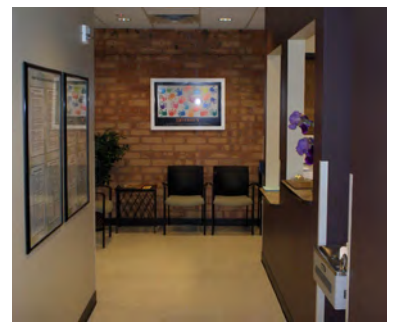


Opening a School-Based Health Center in Colorado



A How-to Manual

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Preface

This manual is intended to serve as a guide for school administrators, health professionals, parents of school-aged children, and other stakeholders who desire to address the preventive and primary health care needs of students in their community. It is intended to be a tool for those considering a school-based health center (SBHC) as a possible solution for unmet needs.

Typically it takes from one to two years to move from initial research to opening a new center. To be successful in this endeavor, it is important to engage parents, students, and community leaders early on in the planning process. Developing a well-thought-out business plan is critical to long-term sustainability. This manual outlines the steps involved in developing a business plan for an SBHC, including conducting a market analysis with needs assessment, determining the management structure, outlining the operations plan, developing financial statements, promoting the services offered, and evaluating the program. The manual concludes with a discussion of the importance of ongoing advocacy and coalition-building.

There are many resources to assist along the way. The Colorado Association for School-Based Health Care (CASBHC) is poised to assist communities throughout the planning process. Many SBHC planners find it helpful to visit operational SBHCs in their area in order to visualize what they are hoping to achieve. Additional resources are described throughout the manual, and a list of relevant websites is provided in Appendix J.

This manual is a project of CASBHC and was generously funded and supported by the Colorado Health Foundation. CASBHC gratefully acknowledges the New Mexico Assembly on School-Based Health Care and the New Mexico Department of Health, Office of School Health. Their resource, *Opening a School-Based Health Center: A How-To Guide for New Mexico SBHC Coordinators* served as the foundation for this manual. CASBHC also wishes to recognize the work of Maureen Daly, M.D., who saw this project through to completion.

We look forward to working with new communities as they embark on the journey to keep children healthy, in school, and ready to learn.

Sincerely,

A handwritten signature in black ink, reading "Deborah K. Costin". The signature is fluid and cursive, with the first name being the most prominent.

Deborah K. Costin
Executive Director
Colorado Association for School-Based Health Care

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Acronyms

BPHC – Bureau of Primary Health Care

CAC – Community Advisory Committee

CASBHC – Colorado Association for School-Based Health Care

CDPHE - Colorado Department of Public Health and Environment

CHP+ - Child Health Plan *Plus*

CLIA - Clinical Laboratory Improvement Amendments

CPT Codes – Current Procedural Terminology Codes

C.R.S. – Colorado Revised Statute

CSNC – Community-funded Safety Net Clinic

DSM IV – Diagnostic and Statistical Manual of Mental Disorders, 4th Edition

ESEA - Elementary and Secondary Education Act

FERPA - Family Educational Rights and Privacy Act

FQHC – Federally Qualified Health Center

HIPAA - Health Insurance Portability and Accountability Act

HRSA - Health Resources and Services Administration

ICD-9, ICD-10 – International Classification of Diseases, 9th Revision and 10th Revision

IEP - Individualized Education Program

MD – Medical Doctor or Physician

MOA – Memorandum of Agreement

NASBHC – National Assembly on School-Based Health Care

NP – Nurse Practitioner

PA – Physician Assistant

RHC – Rural Health Clinic

SAC – Student Advisory Committee

SBHC – School-Based Health Center

TCHF – The Colorado Health Foundation

Chapter One¹



Overview

Chapter 1: Overview

Why School-Based Health Centers Are Important

School-based health centers (SBHCs) help improve the lives of Colorado’s children because they bring essential services to students where they are, in school. SBHCs support student success because healthy students are better learners.

Advantages of SBHCs

- Students have direct access to health care providers while they are at school.
- SBHCs serve all students, whether or not they have insurance.
- Students do not have to miss as much class time to receive basic health care.
- Parents do not have to miss work to take their child to the doctor.
- Transportation problems in seeking health care are reduced.
- Risky behaviors are identified and addressed.
- Students learn how to be effective consumers of health care in a non-intimidating environment.
- Referrals are made to appropriate community providers for services not provided at the SBHC.

Students Who Have Access to Health Centers Inside Their Schools:

- Are more likely to seek services they need.
- Comply with scheduled appointments with very few “no-shows.”
- Get services from on-site providers who can follow-up informally and who have a broader understanding of the student’s functioning in his or her peer group and in school.
- Can get integrated primary and mental health care.
- Have positive role models of health care professionals.

Proven Effectiveness of SBHCs

SBHCs have proven to be effective points of entry into the health care system for children because they lower barriers to accessing care. In addition:

- SBHCs improve school attendance.¹
- SBHCs improve rates of graduation.²
- SBHCs decrease emergency room and urgent care visits.³
- SBHCs decrease hospitalizations for children with asthma.⁴
- SBHCs improve access to and use of mental health services.⁵
- SBHCs improve access to and use of preventive services and improve vaccination rates.⁶
- SBHCs reduce Medicaid expenditures related to inpatient, drug, and emergency department use.⁷

An excellent bibliography of journal articles and other sources describing the value of managing student health in the school setting can be found at <http://www.casbhc.org/publications/index.asp>. Click on: *Bibliography of Journal Articles*.

Facts about SBHCs

SBHCs can provide a wide range of health services, from routine check-ups to treatment for chronic illnesses. They deliver convenient, high-quality, low-cost health services to children and adolescents in school or on a school campus. In addition to primary and preventive health and behavioral health services, these community-driven programs may also include substance abuse counseling, preventive dental care, and health promotion and disease prevention services.

