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# School Health and Prevention

Final Report

September 30, 2010



SYSTEMS RESEARCH FOR BETTER HEALTH

# School Health and Prevention

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## Executive Summary

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Adolescent health programs, whether based in or near schools or in community agencies, present an ideal opportunity to implement preventive health interventions. While the burden of morbidity, mortality, and cost of chronic disease largely falls on adults, health habits that contribute to cardiovascular disease, diabetes, and other chronic diseases are formed in youth. In addition, the rates of some chronic diseases, such as diabetes, in youth are rising.<sup>1</sup> The factors that precipitate many chronic diseases include obesity, poor nutrition, and lack of physical activity. Thus, the risk for mortality or morbidity from many conditions can be reduced, if it not completely prevented, in childhood and adolescence. In fact, almost three-quarters of adolescents' morbidity and mortality are preventable.<sup>2</sup>

Because of the importance of prevention services and the opportunity that school-based health clinics (SBHCs) offer, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) within the U.S. Department of Health and Human Services, contracted with Altarum Institute to examine the provision of population-based preventive services in schools, particularly through school-based health centers. The centerpiece of the project was a series of six site visits to school-based health centers across the country that offer promising approaches to the delivery of population-based preventive services. This project addressed the following questions:

- What is the scope of prevention activities undertaken in schools with school-based clinics?
- How do schools without school-based clinics address wellness and prevention?
- What outcomes are tracked in order to monitor improvements in wellness among students?
- To what extent does Medicaid funding help schools provide chronic disease care and prevention among students?
- What are the funding sources schools use to support their prevention activities and provision of health services?

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<sup>1</sup> Van Cleave, J., Gortmaker, S., & Perrin, J. (2010). Dynamics of obesity and chronic health conditions among children and youth. *JAMA: The Journal Of The American Medical Association*, 303(7), 623-630

<sup>2</sup> Eaton DK, Kahn L, Kinchen S, Shanklin S, Ross J, Hawkins J, Harris WA, Lowry R, McManus T, Cheyen D, Lim C, Brener ND, Wechsler H. Youth risk behavior surveillance – United States, 2007. *Morbidity and Mortality Weekly Report*. 2008; 57: 1-136.

Using data from the National Assembly for School-Based Health Care's 2007-2008 Census; Altarum researchers selected six SBHCs that provided small or large group sessions on at least five health education topics. The sites selected were:

- Vaughn Next Century Learning Center, Pacoima (LA), CA
- Durango High School, Durango, CO
- Windham Middle and High Schools, Willimantic, CT
- Utica Elementary-Middle School, Utica, MS
- Oyler Community Learning Center, Cincinnati, OH
- Hart School District, Hart, TX

Site visits were conducted between March and May 2010. The six sites provide prevention services in different ways, on various topics, with different methods and levels of intensity. However, these diverse strategies can be summarized using three models that describe the alternative mechanisms for delivering prevention services.

- **The Internal Model.** One approach is to provide prevention services via the clinic's staff. This task can be assigned to a single staff member, as is the case at the Vaughn school clinic in Los Angeles, where a full-time health educator conducts classroom presentations, small-group educational sessions, and coordinated large-scale events such as health fairs at which health promotion information is distributed. Alternatively, preventive health activities can be part of the responsibility of a broad range of staff members. At the school-based health center in Hart, TX, the dental hygienist, psychologist, nurse, and the clinic director conduct health promotion activities, and some nutrition and asthma management sessions are conducted via telemedicine at Texas Tech. The advantage of the internal model is that it minimizes the level of coordination that is required to schedule and conduct preventive health services. The challenging aspect of this approach is that the cost of staff members' time that is devoted to health promotion must be covered through existing funding sources, as these programs are rarely billable.
- **External Model.** Prevention programming and resources can also be provided to students by outside agencies and organizations, which is the model that is used by the Oyler Community Learning Center and Windham Middle and High Schools. In this model,

prevention programs are designed and conducted by outside agencies and coordinated by the school or SBHC. The types of agencies that are involved in this model vary widely, and may include community mental health agencies, Federally Qualified Health Centers (FQHCs) or other local health centers, foundations, food banks or other nutrition programs, colleges and universities, and recreational programs (such as Boys & Girls Club). This model has several advantages. For one, it may reduce or eliminate any privacy issues that arise. As health care providers, SBHC staff generally have explicit guidelines for their handling of students' private information, and these guidelines may differ from the privacy policies of outside agencies. Similarly, this format may also improve communication and engagement by students. This model may have a potential financial advantage, as sites showed an interest in providing population-based prevention services to students, but cited a lack of person-hours for grant writing and other activities for securing funds. There are, however, disadvantages. While not bearing responsibility for funding may be advantageous, participation by a variety of agencies with a variety of grant sources results in an often tenuous situation in which loss of funding from one source or another becomes an almost constant possibility. As an organization's participation may change on short notice, there is also a threat to consistency of programming. Another disadvantage of this model is that it may limit the control that the school or SBHC has over content.

- **Integrated School Health Model of Prevention.** The Coordinated School Health Program is a well-known model of school health prevention designed to coordinate health and education and developed by the Centers for Disease Control and Prevention (CDC).<sup>3</sup> The model is based on the concept that healthy children experience school success more easily and are better prepared to learn when their health needs are addressed. Common elements to the successful implementation of this model are the identification of school health coordinators and advisory councils. The coordinators and councils are formed at the school, district, and state levels and have broad representation from the community, including school personnel, community representatives, parents, and students. In Durango, the SBHC is an extension of the public health community and an integrated part of the Durango School District's Healthy Schools initiative. The local health department, county

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<sup>3</sup> Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. Healthy Youth! Coordinated School Health Program. <http://www.cdc.gov/HealthyYouth/CSHP/>. Downloaded August 5, 2010.

human services department, and various other community action programs are primary partners in service provision, including supporting reproductive health services, positive youth development programs, and nutrition education.

Through the site visits, background research, and interviews with key informants, several themes clearly emerged about the elements that are necessary for a successful school-based prevention program and the challenges that schools and school-based health centers face in implementing these programs.

- **Strong community support.** The development of school-based health centers depends on the support of key players throughout the community, including school officials, local leaders, funders, and health care providers. Several sites described the efforts they made to convince local leaders of the value of school-based health services and the benefits of having those leaders' support.
- **Dynamic leadership from within the community.** In addition to support from the community, the role of a tenacious, dynamic leader cannot be overstated. In many of the sites visited, the development of the SBHC and its ongoing sustainability were the direct result of tireless efforts on the part of an experienced leader who had the knowledge to find and use available sources of funding creatively and to establish the connections and partnerships necessary to sustain the center's programs.
- **Reliance on multiple funding sources.** The site visits made clear that school-based health clinics and other Coordinated School Health efforts cannot depend on any single source of financing over the long term. The creative use of State and Federal grants, local foundation funding, Medicaid and CHIP reimbursement, and in-kind contributions is essential to assuring the sustainability of prevention services.
- **Starting prevention efforts early.** Many of the schools studied here served children from kindergarten through high school or a combined middle and high school population. This presented the opportunity to start prevention efforts in the primary grades, including discussion of explicitly health-related topics, such as oral hygiene and nutrition, as well as topics such as character building and life options, which can lay the

groundwork for good mental health, substance abuse prevention, pregnancy prevention, and other adolescent health issues.

- **Making the link between health and wellness and educational success.**

Prevention efforts are notoriously difficult to evaluate, as their benefits may not be seen for decades, and health-related outcomes may not be clearly attributable to any one intervention. However, shorter-term outcomes, such as absenteeism and graduation rates, are easily measured and are of critical importance to school officials.

- **The critical role of partnerships.** Many school-based prevention efforts depend on networks of partners at the State and local levels to deliver both clinical and population-based prevention services. These partnerships are essential to maximize the effectiveness of funding streams that are limited both in amount and in flexibility, and to avoid duplication of services that are already available in the community.

In addition to these shared elements of success, the sites shared common challenges.

- **Sustainable funding sources.** By far the largest and most consistent challenge reported by school-based health center directors and state Coordinated School Health directors is that of assuring sustainable sources of funding for their services. Even those centers that are able to receive Medicaid and CHIP reimbursement require additional funding for prevention services.
- **Leadership succession.** While many centers have benefitted from the vision and energy of their founding directors, these leaders are nearing retirement and require qualified successors. In many cases, while competent professionals are available to take the reins, it is not clear that they possess the range of skills and talents of the original directors.
- **Culturally competent services.** Many of the sites visited served a predominantly minority population, but not all of these sites were run or staffed by members of the population served. More specifically, providers of prevention services did not always speak Spanish, which posed a barrier to communication with students or, more commonly, with their parents.
- **Moving health and wellness from policy into practice, and practice into policy.** While many schools nominally value wellness and have established wellness policies, preventive

health efforts may not be the first priority of school health programs. Especially among high-need, high-risk populations, acute needs frequently take precedence over more long-term health concerns, and keeping health promotion high on a school-based health center's agenda can be a significant challenge. Likewise, once preventive health activities have been implemented, assuring that they continue through policy changes can also be challenging.

- **Monitoring and evaluating outcomes.** Evaluating prevention programs presents a challenge in all settings, but is especially complex in schools, when many of the targeted outcomes may not occur for years. Moreover, funders may be more interested in process measures and short-term outcomes to monitor exactly what they have received for their investment. Therefore, it is difficult to maintain a focus on longer-term outcome measures and on rigorous program evaluation. Exacerbating this challenge is the lack of agreed-upon measures of the success of prevention efforts.

Overall, while there are significant challenges associated with the provision of prevention services in schools, successful models exist, as do experienced leaders who have worked tirelessly to establish these programs in diverse settings. As Federal officials contemplate expanding school-based prevention programs, it is critical that they continue to learn from the experiences of these sites and others that have incorporated population-based prevention into their programs.

## Introduction and Overview

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Adolescent health programs, whether based in or near schools or in community agencies, present an ideal opportunity to implement preventive health interventions. While the burden of morbidity, mortality, and cost of chronic disease largely falls on adults, health habits that contribute to cardiovascular disease, diabetes, and other chronic diseases are formed in youth. In addition, the rates of some chronic diseases, such as diabetes, in youth are rising.<sup>1</sup> The factors that precipitate many chronic diseases include obesity, poor nutrition, and lack of physical activity. Thus, the risk for mortality or morbidity from many conditions can be reduced, if it not completely prevented, in childhood and adolescence. In fact, almost three-quarters of adolescents' morbidity and mortality are preventable.<sup>2</sup>

While significant strides have been made over the last decade in reducing certain adolescent risks, particularly smoking and, until recently, pregnancy, the prevalence of serious and often life-threatening risks are widespread and beginning at younger ages. Obesity is a particularly salient issue, as the percentage of 9<sup>th</sup>- through 12<sup>th</sup>-grade students who are overweight or obese has increased since 1999.<sup>3</sup> Factors contributing to the trend include decreased levels of physical activity and poor dietary behaviors. According to the National Survey of Children's Health, 36 percent of children aged 6–17 participated in vigorous physical activity three days or fewer over the previous 7-day

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<sup>1</sup> Van Cleave, J., Gortmaker, S., & Perrin, J. (2010). Dynamics of obesity and chronic health conditions among children and youth. *JAMA: The Journal Of The American Medical Association*, 303(7), 623-630

<sup>2</sup> Eaton DK, Kahn L, Kinchen S, Shanklin S, Ross J, Hawkins J, Harris WA, Lowry R, McManus T, Cheyen D, Lim C, Brener ND, Wechsler H. Youth risk behavior surveillance – United States, 2007. *Morbidity and Mortality Weekly Report*. 2008; 57: 1-136.

<sup>3</sup> Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Adolescent and School Health. *Trends in the Prevalence of Obesity, Dietary Behaviors, and Weight Control Practices, National YRBS: 1991-2009*.

period. In the 2009 Youth Risk Behavior Survey (YRBS), only 22.3 percent of respondents reported eating the recommended amount of fruits and vegetables in the previous 7 days.

A number of Federal agencies within the U.S. Department of Health and Human Services are involved in the effort to assure that adolescents live healthy lives and develop good health habits for adulthood. Their adolescent health efforts include the following:

- The **National Initiative to Improve Adolescent Health**, led by the CDC's Division of Adolescent and School Health and HRSA's Maternal and Child Health Bureau, brings together different partners, including States, to elevate the focus on the health, safety, and well-being of 10- to 24-year-olds. This partnership includes many systems, including local health departments, State legislatures, the legal system, school mental health services, and youth development programs.
- CDC's **Healthy Youth Initiative**, implemented by the Division of Adolescent and School Health, uses four strategies to achieve its mission: (1) identifying and monitoring risk behaviors and the status of school health education and policies, (2) synthesizing and applying research by identifying policies and programs that show promise in promoting healthy behaviors among young people, (3) enabling constituent groups to implement comprehensive adolescent and school health behaviors, and (4) evaluating and providing support for evaluation to States and local education agencies.
- In cooperation with the **Substance Abuse and Mental Health Services Administration (SAMHSA)**, the CDC is funding two policy analysis centers on school mental health programs, with the goal of promoting successful mental health services in schools, including direct treatment services and prevention efforts. These centers work to increase the capacity of school personnel to identify and address developmental, behavioral, and mental health needs of school-aged children.
- The **National Coordinating Committee on School Health and Safety** works to promote health, safety, mental health and nutrition in schools through collaborative efforts among the Departments of Health and Human Services, Education, and Agriculture.
- The **Office of Adolescent Health** within the **Maternal and Child Health Bureau** "provides national leadership in promoting the health, development, safety, and social and emotional well-being of all school-aged children, adolescents, and young adults in the United

States and their families.” Its adolescent health activities are structured around the four goals of the National Initiative to Improve Adolescent Health, which are collaborations between the Health Resources and Services Administration (HRSA) and the CDC Division of Adolescent and School Health.

In the school setting, the CDC is promoting the coordinated school health approach, which can address some of the fragmentation issues and address health promotion needs. This model has eight components: health education, physical education, health services, nutrition services, counseling and psychological services, healthy school environment, health promotion for staff, and family and community environment.

Schools are a natural location where multiple partners can work together maintain and improve the health of young people. Most youth ages 6–17 spend at least 6 hours a day in school settings. Many have at least one of their weekday meals at school. It has been shown that increased school connectedness reduces the likelihood of engagement in risk behaviors.<sup>4</sup> School-based health centers (SBHCs) can offer a rich opportunity to deliver preventive services on the individual clinical level as well as through small-group and larger, school-wide interventions. SBHCs can be essential pieces of a coordinated school health program through which to address child and adolescent health needs. SBHCs are located on school grounds and cooperate with the school to meet the complex needs of the youth they serve. Given their unique access to the school population, combined with a qualified health professional staff, they often perform health promotion activities along with their clinical services.

SBHCs provide a wide variety of services, including primary care, mental health, dental health, and an array of prevention services, as described above. There are three models of school-based health care: SBHCs (on-site at a school), school-linked health centers (near a school and focused on serving the school population), and mobile school health centers (mobile units that come to school grounds and may serve multiple schools). SBHCs may offer disease prevention and health promotion

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<sup>4</sup> Markham CM, Lormand D, Gloppen KM, Peskin MF, Flores B, Low B, House LD. **Connectedness as a predictor of sexual and reproductive health outcomes for youth.** *Journal of Adolescent Health.* 2010 Mar;46(3 Suppl):S23-41. Epub 2010 Jan 22.

services on a wide range of topics, including chronic disease (such as asthma), substance use (including tobacco, alcohol, and illicit drugs), sexual health (including HIV, sexually transmitted infections, and pregnancy), mental health, nutrition, and violence.

