Santa Rosa Children's Hospital	San Antonio	TX	Open
1996	UT School of Nursing	Austin	TX	Open
1995	Angelo State University	San Angelo	TX	Open
1995	Hidalgo County Health Care Corp.	Pharr	TX	Open
1995	Rogers ISD	Rogers	TX	Closed
1995	Slaton ISD	Slaton	TX	Closed
1995	Socorro ISD	El Paso	TX	Open
1995	Wainwright Family Resource Center	El Paso	TX	Open
1994	Arlington ISD	Arlington	TX	Open
1994	COPC Youth & Family Centers of Parkland Hospital	Dallas	TX	Open
1994	El Centro Del Barrio, Inc.	San Antonio	TX	Closed
1994	Harris County Hospital District	Houston	TX	Open
1994	Hart ISD	Hart	TX	Open
1994	Teen Health Center, Inc.	Galveston	TX	Open
1994	Waco ISD	Waco	TX	Closed



Technology Information Profiles
Federal/State Support Profiles
Staffing Models
Locations
Services Provided



PURPOSE AND SUMMARY

The National Assembly on School-Based Health Care's (NASBHC) 2007-2008 Census is the 11th request for data from school-based health centers (SBHCs) since 1986. The Census:

- Provides a better understanding of the role of SBHCs in meeting the needs of underserved children and adolescents,
- Collects relevant trend data on demographics, staffing, operations, prevention activities, clinical services, and policies,
- Creates a national database of programs.

Data for the 2007-2008 Census were collected from October 2008 through October 2009. The 2007-2008 Census identified 1,909 clinics and programs connected with schools nationwide, including:

- **School-based programs:** Partnerships between schools and community health organizations that deliver health care to students within a fixed site on a school campus.
- **Mobile programs:** Programs without a fixed site that rotate a health care team through a number of schools.
- **School-linked programs:** Health care programs that are formally or informally linked with schools to coordinate and promote health care for students on campus; clinical services are not provided on the school site. These programs (n=86) were not included in this report.

Sixty-four percent (n=1226) of known programs responded to the survey. Efforts were made to confirm that health centers that did not complete a survey were open during the 2007-08 school year. With a few exceptions, the analysis in this report includes programs that provide, at a minimum, primary care services (n=1096). However, all programs (n=1226) – including those that do not provide primary care services – are included in the mental health and health promotion/prevention sections of this report.

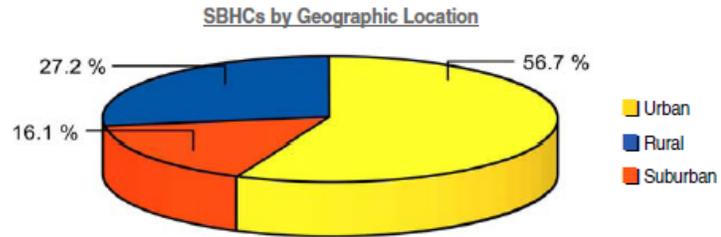
Changes between the 2004-05 Census and the 2007-08 Census include:

- A growing number of SBHCs serve schools with atypical grade combinations.
- An increase in SBHCs that see members of the community beyond the schools they serve.
- A rise in SBHCs that are using health information technology (HIT) to support their work.
- An increase in SBHCs with staffing models other than the traditional three staffing categories of Primary Care, Primary Care – Mental Health, and Primary Care – Mental Health PLUS. While more needs to be learned about the structure of these programs, the majority are programs that provide only mental health services.

LOCATION OF SBHCS (n=1096)

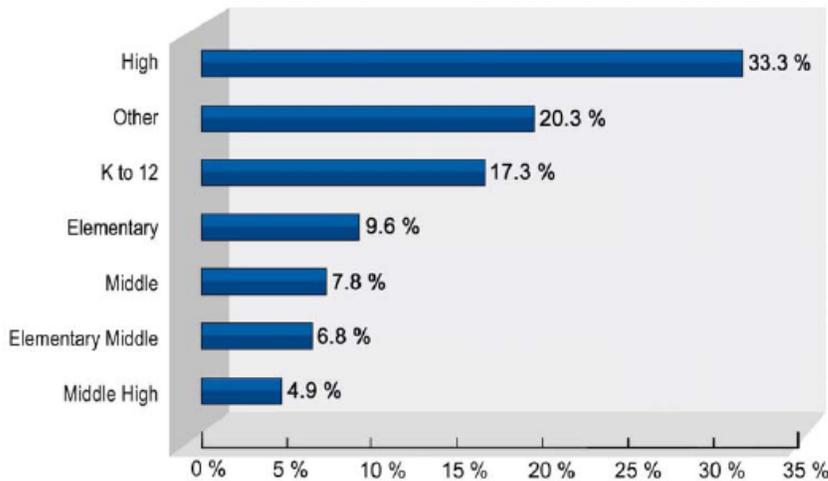
A majority (96%) of the SBHCS are located in the school building, while 3 percent are in a separate facility on school property. Only 1 percent are mobile, or non-fixed.