SBHCs emerged in the U.S. during the 1970s. Communities across the nation enthusiastically embraced SBHCs as a way to address the unmet health needs of children and families. During the 1990s, due to significant investment by the Robert Wood Johnson Foundation, there was a rapid and significant rise in the number of centers. The National Assembly on School-Based Health Care (NASBHC) estimates that there are currently about 2,000 SBHCs in the United States. Centers are found in nearly every state plus the District of Columbia, the U.S. Virgin Islands, and Puerto Rico. They serve children in all grade levels in urban, suburban, and rural settings.

Colorado SBHCs and State Grant Program

The first SBHC in Colorado opened in 1978 in Commerce City. The Colorado Department of Public Health and Environment (CDPHE) began administering federal Maternal and Child Health Block Grant funding for SBHCs in 1985. In 1994, CDPHE established a state SBHC initiative, putting Colorado on the map for its thriving school-based clinical practices, prevention programs, and published research.

In 2006, the Colorado General Assembly passed legislation creating a state general fund-supported grant program specifically for SBHCs. In this legislation, SBHCs are defined as “a clinic established and operated within a public school building, including charter schools and state-sanctioned GED programs associated with a school district, or on public school property by the school district.”⁸ Funds appropriated by the State Legislature are administered by CDPHE. Grants are awarded for “assisting the establishment, expansion, and ongoing operations of SBHCs...with priority given to centers serving a disproportionate number of uninsured children or a low-income population or both.”⁹(C.R.S 25-20.5-503) As provided for in this statute, more specific funding criteria were established by CDPHE with involvement from the state’s SBHC operators.

SBHCs in Colorado fill a critical gap in health care services. Today, there are 46 SBHCs in operation throughout the state in 18 of Colorado’s 178 school districts.

SBHC Models in Colorado

Three Levels of Services

CDPHE’s *Quality Standards for Colorado School-Based Health Centers* describes three levels of services that SBHCs provide depending on their funding and staffing:

Level I programs provide a minimum of 15 hours per week, at least 3 days a week, of primary care and 10 hours per week, at least 2 days a week, of behavioral health services.

Level II programs provide a minimum 20 hours per week, at least 3 days a week, of primary care and 10 hours per week, at least 2 days a week, of behavioral health services.

Level III programs provide a minimum of 30 hours per week, 5 days a week, of primary care and 20 hours per week, at least 3 days a week, of behavioral health services.¹⁰

Types of Services

Each local community determines which services will be offered at its SBHC. Health center staff aim to build cultural sensitivity into all the services they provide. Services vary but many SBHCs include the following:

Medical

- Diagnosis and treatment of illness and injury
- Comprehensive well-child and well-adolescent exams with risk assessment
- Sports physicals
- Management of chronic conditions, such as asthma and diabetes
- Immunizations
- Laboratory tests
- Comprehensive reproductive health services*
- Over-the-counter medications and prescriptions
- Referrals and coordination of outside services such as x-rays, medical specialists, and other services not available at the SBHC

Behavioral Health

- Mental health screening (for depression, anxiety, and other conditions)
- Comprehensive behavioral health assessments
- Crisis intervention
- Individual, family, and group counseling
- Substance abuse screening and treatment
- Mental health awareness and outreach, including suicide prevention

Prevention and Health Education

- School-wide wellness and health promotion services
- Individual and small group targeted health education, such as weight management, nutrition education, asthma management, and smoking cessation

Other Services that May Be Offered

- Medicaid/Child Health Plan *Plus* outreach and enrollment assistance
- Preventive dental services such as exams, teeth cleaning, sealants, and fluoride varnishes
- Case management
- Telemedicine, enabling SBHC practitioners to consult with off-site medical specialists via closed-circuit television or phone

* this service varies by community, with some schools offering care on-site and others referring students to community clinics. Comprehensive reproductive health services “include human sexuality education, a behavioral risk assessment, counseling, pregnancy testing, contraception or referral for contraception, and diagnosis and treatment of sexually-transmitted infections.”¹¹

Rural Versus Urban Models

Colorado's first SBHCs were located in urban areas. Over time, rural Colorado communities also embraced the concept and began to establish centers in their schools. During the 2008—2009 school year, 25 percent of SBHCs in Colorado were located in rural communities. This number is growing.

Urban and rural areas face different challenges in establishing and operating SBHCs, and thus the model can look somewhat different. In rural school districts, school enrollments are generally smaller than the urban setting. Rural SBHCs often serve students from more than one school or even the entire school district.

Rural communities face geographic isolation and thus the target population has unique access issues. Recruiting a licensed medical provider may be more difficult. Creative solutions are often needed to find an effective way to address these challenges.

The unmet needs of the target population in cities and rural areas may also vary, and thus the services offered may be different. Inner city children and youth may experience more violence-related health and behavioral health issues whereas unintentional injuries and safety issues are of major concern among rural school-aged children and adolescents.¹²

Questions Every Advocate Should be Able to Answer

Do parents favor SBHCs?

Yes. Parents appreciate SBHCs because:

- SBHCs help their child to stay healthy and in school.
- Parents miss less work. Without an SBHC, when a child is sick, the parent must miss work to take the child out of school to be seen at a doctor's office or health care facility.
- SBHC services are provided to all students, whether or not the student has insurance.
- According to a nationwide survey commissioned by the W.K. Kellogg Foundation and conducted in 2007, the majority of voters support providing school-based health care.¹³

Do SBHCs interfere with parental authority?

No. SBHCs require the parent or legal guardian to sign a consent form before their minor child may receive services in the SBHC. Because SBHCs take the approach that the provider, parents, and child should work together to resolve health problems, strong family communication is promoted.