There are approximately 2,024 SBHCs in the United States, located in 47 of 50 States, the District of Columbia, and Puerto Rico. State and Territorial education agencies and tribal governments can apply for funding from the CDC to implement a Coordinated School Health Program. Currently, 23 States and tribes are funded through the program.

The National Assembly on School-Based Health Care’s 2007-2008 Census of school-based health centers assessed the provision of health promotion services among SBHCs, as displayed in Table 1 below. In SBHCs located in elementary schools, the most common population-based preventive services addressed asthma, nutrition, mental health, injury prevention, and violence prevention, but fewer than half of SBHCs addressed any of these topics on the small group or classroom level. In middle and high schools, population-based services more commonly addressed adolescent health issues such as tobacco, alcohol, and other drug use; violence; and reproductive health.

<i>Topic</i>	<i>Small Group</i>		<i>Classroom/ Large Group</i>	
	K-5 (N=125)	6-12 (N=514)	K-5 (N=125)	6-12 (N=514)
Asthma	39 (31.3%)	126 (24.5%)	30 (24.2%)	105 (20.4%)
Nutrition/Fitness/Weight Mgmt	49 (39.8%)	208 (40.5%)	54 (43.0%)	203 (39.5%)
Mental Health	40 (32.0%)	203 (39.5%)	34 (27.3%)	214 (41.6%)
Injury Prevention	39 (31.3%)	105 (20.4%)	47 (37.5%)	148 (28.8%)
Violence Prevention	49 (39.8%)	228 (44.4%)	35(28.3%)	195 (37.9%)
Resiliency/Skill Building	51 (40.6%)	209 (40.7%)	28 (22.7%)	125 (24.3%)
Sleep Habits	9 (7.0%)	62 (12.1%)	36 (28.9%)	72 (14.0%)
Tobacco Prevention	27 (21.9%)	193 (37.5%)	45 (35.9%)	235 (45.7%)
Alcohol/Other Drug Prevention	24 (19.5%)	189 (36.8%)	36 (28.9%)	235 (45.7%)
Diversity/Multiculturalism	18 (14.1%)	138 (26.8%)	21 (17.2%)	113 (22.0%)
HIV/STI Prevention	5 (3.9%)	161 (31.3%)	15 (11.7%)	230 (44.7%)
Pregnancy Prevention (Comprehensive)	4 (3.1%)	159 (30.9%)	4 (3.1%)	189 (36.8%)
Pregnancy Prevention (Abstinence Only)	6 (4.7%)	83 (16.1%)	8 (6.3%)	108 (21.0%)
Sexual Assault/Date Rape	6 (4.7%)	99 (19.3%)	5 (3.9%)	100 (19.6%)
Parenting	11 (8.6%)	135 (26.3%)	4 (3.1%)	45 (8.8%)

Source: NASBHC National Census, 2007-2008

Because of the importance of prevention services and the opportunity that SBHCs offer, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) within the U.S. Department of

Health and Human Services contracted with Altarum Institute to examine the provision of population-based preventive services in schools, particularly through school-based health centers. The centerpiece of the project was a series of six site visits to school-based health centers across the country that offer promising approaches to the delivery of population-based preventive services. This report presents the findings of this effort. The next section details the research questions and methods used to address them; this is followed by a brief summary of each of the six sites. We then present three alternative models for the provision of prevention services through school-based health centers, as well as a discussion of how prevention services may be provided and sustained in schools without SBHCs. We also specifically address how prevention services are financed and sustained, and monitored and evaluated, in SBHCs. Finally, we present a set of conclusions and lessons learned based on our examination of prevention services in schools.

# Design and Methodology

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## Purpose

In 2009, ASPE contracted with Altarum Institute to conduct case studies of select SBHCs across the U.S. The project was designed to gather information about how SBHCs are implementing prevention services, the financing mechanisms utilized, and the monitoring and evaluation methods implemented to assess the SBHC's impact on students. The major questions addressed in this project are:

- What is the scope of prevention activities undertaken in schools with school-based clinics?
- How do schools without school-based clinics address wellness and prevention?
- What outcomes are tracked in order to monitor improvements in wellness among students?
- To what extent does Medicaid funding help schools provide chronic disease care and prevention among students?
- What are the funding sources schools use to support their prevention activities and provision of health services?

## Design

To thoroughly and objectively examine the implementation of prevention services within the SBHCs and in schools without SBHCs, the project employed a multi-method design that incorporated several data collection strategies. Qualitative data collection and analysis were necessary to obtain a complete picture of the SBHCs' scope of prevention services, financing mechanisms, challenges, and evaluation methods. Data collection was conducted with 6 selected sites over a 6-month period using information collection from:

- Review of 2007-2008 NASBHC Census data.
- Case studies of select SBHCs, including semi-structured interviews conducted with individuals and groups of SBHC staff, school administrators and staff, and representatives from community partners.
- Review of background information from select SBHCs.
- Telephone interviews with administrators from schools without an SBHC.

**Instrumentation.** Semi-structured interview and discussion guides were developed to collect information about the SBHCs that could not be obtained from secondary data sources. The following guides were developed in collaboration with ASPE:

- Clinical Staff Discussion Guide
- Sponsor Agencies Discussion Guide
- Partner Agencies Discussion Guide
- School Administrators Discussion Guide
- State Officials Discussion Guide

The discussion guides covered a range of topics including: the background and history of the SBHC, the needs of the population, prevention services provided, partnership development and involvement, evaluation and outcomes, successes and challenges, financing, sustainability, and lessons learned. (The discussion guides are included in the Appendix).

## Methods

**Site Selection.** The project team was tasked with selecting six SBHCs to examine their model of providing population-based prevention services. The project team used a three-step approach, first selecting six States based on the need for prevention services and support for school health within the State.

**Criteria for need.** ASPE provided Altarum with a spreadsheet listing data from national data sets with states ranked by: prevalence of risk factors for chronic disease (including obesity and lack of physical activity), rates of diabetes, rates of uninsurance among children, and rates of teen births. The five states with the highest rates were placed in the “high need” category and the five with the lowest rates were characterized as “low need.”

**Criteria for support.** We referred to the CDC’s School Health Policies and Programs study for information about the following:

- States with a coordinator for school health programs (health education, physical education, health services, mental health and social services, and nutrition services)

- States that require teaching in specified health topics (alcohol and other drug use prevention, asthma awareness, emotional and mental health, food-borne illness prevention, HIV prevention, human sexuality, injury prevention, nutrition, other STD prevention, physical activity and fitness, pregnancy prevention, suicide prevention, tobacco use prevention, and violence prevention)

The National Assembly on School-Based Health Care’s 2007 survey also provides information on State-level policies, including:

- Whether the State maintains a grant program for SBHCs.
- Whether the State government has a program unit responsible for providing technical assistance (TA) to communities interested in developing SBHCs.
- Whether SBHCs have been established as a Medicaid provider type.

We sought to identify states in each region (Northeast, Southeast, Midwest, and West) that met as many of these criteria as possible. These were classified as “high support,” while those that consistently did not meet the criteria would be considered “low support.”

Based on the results, the project team further narrowed the list selecting for geographic heterogeneity. As shown in Table 2, the team selected California, Colorado, Connecticut, Mississippi, Ohio, and Texas.

Level of Support and Need		Need	
		High	Low
Support	High	<i>Texas</i>	<i>Colorado Connecticut</i>
	Low	<i>Mississippi Ohio</i>	<i>California</i>

After selecting the States, the team needed to identify sites within those States that may provide population-based prevention services. Using data from the 2007-2008 NASBHC Census, we selected SBHCs that provided small- or large-group sessions on at least five health education topics. A total of 87 sites met the criteria in the six states. Given that none of the sites in Mississippi met the criteria, the team examined all 23 census responses. We further used racial and ethnic distributions, geography, type of sponsoring agency, and grade levels served to develop a preliminary list of potential sites to participate in the project. Altarum consulted with the Executive Director of the National Assembly on School Based Health Care who used her knowledge of the program activities and specific communities to recommend a list of sites and one alternate site in each state. The sites selected for this project were:

- ▲ Vaughn Next Century Learning Center, Pacoima (LA), CA
- ▲ Durango High School, Durango, CO
- ▲ Windham Middle and High Schools, Willimantic, CT
- ▲ Utica Elementary-Middle School, Utica, MS
- ▲ Oylar Community Learning Center, Cincinnati, OH
- ▲ Hart School District, Hart, TX

**Data Collection Methods.** The project relied on several methods to collect and analyze information. Data collection methods are summarized in Table 3. Qualitative data, including interview responses and abstracted information from site documents, were stored and cleaned in Microsoft Word and prepared for content analysis. The data were analyzed for key themes and differences in responses across participants. Because the data were collected by a small team, qualitative software was not needed for this analysis.

Table 3. Summary of Data Collection Methods		
Data Collection Method	Data Sources	Participants
Interviews with SBHC staff	Primary data; semi-structured interviews occurred in person at SBHC and within community; 2-3 day site visit	School administration; SBHC clinic staff; representatives from sponsor agencies; representatives from partner agencies
Interviews with administrators at schools with no SBHC	Primary data; semi-structured interviews occurred by telephone	School administrators
Review of SBHC documents and data	Secondary quantitative data retrieved from 2007-2008 NASBHC Census	SBHCs

### Limitations

There are several limitations to this project due to time and funding constraints, including lack of generalizability of findings, purposive sample of sites, and self-reported data.

**Generalizability of findings.** Efforts were made during site visit selection to ensure that general characteristics of SBHCs were represented; however, the SBHCs selected for site visits may not be representative of all SBHCs. It is possible that additional site visits and interviews conducted with all SBHCs might lead to slightly different themes and conclusions. The generalizability of the results is therefore limited due to the small number of sites that participated in the project. The purposive sample approach also does not allow inferences to be made with this data.

**Purposive sample of sites.** Sites were invited to participate in the project but were given the option to accept or decline participation, thus resulting in self-selection bias. This convenience sample of sites calls into question whether these sites are representative of a “typical” site implementing prevention services using a SBHC model.

**Self-reported data.** Project participants provided all data. The project did not include an independent assessment of SBHC prevention service delivery and impact.

## Summary of Sites

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As described above, the six sites represent a range of geographic regions, demographic populations, and program designs. This section provides detailed descriptions of each of the six schools, their school-based health centers, and the prevention services they offer.

### **Oyler Community Learning Center, Cincinnati, OH**

Oyler Community Learning Center is in the Cincinnati community of Lower Price Hill, an economically disadvantaged area bordering the industrial region of the Ohio River Valley known as “urban Appalachia”. The community is geographically, socially and economically isolated, and historically, when there was no high school in the area, the majority of students dropped out of school after 8<sup>th</sup> grade rather than attend high school in another area of the city; the dropout rate was cited as approximately 85 percent. The community’s response to this problem was to expand the local elementary school into a Community Learning Center, adding one grade each year, until in 2006 the Oyler School graduated its first class of high school seniors through an online program, and the first traditional class graduated in 2010. The graduation rate is now nearly 100 percent. The school has the complete support of the community, which has long advocated for a high school and appears to rely on the many services provided there.

The development of the school involved an extensive, community-based process of needs assessment and organizing, including door-to-door surveys, petition drives, parent forums, and interviews with community agencies, culminating in a presentation to the Cincinnati Public Schools (CPS). Based on this presentation and the clear demonstration of the need in the community, CPS agreed to expand the elementary and middle school into a full K-12 school. Health care was a critical element in the planning and development of the school, as leaders recognized that poor health and health risks are major causes of absenteeism and a barrier to learning.

The Community Learning Center model is essential to the school’s success. It hinges on partnerships with community agencies such as the Boys & Girls Club, the city’s Health Department, St. Aloysius Orphanage, and other agencies to provide recreational programs, morning and evening meals, mentoring programs, and health services on-site, year-round at the school. The ability to improve attendance (by offering services that families need) increases the school’s budget (as they

are funded on a per-diem basis) and improves graduation rates, the school's ultimate measure of success. The partnerships with local agencies are managed by a Resource Coordinator, who manages the many partnerships involved in the school, and a School Community Coordinator, who works with families and makes referrals to social service agencies, in each building.

The community is approximately 60-65% White and 35-40% African American. Some of the major health risks are environmental (due to the industrial nature of the area and the fact that it sits in a river basin, leading to poor air and water quality), including high rates of lead poisoning and asthma. Drug use is common, and immunization rates are low. Other major health problems seen in the school are mental health needs (including child abuse and neglect); oral health needs, and head lice.

### **School-Based Health Center Overview**

The school-based health center at Oylar is sponsored by the local health department, which also operates a community clinic in the immediate neighborhood of the school. The SBHC employs a part-time director and full-time nurse practitioner, who essentially functions as an out-stationed member of the clinic's staff.

The clinic began with a \$4,000 planning grant in the 2008-09 school year, with funding provided by the Health Foundation of Greater Cincinnati. The clinic director was hired at that time. The nurse practitioner was hired in the fall of 2009; she works full-time and her salary is covered through reimbursements, primarily from Medicaid. The Price Hill clinic serves as the primary care provider for students who are seen at the SBHC, and the clinic takes responsibility for billing for her services. However, the clinic is primarily funded by the Health Foundation's grant of \$350,000 for 5 years.

The project officer at the funding organization described the overall strategy for the provision of school-based health services in Cincinnati. The Foundation funds school-based clinics in 30 schools in the city, and in general they are focused on treatment rather than prevention; however, an economist working for a Federally Qualified Health Center in the area has calculated that if a school clinic serves at least 400 students and at least 75 percent of them are enrolled in Medicaid, they should be able to generate enough revenue through billing to cover an additional staff person to provide population-based prevention services.

The SBHC focuses on providing well-child and acute care for Oylar students, in collaboration with the school nurse, who is an employee of the health department. Parental consent is required for students to be seen at the clinic; this is obtained at the start of the school year and throughout the year, as needed. The major services provided in the clinic are:

- **Dental.** Oral health services are provided at a clinic across the street, and every Monday and Wednesday the clinic staff walk students (up to 25 at a time) over for cleanings and sealants.
- **Well-child care.** Early Periodic Screening, Diagnosis, and Treatment (EPSDT) screens, immunizations, sports physicals, and referral for vision and other services are provided in the clinic. Referrals from the clinic are put on a fast track for follow-up through the Price Hill clinic.
- **Sick care.** Students with immediate acute care needs are seen first by the school nurse, and if a consent form is on file, she refers them to the nurse practitioner. Common needs include lice, bedbug bites, and ear infections. A one-time consent can be obtained by phone for immediate needs as well.
- **Mental health and sexual health.** The nurse practitioner also sees students with needs for mental health care and family planning services. She provides initial screening and counseling, and then refers to other providers (including those within the school, who are employed by St. Aloysius) for additional services.

On average, the nurse practitioner sees five to six students a day in the clinic. She follows up with parents after their children's visits whenever possible, and sends letters home. The goal of the clinic is for the students to transition to a more permanent medical home, but given the lack of resources in the community, that may be difficult to achieve.

In addition to the services provided through the SBHC, the school also has a school nurse, who is an employee of the local health department. She is primarily responsible for acute care visits; she refers to the nurse practitioner in the clinic whenever necessary, as described above. She also assists with the management of chronic conditions, testing glucose levels for children with diabetes and assisting in asthma management.