SBHCS are located in geographically diverse communities, with the majority (57%) in urban communities. More than one-quarter (27%) of SBHCS are in rural areas.



TYPES OF SCHOOLS WITH SBHCS (n=1096)

Types of Schools With SBHCS



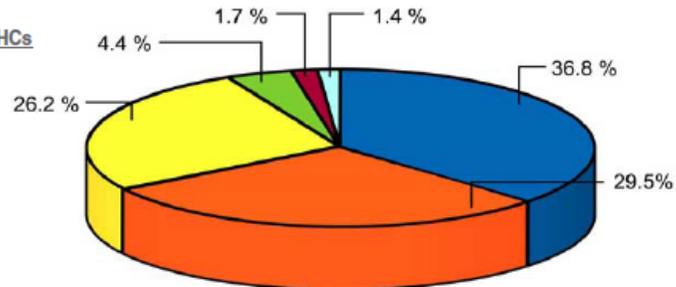
Settings for SBHCS are as varied as the types of schools in the United States. A large majority (80%) of the programs report serving at least one grade of adolescents (sixth grade or higher). A national trend over the last few years has been to redesign schools to create non-traditional grade combinations as a way to improve students' academic success. The Census shows a similar change in the number of SBHCS located in "other" schools with non-traditional grade combinations such as grades seven through twelve (20%).

STUDENT POPULATION IN SCHOOLS WITH SBHCS (n=1096)

Students in schools with SBHCS are predominantly members of minority and ethnic populations who have historically experienced under-insurance, uninsurance, or other health care access disparities.

Ethnic/Racial Profile of Schools with SBHCS

- Hispanic/Latino
- White (non Hispanic/Latino)
- Black (non Hispanic/Latino)
- Asian/Pacific Islander
- Native American/Alaskan Native
- Other



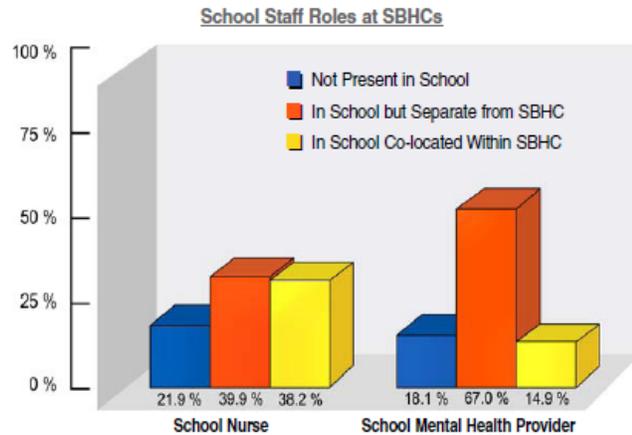
Thirty-six percent of SBHCS report serving only children who attend the school(s) they serve, a decrease from the 2004-2005 Census, where 45 percent reported serving only the student population. This trend indicates that SBHCS are expanding their ability to provide access to care to others in the community. Factors that may have influenced this trend are increased budgetary constraints and a weak economy, coupled with greater need for affordable health care in the community. Patient populations seen by SBHCS that open their doors beyond their school's students include: students from other schools in the community (58%); out-of-school youth (34%); faculty and school personnel (42%); family members of students (42%); and other community members (24%).

SCHOOL – SBHC PARTNERSHIPS (n=1096)

Sponsors (organizations that serve as the primary administrative home) of SBHCs are most typically a local health care organization, such as a community health center (28%), a hospital (25%), or local health department (15%). Other community sponsors include nonprofit organizations, universities, and mental health agencies. Twelve percent of SBHCs are sponsored by a school system.