Do health centers take money away from classrooms?

No. SBHCs get their funding from many different sources. Schools generally provide only in-kind support to their health centers, such as space, utilities, and custodial services. School districts recognize that student achievement gaps can be closed if all students are physically and mentally healthy.

How are SBHCs in Colorado funded?

Colorado SBHCs are funded through a mix of resources, including: federal, state and local government dollars, private grants and donations, insurance billing, and in-kind support. All SBHCs are encouraged to develop a diversified funding base so they are not overly dependent on one source.

Shouldn't schools just focus on education?

"Studies have found direct links between SBHC use and learning readiness."¹⁴ Schools cannot do their job of educating if students are not in school or are unable to concentrate because of pain or other health problem. Research shows that students who use SBHCs are less likely to be absent or tardy¹⁵ and more likely to graduate or be promoted than nonusers.¹⁶

Do SBHCs eliminate the need for school nurses and school counselors?

No. SBHCs do not replace school nurses or counselors. Rather, they complement services already being provided by placing additional resources in the schools. School nurses and counselors are vitally important to comprehensive health care for students.

Do SBHCs take patients away from local providers?

No. SBHCs collaborate with and make referrals to community medical providers. SBHCs are another entry point into the community’s health care system for children who may not otherwise be able or willing to seek help outside the school.

Are practitioners at SBHCs qualified?

Yes. All medical, dental, and behavioral health care providers at SBHCs must be licensed, and the services they provide are limited to their type of licensure.

What age groups do SBHCs serve?

SBHCs are located in preschools and elementary, middle, and high schools.

Overview of Key Partners

National Assembly on School-Based Health Care

NASBHC is a non-profit membership association whose mission is to improve the health status of children and youth by supporting the development and improvement of SBHCs and advocating for school-based health care. Based in Washington, D.C., NASBHC advocates for the school health care community. It seeks to be its members’ primary resource for professional development, knowledge exchange, and services. In addition, NASBHC is a leading information source for the public on school health care and services. For more information, visit <http://www.nasbhc.org>.

Colorado Association for School-Based Health Care

Established in 1996, the Colorado Association for School-Based Health Care (CASBHC) is a non-profit membership organization for the state’s SBHCs. It is a state affiliate of NASBHC. Its mission is to keep children healthy, in school, and ready to learn. CASBHC promotes SBHCs that provide preventive health, primary health, oral health, and behavioral health care for Colorado’s children and families. The organization supports school health as an essential strategy for improving the lives of children and optimizing their opportunities for success in school and society. CASBHC supports its members by providing advocacy, technical assistance and training, and quality improvement and evaluation. The CASBHC membership form for collaborating organizations and individuals can be found in Appendix G. For more information, including additional membership information visit <http://www.casbhc.org>.

Colorado Department of Public Health and Environment/SBHC Program

The state’s SBHC Program is located in the Child, Adolescent, and School Health Unit of CDPHE. The Child, Adolescent and School Health Unit leads efforts to improve the health and well-being of all Colorado children and adolescents through health promotion, public health prevention programs, and access to health care. At present, available funding is being used to support ongoing operation of existing SBHCs. In 2009-2010, the state supported 41 operating SBHCs. For more information about state funding opportunities for SBHCs visit <http://www.cdphe.state.co.us/ps/school/index.html>.

The Colorado Health Foundation

The Colorado Health Foundation (TCHF) announced a four-year, \$10.8 million initiative in 2009 to support new and expanded school-based health care programs. TCHF is supporting the development of new SBHCs and/or

the integration of mental or dental health services into existing SBHCs. For more information on the Foundation's School Health Initiative visit http://coloradohealth.org/school-based_health_care.aspx.

The Center for Health and Health Care in Schools

The Center for Health and Health Care in Schools is a non-partisan resource center at The George Washington University School of Public Health and Health Services. The Center provides up-to-date information to health and behavioral health professionals, educators, and others to assist in promoting the health of children and adolescents through school-connected programs. For more information about the Center and to access valuable information about school-connected programs and services visit <http://www.healthinschools.org/>.

Chapter Two



Community Planning

Chapter 2: Community Planning

Why Strong Community Planning and Relationship-Building Are Important

The first step in starting an SBHC is to bring together interested parties in the community. This is essential for planning and assessing community interest and resources. The planning stage helps identify community concerns about the health center, and it helps build and maintain widespread community support. In addition, community members bring expertise to be drawn upon in determining key components, such as floor plans and services to be offered.

A well thought out and effective community planning process can make the difference between a successful SBHC and one that closes its doors due to lack of community support or funding. This process must reflect the culture and priorities of the community.

Who Should Be Involved?

School Administrators

The school district should be an active participant in the planning process because the health center will be located on school property. The SBHC is a guest in the school, and education leaders should be involved in planning from the beginning – especially the principal. School district administrators can also be instrumental in helping identify funding for the health center.

School Board

In order to have an SBHC on school property, the approval of the school board is needed. School boards typically pass a resolution in support of an SBHC in order for the health center to exist. Further, the school board approves what, if any, financial support the school district will provide the SBHC. In some cases school board members participate directly in the planning. In most cases, the board is kept informed of the planning process by district-level administration.

School Staff

School staff, including school nurses, teachers, school counselors, school psychologists, and school social workers have a great deal of contact with students and parents and therefore are influential in encouraging them to use the health center. School staff members are great resources for determining what types of services students most need and advising SBHC staff on operating an effective program within the school building.

Parents

Parents are important to involve from the beginning because they can be influential in encouraging students to use the health center. They can also become powerful advocates for SBHCs on national, state, and local levels. In addition, any objections or concerns parents may have about the health center are best dealt with during the planning stage.