Finally, on-site direct mental health services are provided at Oyler through St. Aloysius Orphanage, a community mental health agency. The staff of St. Al's at Oyler includes two therapists and an intern, and a third professional staff member will be starting soon. In addition, a pediatrician is at the school several days a week to manage medications for students with ADD/ADHD and other disorders, and a school therapist does some prevention work in the classrooms, as described below.

## **Prevention Services**

Prevention services at Oyler are largely provided through the Community Learning Center and its community partners. These include the following:

- **Mental health.** MindPeace, a nonprofit collaborative mental health planning agency, works with all the schools in Cincinnati to select a mental health partner and provides technical assistance in the provision of mental health services, including prevention, intervention, and treatment. St. Aloysius, the mental health partner for Oyler, conducts some prevention activities, although their focus is on direct mental health services. Their staff work to educate the teachers on behavioral issues, including the triggering effects of yelling in the classroom on children, and to work with younger children before problems develop. In addition, the school therapist conducts school-wide prevention efforts, conveying behavioral goals and expectations for each grade level. Finally, the Asset Builders program teaches conflict resolution and self-esteem to 11- to 16-year-olds, with about 15 students involved at a time.
- **Physical activity.** Growing Well Cincinnati, a project of the Health Foundation of Greater Cincinnati, oversaw a program called Partners for School Health, which is in its final year of implementation. This program focused on measuring 4<sup>th</sup> to 6<sup>th</sup>-grade students' physical fitness in six areas and assessing whether each student fell into a "Healthy Fitness Zone" based on their personal body-mass index (BMI) and goals. In addition, each school is expected to have a Wellness Team that oversees various activities within the school. This team is not currently active at Oyler, but the team did host an "Oyler Go Active" day in April 2009 that included a 3-kilometer school-wide walk. The school has also instituted its first cheerleading team.

- **Nutrition.** Hunger is a major problem in the Lower Price Hill community, so nutrition programs at Oyler are generally tied to food banks and other programs. There is a dinner program at the school called Kids Café, and a local food bank offers bags of groceries for the weekend. A group of students at nearby Xavier University conducted a healthy eating intervention at Oyler recently as well; this involved focus groups and surveys of Oyler students about what they eat and why, with the goal of developing a plan to address obesity among Oyler students.
- **Infectious disease.** The school nurse goes into classrooms to show videos and discuss handwashing and proper coughing and sneezing procedures in every classroom every year. These are among the health education requirements set by the school district for elementary schools.
- **Substance abuse prevention.** Few substance abuse prevention programs appear to be in place, other than Drug Abuse Resistance Education (DARE) for 5<sup>th</sup> graders. The need for such prevention programs was mentioned.
- **Violence prevention.** Beech Acres is a family peer-support agency that provides services to families of school-aged children experiencing behavior problems; they also conduct domestic violence prevention sessions. Santa Maria Community Agency conducts the Asset Builders Group, in which participants learn conflict resolution skills and participate in service projects in the community. The YWCA also conducts an eight-session program on relationship violence called AMEND.
- **Pregnancy prevention.** The school nurse discusses pregnancy prevention in the clinic when needed, and Girls Inc. conducts pregnancy prevention programs for 7<sup>th</sup> and 8<sup>th</sup> graders.

In addition, the local Boys and Girls Club is a major partner; it offers after-school programs that include meals, tutoring, computer classes, health and wellness programs (including physical education classes and group sessions on making positive choices), and recreational activities. The Community Learning Center also involves a number of partners that focus on educational objectives, offering mentoring, tutoring, college counseling and readiness programs, and vocational counseling.

Despite all of these efforts and activities, however, the school staff identified a need for additional prevention efforts in the areas of sexual abstinence and substance abuse prevention.

### **Monitoring and Evaluation**

The clinic monitors and reports many outcome measures to its funder, including the number of children with asthma whose condition is under control, the use of prenatal care and birth weight of infants born to Oylar students, and the percent of currently enrolled students who are also enrolled for care in the SBHC.

In addition, the Cincinnati Public Schools monitors its Community Learning Centers with a standard progress report that includes a number of indicators that are not directly related to educational outcomes, and in many cases are related to health and wellness. These include the following qualitative measures:

- Use of school facility for community programming and services during and beyond the school day is maximized.
- Community is engaged in the continuous development of the CLC.
- Clearly identified resource coordinator who manages all of the CLC programs, partnerships, and resources.
- CLC provides regularly scheduled programming daily and year-round, with extended hours of operation.

The CLCs are required to monitor community engagement through the number of parent/family activities, parent participants/volunteers, community activities, and community participants/volunteers in each school year. In addition, the following indicators of physical and mental health are included in each annual progress report:

- Physical health: percentage of children who are fully immunized and the percentage of medical referrals that are completed.
- Dental health: the percentage of dental referrals that were completed.

- Mental health: the percentage of students referred for services who were treated or referred.

Finally, the school prepares a monthly collaboration/involvement report that monitors the number of visits or participants in each of the partner agencies' programs. This report is developed based on monthly tracking forms submitted by each partner agency. School administrators also conduct biweekly meetings with their partners to evaluate their progress, discuss new ideas, and examine what has not worked; this process allows them to monitor their partners' efforts in real time.

### **Sustainability**

Because nearly all of Oyler's students are eligible for Medicaid, reimbursement from Medicaid can provide ongoing support for the nurse practitioner in the school-based clinic. However, additional funding is needed for the clinic coordinator, as her salary is currently covered through grant funds. The clinic's project officer at the Health Foundation of Greater Cincinnati estimates that the site will have to raise an additional \$30,000 per year to cover its costs in addition to their Medicaid reimbursement. In addition, the clinic director would like to be able to hire a medical assistant to support the nurse practitioner.

From the school's perspective, sustainability is a critical element of the development of partnerships with community agencies. The school administration much prefers to enter into partnerships that have long-term potential, rather than short-term, 1-year efforts.

### **Lessons Learned**

The very existence of the Oyler Community Learning Center is attributable to the strong support of the community, as well as the efforts of the Cincinnati Public Schools to develop community learning centers throughout the city to address dropout rates. The support of the community is essential to Oyler's provision of prevention services to children and their families; in addition, the strategy of bringing providers and services into the school, rather than referring out, assures that the programs reach those most in need. The community's approach of assessing its needs systematically and marshaling its resources to advocate for their school was also critical to the success of their efforts.

In the effective implementation of prevention services, Oyler faced a major challenge: the level of acute need in the community tends to overwhelm the staff and push prevention to the back burner. While the Growing Well Cincinnati staff discussed the range of activities they sponsored around healthy eating and physical activity, and provided newsletters and other evidence that these activities had in fact taken place, Oyler staff never mentioned these activities we asked about prevention activities. For them, the immediate needs involving hunger, violence, lice, and mental health took precedence when discussing health-related efforts. The school staff readily acknowledged that longer-term prevention services—such as pregnancy prevention, substance abuse prevention, and parenting education—are still lacking and represent significant unmet needs.

### **Hart School District, Hart, TX**

Hart is an agricultural community with a predominantly Hispanic population. In the community as a whole, the population is declining and aging, as agricultural technology requires fewer workers; the school population has fallen by half since 1993. In addition, the area is economically depressed, and most families have low incomes and extensive needs. The rate of teen pregnancy and drug use is high, and other needs include dental care and mental health services.

There are particular challenges associated with health care in rural areas. The aging of the physicians in rural areas is reducing access to care, and 23 rural counties in Texas have no primary care physicians at all. The closest pediatricians to Hart are in Lubbock or Amarillo, each about 45 minutes away, so the SBHC provides a source of primary care for the entire community. Access to dental care is even more limited.

The Hart School-Based Health Center is located in the Hart School District complex, which includes pre-K through high school.

### **School-Based Health Center Overview**

The center was established in 1993 by the school nurse, with the support of a local physician. Initially, the school district was the sponsoring agency, but in 2005, the Governor issued an Executive Order requiring that 65 percent of the school budget support direct classroom education. The school district needed to remove the clinic from its budget to meet this requirement, so the Plainview Foundation for Rural Health Advancement was established to oversee the clinic. The

Foundation pays the clinic director through the “fund balance” of unspent funds that were transferred to the foundation from the school district (from which the clinic director is officially retired). The clinic’s services are supported with a patchwork of state grants through Title V and primary care, as well as Medicaid and CHIP reimbursements. The school district provides the clinic space on an in-kind basis.

The clinic is staffed by a director, a nurse, a dental hygienist, and several pediatric residents from Texas Tech. In addition, a clinical psychologist makes monthly visits and is available weekly via telemedicine. The clinic provides a full range of primary care, acute care, mental health, and dental services. Although the school population is 327 students, the clinic has a caseload of 700 children and adults, and saw 1,200 unduplicated clients last year. About 98% of students have their parents’ consent to use the clinic, which also sees students from five schools in the surrounding area.

The clinic houses two dental chairs and provides basic oral health services, including cleanings, sealants, fluoride treatments, and fillings. In addition, the clinic has a telemedicine service provided through Texas Tech University Health Sciences Center. This service, which was initially funded through the *Frew* settlement<sup>5</sup>, provides for long-distance diagnostic services, nutrition counseling, mental health counseling with child psychologists, and asthma management clinics. Educational handouts are sent to the clinic by fax, and students are also referred to web sites for additional information. The clinicians report that students are more comfortable opening up to physicians and other providers on sensitive subjects when they are not in the same room with them and often, prefer this approach.

### **Prevention Services**

The clinic provides a range of prevention services, both in the clinic and in the classroom.

These include:

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<sup>5</sup> *Frew vs. Hawkins*, a class-action lawsuit originally filed in 1993, addressed access to care under the Texas EPSDT program. In 2007, a settlement was reached that required the state to increase Medicaid reimbursement rates and fund specific access initiatives, including mobile clinics, loan forgiveness programs, outreach, and telemedicine projects.

- **Oral health.** The dental hygienist does classroom presentations appropriate to each grade on oral health and hygiene. For younger children, this includes the importance of brushing and flossing; for adolescents, it covers the oral health effects of illicit drugs and sexually transmitted infections (STIs). Other topics covered include the effects of tobacco, oral sex and STIs, the potential damage from piercings, and basic oral hygiene. Education is provided in the clinic and to parents as well.
- **Nutrition.** Nutrition counseling is provided by nutritionists via telemedicine, and involves counseling children weekly in pairs or in groups about their diet (focusing on drinks, and on eating healthy food instead of relying on supplements) and activity levels. Groups are also offered for athletes who might have unusual approaches to nutrition and supplementation. In addition, the clinic uses the Coordinated Approach to Child Health (CATCH) curriculum developed by the University of Texas, School of Public Health to address nutrition and physical activity for all grade levels.
- **Abstinence education.** The clinic maintains an extensive library of abstinence curricula, from which teachers are encouraged to borrow. The focus of abstinence education efforts, which overlap significantly with preventive mental health programs, is on character-building, goal-setting, and alternatives to early parenthood. One such program is called “Dream Catchers,” which emphasizes setting goals, avoiding risky behaviors, and focusing on the future.
- **Character development.** The clinic director works with teachers at all grade levels to incorporate prevention messages into their lesson plans, primarily during the students’ reading time. One such program is called “Success for All,” a program that focuses on decision-making skills. In addition to the classroom sessions, small group sessions are conducted to address identified needs among the student body. This year’s program, aimed at 6th -graders, addresses bullying prevention.

It was reported that teachers have been very accepting and supportive of the prevention activities; however, a high rate of turnover among the professional staff (50% annually) makes it challenging to continually educate and involve teachers. It was also reported that adolescent pregnancy is a major problem in the community and additional prevention resources are needed to address the issue.

## **Monitoring and Evaluation**

Monitoring and evaluation are largely conducted through the reporting systems of the clinic's various funders, including Title V, Medicaid, and state Primary Care funding streams. These forms largely address procedural and record-keeping issues, however, not the quality (or quantity) of clinical care provided, and do not address prevention at all. An on-site audit is also conducted by these funders every two years.

In addition, the clinic conducts satisfaction surveys of the student population (and recently added dermatology services in response to students' requests.) The telemedicine program monitors the number of children accessing pediatric and subspecialty care who would not otherwise receive these services.

## **Sustainability**

School-based health services, especially prevention services, will never be self-sustaining based on reimbursements alone. The Plainview Foundation aims to have 6 months' worth of funding in their fund balance; they have not yet achieved their goal, but the school pays the Foundation under a contract to operate the clinic.

For the most part, the clinic's services are supported with a variety of grants from the Texas Department of State Health Services, as well as Medicaid and CHIP reimbursements. Prevention services are covered through the salaries of the staff members who provide the services (such as the dental hygienist). A CPT code has been established for educational services in the dental clinic. Occasionally, sources of grant funding for educational services are available; at one point, the clinic used an Abstinence Education grant to fund the preventive mental health and character-building programs conducted by the child psychologist. However, finding grant funding specifically for prevention programs is challenging, as funders want to see widespread impact of their investments, which is unlikely in a small community.

Therefore, addressing the challenge of sustainability depends on the involvement of a resourceful, creative, knowledgeable leader who can find funding sources and adapt them to the community's

needs. In addition, funding dedicated to prevention services is necessary to assure that these services are sustained.

## **Lessons Learned**

The key ingredients of the Hart SBHC's success include the strong support of the community; the energy and initiative of the clinic director; and the relationships with institutions, primarily Texas Tech, which allow for a broader range of services. These are discussed in more detail below.

- **Community support.** The community, including parents, values the clinic because it is an essential provider of primary care services. In addition, the support of the faculty and school administration are critical to the clinic's success; while the clinic has demonstrated its value to the school (by reducing absenteeism), it had to earn the trust of the school administrators.
- **A strong leader.** It was universally noted that the clinic would not exist and its success would not have been possible without the efforts of its current director. Her flexibility, creativity, and persistence have been essential to the development and maintenance of complex financing structures. However, this situation presents a challenge as well as a benefit, as the director is well past retirement age and replacing her will not be easy.
- **Partnerships.** Especially in a rural area with few health care resources, the partnership with Texas Tech has been an invaluable source of clinical and technological support. The university provides pediatric residents for clinical care and telehealth services for a wide range of services, both of which make possible the comprehensive care, including prevention services, provided by the clinic.
- **Cultural competence.** The Hart community is almost entirely Hispanic, and most of the clinic's staff are from the community and speak Spanish. Having bilingual staff is critical for communicating with parents, who may be recent immigrants, and for presenting prevention messages in culturally appropriate ways.

Overall, the key informants in Hart were unanimous in their recommendation that the relationships at the local level (including those with teachers, coaches, and the school nurse, as well as other health care providers), the presence of a trusted leader, and a clear demonstration of the need for a clinic are the essential elements of their program's success.

## **Windham Middle and High School, Willimantic, CT**

Willimantic, CT, is an urban center in the rural area of Windham. Its unique location makes it vulnerable to problems characteristic of both urban and rural areas, including a high rate of drug use and a lack of transportation infrastructure. In the 1950s, the local mills actively recruited workers in Puerto Rico; consequently, the community has a large Hispanic population. There is also a significant population of migrant farm workers. Fully two-thirds of the school population is Hispanic.

The student population has a number of high-priority health needs, including teen pregnancy and STD infection. The highest rate of HIV in the area is among 13- to 18-year-olds, and girls as young as middle school are actively seeking pregnancy. Students also experience frequent episodes of violence and emotional difficulties, and obesity and dental caries are also major concerns. According to the high school principal, the student body is “socioeconomically deprived and needy.” The middle school principal believes that students come from “very stressed families who have trouble meeting basic needs,” which leads to little emphasis on health and education. Approximately one-third of students receive Medicaid, and another one-third are uninsured.