SBHCs are often supported by schools and others through in-kind donations of space and services. The majority indicate that they do not have financial responsibility for construction and renovation (66%); maintenance and/or janitorial services (77%); utilities (82%); or rent (93%).

School health services and SBHCs partner to provide care for students. Census data show that over three-quarters (78%) of schools in which SBHCs are located have a school nurse. Where both are present, 40 percent are located in separate facilities while 38 percent are co-located within the same health suite.



Schools and SBHCs work together to ensure the safety and efficient functioning of the school by participating in emergency preparedness planning and school-wide teams.

A majority of SBHCs have emergency preparedness plans in place with response strategies to address school-based events that include:

- Medical/mental health emergencies (91%)
- Natural disasters (87%)
- School shootings (72%)

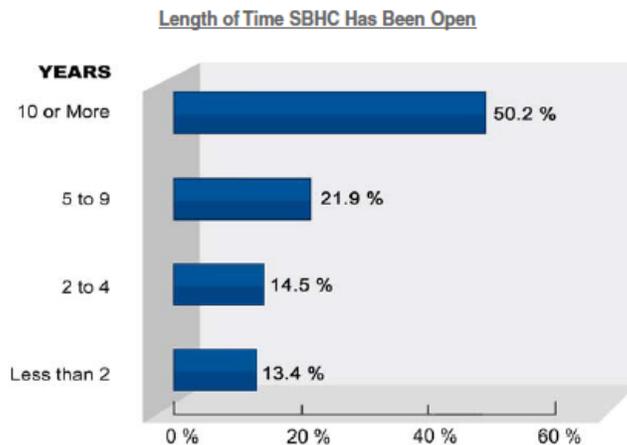
SBHCs also participate on school-wide teams:

- Crisis management team (45%)
- Mandatory school/district wellness committee (35%)
- Early intervention team (32%)

Just over 80 percent (82%) of schools in which SBHCs are located have a school-employed mental health provider in the building – of these 67 percent are separate from the health center, and 15 percent are co-located with the health center.

Thirty percent of SBHCs partner with the school to support students with special health care needs (students with health issues that affect their ability to learn and/or attend school). SBHCs support the academic success of these students in several ways: monitor medications (95%); review medical records (94%); assist in implementing the Individualized Health Plan (IHP) (75%); and serve on the Individualized Education Plan (IEP) development committee (70%).

SBHC OPERATIONS (n=1096)



Seventy-two percent of the nation's SBHCs are five years or older, up from 41 percent in 1998 and 67 percent in 2004 – attesting to the sustainability of the model. Also, 287 SBHCs opened in the past 4 years, indicating a growth in demand for the model.

The majority of SBHCs (95%) are open during normal school hours. Beyond the school day, the Census shows that 60 percent are open after school, 49 percent before school, and 36 percent during the summer. SBHCs are typically open for more than 30 hours per week. Sixty-seven percent report a pre-arranged source of after-hours care to assist students outside of normal SBHC operating hours through an on-call service or referral to another health center.

SBHC STAFFING MODELS (n=1096)

SBHCs have a wide range of staffing models, from a provider onsite two hours a week up to seven full-time staff members onsite full time. Centers with larger staff represent multidisciplinary teams and operate in centers open beyond the school hours. Whatever the staffing model, the presence of primary care providers – in any combination of physician, nurse practitioner, or physician assistant – is the common denominator for Census responders. Below are the three most commonly reported staffing models for SBHCs:

SBHC Staff and Mean Hours/Week by Model

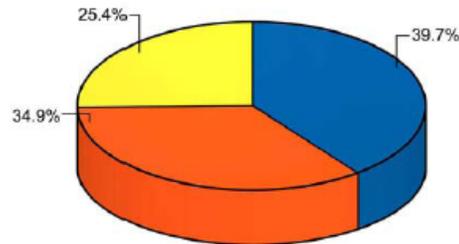
Provider Type	Number of SBHCs (%)	Mean Hours per week		
		Primary care hours	PC-MH hours	PC-MH+ hours
Primary Care Providers	1096 (100 %)	24.0	29.1	33.2
Nursing/Clinical Support	996 (90.9 %)	38.8	46.6	54.0
Mental Health Providers	818 (74.6 %)	0.0	30.2	36.0
Health Education	204 (18.6 %)	1.4	0	8.9
Nutrition	157 (14.3 %)	0.6	0	3.7
Dental Providers	134 (12.2 %)	2.8	0	8.4

Primary Care (PC): The primary care model is typically staffed by a nurse practitioner or physician assistant with medical supervision by a physician. While 25 percent of SBHCs with a PC model have physicians on staff, their role is largely administrative: 61 percent of those physicians report providing four or less hours of clinical services per week. Clinical support to primary care providers is offered by a registered or licensed practical nurse with assistance from a medical assistant or health aide. In a small percentage of these SBHCs, primary care staff may be augmented by social service, health education, or dental professionals. Mental health services are not offered in this model.