Youth

Students are critical to the planning process when the target market is middle and/or high school students. Involving youth in the planning process is essential to understanding the services most valuable to them. Youth who are involved in the planning process will also help market the SBHC to their peers once it is operational. Students who are involved in planning their SBHC gain valuable leadership skills.

Health Care Professionals

It is important to gain support from health care professionals in the community, including practicing physicians, mental health providers, and dentists, and to communicate that SBHCs do not take business away from local providers. In fact, referrals from SBHCs can increase the business of local health care providers.

Community Leaders

Community leaders are an important group that should also be considered during the planning phase. Including them can help in fundraising efforts as well as in building community support. These leaders can include business owners, members of civic clubs, legislators, members of the media, religious leaders, judges, or other influential women and men in the community.

Public Health Professionals

Public health offices can be great partners in planning, providing data for the needs assessment, identifying community health care professionals to involve, and determining the types of services the health center should provide. The SBHC and the local health department should coordinate rather than duplicate provision of mandated health services.

Local Foundations and Other Funders

It is important to consider involving local foundations and other potential funders in the planning process. Foundations, in addition to potentially funding the project, may have other resources, such as expertise in financial management, grant writing, and evaluation, to contribute to the process.

Establishing a Community Advisory Committee

The participation of the community in the planning and operation of the SBHC should be formalized through the establishment of a community advisory committee (CAC). A representative, supportive CAC is essential for the successful development and operation of an SBHC. CACs are comprised of a diverse group of community members, including the groups mentioned above. CACs should reflect gender and racial/ethnic diversity.

CACs provide guidance and advocacy, and assist with the identification of resources and funding. CACs can play a major role in helping school districts develop effective school health programs. CACs are often asked to review and endorse budgets, the scope of services, hours of operation and other policies, client satisfaction, pay scales, staffing plans, community partnerships, and advocacy efforts. CACs are generally comprised of 10-15 members and should include the following:

- A representative of the SBHC's licensed medical provider (see Chapter 4)
- School principal
- Teacher
- School board member or district administrator
- School nurse
- Representative from the local medical community, such as a pediatrician or family practice physician
- Community mental health professional
- Dental health professional
- Public health professional
- Community members, such as business, civic, religious, and/or political leaders
- Parents, such as a representative of the parent group and/or PTA
- Students, when age-appropriate

It is suggested that each person serve a minimum two-year commitment with a renewal option to encourage continuity and enhance committee function. Terms might be staggered so that rotation occurs for only half the committee each year.

Establishing a Student Advisory Committee

Meaningfully involving youth in the decision-making process for middle and high school students is very important. It enables a better understanding of adolescent health issues facing the community. Many youth are willing and able to get involved, but adults typically overlook them as a resource.

To involve youth in the planning process, a separate student advisory committee (SAC) may be considered. For additional information on youth engagement, contact the Colorado Association for School-Based Health Care (CASBHC) and request a copy of their issue brief, *Youth Engagement in SBHCs*. In addition, helpful information on positive youth development can be found in the following document: *Engage Youth: Colorado’s Guide to Building Effective Youth-Adult Partnerships*.¹⁷

A SAC often consists of 6-10 youth who meet regularly and make recommendations to health center staff. Youth can be intimidated speaking among a group of adults. Therefore, SACs are a great way to get youth feedback and help prepare youth to become future members of the CAC. The success of a SAC greatly depends on the level of support and mentorship provided by the organizers.

Common Youth Participation Challenges

The following table presents common challenges and solutions to involving youth.

The Problem	Potential Solutions
<p>Under-prepared youth: Youth are uncomfortable or bored because they do not have the confidence or training to contribute effectively.</p>	<ul style="list-style-type: none"> • Provide a one-time orientation for new youth members that introduces them to SBHC issues, how the meetings are run, and common acronyms (like SBHC, CAC). • If funds are available, assign an SBHC staff member to provide ongoing training to the youth members. • If funds are <i>not</i> available, turn to other youth organizations in the community to identify young people already trained in health, youth, or governance issues.
<p>Poor logistics: Youth can't attend the meetings because of when or where they are organized.</p>	<ul style="list-style-type: none"> • Offer to conduct meetings during school, after school, on weekends, or in the evenings. • Hold meetings at or near the school.
<p>Students may be hard to contact: Because students are in class all day, it is often hard to reach them and get a prompt reply.</p>	<ul style="list-style-type: none"> • Ask that each youth participant has an email account or consider using Facebook or Twitter. • Consider text messaging as a way to communicate with youth.
<p>Finding students to participate: SAC organizers have a hard time recruiting youth who are willing to take on the responsibility.</p>	<ul style="list-style-type: none"> • Get youth excited about serving on the SAC by producing fun recruitment flyers that point out how important the SBHC is (or will be) to teens. • Provide refreshments at the meetings. • Recruit through people who deal with youth every day, such as teachers and youth organization staff. • Recruit youth who display an interest in health issues, such as peer mentors, health advocates, or those interested in pursuing a health career. Avoid

The Problem	Potential Solutions
	recruiting overextended youth. <ul style="list-style-type: none"> • Offer a modest financial stipend.
Meetings too technical: The content of the meetings is too complicated for youth to understand.	<ul style="list-style-type: none"> • Make sure agendas specifically draw on the youths' expertise, such as what services teens need, what concerns students at school have, or how to make the health center increasingly "teen-friendly." • Email the agenda in advance, so youth have time to look over it and ask questions before the meeting. Alternatively, write the agenda on a white board at the beginning of the meeting and have youth comment.