### **School-Based Health Center Overview**

Over 20 years ago, Connecticut state government had the foresight to fund SBHCs, which are now well-established across the state. There are currently two SBHCs operating in Willimantic, at the Middle and High Schools. Windham’s funding originates with the Public Health Department, which supplies grant money to the Department of Education. The Department in turn subcontracts with Windham Hospital to run the health centers. The hospital can bill for services, although they frequently experience problems because reimbursement for services provided by mid-level practitioners is variable, and there are a number of services which insurance companies do not approve hospitals to provide (such as immunizations).

The SBHCs at Windham Middle School and High School each have a dedicated mental health practitioner, as well as a medical assistant. The sites share a primary provider (who at this time is a doctor of osteopathy), and a coordinator. The clinic provides a full range of primary care, acute care, and mental health services. Physicals are especially popular due to long wait times for appointments

with local providers. A wide range of resources is available to the SBHCs through both the Department of Education and Windham Hospital due to the structure of the grant.

## **Prevention Services**

In Willimantic, prevention services are primarily provided to students by community agencies. The SBHCs often organize logistics, and sometimes serve in an advisory role in planning content and securing additional community involvement. Through this model, a range of services is offered to students.

- **Mental/Behavioral Health.** The SBHC psychologist in the high school does several small group prevention activities. One of these is weekly “talking circles.” Students write down their concerns and thoughts, and without giving advice, fellow students discuss how that situation might feel. There is also a garden club, which allows children to take action and “feel a sense of agency.” The middle school social worker provides information on bullying and sex education at the classroom level. Windham Middle School has implemented the Positive Behavioral Supports program, a schoolwide, collaborative data-driven program that uses an early intervention to address and manage behavior problems.
- **Nutrition and Physical Activity.** Nutritionists at Windham Hospital developed a program called “Smarter Me,” which involves hands-on food activities to teach nutrition principles. The program was originally for children with high BMIs, but was opened to everyone to reduce stigma. There has also been a walk-a-marathon program for 5<sup>th</sup> graders. Nutritionists are hoping to secure a grant from a local bank to expand, including the addition of a nutrition component.
- **Reproductive Health.** “Alternative Connections to Women’s and Girls’ Health” is provided through Generations Family Health Center. The program makes HIV counseling and testing available once a month to students. The health center also sponsored an AIDS interactive theatre with the Department of Public Health, which offered free testing for seniors, as well as a presentation and hands-on activities.
- **Alcohol and Other Drugs/Tobacco.** Generations Family Health Center continually offers smoking cessation programs to students in the high school. The target audience changes depending on which grants Generations is able to secure. For instance, in the past, Generations has received grants for women of childbearing age and men ages 18 to 34. They

are also involved in a statewide program, “Tobacco is a Waste,” which focuses on developing peer mentors to discourage tobacco use.

- **Oral Health.** Generations also has a mobile dental unit that visits the local schools as well as community sites. The equipment was originally purchased with a grant, and will be sustained with reimbursements. The SBHC was involved in planning the program, and assists with scheduling visits and distributing information to families. The dental unit offers sealants, cleanings, exams, and referrals.
- **Other.** Perception Programs, a non-profit behavioral health agency, offers the “Right Turn” program to high school and middle school children who have been identified as at-risk. The program focuses on health and behavior, and uses a small group format to discuss drug use, addiction, sex, STDs, and peer pressure. Perceptions offers a mixed gender team to provide a comfortable environment for students, and encourages students to explore their options and make positive choices. The SBHC helps coordinate the program and provides limited referrals, but is otherwise uninvolved.

The SBHC has also helped to coordinate several programs through Eastern Connecticut State University. A professor there has developed several programs for middle school students, including a yoga and healthy snack program using grant money from the hospital, and the “Sisterhood Project,” in which college students mentor at-risk girls. Her students also have individual service projects at the school. These have included an HIV fair, a project of embedding health into math curriculum, and a project promoting healthy transition from elementary to middle school.

## **Evaluation**

Data on general progress, health, and well-being of students are collected regularly schoolwide. In the middle school, this task is performed monthly through the University of Connecticut, which also relies on data collected by external entities, such as the Youth Risk Behavior Surveillance.

Satisfaction data of clinical services provided through the SBHC are also collected monthly through surveys provided to students who have used the services.

Preventive services are evaluated based on the requirements of their individual grants. For instance, the mobile dental unit grant requires a thorough evaluation that includes tracking of services and

clinical indicators. An evaluation component will be added to the walk-a-marathon program if additional grant funding is secured.

## **Sustainability**

The SBHC itself is sustained through a grant from the Public Health Department, which is then supplemented with reimbursements for clinical services by student insurance. Although the budget is lean, reimbursements are sufficient enough that services are not currently in jeopardy.

As with evaluation, sustainability of individual preventive services varies with each source. Many of the programs were reported to be sustainable because an initial infusion of funds allowed for the purchase of necessary equipment, while continuing services are provided either through insurance reimbursement or volunteer hours. For instance, equipment for the mobile dental unit was originally purchased with a rural health grant. A modest number of reimbursed visits are enough to fund the labor necessary to sustain the program. For the “Smarter Me” program, Windham Hospital nutritionists include a small item in their budgets for supplies, and their labor is paid through salary. The variety of projects sponsored by Eastern Connecticut State University students are service learning and supported by students’ volunteer hours.

## **Lessons Learned**

The SBHC is very popular with the community and has had a great deal of success in reaching students through direct clinical services and coordination of preventive programs. Its staff credit several factors, which they believe are essential in the development and sustainability of a program. One factor is wide support from the Board of Education, school administrators, and teachers, who have demonstrated flexibility and a willingness to coordinate with programs, especially around sensitive issues such as reproductive health. They allow for the use of school time and space, and teachers are largely invested in the model and allow students to be absent from class to participate.

The Willimantic SBHC, also has broad support from the community, although the SBHC coordinator noted that this relationship could be strengthened using community liaisons, as there are not currently leaders from the Hispanic or faith communities involved. This is especially important as there are cultural foundations for several current issues of concern, such as the teen pregnancy

rate. Many of the teenagers at the school were themselves born to teenage mothers, and community feedback and involvement are necessary to help break this cycle.

Another factor in the SBHC's success is a strong advisory board with input from a variety of community stakeholders. The advisory board for the Willimantic SBHC is very engaged and provides essential feedback and support for its activities. The commitment of the coordinator also plays a large role in the center's involvement in prevention activities provided by outside agencies.

### **Vaughn Next Century Learning Center, Pacoima (Los Angeles), CA**

Vaughn Next Century Learning Center is a charter school in an urban area in San Fernando County, CA. In 1980, the then-Vaughn Elementary was deemed the worst school in the Los Angeles Unified School District. The school had no special education services and all of its gifted and talented students were bussed to other schools in the Los Angeles Unified School District. The school had 95% English learners, 100% Title I, 100% Free and Reduced lunch, and was 100% minority. Fifty percent of the teachers had no credentials and it was the first multi-track school in the district to deal with overcrowding. The neighborhood was plagued with gang and drug violence and violence due to issues with racial understanding. The school was staffed with a nurse only one day a week. Three students died because of health-related problems; school staff noted that lack of access to health care played a part in those deaths.

These deaths demonstrated the need for SBHC in new school plans. In 1993, Vaughn Elementary became the first school in the nation to be a conversion charter; when building the new facility, a decision was made to include an onsite SBHC. The former principal stated, "I didn't want to plant another tree" to memorialize a student death. The school continued to serve same high-need student population.

The former principal used community resources including businesses, parents, students and juvenile justice to build the clinic. She stated, "If you depend on public funds it's never going to happen."

Vaughn Next Century Learning Center's motto is "Healthy Kids Learn Better." It serves 2,400 students from Pre-K-to community college. It is now a California distinguished school and a California Blue Ribbon School. It has dramatically increased student test scores. Parents are required

to provide volunteer time and attend parent educational forums. The efforts in the school have raised economic standards for the community, although the school is still in a gang injunction zone and an economic empowerment zone. Beyond education, the school provides gang prevention, drug rehabilitation, senior care, family empowerment, and a global resource center. The school sees the SBHC as contributing to the overall success of the school.

### **School-Based Health Center Overview**

The Panda Clinic, the SBHC located at Vaughn Next Century Learning Center, also serves the 13 other schools in the area. The project is a collaboration between the school and the Los Angeles County Department of Health Services (DHS) Valley service planning area. Vaughn Next Century Learning Center provides the mortgage payment, utilities and custodial, repair and parking. DHS provides staff, including a health educator, a nurse manager, and a licensed clinical social worker. The staff are part of the personal health department, which is focused on clinical acute and preventive visits. The social worker is a member of the school crisis team and attends the meeting of the school mental health team and school special support team. SBHC funding comes from Title X, Unihealth Grant and county funds. In addition, the sponsor bills Medicaid, CHIP, and LA Care.

The SBHC helps DHS meet its own mission of serving underserved and unserved populations in the San Fernando and Santa Clarita Valley. Providing services onsite is convenient and helps to develop a high level of trust among parents. The clinic is open year-round; in 2009, it had 1,400 visits. The clinic provides clinical physical health services and, under Title X, reproductive health, STD screening, treatment and education.

The clinic conducts an annual survey of students, parents, and teachers to assess the health education needs of the student population. The county DHS also has to conduct a tri-annual community needs assessment; as a not-for-profit hospital, it must also submit a needs assessment. Parents and students identified their top needs as:

- Stress management
- Weight control
- Physical activity

- Reproductive health
- Self esteem
- Peer pressure.

During the site visit, clinic staff identified additional needs in the areas of oral health, teen pregnancy, birth control, Chlamydia and other STDs, and nutrition, specifically a lack of fruit and vegetable consumption.

Staff pointed to some challenges to working in the school, such as school nurses feeling threatened, limited access to classroom time, lack of space, and absence of a private entrance. With a full service clinic in place SBHC staff noted that some of the school nurses serving the 13 schools may feel that their more limited role as a school nurse may be less valued. SBHC health education staff would like to collaborate more with classroom teachers, but the focus on educational hours to meet the adequate yearly progress has made this a challenge. Staff also indicated that the physical structure of the clinic may be a barrier: The staff has to share offices and there are only few areas for confidential sessions with students. The SBHC is physically onsite at the middle school, where its entrance, which can be seen by students and parents, needs to be accessible to students from all 13 schools. Parent volunteers present on the school grounds and the staff felt that this entrance presents a barrier to confidentiality.

### **Prevention Services**

The clinic provides a limited set of small and large group activities, as well as schoolwide prevention activities. This includes health education talks for parents and students and school awareness activities. Staff found it easier to get into student clubs and organizations than into the classroom. The adult student group leader approaches the SBHC health education staff to present to the students. STDs/reproductive health is the most requested topic. The high school principal indicated that teachers are very protective of their academic time and suggested that the SBHC be considered during the design of the education framework. In the annual needs assessment survey, teachers indicated wanting to use the SBHC staff in the classroom for health education, although only one teacher scheduled an in-class presentation. The HS principal indicated using advisory periods to also give prevention messages especially about STDs, pregnancy and drugs.

The staff completed the following educational activities for the students in the 09-10 school year:

- **Reproductive Health.** The SBHC uses its full-time health educator to work with student groups to provide small group sessions. This year the health educator worked with the Middle School Chicas group to provide lunch-time sessions on reproductive health, focusing on female anatomy, hygiene and products; birth control methods; and STDs. The SBHC uses lunch periods as an opportunity for campus-wide education and has provided pamphlets on STDs, birth control, and nutrition. They also held 45-minute tables for World AIDS Day and National Condom Day, distributing information about birth control and safer sex, as well as condoms.
- **AOD.** Vaughn SBHC used one of their school-wide assemblies to address the emerging issue of the inhalant use. The health educator and guest speaker provided information on the dangers of inhalants. The assembly was attended by 250 students. They have also presented information on Ecstasy use. The school also has an Al-Anon group. Parent Forums. Parents are required to attend educational forums. The health educator provided sessions on 1) H1N1, 2) nutrition 3) disaster preparedness 4) and communication skills between parents and teens. At these mandatory parent forums the SBHC trainings that are attended by anywhere from 20-375 parents and family members on this and other issues, including:

Outside of the current prevention efforts, the SBHC and school administrators would like to do more programs on obesity prevention, alcoholism, and preventing child molestation. Staff would also like to use technology to send health education messages. For the parents, they would like to see more done on prevention of domestic violence.

### **Funding and Sustainability**

The prevention activities are funded through a grant that may end in the next year. Beyond those funds, the SBHC staff said, “we try to get reimbursement anyway we can.” The nursing positions are budgeted by DHS but county budget issues might curtail positions. The health education staff are not in the county budget. Although the SBHC bills third-party payers, most of the school population, which includes a large, undocumented population, is non-reimbursable. However, they are able to get reimbursed for their clinical Title X services. The clinic coordinator feels that “reimbursement won’t sustain the staffing.” No state or local education dollars contribute to the

SBHC. They have also tried unsuccessfully to get a carve-out from the HMOs. The staff at the SBHC are very worried about the ability to sustain their operations at the current level beyond the next year. They know that closing the SBHC is a possible option given that it closed during its third year of operation due to lack of funding.

They would like to look into the funding from the White House Office of Faith-Based and Neighborhood Partnerships, which supports nonprofit organizations to serve people in need, if it becomes available. They also see opportunities in the new health reform legislation that included SBHCs as an authorized provider.

### **Monitoring and Evaluation**

To evaluate the SBHC the sponsor DHS has visit counts and the yearly student and parent surveys. When possible, they conduct pre- and post-tests that measure knowledge, attitudes, and behaviors. They also do a satisfaction survey after each parent forum event.

### **Lessons Learned**

The importance of collaboration was the most cited ingredient for success by clinic staff, clinic administrators, and school administrators. They felt that SBHCs need to get buy-in from the school administration, teachers, and the community. There also has to be ongoing communication. The high school principal felt that a school has to set its own goals and “think out of the box” to determine how an SBHC can help meet their goals. In addition to having a champion, they mentioned that a SBHC also needs to plan for succession and to cultivate the leadership from within the staff. The SBHC has to show what the community needs are and how it can meet those needs. Staff also felt it was important to be “open minded and flexible” and innovative in getting things done. They recommended being sure to choose staff members who “really know kids.” They also suggested having someone who can relate culturally to the students might be well received.

### **Durango High School, Durango, CO**

Durango is a resort town located in southwest Colorado. The landscape presents challenges in the winter due to extreme weather and mountainous areas. The closest urban area is Albuquerque, NM, which is four hours away. Although a popular vacation destination, the residents of Durango earn low wages and the cost of living is high.

There are several challenges to providing health care to children in rural Colorado. Barriers to care for the school-aged population include geographic isolation due to long distances to reach available providers, lack of transportation, increasing poverty, lack of health insurance, increasing cost of health care, and competing parental work demands. Colorado also ranks 50th among all States in the U.S. for school funding per student and that school funding continues to decrease. The greatest unmet needs for this population are mental health, reproductive health, and substance abuse treatment. Another area of concern is unintentional injury and safety due to unsafe driving practices and motor-vehicle accidents.

Durango High School has 1,500 students and is the only high school in Durango. The student population is diverse and comprised of students who are Non-Hispanic White (84%), Hispanic (9%), Black (6%), and Asian/Pacific Islander (1%).