Primary Care – Mental Health (PCMH): The largest group of SBHCs is staffed by primary care providers in partnership with a mental health professional – whether a licensed clinical social worker, psychologist, or substance abuse counselor. Clinical and administrative support is similar to the PC model.

Primary Care – Mental Health PLUS (PCMH+): This model is the most comprehensive; primary care and mental health staff are joined by other disciplines to complement the health care team. The most common addition is a health educator, followed by social services case manager, and nutritionist.

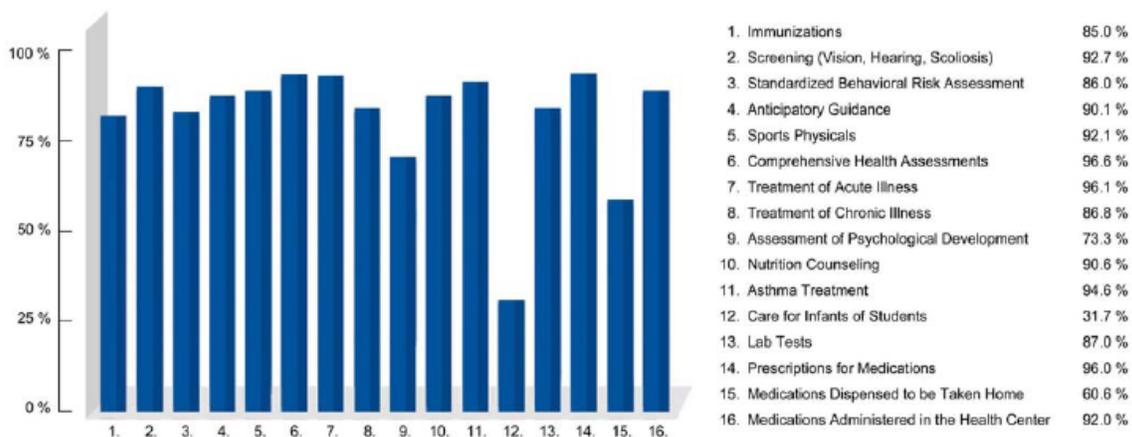
SBHC Staffing Models



PRIMARY CARE SERVICES PROVIDED ON-SITE BY SBHCS (n=1096)

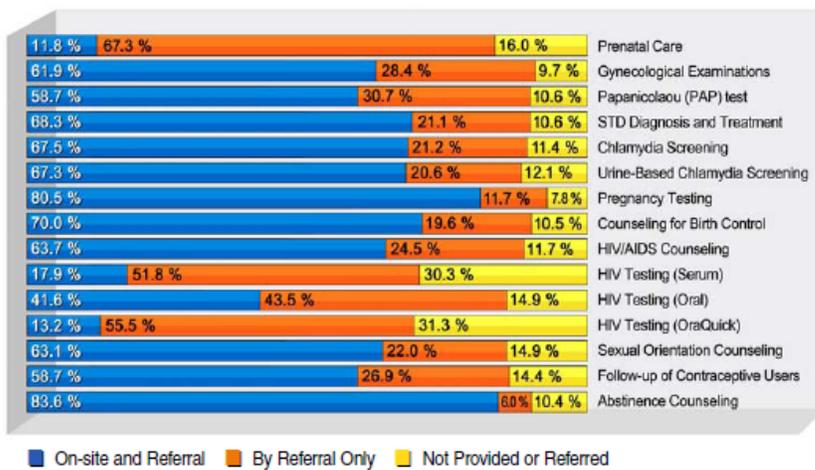
The majority of SBHCs provide comprehensive health assessments, anticipatory guidance, vision and hearing screenings, immunizations, treatment of acute illness, laboratory services, and prescription services.