Ways Youth Strengthen SBHCs

- Assisting with facility preparation, such as selecting colors, waiting room art, and furniture.
- Advising on clinic policies, such as when the center is open, what types of services to offer, and, in some cases, whether those services are offered in culturally appropriate ways
- Developing or assisting with marketing efforts that reach teens
- Helping with health education efforts on nutrition, active lifestyles, substance abuse, etc.
- Evaluating services and practices
- Advocating for the health center with policy-makers and administrators

Ways Youth Benefit From Engagement

In addition to youth engagement being valuable to the SBHC, it is great for the teens involved. Young people involved in decision-making grow developmentally and academically. They build skills that help them become healthy, confident, well-rounded community leaders. Academically, youth involved in policy processes build critical thinking, public speaking, writing, and other skills that can boost their grades and workforce preparation.¹⁸ In addition, youth who are involved in their SBHC often develop a positive, nurturing connection with a caring adult employed at the health center. These types of relationships are invaluable to young people.

Maintaining Community Involvement Long-term

Establishing a CAC, starting a SAC, and conducting a needs assessment, (see Chapter 3), are all ways to get the community involved in the SBHC. As mentioned previously, these activities are important to ensuring adequate support for a new health center. However, *maintaining* that community involvement long-term is essential to the SBHC's ongoing success. Ideas for maintaining community involvement include the following:

- Host an open house at the beginning of each school year so that students, parents, and community leaders are familiar with the SBHC.
- Make sure the CAC members continue to meet regularly and represent different viewpoints and backgrounds.
- Keep CAC and SAC members informed on how their ideas were implemented.
- Create a health newsletter that lets students and parents know what is happening in the SBHC. (Consider collaborating with the journalism class to produce the publication once a quarter; the class then becomes another recruitment source for the SAC.)
- Plan a round-table luncheon twice a year with members of the health community.
- Train a cadre of youth to conduct outreach to youth-serving organizations in the community.

- Suggest that adult and student advisory members help organize booths or information tables at local community festivals, cultural holidays, or other events that parents, students, and potential SBHC supporters are likely to attend.
- Ask members to serve as speakers on behalf of the SBHC program.

Chapter Three



Entrada SBHC, courtesy of Harrison 2 School District

Business Plan: Overview and Market Analysis

Chapter 3: Business Plan Overview & Market Analysis with Needs Assessment

What is a Business Plan and What Does It Include?

In starting an SBHC, it is helpful to develop a business plan. A business plan is a written guide that defines the business; presents the vision, goals, and objectives; and outlines the path to operational success and financial stability. It serves as an important communication tool to inform key stakeholders, including potential funders, of the clear and compelling case for the project. A well-written business plan that makes the case for the business and describes the resources needed to accomplish the goals “can be a powerful tool for marketing and fundraising.”¹⁹

A complete business plan includes the following components: executive summary; market analysis, including a needs assessment; description of sponsoring organization; mission, vision, goals, and objectives of project; management structure; operations plan and description of products or services; marketing strategy; financials; and appendices. The appendices should include:

- Most recent audited financial statement of sponsoring agency, including at least a balance sheet and profit and loss statement
- Organizational chart
- Resumes of key team members
- Job descriptions for all SBHC positions
- Copies of professional licensure of SBHC providers
- Memorandum of agreement (MOA) between licensed medical provider and school district (see Appendix D)
- Sub-contracts for specific services, such as laboratory, behavioral health, dental, and pharmacy services
- Copy of 501(c)(3) designation if sponsoring agency is a private, non-profit organization

The market analysis is discussed below. The management structure, operations plan, marketing strategy and financials of a business plan, in the context of planning an SBHC, are discussed in later chapters.

How Does a Business Plan Differ From a Strategic Plan?

A business plan differs from a strategic plan in several ways. A business plan generally is written “when one is starting something new – a business or a product/service line within a business.”²⁰ A strategic plan, on the other hand, “determines where an organization is going over the next year or more, how it's going to get there and how it'll know if it got there.... The focus of a strategic plan is usually on the entire organization, while the focus of a business plan is usually on a particular product, service or program.”²¹ A strategic plan is generally an internal document used by the company to achieve its goals; whereas a business plan is used to describe the financial, marketing, and operational goals of the new service or program to stakeholders and potential investors.

Market Analysis

What is a Market Analysis?

A market analysis is an important component of a business plan and is one of the first steps undertaken when considering an SBHC. A market analysis informs the planning activities. The goal of the market analysis is to define the target market or the customers to whom services will be provided. For SBHCs, the target market is the children and adolescents who will have access to the SBHC services. Parents must also be considered when doing a market analysis, however, because although they will not be users of the services, they are consumers or buyers of the services. The parents will ultimately decide if their children will use the SBHC.

The market analysis also assesses the specific behaviors and needs of the target market and the extent to which these needs are or are not being met. The needs of the target market and the extent to which the needs are or are not being met vary from community to community and can be determined by doing a needs assessment.

What Should a Market Analysis Include?

In the context of planning an SBHC, the “market” is the school district. A market analysis should provide a description of the following:

- Geographic boundaries and characteristics of the community, school district and/or service area
- Schools within the district, their size, student profiles (including percent of students enrolled in the free and reduced-price lunch program) and proximity to each other
- Socioeconomic characteristics and demographics of the population, including size, education, income, ethnicity, language(s) spoken, religion, and other cultural factors
- Major industries and employers
- Market trends, such as population shifts or economic situations, that may occur and impact the target market
- Major health and behavioral health care providers and programs within the boundaries of the identified service area providing the same or like services
- Existing school nurse, school counseling, and other school health services
- Major decision-makers or those who have authority to accept or reject the plan

Target Market

Based on the market analysis, the best location for the SBHC is determined. The students with access to services are the target market. Some SBHCs serve only the students enrolled in the host school (the school that houses the SBHC). This is often the case in large urban schools. Other SBHCs also serve students enrolled in designated feeder schools. In many rural communities, where school enrollments are lower, students throughout the district may have access to the SBHC services. Some SBHCs also may choose to provide services to the siblings and/or children of students.