### **School-Based Health Center Overview**

The SBHC was established in 2007 with two part-time staff – a nurse practitioner and behavioral therapist. With increasing demand for services, the SBHC’s staffing has expanded to currently include a nurse practitioner, grant administrator, immunization outreach nurse, behavioral health consultant, health service provider, pediatrician, district nurse, SBHC coordinator, family health advocate, and administrative assistant. In addition, consultation is available with a nutrition educator, health educator, social worker, and psychiatrist.

The center serves students as well as school staff with health concerns. Approximately 50-60 students are served per day with 7,000 contacts during the 2008-2009 school year. In response to requests received from other school principals to provide health care services to their students, particularly neighboring elementary schools, the center also serves students from other schools.

The SBHC implements an integrated health care model that coordinates across school nursing, primary care, and behavioral health. The SBHC is part of the larger Coordinated School Health Program within the school district, which facilitates a close working relationship between the SBHC, the school, and the school district.

Funding is primarily provided by grants and Durango School District 9-R. Community partnerships are an integral part of services that are offered. AXIS Health Systems and San Juan Basin Health Department are the primary partners. AXIS Health Systems employs the behavioral therapist and the health department designated the SBHC as a satellite site and offers reproductive health services under the Title X program as well as immunizations. Other community partnerships include:

- Southern Ute Community Action Program – sponsors annual Healthy Kids Colorado survey
- Healthy Lifestyles La Plata – volunteers to teach healthy eating and supports wellness teams
- La Plata County Human Services Department – supports positive youth development programs

### **Prevention Services**

The SBHC provides a range of health care services to students and school staff during school hours. These include:

- **Health Education.** The center supports health education initiatives and curriculum related to tobacco prevention and sex education. Two such initiatives are the “Not on Tobacco” program which offers tobacco cessation support and “Second Chance,” which is a non-punitive program for students with tobacco violations. In addition, the center has implemented “Safer Choices,” a comprehensive sex education program.
- **Physical Activity.** The center offers continual professional development for school staff to learn about physical activity and its impact on health. The center encourages physical activity in the classroom, promotes general physical activities as a lifestyle, and supports increases in walking trails, walking clubs, and school gardens.
- **Nutrition Services.** The school has established a connection with “Farm to School” and the “Garden Project” to enhance nutrition education and incorporate local garden-grown produce into their school menus. Food service staff also receive professional development in food safety and healthy cooking for kids. The center was able to initiate changes in the food service program, including only offering cereals in the breakfast program that contain less than 4g of sugar and the use of whole grain products.

- **Counseling, psychological, and social services.** The center offers several programs and initiatives to address mental health and provide emotional support services to students and school staff. One such program is “Discovery,” which is a social emotional learning program that helps students communicate, work in teams, and effectively handle family and personal issues that may get in the way of learning. Another program is “HEAL,” Healthy Eating and Active Living. This program addresses depression and eating and the interaction of the two.
- **Additional services.** The center also offers well child exams, sports physicals, chronic care management, care for acute illnesses and injuries, preventive dental services, immunizations, family planning services (STD testing and treatment), and a family advocate to assist with insurance eligibility.

### **Monitoring and Evaluation**

Monitoring and evaluation of the impact of prevention services provided by the center on student behavior and classroom success is a challenge due to limited staff capacity and different data tracking systems. The center collects data through hardcopy patient health questionnaires and regularly updated health histories to monitor and track student progress and general health status of the student population, however, the center does not have the staff capacity to analyze the data and draw conclusions about the effectiveness of services provided. The school district collects other data elements on a routine basis and stores these data electronically, which presents challenges to the center in aggregating data of different formats. In order to routinely identify health risks and behaviors in the community, the center utilizes data provided by the Colorado Healthy Kids Survey (which includes YRBS).

### **Sustainability**

The Colorado Association for School-Based Health Centers (CASBHC) established the Rural Health Consortium (RHC) to support the development of rural SBHCs and provide a foundation for their growth and sustainability. The RHC is comprised of members from the various counties across the State, and also the Colorado Department of Public Health and Environment, The Colorado Health Foundation, and the Colorado Rural Health Center. The RHC offers members opportunities for networking and support, training, creative problem solving, and joint advocacy. The RHC helped

advocate for additional funds to expand SBHCs and now the Colorado state legislature provides a total of approximately \$1 million to all SBHCs in the State annually; \$78,000 is provided to Durango High School's SBHC per year.

These funds, in combination with grant dollars, such as the Federal Maternal and Child Health Block Grant and foundation dollars, are administered by the Colorado Department of Public Health and Environment to the SBHCs.

## **Lessons Learned**

The success of the Durango High School SBHC is due to its strong leadership, support from the community, including commitment from the school administration and school district, and flexibility with the use of financial resources. Key to its success have been its ability to:

- **Identify a champion to advocate for the SBHC.** Strong leadership is a critical component of the SBHC to articulate the value of an SBHC to school-aged children, the school, and the larger community. The champion should be a person who is well-respected within the community and is able to network with foundations, community agencies, and health care facilities, and able to think creatively about financing and sustainability.
- **Develop partnerships within the community.** The lack of a support structure within the community presents challenges to rural SBHCs to provide sufficient care. Absent connections and partnerships within the community, SBHCs may face problems with referrals or consultation on complicated cases and after-hours coverage. Durango High School's SBHC has partnered with a Title X funded agency, for example, to provide family planning services; this facilitates accessibility and affordability of services.
- **Obtain support from appropriate school officials.** Communicating with the school administration and school district about the value of and need for an SBHC was an early challenge. The champion was persistent in seeking out administration officials at the school- and district-levels to discuss the relationship between student health and education outcomes.
- **Be creative and flexible with financing.** Without a steady stream of sufficient funds, the SBHC must be able to expend resources cost-effectively and creatively. Financial resources

are obtained from a range of funding sources; the SBHC champion must have a comprehensive understanding of the Federal, State, and local funding opportunities and legislation in order to maximize the use of current dollars and think strategically about how to sustain and expand services.

### **Utica Middle School, Utica, MS**

Utica is a rural community approximately an hour from the State capital of Jackson. The area was populated in the past, but the creation of a nearby highway resulted in many jobs being relocated to more urban areas. Consequently, the area is economically depressed with limited access to health services. It is an area steeped in culture and tradition, and “everyone is related,” so negative events in the community are felt widely, creating mental and emotional health problems.

In Utica, the elementary and middle schools are co-located; students were identified as having a wide variety of health needs. The most notable are obesity, poor nutrition, anemia, asthma, and poor hygiene. Students are accustomed to eating fast food and their acceptance of healthier foods is low, and there are no health-related groups or clubs available other than sports teams.

Students’ health needs have been identified through secondary data and anecdotal evidence; no formal needs assessment of the students has been conducted. There has been recent emphasis on addressing several of these problems, resulting in an overhaul of the school lunch menu and the hiring of a more engaged physical education teacher.

### **School-Based Health Center Overview**

The SBHC at Utica Elementary-Middle School is sponsored by the Jackson-Hinds Comprehensive Health Center, a Federally Qualified Health Center based in Jackson. Jackson-Hinds was a pioneer in school-based health, having established their first clinic in 1972. They suspended their SBHCs for some time during the 1990s because they were a “fiscal drain” on the organization. However, they think it is an important entity and decided that they would cut back elsewhere to make the SBHCs work. Jackson-Hinds sponsors 19 SBHCs in total, with operating costs covered by Medicaid and CHIP reimbursement, as well as by FQHC funding for the uninsured.

The Utica SBHC site operates two days per week, and is staffed by a medical assistant, a nurse practitioner, and an administrator. The center is very popular among students, teachers, and parents alike. It provides screenings, physicals, acute care, and has a nurse practitioner on staff who can write prescriptions. The center allows students whose parents lack transportation, which is a common problem, to get medical care. Checkups are scheduled automatically, which is convenient for parents and helps assure continuity of care. The center also reduces absences since children can be evaluated and treated and sent back to class rather than being sent home. The SBHC also performs sports physicals, which increases participation and is a convenience for the school which then does not have to go through the process of getting a bus to take the students to an outside clinic.

## **Prevention Services**

Prevention services are largely provided through clinical encounters, as limited prevention activities are offered school wide. The DARE program is offered to 5<sup>th</sup> grade students and GREAT (which focuses on drug and gang prevention) is offered to 7<sup>th</sup> and 8<sup>th</sup> grades. During clinical encounters, students complete a psychosocial screening tool, and staff will provide referrals to social workers or other resources as necessary. Clinicians also provide information about nutrition and physical activity.

Although population-based preventive services aren't generally offered in Utica, Jackson-Hinds staff described several prevention programs in the other schools with which they are involved. One of these programs was a one-time dental program, called "Lesson in a Lunchbox," that was funded through a grant from the American Dental Association. Several staff members are also involved in a mentoring program for young women, the African American Women's Health Initiative. Although it is health and prevention focused, it is not funded or coordinated through the health center.

According to Jackson-Hinds staff, there is a mobile dental unit available through the SBHCs, but the Utica site coordinator reported that it has not come to the school in recent years. The schools that it has visited are seeing greatly reduced acute needs due to prior years' preventive services.

## **Monitoring and Evaluation**

Although there is a wellness committee on paper, the Utica site coordinator reported that no meetings have been held. According to staff at Jackson-Hinds, there is a recent push to monitor services, such as sealant application, and evaluate student health, but no details were available.

## **Sustainability**

The clinical services provided through the SBHC, including dental, are sustainable through insurance reimbursement and FQHC funding. The sustainability of prevention services varies based on the individual program. For instance, the African American Women's Health Initiative is dependent upon volunteers from the community, and the "Lesson in a Lunchbox" was funded through a one-time grant.

## **Lessons Learned**

Staff from both the SBHC and Jackson-Hinds identified several barriers to implementing population-based health prevention in the schools. For Jackson-Hinds staff, the most prominent barrier is a lack of funding. Although grant funding could be secured for programming, a coordinated group effort or particularly dedicated individual would be needed to write proposals and administer the grants. According to SBHC staff, the unmet basic health needs of the students make focusing on prevention difficult, as does a lack of engagement or leadership from the sponsoring agency. Families often lack engagement and can be unsupportive of the SBHC's efforts.

## Population-Based Prevention Services

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The extent to which programs are providing preventive health services at the small group, large group and schoolwide levels varies greatly across sites. Although certain topics were more commonly addressed in high schools than middle schools (such as reproductive health and substance abuse prevention), prevention programs covered a wide range of health promotion and disease prevention issues. The methods used to deliver health promotion and disease prevention services also varied, from individual and small group health education sessions, to classroom education sessions, to school-wide health fairs and other activities. In several instances, schools implemented nationally recognized prevention programs that had a defined curriculum and extended over multiple sessions. For the most part, prevention services were delivered by the school nurse or the SBHC staff; student involvement in the design and operation of these prevention activities was generally limited, and little evaluation of these efforts took place. Several efforts, however, linked community- and school-based prevention programs.

The majority of population-based prevention activities focus on five main areas: 1) reproductive health 2) alcohol, tobacco and other drugs 3) physical activity 4) nutrition and 5) oral health. Nearly all of these programs are grant-funded, which greatly affects their prospects for sustainability. However, some of the grants provide opportunities for staff training, equipment purchases and policy changes that may be sustained when funding is decreased or ends. The following sections discuss the prevention services provided in the six sites in each of these areas.

### Reproductive Health, Pregnancy Prevention, STD/STI

	Oyler	Hart	Durango	Windham	Vaughn	Utica
Small group	X	X			X	
Large group			X	X	X	
Schoolwide			X		X	

While most sites address pregnancy prevention and sexual health in some way, the approach to these services varies greatly (Table 4). In Hart, TX, the focus is clearly on abstinence education, despite a high rate of pregnancies within the student population, while in the Los Angeles (Vaughn) site, the health educator focuses on comprehensive pregnancy and STI prevention education. These

educational services are provided on the small- and large-group level, and Title X funds are used in two sites to support reproductive health services and education.

The topical focus of these sessions includes a wide range of subjects, including prevention of HIV/AIDS, sexual harassment, and date rape, as well as contraceptive use and abstinence education,

### **Tobacco, Alcohol and Other Drugs**

Table 5. Tobacco, Alcohol, and Other Drug Prevention Services						
	Oyler	Hart	Durango	Windham	Vaughn	Utica
Small group		X	X	X		
Large group					X	
School-wide						

Most of the sites offer some curriculum related to tobacco, alcohol, and prevention (Table 5). Two sites, Durango and Windham, use the American Lung Association’s “Not on Tobacco” curriculum to help teens quit smoking.

Vaughn SBHC used one of its schoolwide assemblies to address the emerging issue of inhalant use. The health educator and guest speaker provided information on the dangers of inhalants. The assembly was attended by 250 students.

### **Physical Activity**

Table 6. Prevention Services Promoting Physical Activity						
	Oyler	Hart	Durango	Windham	Vaughn	Utica
Small group			X	X		
Large group				X		
School-wide	X	X	X			

Small-group activities in this area include the “Brain Gym” curriculum, used in Durango classrooms to add physical activity throughout the school day, and the “Smarter Me” program, used in Windham as an after-school program (Table 6). Schoolwide programs include the “Growing Well Cincinnati” effort to track students’ BMI and introduce schoolwide walking and other activity programs.

## Nutrition Services

Table 7. Prevention Services Promoting Nutrition Education						
	Oyler	Hart	Durango	Windham	Vaughn	Utica
Small group		X				
Large group				X		
School-wide	X		X			

Hart, TX, was the only site providing small-group nutrition counseling (Table 7). In this site, these services are provided by nutritionists via telemedicine, which involves counseling children weekly in pairs or in groups about their diet (focusing on drinks, and on eating healthy food instead of relying on supplements) and activity levels. Groups are also offered for athletes who often have unusual approaches to nutrition and supplementation.

Schoolwide nutrition activities focus on improving the quality of school lunches (as in Durango’s “Farm to School” efforts) and addressing pervasive hunger (as in Oyler’s Kid’s Café and weekend grocery programs.)

## Counseling, Psychological, and Social Services

Table 8. Preventive Mental Health Services						
	Oyler	Hart	Durango	Windham	Vaughn	Utica
Small group	X	X	X	X	X	
Large group						
School-wide	X			X		

Several sites have established groups that allow students to discuss personal issues; Durango High School also has a group called “Discovery,” which is a social/emotional learning program that helps students communicate, work in teams, and effectively handle family and personal issues that may get in the way of learning (Table 8).

The Windham high school SBHC counselor convenes lunch-time talking circles. Students can voluntarily come to her office to discuss concerns in a group setting. She has the students write down their concern and they are put into a bowl. She picks one at a time and the students talk about how that might feel, but they are not allowed to give advice.

In Hart, TX, the clinic director works with teachers at all grade levels to incorporate prevention messages into their lesson plans, primarily during the students’ reading time. One such program is called “Success for All,” a program that focuses on decision-making skills. In addition to the classroom sessions, small group sessions are conducted to address identified needs among the student body. This year’s program, aimed at sixth-graders, addresses bullying prevention.

At Oyler in Cincinnati, Santa Maria Community Agency conducts the “Asset Builders Group,” in which participants learn conflict resolution skills and participate in service projects in the community. The YWCA also conducts an eight-session program on relationship violence called AMEND.