Primary Care Services Provided On-site



REPRODUCTIVE HEALTH SERVICES OFFERED TO ADOLESCENTS ON-SITE (n=877)

Reproductive Health Services at SBHCs Serving Adolescents

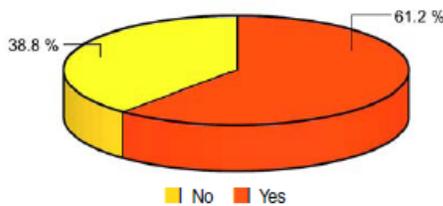


Health centers serving middle and high school-aged students are more likely than those serving younger students to offer abstinence counseling (84%) and provide on-site treatment for sexually-transmitted disease (68%), HIV/AIDS counseling (64%), and diagnostic services such as pregnancy testing (81%). A minority does not provide on-site or refer to an off-site provider for any reproductive health services. These data are reported for SBHCs serving grade six or higher.

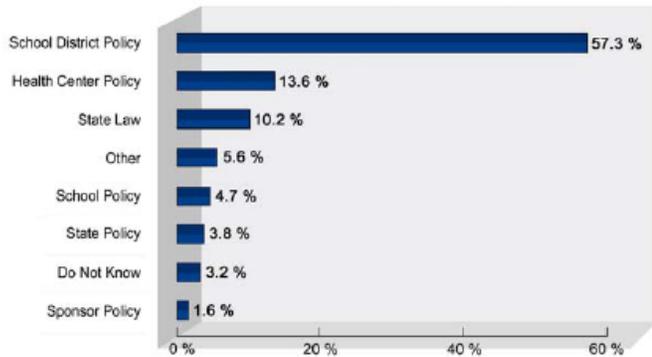
CONTRACEPTION PROHIBITION AT SBHCS SERVING ADOLESCENTS (n=877)

About 60 percent of SBHCs are prohibited from dispensing contraception – a policy determined most often by the school district (57%).

Contraception Dispensing Prohibited in SBHCs



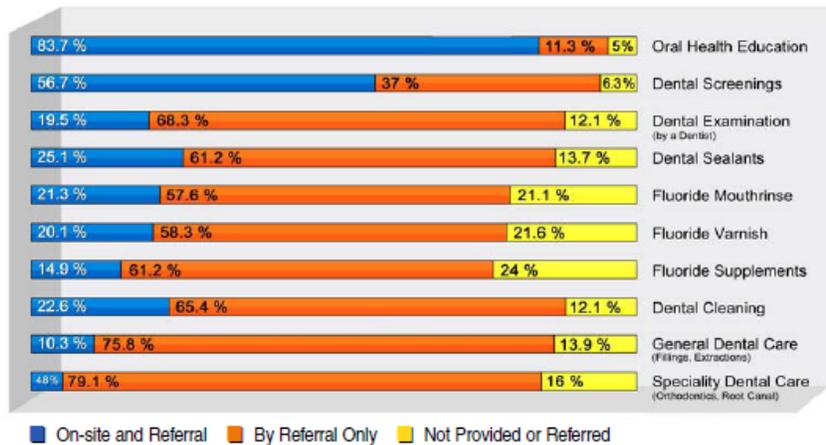
Who Prohibits Dispensing Contraceptives in SBHCs



ORAL HEALTH IN SBHCS (n=1096)

Oral health is an important component of the overall health and well-being of children and adolescents. A majority of SBHCs provide oral health education (84%) and dental screenings (57%). A smaller percentage of SBHCs provide dental examinations (20%), sealants (25%), and cleanings (23%). Very few SBHCs are equipped to provide general (10%) or specialty (5%) dental care to students. Only twelve percent of SBHCs report that they have a dental provider on staff.

Oral Health Services Provided



PREVENTION, EARLY INTERVENTION, AND RISK REDUCTION (n=1226)

Prevention, early intervention, and risk reduction activities are provided most commonly to students during individual clinic visits through services such as immunizations, vision, hearing, and scoliosis screenings, and behavioral risk assessments.

Additionally, a great majority of SBHCs provide individual-level health promotion services, as well as at small group, classroom, and school levels. The topics of health promotion activities vary widely and are based on the needs of the student population.