An SBHC may decide to provide limited services to school staff and faculty members. However, it should be remembered that an SBHC is not a community clinic in a school. School-based health care has a pediatric/adolescent focus that aims to improve the health and academic success of children. SBHCs are typically staffed with pediatric nurse practitioners (NPs). Serving adults may detract from the focus on children and adolescents. In addition, serving adults in the school setting presents its own challenges, including the need to staff with providers qualified to treat both children and adults. There are also security considerations when opening an SBHC up to adult community members.

Assessing Market Size and Utilization

As part of the market analysis, it is important to consider whether market size and anticipated utilization will be sufficient to be cost effective. There are a number of factors that influence utilization.

Number of Student Users

To be cost effective, a minimum number of students in the target population must be using the services. Nationally, the average student body enrollment rate (students who registered with the SBHC and had a consent form on file) was 64 percent of the target population, and the average SBHC utilization rate was 84 percent of enrollees.²² National benchmarks for an SBHC target population do not exist, but work by the National Assembly on School-Based Health Care (NASBHC) suggests that there be a minimum of 600 users per SBHC staffed with one primary care provider.²³

Average Utilization of Users

During the 2008—2009 school year, Colorado SBHC student users made an average of three visits with a range of two to five visits. Higher utilization may result depending on the availability of daily behavioral health services.

Age is also a factor in SBHC utilization. Research would suggest that adolescents (ages 10-19) are more in need of health services and face greater barriers to accessing health care than younger children.²⁴ Adolescents are known to avoid or delay seeking needed services in traditional settings. Twenty percent of insured adolescents in one study went without care that they thought they needed.²⁵ SBHCs have been found to be an effective way to reach the adolescent population and meet their needs. The availability of both on-site medical and behavioral health services offered by SBHCs addresses the adolescent's needs for care in a way that few traditional providers are able to duplicate. SBHCs have been shown to eliminate many of the barriers to adolescents accessing health care; thus, "adolescents attending SBHCs had higher rates of visits for health and medical care than adolescents using traditional sources of medical care."²⁶

Identifying the Major Decision-Makers

The market analysis defines the target market and should also identify the major decision-makers. Decision-makers are those who have the authority to choose or reject the plan. In the case of SBHCs, decision-makers include the school board members, the superintendent, and the principal of the host school, as well as the director or chief executive officer of the licensed medical provider (see Chapter 4). Involving the decision-makers and other key community members early in the planning process, as described in Chapter 2, is an effective strategy for identifying concerns early and fostering support.

Doing a Needs Assessment

What is a Needs Assessment?

A "needs assessment" is a tool to determine the needs and priorities of the target market as well as the best methods for addressing those needs. Needs assessments can include surveys, focus groups, interviews with community leaders, or other strategies developed to gather information. In conducting such an assessment, it is important to identify community assets, as well as service gaps that may exist in the community's health care delivery system. It is also important that the needs assessment gather information about the ways the community's culture and history influence people's views about health care. (For example, to what degree are the members of the community in favor of nontraditional health care systems? How might those beliefs influence people's willingness to use the SBHC?)

Needs assessments answer questions about the type of services the health center should offer and how to structure those services so they fill gaps that are experienced by the target population.

What One Can Learn From a Needs Assessment²⁷

It is important for planners to identify the questions they hope to answer through a needs assessment. Common questions that needs assessments help answer are listed below.

- What are the specific health problems the community faces?
- What do the students voice as their biggest health problems and/or concerns?
- What kinds of services would address the identified needs?
- What community and school health resources already exist?
- Which health facilities are used most and why?
- Are there services in the community that could meet these needs that are not being utilized and why are they not being utilized?
- Is the community satisfied with the current set of services?
- How well are services coordinated? How might coordination of services be improved?
- What service gaps exist?
- What are the barriers students and families experience in accessing the services they need, such as hours of operation, transportation, language barriers, and available appointment times?
- In what ways do language, race, and culture influence people's views about health issues in the community?
- Would the SBHC services be utilized by the target population?
- Would the SBHC or another service model be best suited to meet student needs?

Strategies for Answering Needs Assessment Questions

There are many ways to answer the questions listed above. Different needs assessment strategies will probably need to be used in order to get all the answers. This section presents four approaches to collecting information.

Existing Data

Existing data should be gathered before collecting new data to avoid duplicating the effort of other agencies and wasting resources. Data concerning the health and well-being of the community will help determine the students' health care needs. It will also prove helpful later when writing grant proposals.

Existing data may come from a variety of sources, including the following:²⁸

- Census Data-information on geography, population, housing, and economics of a particular area
- Vital Statistics-data from the Colorado Department of Public Health and Environment (CDPHE) on causes of mortality and morbidity as well as birth rates for a defined population
- State Department of Education-academic performance indicators by school district and individual school, as well as school safety and discipline records, free and reduced-price lunch eligibility, etc.
- School District Offices-school nurse records, including immunization rates, number of students with asthma, disabilities, and other chronic conditions
- Local Chamber of Commerce-information on industries and major employers in the community
- Local Journals and Newspapers-articles pertaining to local health concerns and existing programs

- Student Survey Data-Local and state agencies may conduct assessments of health risk behaviors of students, such as tobacco, alcohol, and drug use, as well as mental health concerns. The Youth Risk Behavior Survey (YRBS) is conducted biennially in Colorado by CDPHE. School principals would likely know what surveys have been conducted and what local data is available for review.

The following table lists useful online resources.