An example of a schoolwide behavioral health program is Windham Middle School’s “Positive Behavioral Supports” program, a collaborative data-driven program that uses early intervention to address and manage behavior problems. Interventions happen at the schoolwide, small group, and individual levels. The SBHC counselor is a part of the school team and provides the group intervention sessions. St. Aloysius, the mental health partner for Oyler, conducts some prevention activities, although their focus is on direct mental health services. Their work centers on educating teachers on behavioral issues, including the triggering effects of yelling in the classroom on children, and to work with the younger children before problems develop. In addition, the school therapist conducts schoolwide prevention efforts, conveying behavioral goals and expectations for each grade level.

## Oral Health

	Oyler	Hart	Durango	Windham	Vaughn	Utica
Small group		X				
Large group						
Schoolwide						

While oral health was mentioned as a major need in many sites visited, it was not frequently addressed in health education efforts (Table 9). One exception was Hart, TX, where the dental hygienist does classroom presentations appropriate to each grade on oral health and hygiene. For younger children, this includes the importance of brushing and flossing; for adolescents, it covers the oral health effects of illicit drugs and STIs. Other topics covered include the effects of tobacco,

oral sex, and STIs, the potential damage from piercings, and basic oral hygiene. Education is provided in the clinic and to parents as well.

Several sites, including Durango, Windham, Utica and Oyler, work to connect students to oral health services in the community, but few are able to provide direct dental health services within the SBHCs.

## **Models of Prevention Services**

The six sites provide prevention services in different ways, on various topics, with different methods and levels of intensity. However, these diverse strategies can be summarized using three “models” that describe the alternative mechanisms for delivering prevention services.

### **The Internal Model**

One approach is to provide prevention services via the clinic’s staff. This task can be assigned to a single staff member, as is the case at the Vaughn school clinic in Los Angeles, where a full-time health educator conducts classroom presentations, small group educational sessions, and coordinated large-scale events such as health fairs at which health promotion information is distributed. Alternatively, preventive health activities can be part of the responsibility of a broad range of staff members. At the SBHC in Hart, TX, the dental hygienist, psychologist, nurse, and the clinic director conduct health promotion activities; some nutrition and asthma management sessions are conducted via telemedicine at Texas Tech.

The advantage of the internal model is that it minimizes the level of coordination that is required to schedule and conduct preventive health services. With all of the staff readily accessible, small group sessions and schoolwide activities can be scheduled easily. The challenging aspect of this approach is that the cost of staff members’ time that is devoted to health promotion must be covered through existing funding sources, as these programs are rarely billable.

### **External Model**

Prevention programming and resources can also be provided to students by outside agencies and organizations, which is the model that is successfully used by the Oyler and Willimantic schools. In

this model, prevention programs are designed and conducted by outside agencies and coordinated by the school or SBHC. Although the school or SBHC is essential in bringing these services to the students, it provides neither the funding nor the staff for the activities. The types of agencies that are involved in this model vary widely, and may include community mental health agencies, FQHCs or other local health centers, foundations, food banks or other nutrition programs, colleges and universities, and recreational programs (such as Boys & Girls Club).

Generally, this model uses a central coordinator to liaise with providers, organize time and space for activities, recruit students, and secure other resources as needed. There are several variables in this model of service provision that can differ by site, such as the manner in which the services are coordinated. At Oyster, the partnerships with local agencies are managed by a dedicated school-based resource coordinator who oversees the many partnerships involved in the school, and a school-community coordinator who works with families and makes referrals to social service agencies. In Willimantic, the process is less structured and is coordinated primarily through the SBHC director, who takes on this dual role in an unofficial capacity. The extent to which the school or SBHC is involved in coordination may also vary, from simply securing time and space for programming, to referring students for services and even more formal linkages such as participation on advisory committees. As with other models of programming, aspects such as content, setting (in classroom or after school), and structure may also vary across sites.

There are several advantages to having services provided by external community agencies. For one, it may reduce or eliminate any privacy issues that arise. As health care providers, SBHC staff generally have explicit guidelines for their handling of students' private information, and these guidelines may differ from the privacy policies of outside agencies. Similarly, this format may also improve communication and engagement by students. In Willimantic, one of the partner agencies said that although the school social worker refers students to their program, she does not attend the sessions and the students are often more willing to open up about sensitive topics in her absence. There is also a potential financial advantage to this model, as sites showed an interest in providing population-based prevention services to students, but cited a lack of person-hours for grant writing and other activities for securing funds. As many community agencies have experienced or even dedicated grant writers, the students are receiving services and the SBHC can be involved without struggling with fiscal resources, leaving more time for clinical care.

While not bearing responsibility for funding is often an advantage of this model, participation by a variety of agencies with a variety of grant sources results in an often tenuous situation in which loss of funding from one source or another becomes an almost constant possibility. As an organization's participation may change on short notice, there is also a threat to consistency of programming. Another disadvantage of this model is that it may limit the control that the school or SBHC has over content.

Both the Oylar and Willimantic sites demonstrate several attributes that may influence the success of programs built on this model. Each site has a coordinator who is responsible for managing activities for the various programs (although in Willimantic it was not part of the job description, rather she provided those services out of commitment to the students). Also important is support from and communication with school officials, and a close relationship with the outside agencies. There is also a role for an advisory committee and outreach for gaining public support.

### **Integrated School Health Model of Prevention**

The Coordinated School Health Program is a well-known model of school health prevention designed to coordinate health and education and developed by the CDC.<sup>6</sup> The model is based on the concept that healthy children experience school success more easily and are better prepared to learn when their health needs are addressed. It entails an integrated set of planned strategies, activities, and services affiliated with the school system and designed to promote the optimal development of students from a physical, emotional, social, and educational perspective. The program is coordinated by a multidisciplinary team and takes into account the local community's needs, resources, standards, and requirements. This approach to school health is based on the idea that students' health and capacity to learn improves through the combined and coordinated support of the family, community, and schools in prevention and intervention. The Coordinated School Health Community Program model consists of eight interactive components—healthy school environment; health education; health services; nutrition services; counseling, psychological and social services; physical education, health promotion for staff; and family/community involvement.

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<sup>6</sup> Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. Healthy Youth! Coordinated School Health Program. <http://www.cdc.gov/HealthyYouth/CSHP/>. Downloaded August 5, 2010.

Common elements to the successful implementation of this model are the identification of school health coordinators and advisory councils. The coordinators and councils are formed at the school, district, and state levels and have broad representation from the community, including school personnel, community representatives, parents, and students. Their charge is to identify the needs, priorities, and strategies for the school health program, integrate the various components of the model, and evaluate and improve programs.

The SBHC offers a practical approach for providing preventive and primary health care services to students during school hours. In Durango, the SBHC is an extension of the public health community and an integrated part of the Durango School District's Healthy Schools initiative. The primary goal of the SBHC is to minimize the time students are out of school in order to ensure sufficient time in the classroom and maximize the opportunity for learning. The SBHC provides services to students who are uninsured or underinsured, cannot afford health care, lack accessibility to a health care provider due to transportation challenges or family members who are unable to take time off from work to take their children to a health care provider.

The services at the SBHC are provided by a licensed practical nurse who also functions as the SBHC coordinator; a nurse practitioner; two physicians; a behavioral health consultant; and an administrative assistant. Students are referred to other medical providers in the community as needed. Community partnerships are an integral part of the services that are offered. The local health department, county human services department, and various other community action programs are primary partners in service provision, including supporting reproductive health services, positive youth development programs, and nutrition education.

### **Outside of School-Based Health Centers**

In schools that do not have SBHCs, prevention services are generally provided through the schools' health education programs, which may be conducted by the school nurse, health teachers, and physical education teachers. The CDC Division of Adolescent and School Health (DASH) gathers

data on health programs in secondary schools, including health education programs, and publishes their findings in the biennial *Profiles* publication.<sup>7</sup>

The CDC's assessment of health education services focuses on four topics: health education requirements in middle and high schools; tobacco-use prevention; HIV, STD, and pregnancy prevention topics; and nutrition and physical activity. The major findings of the 2008 survey on each of these topics are presented below.

- **Health education.** Among States, the median percentage of schools that required health education for any students in grades 6 through 12 was 90.6. Health education requirements were more common in middle schools than high schools. The most commonly required topics for health education classes included alcohol or other drug use, emotional and mental health, HIV prevention, nutrition and dietary behavior, physical activity and fitness, tobacco use prevention, and violence prevention. All of these topics were required by more than 90% of schools across States. Nearly all schools requiring health education also included specific skills in their curricula, including comprehending concepts related to health promotion and disease prevention; analyzing the influence of family, peers, culture, and media on health behaviors; accessing valid information and services to enhance health; using communication and decision-making skills to avoid health risks; practicing healthy behaviors; and advocating for personal, family, and community health.
- **Tobacco-use prevention.** Over 90% of schools across States included various specific topics in their tobacco prevention curricula, including identifying tobacco products and the harmful substances they contain, identifying the health consequences of tobacco use, understanding the addictive nature of nicotine, understanding the effects of secondhand smoke, and understanding the social and cultural influences on tobacco use. Other topics commonly addressed included identifying reasons why students do and do not use tobacco, making accurate assessments of how many peers use tobacco, using communication skills to avoid tobacco use, and using goal-setting and decision-making skills related to not using tobacco.

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<sup>7</sup> Brener ND, McManus T, Foti K, Shanklin SL, Hawkins J, Kann L, Speicher N. *School Health Profiles 2008: Characteristics of Health Programs Among Secondary Schools*. Atlanta: CDC, 2009.

- **HIV, STD, and pregnancy prevention.** The reproductive and sexual health topics addressed in high school health education classes differed from those offered in middle schools, and there was more variation across States in the percentage of schools including each topic in their required curricula. In grades 6-8, topics commonly taught included the differences between HIV and AIDS; how HIV and other STDs are transmitted, diagnosed and treated; the health consequences of HIV, other STDs, and pregnancy; and how to prevent HIV, other STDs, and pregnancy. In grades 9-12, topics commonly addressed included the relationship among HIV, STDs, and pregnancy; the relationship between alcohol and other drug use and risk for HIV, other STDs, and pregnancy; the benefits of sexual abstinence; and how to prevent HIV, other STDs, and pregnancy.
- **Nutrition and dietary behavior.** Topics that were included in health education curricula in a majority of schools included the benefits of healthy eating, guidance in using MyPyramid, using food labels, balancing food intake and physical activity, choosing foods, and the risks of unhealthy weight control practices.
- **Physical activity.** As with nutrition, the physical activity topics addressed in health education were consistent across schools, with a majority discussing the physical, psychological, and social benefits of physical activity; health-related fitness; the phases of a workout; how much physical activity is enough; and preventing injury during physical activity.

These health education programs can be supported with grant funds or through school district budgets. A critical source of seed money for school health programs is the CDC's Comprehensive School Health Program (CSHP) grants, which fund States' efforts to develop the coordinated school health model in local school districts by building district-level teams to guide the prevention model. On the State level, the CSHP grants are used to support professional development and technical assistance for the CSHP coordinators in the local school districts. The continued success of these programs depends on the State's ability to sustain its CSHP efforts beyond the initial grant period.

To enhance our understanding of how these grants are used and sustained, Altarum researchers conducted telephone interviews with officials of three states—Mississippi, Tennessee, and Maine—that have proven especially successful at leveraging their CSHP grants for ongoing school health systems development efforts. The highlights of these interviews are presented below.

- Mississippi and Maine use tobacco settlement funds to support school health. In Maine, these funds are administered through the Department of Health and Human Services' Healthy Maine Partnerships grants, which fund school health coordinators in each district. However, the Coordinated School Health grant is administered by the state's Department of Education, so the interagency partnership is essential to the successful implementation of the Coordinated School Health model.
- Tennessee is the only State in the nation that has mandated that all school districts implement the Coordinated School Health model. State funding is provided to local school districts based on their applications, which must detail the services to be provided within the framework presented by the state, with a focus on physical activity, healthy food and nutrition, and health education. The State's RFP requires that each school district detail their activities in each of the eight areas of the CSH model, and that they meet 45 specific administrative and oversight requirements. While no specific curricula are required, any program that the local agencies propose must be evidence-based, and the State can encourage use of specific curricula (such as the Michigan Model for Health) by providing training and materials at no charge.
- Leveraging CSHP funding to receive other sources of private financing is essential for sustainability. Tennessee's local school districts, which have already made the transition from CDC funding to State funding, have used their grants to attract monetary and in-kind donations from local health care agencies and foundations in the amount of \$20 million in a single year. On the State level, Mississippi received a substantial 5-year grant from a local foundation to sustain its Coordinated School Health program after CDC funding ended.
- Demonstrating the success of the CSHP has been essential to its ongoing viability in these three states. In Tennessee, the state has documented a decline in childhood obesity rates between 2007-08 and 2008-09, a finding that helped to assure continued legislative support for the CSHP model. Maine has integrated YRBS with other surveys on drug and alcohol use, tobacco use, the Developmental Assets Profile, and screening data, to provide a comprehensive resource for ongoing monitoring of school health efforts.

## Financing and Sustainability

There are significant challenges to financing SBHCs, which rely on multiple funding streams. SBHCs are financed in a myriad of ways. For instance, SBHCs are often not recognized primary care providers by Medicaid and private health insurers; few general and behavioral health plans include SBHCs in their provider network. Most SBHCs bill third-party payers for health center visits, including Medicaid (72%), private insurance (50%), and the State Children’s Health Insurance Program (45%). Twenty percent bill students or families directly. Two out of three SBHCs report that patient revenue comprises less than 25% of their total budget, and only 8% report greater than 50% of their total budget (Juszczak, Schlitt, & Moore, 2007).

The funding models for SBHCs varied across the six sites. However sites generally acquire funding for three main purposes: operations, clinical staff positions, and prevention programming. In all cases, the school district provides, at a minimum, in-kind space and maintenance. The majority of prevention services are funded through grants of 3 years or less; prevention funding comes from a variety of sources, such as the American Lung Association, Ryan White HIV/AIDS Program grants, Title V, and State/regional health foundations. The exception to this is that three of the sites have at least a part-time clinical staff member who is providing reimbursable behavioral health services. The next section describes the funding across the site by type of funder (Table 10).

**Table 10.**  
**Funding Sources by Site**

	Federal Government	State Government	Local Government	Foundation	Medicaid/CHIP	School District
CA		X	X	X	X	X*
CO	X	X	X	X	X	X
CT	X	X				
OH				X	X	
MS	X				X	
TX		X		X	X	

\*Vaughn Next Century Learning Center is an independent charter school. In this case the school is providing the funding directly.

**Federal Funding.** Across the six sites federal funding is limited. Mississippi, being run by a CHC, uses the 330 funding for services that are not billable. Two of the other sites are also using Title X funds for their reproductive health services. Outside of that, sites use Federal funding tied to specific prevention grant initiatives. For example, Generations, one of the partners in Willimantic, CT, uses

some of its Ryan White funding for programs within the high school. Another example is the Carol M. White Physical Education Program funding Durango received to add new physical activity equipment to several schools in the district.

**State and Local Government Funding.** Three of the sites reported receiving state funding for SBHCs. In Connecticut, the State Department of health has a competitive grant program that provides basic funding to their SBHCs. Durango SBHC receives a portion of the \$1million dollars the Colorado state legislature provides. The local health department provides about 45% of the funding for Vaughn SBHC. The Texas State Health Department provides limited funding to its SBHCs through Title V and primary care funding. When available, sites often apply for State prevention program funding, such as the Colorado Department of Health Environment funding for tobacco prevention, which allowed Durango to run two well-recognized prevention programs.