Prevention, Early Intervention, and Risk Reduction Strategies Offered by SBHCs
N=125 (SBHCs that serve schools with only grades K through 5)

	Individual (%)	Small Group (%)	Classroom/School (%)	Parents (%)
Asthma	89.8	31.3	24.2	29.7
Nutrition/Fitness/Weight Management	85.2	39.8	43.0	33.6
Mental Health Promotion/Prevention	80.5	32.0	27.3	25.8
Injury Prevention	78.9	31.3	37.5	22.7
Violence Prevention	78.1	39.8	28.3	24.2
Resiliency/Social Skills/Skill Building	71.9	40.6	22.7	20.3
Sleep/Sleep Habits	59.4	7.0	28.9	14.8
Tobacco Prevention	58.6	21.9	35.9	14.8
Alcohol/Other Drug Use Prevention	55.5	19.5	28.9	11.7
Diversity/Multiculturalism/Race Relations	45.3	14.1	17.2	7.0
HIV/STD Prevention	43.0	3.9	11.7	5.5
Pregnancy Prevention-Comprehensive	35.2	3.1	3.1	3.8
Drop Out Prevention	32.8	7.8	10.2	5.5
Sexual Assault/Date Rape	34.4	4.7	3.9	3.8
Pregnancy Prevention-Abstinence Only	25.8	4.7	6.3	0.8
Parenting	28.1	8.6	3.1	35.2

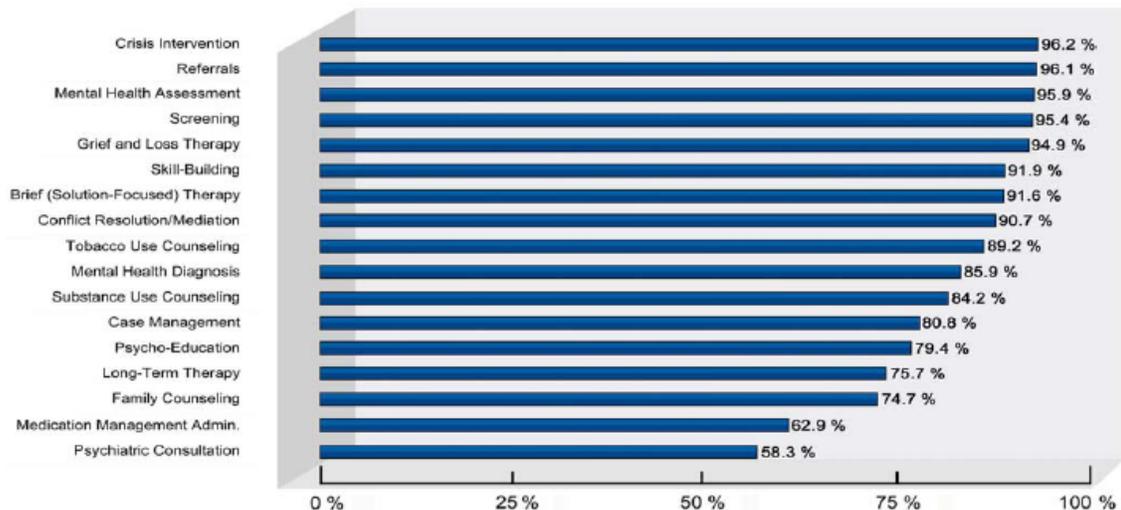
N=514 (SBHCs that serve schools with only grades 6 through 12)

	Individual (%)	Small Group (%)	Classroom/School (%)	Parents (%)
Nutrition/Fitness/Weight Management	92.4	40.5	39.5	14.6
Asthma	91.1	24.5	20.4	15.4
Tobacco Prevention	91.1	37.5	45.7	17.9
Violence Prevention	88.1	44.4	37.9	8.2
Mental Health Promotion/Prevention	87.9	39.5	41.6	15.8
Alcohol/Other Drug Use Prevention	87.2	36.8	45.7	17.3
Injury Prevention	87.2	20.4	28.8	7.6
HIV/STD Prevention	87.2	31.3	44.7	9.5
Resiliency/Social Skills/Skill Building	82.1	40.7	24.3	8.2
Pregnancy Prevention-Comprehensive	80.0	30.9	36.8	10.1
Sleep/Sleep Habits	78.4	12.1	14.0	6.8
Diversity/Multiculturalism/Race Relations	59.7	26.8	22.0	3.1
Sexual Assault/Date Rape	54.3	19.3	19.6	4.5
Pregnancy Prevention-Abstinence Only	52.3	16.1	21.0	5.4
Parenting	50.6	26.3	8.8	14.4
Drop Out Prevention	47.5	12.1	10.7	6.2

MENTAL HEALTH SERVICES (n=1226)

Mental health and counseling services in SBHCs include mental health assessments, crisis intervention, brief and long term therapy, family therapy, teacher consultation, and case management. These services are provided when mental health professionals are included as health center staff. Primary care providers also provide mental health services such as referrals (72%), screening (59%), and crisis intervention (56%) when there is no mental health staff at the SBHC.