Data Source	What it Contains	URL
U.S. Census Bureau American Fact Finder	Community level population, housing, economic, and geographic data	http://factfinder.census.gov/home/saff/main.html?lang=en
State of the Cities Data System	Data for individual metropolitan areas, central cities, and suburbs	http://socds.huduser.org
Division of Local Government, State Demography Office	Population and demographic information that serves as a resource to state and local organizations in program planning	http://www.dola.state.co.us/dlg/demog/index.html
CDPHE	State and county level health data, including: vital statistics, maternal and child health, communicable diseases, injury surveillance, child health survey, Colorado Youth Risk Behavior Survey, etc.	http://www.cdphe.state.co.us/hs/datahome.html
CDPHE - Colorado Health Information Dataset	Tool for users to access data on health status by neighborhood, community, county, or region in Colorado	http://www.cdphe.state.co.us/cohid/index.html
Colorado Department of Human Services - Alcohol and Drug Abuse Division	Resource on substance abuse prevention, treatment, and recovery services in Colorado	http://www.cdhs.state.co.us/adad/
Colorado Health Institute	State and county level health-related information, including: access to care, health care costs, delivery systems, health indicators, workforce, etc.	www.coloradohealthinstitute.org
Colorado Rural Health Center	Information and resources for rural communities to assure adequate access to health care	www.coruralhealth.org

Data Source	What it Contains	URL
Colorado Children's Campaign - Kids Count	State and county data relevant to the health status of children, including: vulnerable families, family economics, education, and maternal and child health indicators	http://www.coloradokids.org/facts/kids_count.html
Colorado Department of Education	School accountability reports	http://reportcard.cde.state.co.us/reportcard/CommandHandler.jsp
Colorado Department of Education	Colorado education statistics, district and school level	http://www.cde.state.co.us/index_stats.htm
Colorado Bureau of Investigation	Data on crimes and arrests reported by local law enforcement agencies	http://cbi.state.co.us
Colorado General Assembly	Information on health care issues and programs, listings of major legislation, committee members who sit on health and education committees	http://www.leg.state.co.us/

In addition, check the websites of the local public health department, social service agency, and school district for valuable information.

Focus Groups

In addition to collecting statistical data about the community, it is important to gather information about the community members' needs and wants. A focus group is one strategy for collecting that information. A focus group is a meeting of about ten people during which a moderator asks questions about a particular topic. It can be a good way to gather feedback relatively quickly, but the results may reflect only the opinion of the people present. It is an *excellent* pre-cursor to a survey because it can help refine future survey questions and topics. It is also a good way to collect information about cultural values and concerns. Frequently, subtle types of information will come out more readily in a focus group than in the more traditional forms of needs assessments, such as surveys.

Depending on the budget, a consultant who specializes in planning and facilitating focus groups can be hired, or planners may attempt it on their own. Perhaps the simplest way to conduct one is to start by brainstorming a set of open-ended questions on the topic for which feedback is wanted. Next, schedule group meetings of students, community leaders, policy-makers – or whoever's feedback is desired. For example, if the goal is reaching out to the community in general, include adults who reflect the ethnicities, lifestyles, and economic backgrounds of the community. Once a group has been convened, ask questions, giving everyone a chance to speak. Make sure to assign someone to take notes or record the meeting.

Key Informant Interviews

Interviewing key formal and informal leaders in the community is an effective way to gather information on available school and community resources, programs, and gaps in services. It also provides an opportunity to

discuss SBHC services and gain the support of these leaders.²⁹ Leaders might include directors of the local health, probation, and social service agencies; representatives from local foundations; major employers in the area; heads of youth-serving agencies; religious leaders; local health and mental health providers; community organization representatives, including parent-teacher associations; and school nurses and counselors.

Community Surveys

A survey can be a very effective tool. Surveys of parents, students, school staff, and community members provide information about the perceived health needs of students from a variety of perspectives. Again, an outside consultant can be hired to design, disseminate, and evaluate the survey – or planners can attempt one on their own. The survey can be as simple as a brief questionnaire asking people to rank their top priorities for a new SBHC. Depending on the issue and audience, a more complex survey can also be developed with detailed policy questions (for sample parent, student, and teacher/school staff surveys for assessing student and school health needs see <http://www.cdphe.state.co.us/ps/school/planning.html?col3=open,col4=open> and Appendix B).

Utilizing Results

Once all the data for the needs assessment is collected and a preliminary analysis has been completed, it is important to summarize it in written and presentation forms so it can be shared with stakeholders. This provides the opportunity to get the “go-ahead” to establish a new SBHC, to clarify plans for implementation, to build enthusiasm among stakeholders, to cement cooperation from partner agencies, and to identify next steps. The general conclusions from the needs assessment may also be appropriate to share with the community-at-large to build awareness and support.

Chapter Four



*Northside Elementary SBHC, courtesy of
Montrose County School District*

Business Plan: Governance and Management Structure

Chapter 4: Business Plan - Governance and Management Structure

As discussed in Chapter 3, a good business plan includes the following elements: market analysis with needs assessment; management structure; operations plan; marketing strategy; and financials. The market analysis was reviewed in Chapter 3. The management structure is detailed in this chapter.

Governance and Management Structure

An SBHC is a partnership between, at a minimum, a licensed medical provider and a school district. Other organizations, such as a mental health agency or a dental clinic, may be included in the partnership. Which of the partners takes the lead role and becomes the “sponsoring agency” is one of the first decisions the Community Advisory Committee (CAC) should make. The sponsoring agency takes responsibility for operating the health center, coordinates the activities of all partners, and acts as fiscal agent.