**Medicaid/CHIP Funding.** Generally, staff at all of the sites agreed that reimbursement from billing Medicaid and other third party sources does not generate sufficient revenue to cover all of the SBHC operational expenses. Ohio and Mississippi reported being moderately successful with billing Medicaid as they both have a large Medicaid population and an administrative entity that can support their billing. Although the California site does bill Medicaid, it has a high population of undocumented students, making many of the students ineligible for Medicaid/CHIP. In Connecticut, most of the staff are employed by the local hospital but they encounter problems with reimbursement due to their use of “low-level” practitioners (e.g., nurse practitioners). Durango does not have the infrastructure to bill through the school district as they are not a recognized Medicaid billing entity. They explored working with a local hospital that was willing to serve as their administrator; however, because it is a religious hospital, it could not work with SBHC, which provides Title X services. The Durango SBHC is in the process of working with one of their other partners to assume the role of medical sponsor, which may allow them to bill for services. Despite this, they were granted funds to be a pilot CHIPRA enrollment site. They have a part-time person who works with students and parents to enroll in Medicaid and CHP+ and they are a presumptive eligibility site.

**Foundation Funding.** State and local foundations play a tremendous and varied funding role in the SBHCs. First they are able to support basic operations, such staff positions and supplies. In Ohio,

the clinic is primarily funded by the Cincinnati Health Foundation's grant of \$350,000 for 5 years. Vaughn has funding from a local foundation, Unihealth, which supports staff positions including their Health Educator. A grant from the Colorado Health Foundation allowed Durango High SBHC to expand its services to additional days during the week. The Texas SBHC was originally funded by the school district, however policy changes necessitated that they become creative with their base funding. The Governor issued an Executive Order requiring that 65% of the school budget support direct classroom education. The school district needed to remove the clinic from its budget to meet this requirement, so the Plainview Foundation for Rural Health Advancement was established to oversee the clinic. The Foundation uses the "fund balance" of unspent funds that were transferred to the foundation from the school district as their basic funding.

Second, foundations with an interest in children's and community's health are funding SBHCs to implement specific prevention programs that will benefit the local school population. For example, The Health Foundation of Greater Cincinnati funds one of the physical activity programs. Durango uses funds from Live Well Colorado/Healthy Lifestyles La Plata to fund their Farm to School initiative.

**School District Funding.** In the six sites, school district funding beyond that for space, utilities and maintenance, is limited. Only one site could be considered to have the school district as its sponsor as the practitioners directly contract with the school district. However, this does not indicate the true level of provided by the school district, which also supports the program in non-monetary ways that are critical to the operations of the SBHC.

**Sustainability.** Generally speaking, all the sites have diversified yet unstable funding sources. Having access to funds through a State SBHC program allows the SBHC to have a relatively stable source of funding. However, the amount of this funding appears to be inadequate and must be supplemented with other funding. In all cases the clinic coordinators are very creative, weaving together grants from many sources to design a service array that meets many of the needs of their community. In some cases this means that identified needs may be addressed in limited fashion when grant funds are not available. The short-term nature of grant and foundation funding also prevents most sites from planning long-term for population-based prevention services. Sites are also vulnerable when their community partners also depend on grant funding. When asked about plans

for prevention activities in the next year, one site's coordinator could not tell us what her plans were because she was unsure of her future funding levels. The staff at one of the rural SBHCs felt that "fundors want to see a wide impact" of their programs which poses a challenge programs in small rural communities. One clinic coordinator expressed wanting more long-term partnerships and not just 1- year grants. With such variable funding, all of the respondents indicated that their current funding resources were not sustainable.

## Evaluation and Outcome Measures

Assessment and evaluation of the outcomes of services provided by SBHCs is critical to their continuous quality improvement, financing, and sustainability. Documentation of program impacts to show changes in population health measures or academic achievement, however, has been challenging.<sup>8</sup> NASBHC has outlined several evaluation goals and outcomes for SBHCs to consider (Table 11)<sup>9</sup>. These goals and outcomes are reflected in the monitoring and evaluation activities for the SBHCs that participated in this project.

<b>SBHC Goal</b>	<b>Outcomes</b>
Supports the school	<ul style="list-style-type: none"> <li>• Recognition by school personnel of the value the SBHC provides in meeting educational mission</li> <li>• High satisfaction of school personnel with SBHC services</li> <li>• Increased number of appropriate referrals by school personnel</li> <li>• Reduced number of students who leave school during the day due to illness</li> <li>• Performs effectively according to plan for crisis or disaster management</li> </ul>
Responds to the community	<ul style="list-style-type: none"> <li>• Improved access to primary care as measured by increased utilization of SBHC services</li> <li>• Community recognition of the value of SBHC services in meeting the needs of students and responding to community values</li> <li>• High parent satisfaction</li> <li>• Improved utilization of other community resources through referrals and/or interprogram collaboration</li> </ul>
Focuses on the student	<ul style="list-style-type: none"> <li>• Increased enrollment for and utilization of SBHC services</li> <li>• High user and parent awareness of SBHC policy regarding access to confidential services</li> <li>• Improved user knowledge of how and when to utilize the health care system</li> <li>• Students with chronic disease or behavioral issues can demonstrate self-care skills</li> <li>• High satisfaction among users</li> </ul>
Delivers comprehensive care	<ul style="list-style-type: none"> <li>• Patient perception that well-being has improved</li> <li>• Increasing number of students receiving comprehensive well exam, including risk assessment</li> <li>• Increasing compliance rates as measured by follow-up visits completed, prescriptions filled, therapy attended, referrals completed, etc.</li> <li>• Reduced number of students with disruptive behavior or discipline problems</li> </ul>

<sup>8</sup> Hackbarth D. and Gall GB. Evaluation of school-based health center programs and services: the whys and hows of demonstrating program effectiveness. *The Nursing Clinics of North America*. 2005;40(4):711-24.

<sup>9</sup> National Assembly on School-Based Health Care. (n.d.) School-Based Health Center Performance Evaluation. Retrieved from [http://www.nasbhc.org/site/c.jsJPKWPFJrH/b.2719357/k.6312/EQ\\_Quality\\_Improvement.htm](http://www.nasbhc.org/site/c.jsJPKWPFJrH/b.2719357/k.6312/EQ_Quality_Improvement.htm)

Table 11. SBHC Performance Evaluation Framework	
SBHC Goal	Outcomes
Advances health promotion activities	<ul style="list-style-type: none"> <li>• Increased student awareness of health threats and risk factors</li> <li>• Reduced high risk behaviors among students</li> <li>• Increased positive health and safety behaviors among students</li> <li>• Increased student understanding of important health and psychosocial issues</li> <li>• Increased student ability to access valid health information and health promoting products and services</li> <li>• Increased student knowledge of health care rights and responsibilities</li> <li>• Increased student ability to communicate about and advocate for improved personal health</li> <li>• Increased participation of parents in health promotion activities</li> </ul>
Implements effective systems	<ul style="list-style-type: none"> <li>• Staff knowledge of current laws and regulations affecting delivery of services</li> <li>• Treatment for high-volume, high-risk problems consistent with current professional knowledge</li> <li>• High SBHC provider and staff satisfaction</li> <li>• Low SBHC provider and staff turnover</li> <li>• Increased provider productivity</li> <li>• High patient and parent satisfaction with ease of appointment-making and waiting time</li> <li>• Operations within budget</li> <li>• Eligibility for reimbursement from public and private third parties</li> </ul>
Provides leadership in adolescent and child health	<ul style="list-style-type: none"> <li>• Increased public awareness of the health care needs of children and adolescents</li> <li>• Greater number of children and adolescents with a medical home</li> <li>• Improved access to primary care</li> <li>• Increased exposure of health professionals to the SBHC model</li> <li>• Legislation and regulation supportive of the SBHC model</li> <li>• Increased investment in SBHCs by Federal, State, local and private funding sources</li> <li>• Increased participation of SBHCs in Medicaid and Child Health Insurance Plans</li> <li>• Appropriate contracts with managed care organizations</li> </ul>

SBHC evaluation intent, methods, and execution varied widely across the sites. Outcome measurement and program performance data are most often collected to satisfy the reporting requirements of the SBHCs’ various funders, including the Title V program and Medicaid. The SBHCs, however, have limited capacity and data systems to monitor and evaluate the impact of their prevention services on students, school staff, and the community beyond these reporting requirements. In some instances, funders require standard progress reports on a monthly, quarterly, or annual basis that include specific outcome measures and indicators whereas other funders are focused on process measures.

Many sites were conducting or planned to conduct student and/or parent satisfaction surveys. The funders’ reporting requirements are often supplemented by school-sponsored qualitative data collection. SBHCs rely on parent and student surveys to assess their performance, effectiveness, general health status of the student population, and unmet needs. The surveys are not standardized and, in several schools, are conducted on an annual basis. These data are then used, along with other data collected on a routine basis from the school district and the YRBS, to make policy and program changes as needed to improve performance. Table 12 presents a compilation of the various data collection methods and evaluation criteria and indicators measured by the sites.

Table 12. Evaluation Methods and Criteria		
Agency/ Organization	Data Collection Form	Criteria
State Department of Health Services	On-site Evaluation Report	<ul style="list-style-type: none"> <li>• Clinic record review</li> <li>• Program management</li> <li>• Use of appropriate screening and eligibility tool</li> <li>• Appropriate billing methods</li> <li>• Adherence to appropriate laws, regulations, and policies</li> <li>• Existence of written and implemented clinic operations policies</li> <li>• Existence of written and implemented internal quality management plan</li> <li>• Existence of written and implemented facility policies</li> </ul>
School	Monthly tracking form	<ul style="list-style-type: none"> <li>• Number of students served by the program</li> <li>• Number of students on waiting list</li> <li>• Number of staff</li> <li>• Description of services provided</li> <li>• How services offered accelerate academic achievement</li> <li>• Limitations in service provision</li> <li>• Number of parents involved in program</li> <li>• Events and activities parents are involved in</li> <li>• Events held and upcoming</li> <li>• Monthly success stories</li> <li>• Number of children with asthma whose condition is under control</li> <li>• Use of prenatal care and birth weight of infants born to students</li> <li>• Percentage of currently enrolled students who are also enrolled for care in the SBHC.</li> <li>• Percentage of children who are fully immunized and the percentage of medical, dental and mental health referrals completed</li> <li>• Number of parent and family activities held</li> <li>• Number of parent participants and volunteers</li> <li>• Number of community activities held each year</li> <li>• Number of visits or participants in each of the partner agency’s programs</li> </ul>

**Table 12.**  
**Evaluation Methods and Criteria**

Agency/ Organization	Data Collection Form	Criteria
SBHC	Student survey	<ul style="list-style-type: none"> <li>• Grade</li> <li>• Age</li> <li>• Gender</li> <li>• Preferred language</li> <li>• Perceptions about school and home life</li> <li>• Diet and exercise</li> <li>• Violence and bullying</li> <li>• Personal safety</li> <li>• Substance abuse</li> <li>• Feelings and emotions</li> <li>• Sexual behavior</li> <li>• Clinic usage</li> </ul>
SBHC	Staff survey	<ul style="list-style-type: none"> <li>• Student health education needs</li> <li>• Parent health education needs</li> <li>• Suggestions for addressing needs</li> </ul>
SBHC	Parent Survey	Student's experience with: <ul style="list-style-type: none"> <li>• School and home life</li> <li>• Diet and exercise</li> <li>• Violence and bullying</li> <li>• Personal safety</li> <li>• Substance abuse</li> <li>• Feelings and emotions</li> <li>• Sexual behavior</li> <li>• Learning interests</li> </ul>

## Conclusions and Lessons Learned

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Through the site visits, background research, and interviews with key informants, several themes clearly emerged about both the elements that are necessary for a successful school-based prevention program and the challenges that schools and SBHCs face in implementing these programs.

Successful programs shared many attributes, which are described below.

- **Strong community support.** The development of school-based health centers depends on the support of key players throughout the community, including school officials, local leaders, funders, and health care providers. Several sites described the efforts they made to convince local leaders of the value of school-based health services and the benefits of having those leaders' support.
- **Strong leadership from within the community.** In addition to support from the community, the role of a tenacious, dynamic leader cannot be overstated. In many of the sites visited, the development of the SBHC and its ongoing sustainability were the direct result of tireless efforts on the part of an experienced leader who had the knowledge to find and use available sources of funding creatively and to establish the connections and partnerships necessary to sustain the center's programs.
- **Flexibility regarding financing.** The site visits made clear that school-based health clinics and other Coordinated School Health efforts cannot depend on any single source of financing over the long term. The creative use of State and Federal grants, local foundation funding, Medicaid and CHIP reimbursement, and in-kind contributions is essential to assuring the sustainability of prevention services.
- **Starting prevention efforts early.** Many of the schools studied served children from kindergarten through high school or a combined middle and high school population. This structure presented the opportunity to start prevention efforts in the primary grades, including discussion of explicitly health-related topics, such as oral hygiene and nutrition, as well as topics such as character building and life options, which can lay the groundwork for substance abuse prevention, pregnancy prevention, and other adolescent health issues.
- **Making the link between health and wellness and educational success.**  
Prevention efforts are notoriously difficult to evaluate, as their benefits may not be seen

for decades, and health-related outcomes may not be clearly attributable to any one intervention. However, shorter-term outcomes, such as absenteeism and graduation rates, are easily measured and are of critical importance to school officials. The relationship between school-based health services, including prevention services, and these educational outcomes must be clearly demonstrated and articulated to assure the ongoing viability of school health services.

- **The critical role of partnerships.** Many school-based prevention efforts depend on networks of partners at the State and local level to deliver both clinical and population-based prevention services. These partnerships are essential to maximize the effectiveness of limited funding streams and to avoid duplication of services that are already available in the community. Moreover, involving community agencies in the SBHC helps to solidify the community's buy-in and support for the centers and their prevention efforts.

In addition to these common attributes, common challenges were evident across the case study sites as well. Across the nation, school-based health centers are facing uncertain financial futures, the need for succession plans, and the challenge of defining and monitoring their outcomes and demonstrating their successes. These challenges are discussed in more detail below.

- **Sustainable funding sources.** By far the largest and most consistent challenge reported by SBHC directors and state Coordinated School Health directors is that of assuring sustainable sources of funding for their services. Even those centers that are able to receive Medicaid and CHIP reimbursement require additional funding for prevention services.
- **Leadership succession.** While many centers have benefitted from the vision and energy of their founding directors, these leaders are nearing retirement and require qualified successors. In many cases, while competent professionals are available to take the reins, it is not clear that they possess the range of skills and talents of the original directors.
- **Culturally competent services.** Many of the sites visited served a predominantly minority population, but not all of these sites were run or staffed by members of the population served. More specifically, providers of prevention services did not always speak Spanish, which posed a barrier to communication with students or, more commonly, with their

parents. It can be challenging to deliver prevention messages in a way that is effective and appropriate both for children and their parents.

- **Moving health and wellness from policy into practice, and practice into policy.** While many schools nominally value wellness and have established wellness policies, preventive health efforts may not be the first priority of school health programs. Especially among high-need, high-risk populations, acute needs frequently take precedence over more long-term health concerns, and keeping health promotion high on a school-based health center's agenda can be a significant challenge. Likewise, once preventive health activities have been implemented, assuring that they continue through policy changes can be challenging.
- **Monitoring and evaluating outcomes.** Evaluating prevention programs presents a challenge in all settings, but is especially complex in schools, when many of the targeted outcomes may not occur for years. Moreover, funders may be more interested in process measures and short-term outcomes, so as to monitor exactly what they have received for their investment. Therefore, it is difficult to maintain a focus on longer-term outcome measures and on rigorous program evaluation. Exacerbating this challenge is the lack of agreed-upon measures of the success of prevention efforts.