Mental Health Services in SBHCs with Mental Health Providers
N=878 (Total Number of SBHCs with Mental Health Provider)

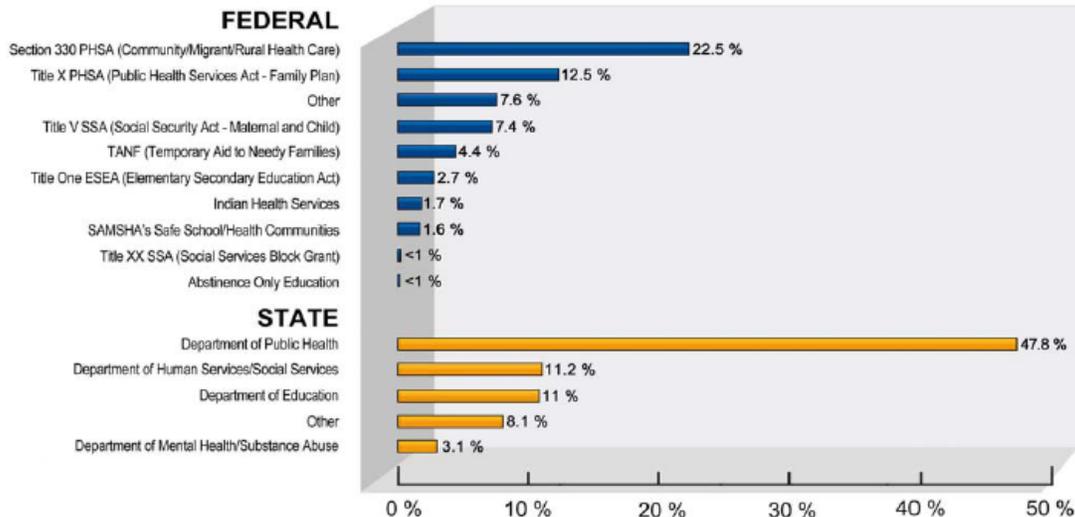


FINANCING OF SBHCS (n=1096)

The majority of SBHCs bill public insurance for health center visits, including Medicaid (81%), the Children's Health Insurance Program (68%), and Tri-Care (41%) – the health care program serving active duty service members, National Guard and Reserve members, retirees, their families, and survivors. Fifty-nine percent bill private insurance and 38 percent bill students or families directly. SBHCs (85%) also assist children and families with enrollment in public insurance programs. State policies are a major determinant of SBHC reimbursement. Improving the effectiveness of billing practices and enrolling children and families in public insurance so there is a payor has been a major focus of sustainability efforts.

SBHCs report receiving support from a variety of revenue sources not related to billing, including state government (76%), private foundations (50%), sponsor organizations (49%), and school or school district (46%). Thirty-nine percent of SBHCs receive funding from the federal government.

Source of SBHC Support Given from Federal or State Government



Managed care organizations (MCO) play a large role in SBHCs' ability to get reimbursed for services. Critical to being reimbursed for care is whether an MCO recognizes services delivered in a SBHC and whether the provider is considered to be a primary care provider or part of the recognized/approved primary care network. The census showed that 35 percent of MCOs recognize SBHC staff as primary care providers/preferred providers, while 30 percent of SBHCs indicate that MCOs do not recognize them as such.