Overall, while there are significant challenges associated with the provision of prevention services in schools, successful models exist, as do experienced leaders who have worked tirelessly to establish these programs in diverse settings. As Federal officials contemplate expanding school-based prevention programs, it is critical that they continue to learn from the experiences of SBHCs that have incorporated population-based prevention into their programs.

This challenge is particularly relevant now, given the multitude of new opportunities for Federal agencies to support prevention services in schools under the Patient Protection and Affordable Care Act (PPACA) and other initiatives. PPACA made available \$50 million, to be awarded in January 2011, to expand the capacity of existing school-based health centers to provide primary care services to children, and the Office of Adolescent Health within DHHS's Office of Public Health and Science is currently awarding \$75 million in funding to replicate successful programs to reduce teenage pregnancy and risk behaviors. In addition, DHHS has recently awarded \$372 million in funding for prevention and wellness activities under the Communities Putting Prevention to Work

program, focused on prevention of chronic disease. Some of the findings of this study that are especially applicable to these new programs include:

- The importance of a comprehensive needs assessment to guide program planning. As these six case studies show, the types of preventive services that are most needed, and the balance between acute and chronic needs, varies widely across sites. Prevention programs should be designed to incorporate a thorough needs assessment so that prevention efforts meet the community's needs.
- The value of culturally competent services and providers who can convey prevention messages to youth in a way that is meaningful to them. In diverse communities and those with a large immigrant population, it is critical that SBHC staff be able to communicate effectively with both students and their parents if prevention efforts are to be effective.
- The need to coordinate SBHC-based prevention efforts with the school curriculum. While some SBHC staff reported great success in collaborating with teachers and bringing relevant prevention messages into classrooms, others reported that time constraints and competing priorities made this difficult. A school-wide commitment to health and wellness is needed to be sure that the SBHC's prevention efforts reach all students.
- The vital need for evaluation strategies, performance measures, and outcome indicators for school-based prevention services. The implementation of new prevention programs and new funding sources for school health presents an opportunity to develop indicators, gather baseline data, and monitor over time the effectiveness of prevention efforts.

As new programs are funded and their interventions evolve, these findings may provide useful guidance in developing and implementing population-based prevention services.

# Appendix A

## Data Collection Instruments and Materials

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## Sample Introduction Letter

October 7, 2010

Dear \_\_\_\_\_:

On behalf of Altarum Institute and the U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, I am writing to request your assistance on a research study currently being conducted by Altarum Institute. The study, titled “School Health and Prevention,” examines models across the country for the provision of population-based preventive services in school settings. The major research questions to be addressed through the study include:

- What is the scope of prevention activities undertaken in schools with school-based clinics?
- How do schools without school-based clinics address wellness and prevention?
- What outcomes are tracked in order to monitor improvements in wellness among students?
- To what extent does Medicaid funding help schools provide chronic disease care and prevention among students?
- What are the funding sources schools use to support their prevention activities and provision of health services?

These questions will be addressed through a series of case studies, to be developed through site visits to six selected schools. The findings of these site visits will be analyzed and presented in a final report with recommendations for supporting and expanding preventive health services in schools. All interviews will be strictly confidential, and nothing in the report will be attributed to any individual interviewed.

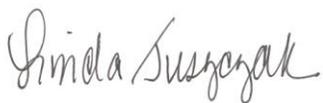
The states and schools to be included in the case studies were selected through a careful process involving examination of health statistics on the State level, States’ responses to the CDC’s School Health Policies and Programs study, and school-based health centers’ responses to the National Assembly on School-Based Health Care’s 2007-08 Census survey. Based on these data sources, six states were chosen for the study, including \_\_\_\_\_, and within \_\_\_\_\_ the \_\_\_\_\_ was selected for its model of providing population-based preventive services.

Therefore, we are writing to request your cooperation with this study. Altarum Institute and its team would like to conduct a 2-day site visit at \_\_\_\_\_ this spring, including interviews with school officials, health center staff, and partner agencies. We will **not** be interviewing students and are not requesting access to **any** individual’s health or clinical records.

Renee Schwalberg of Altarum Institute will be contacting you in the coming days to discuss your center's participation in the study and to begin to schedule a site visit. In the meantime, if you have any questions, you may feel free to contact any of us at the phone numbers listed below. Thank you for your help with this important work.

Sincerely,

Renee Schwalberg, MPH  
Project Director  
Altarum Institute  
(207) 772-1410



Linda Juszczak, DNSc, MPH, CPNP  
Executive Director  
National Assembly on School-Based Health Care  
(202) 638-5872

Cc: Lee Wilson  
Director, Division of Public Health Services  
Office of Health Policy  
Assistant Secretary for Planning and Evaluation  
(202) 690-6051

## School Health and Prevention Study School Administration Discussion Guide

Hello. We are from Altarum Institute, a nonprofit health systems research institute located in Washington, DC. We have been contracted by the U.S. Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation to conduct a qualitative study of the role that schools play in prevention through the provision of school-based health centers and health education. We have selected six school sites, including [site] that have SBHCs and are actively involved in a variety of prevention activities.

In addition to meeting with staff of the SBHC, its sponsoring agency, and community partners, we would like to talk to school officials about your role in prevention activities. We appreciate your taking the time to meet with us today. With this information we will prepare a case study of your site that will be used in a briefing to DHHS administrators and staff.

### Questions:

1. What role do you see your school playing in disease prevention and health promotion?
2. What is the school's official relationship with the SBHC and its sponsoring agency?
3. What are the major physical, emotional and mental health needs that need to be addressed on your school campus?
4. How does the school assess students' health needs?
5. Which needs are being met by the SBHC through school-wide preventive activities – in individual clinical preventive services as well as in the classroom, small groups, other?
6. Were school officials or teachers involved in the development of these preventive services or their curricula?
7. What, if any, resources do you provide to the SBHC besides space? What funding sources support other school prevention activities?
8. What are the funding challenges that your school faces in supporting these prevention activities?
9. What issues does the school face in coordinating with community primary care systems and with other community health or mental health services?
10. If more resources were made available to the school to improve student health, what prevention programs would you like to expand or change?
11. What do you think are the critical elements of a coordinated school prevention program?

12. What suggestions or recommendations would you make to other school administrators interested in building strong, effective school health prevention programs?

## School Health and Prevention Study Clinical Staff Discussion Guide

Hello. We are from Altarum Institute, a nonprofit health systems research institute located in Washington, DC. We have been contracted by the U.S. Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation to conduct a qualitative study to examine the role that schools play in prevention through the provision of school-based health center services and health education. We have selected six school sites, including [site] that are actively involved in a variety of prevention activities.

In addition to the clinic staff, we will be speaking with the clinic's sponsoring agency, school administrators, and community partner agencies. Thank you for taking the time to meet with us today. With this information we will prepare a case study of your site that will be used in a briefing to DHHS administrators and staff.

### **History**

- A. Can you tell us why the SBHC was originally established?
- B. What was its mission?
- C. What was the rationale for furnishing group or classroom activities in addition to clinical preventive services in the SBHC?
- D. Was a needs assessment conducted? If so, how were the results used to inform the SBHC prevention services/activities?
- E. What are the major physical, emotional, and behavioral health needs that need to be addressed on your school's campus?
- F. How were school-wide prevention services/activities planned, developed, and implemented?

Probes: Who was involved? Were students or parents involved?

### **Prevention Activities**

From your response to the NASBHC Census, we understand that you provide clinical preventive services to students and also provide a variety of other prevention activities in small groups, in the classroom, and in large groups? Is this correct, or have there been any changes since the survey?

- A. Can you tell us about the small group prevention activities that you offer?
  - 1. What topics are addressed, and what is the content you aim to cover?
  - 2. Who is responsible for providing or running the small groups?
  - 3. How many students participate, and what are the criteria used to select them?

- B. Can you tell us about the classroom prevention curriculum that you offer or participate in?
  - 1. What topics are addressed, and what is the content you aim to cover?
  - 2. Who is responsible for teaching the classes?
    - 1. What curriculum do you use and who helped to develop it?
- C. Can you tell us about other large group prevention activities that you offer or participate in?
  - 1. What topics are addressed, and what is the content you aim to cover?
  - 2. Who is responsible for providing or running the large groups?
  - 3. How many students participate, and what are the criteria used to select them?
- D. Who funds each of these (small group, classroom, and large group) prevention activities?
- E. Do you feel that this is an effective way of meeting your objectives with the student population?
- F. What are the most successful parts of your school prevention services/activities?
- G. What are the needs for population-based preventive services that are currently unmet?
- H. How does the population of students who use the SBHC for clinical services compare to the group who participate in these population-based services? Are they the same students or different ones? Do the prevention services serve to bring new students into the clinic, or vice versa?
- I. What might you do differently if you had more funds?
- J. How do you tailor your prevention activities to be culturally relevant to populations you serve?

### **Partnership**

- A. How are the school principal and administrative staff involved in prevention activities at your school?
- B. How are teachers involved?
- C. Do you feel that you are getting adequate support from the administration and teachers for these activities?
- D. Does the PTA play any role in prevention activities?
- E. Are there any community agencies that partner with you on your school prevention activities? If so, what agencies and how are they involved?

## **Evaluation and Outcomes**

Now we'd like to talk about how you know whether these programs are working.

- A. What outcomes are you looking at in assessing the effectiveness of your prevention activities?
- B. Do you conduct surveys of your students, such as the CDC's Youth Risk Behavior Survey? If so, do you develop your own survey instruments or use existing ones? Which ones? (Get a copy of surveys if possible.)
- C. Do you gather specific data to measure outcomes?  
Probes: (If a needs assessment was conducted, do you compare your outcomes to the needs assessment results?) Do you monitor specific sentinel indicators, like pregnancy rates? Which ones? How often? Do you involve any external evaluators?
- D. Do you use any of the following:
  - Pre-post comparisons
  - Comparisons with other schools
  - Focus groups with students
  - Satisfaction surveys
  - Utilization information
  - Other
- E. Do you use the findings of your monitoring and evaluation efforts for continuous quality improvement? (For example, to plan new programs, improve existing programs, or reach new populations?)

## **Conclusions and Lessons Learned**

- A. What do you think are the advantages of providing school prevention activities outside of the SBHC?
- B. Are there any disadvantages?
- C. Are there issues in the community or the health care environment that you think will influence the school's ability to provide prevention activities, positively or negatively?
- D. What recommendations would you make to other SCHCs that are interested in broadening their role in prevention activities?

## School Health and Prevention Study Sponsor Agencies Protocol

Hello. We are from Altarum Institute, a nonprofit health systems research institute located in Washington, DC. We have been contracted by the U.S. Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation to conduct a qualitative study of the role that schools play in prevention through the provision of school-based health centers and health education. We have selected six school sites, including [site], which are actively involved in a variety of prevention activities.

In addition to meeting with staff of the SBHC, school administration, and community partners, we would like to talk to the SBHC's sponsoring agency. Thank you for taking the time to meet with us today. With this information, we will prepare a case study of your site that will be used in a briefing to DHHS administrators and staff.

### **Background and History**

- A. How did your agency come to sponsor a school-based health center?
- B. Why did you choose this particular school?
- C. How was the SBHC originally funded?

### **Preventive Services**

- A. Has your agency participated in the design of the SBHC's classroom or group prevention activities in the school? How? Which ones?
  - B. How do you think prevention activities in the school fit into the larger scope of the SBHC's mission? How does it fit into your agency's activities?
  - C. Has a needs assessment been conducted? If so, did it address the needs of the community as a whole or just of the student population? If so, how were the results used to inform the prevention activities?
  - D. What are the major physical, emotional, and behavioral health needs that need to be addressed on your school's campus?
  - E. Is your agency involved in monitoring or evaluating the SBHC's preventive activities? If so, how? What measures are used?
- For sponsoring health care agencies:*
- F. Does the SBHC refer students to your agency for follow-up services? For what services do students usually come to your agency?
  - G. Does your agency share staff with the SBHC? If so, what staff?

*For sponsoring school districts:*

H. What new roles and responsibilities did your district have to take on in becoming a health care provider?

**Financing and Sustainability**

A. How are SBHC direct services now funded?

B. How are the prevention activities in the school funded? To what extent have the requirements of payers driven the prevention activities?

Probe for each funder and for small group, classroom, and large group

C. What issues do you anticipate in the future could affect the sustainability of the SBHC generally or prevention activities in particular?

D. What recommendations would you make to other SBHCs who are interested in broadening their involvement in school prevention activities?

## School Health and Prevention Study Partner Agencies Protocol

Hello. We are from Altarum Institute, a nonprofit health systems research institute located in Washington, DC. We have been contracted by the U.S. Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation to conduct a qualitative study of the role that schools play in prevention through the provision of school-based health centers and health education. We have selected six school sites, including [site], which are actively involved in a variety of prevention activities.

In addition to meeting with school officials, staff of the SBHC, and its sponsoring agencies, we would like to talk to community partners. Thank you for taking the time to meet with us today. With this information, we will prepare a case study of your site that will be used in a briefing to DHHS administrators and staff.

### **Questions**

1. How did your community agency first become involved with the SBHC?
2. What are the major physical, emotional, and behavioral health needs that need to be addressed on your school's campus? How do you think the SBHC and other school prevention activities are meeting these needs?
3. As you know, the [site] provides health education and health promotion services to small groups, classrooms, and the school community as a whole on the following topics: [list]. Is your agency involved in any of these efforts? Which ones, and in what way? (*probes: selecting topics, providing speakers, reviewing materials?*)
4. Are there other prevention activities you think the SBHC or the school should implement?
5. Are there ways that partner agencies' relationships with the school could be improved?
6. Are there other community agencies that you think should be playing a role in school prevention activities?
7. What do you think are the advantages and disadvantages of offering prevention activities in a school setting?  
  
Probe: SBHC, small group, curriculum, large group?
8. Are there issues in the community or the health care environment that you think influence or will influence the school's ability to provide prevention services and activities, positively or negatively?
9. What recommendations would you make to other community partners who are interested in becoming involved in school prevention activities?

## School Health and Prevention Study State Officials Protocol

Hello. We are from Altarum Institute, a nonprofit health systems research institute located in Washington, DC. We have been contracted by the U.S. Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation to conduct a qualitative study of the role that schools play in prevention through the provision of school-based health centers and health education. We have selected six school-based health centers which are actively involved in a variety of prevention activities for in-depth case studies.

In addition to these case studies, our research plan includes the question of how schools *without* school-based health centers provide prevention services. One prominent source of support for those services is the CDC's Coordinated School Health grant program. Your state was recommended to us by Dr. Howell Wechsler at CDC as one that has successfully leveraged its Coordinated School Health grant to create sustainable prevention programs in schools.

Can you give us an overview of how your state has used the CDC funding to support prevention efforts?

- Physical activity
- Nutrition
- Tobacco use prevention

What prevention activities are provided on the small group or classroom level? The large group or school-wide level?

How do you monitor and oversee efforts in individual school districts?

Do individual schools apply for grants or are all schools expected to participate?

What data are reported to the CDC about prevention efforts?

What data are schools expected to report to the state agency?

How are outcomes monitored (the YRBS, other surveys or monitoring systems)?

How have you engaged outside funders and sustained the Coordinated School Health program?