PARENT AND YOUTH ENGAGEMENT (n=1096)

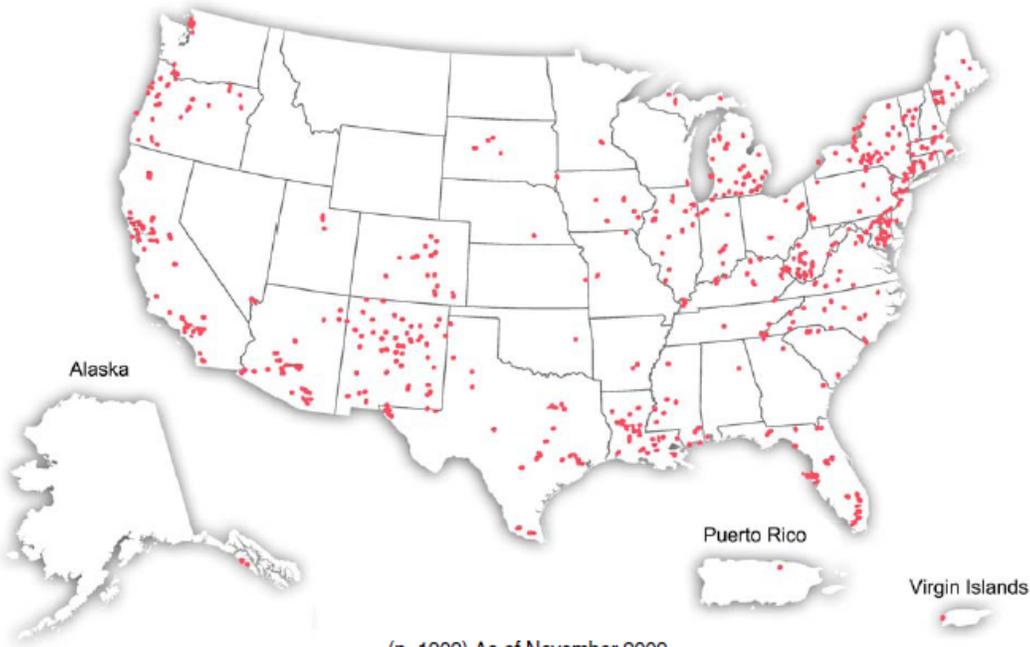
Parent engagement with SBHCs begins during an SBHC's enrollment, when the SBHCs builds awareness of what kinds of services are available and the operational policies of the center in their school. However, 54 percent of SBHCs report that parents have the ability to restrict their child's access to specific services. Parents participate as valuable volunteers and contribute to their SBHC in many ways, including volunteering as an advisor or board member (40%) and participating in organizing center-sponsored health education events (24%).

Young people, often SBHC users, are also important members of their SBHC community and are engaged most frequently by participating in organizing center-sponsored health education events (29%). Many young people also participate in advocacy activities for their health center at local, state, or national levels (20%) and advise on the development, design, and delivery of health services at their SBHC (18%).

HEALTH INFORMATION TECHNOLOGY (HIT) (n=1096)

SBHCs are adopting HIT to enhance their work with more than half (56%) using electronic billing systems, and 53 percent with a management information system. A smaller number use an electronic medical record (32%) and electronic prescribing (22%) and 7 percent of SBHCs have a telemedicine system.

SCHOOL-BASED, MOBILE, AND LINKED HEALTH CENTERS - School Year 2007-08



Alabama	5	Indiana	87	Nebraska	1	Rhode Island	2
Alaska	3	Iowa	16	Nevada	6	South Carolina	7
Arizona	81	Kansas	2	New Hampshire	1	South Dakota	6
Arkansas	4	Kentucky	20	New Jersey	40	Tennessee	21
California	160	Louisiana	64	New Mexico	79	Texas	70
Colorado	45	Maine	26	New York	206	Utah	5
Connecticut	79	Maryland	71	North Carolina	49	Vermont	5
Delaware	28	Massachusetts	59	Ohio	17	Virgin Islands	1
District of Columbia	4	Michigan	90	Oklahoma	11	Virginia	19
Florida	245	Minnesota	16	Oregon	51	Washington	20
Georgia	3	Mississippi	31	Pennsylvania	28	West Virginia	50
Illinois	62	Missouri	3	Puerto Rico	2	Wisconsin	8

For a complete view of the census results, visit our website at www.nasbhc.org.

OUR MISSION

The National Assembly on School-Based Health Care (NASBHC) is the national voice for SBHCs. Founded in 1995 to promote and support the SBHC model, NASBHC's mission is to improve the health status of children and youth by advancing and advocating for school-based health care. Built from the grassroots up by SBHC staff and sponsors, NASBHC is a true reflection of the movement it supports. We advocate for national policies, programs, and funding to expand and strengthen school-based health centers, while also supporting the movement with training and technical assistance.

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