The governance and management structure defines the relationship between the sponsoring agency and other partners. It also includes a staffing plan. Determining the governance and management structure is critical to success. Funders want to be assured that the sponsoring agency is knowledgeable and experienced, that staffing levels will be appropriate, and that the staff will be qualified to provide the services.

Role of Sponsoring Agency and MOA between Licensed Medical Provider and School District

The sponsoring agency is usually either the affected school district or a licensed medical provider in the community. No matter which takes the lead, it is necessary to spell out the responsibilities of each party in a memorandum of agreement (MOA). While the sponsoring agency is ultimately responsible for all operations of the health center, the MOA should clarify issues, such as who will employ the SBHC staff, who will handle third-party billing, who will own the medical records, who will maintain professional liability (malpractice) insurance, who will ensure adherence to federal and state regulations, who will collect data for reporting and program evaluation purposes, and how program decisions will be made (see Appendix D).

In order to develop an MOA between the school district and licensed medical provider, regardless of which organization is the sponsoring agency, the following functions need to be discussed and primary responsibility determined:

- Providing physical space for the SBHC
- Determining the layout of the SBHC facility
- Remodeling or building the SBHC facility
- Establishing/coordinating the CAC
- Establishing MOAs with community partners
- Hiring, supervising, and training health center staff
- Ensuring that staff are credentialed
- Providing liability coverage for health providers and staff
- Orienting health staff about school policies
- Securing funding for the SBHC
- Developing an integrated budget

- Deciding how billing revenues will be used and reported
- Contracting with Medicaid and commercial carriers and billing for services
- Book-keeping
- Communicating with parents about the SBHC
- Marketing the SBHC and media relations
- Establishing clinical policies and procedures
- Following state and federal health regulations governing medical record-keeping, lab testing, patient confidentiality, and pharmaceuticals
- Collecting data on clinical encounters and reporting to funders and the school district
- Ensuring regular communication between school staff, including the principal or his/her designee, and health center staff

Types of Licensed Medical Providers

Federally Qualified Health Centers

Federally qualified health centers (FQHCs) are public or private non-profit entities recognized by the U.S. Health Resources and Services Administration (HRSA) as community-based and patient-driven organizations that provide primary care and other services to people in medically underserved areas. (Additional information about FQHCs can be found at: <http://bphc.hrsa.gov/>.) Their services must be available to all residents in their service area, regardless of their ability to pay, and must meet other administrative, clinical, and financial requirements as mandated and regulated by HRSA's Bureau of Primary Health Care (BPHC).

The law defining this program is Section 330 of the Public Health Service Act and therefore sometimes FQHCs are described as "Section 330" organizations. FQHCs include three types of clinics:³⁰

- Health centers funded under Section 330, such as Community Health Centers (CHCs), Migrant Health Centers, Health Care for the Homeless Health Centers, and Public Housing Primary Care Centers
- FQHC "Look-Alikes" that have been identified by HRSA and certified by Centers for Medicare and Medicaid Services (CMS) as meeting the definition of health center under Section 330 but do not receive grant funding under Section 330
- Outpatient health programs operated by tribal organizations

FQHCs can provide billing and staffing infrastructure, and are reimbursed for the services they provide to Medicaid enrollees at their actual cost for providing those services.

Rural Health Clinics

Rural health clinics (RHCs) are federally-designated clinics located in rural, underserved areas. The law defining this program is the Rural Health Clinics Act (P.L. 95-210) that was signed into law in 1977. RHCs and FQHCs differ in eligibility criteria, governance structure, management requirements, and scope of services among other things. The Colorado Rural Health Center serves as the State Office of Rural Health for Colorado (<http://www.coruralhealth.org/>). Like FQHCs, RHCs receive cost-based reimbursement from Medicaid.

Community-Funded Safety Net Clinics

Community-funded safety net clinics (CSNCs) provide primary care services to low-income, uninsured, and underinsured Coloradoans. Like FQHCs and RHCs, CSNCs are part of the health care safety net in Colorado. Unlike FQHCs and RHCs, they are not eligible for enhanced reimbursement rates under Medicare and Medicaid. They are funded by private and public grants, patient revenues, and contributions. ClinicNet is the state advocacy organization for CSNCs and RHCs in Colorado (<http://www.clinicnet.org/>).

Hospitals

Local hospitals that provide outpatient services generally have the necessary billing and staffing infrastructure to sponsor an SBHC. In addition, many hospitals regard SBHCs as an important part of their community service and outreach efforts and as a strategy for reducing unnecessary emergency department visits and hospitalizations through the provision of timely, accessible, primary and preventive health care.

Universities/Provider Training Programs

Universities with affiliated training programs for physicians, nurse practitioners, and physician assistants can serve as SBHC sponsors. This is usually a mutually beneficial arrangement as SBHCs can serve as valuable community-based clinical sites for their students.

Physician or Physician Group

This approach to SBHC sponsorship is most likely to occur in small communities where few if any non-profit health agencies exist. Under this structure, the doctor's practice hires and supervises the SBHC's practitioner(s) and provides insurance billing.

Local Public Health Department

Local public health departments have sponsored SBHCs in other states although no local public health agency currently sponsors an SBHC in Colorado. In most Colorado communities, public health agencies have moved away from providing direct health care. However, public health departments make good community partners because they have relationships with many local agencies that provide health and human services, and an understanding of the community and its health needs.

Choosing a Sponsoring Agency: School District or Licensed Medical Provider?

As stated above, an SBHC is a partnership between a school district and a licensed medical provider. For practical reasons, one or the other should be designated as the sponsoring agency. Local conditions often drive the decision regarding sponsorship. The agency best positioned to take leadership and having key staff who are highly motivated and have the energy to plan and implement the project most often becomes the sponsoring agency.

Licensed Medical Provider as SBHC Sponsor

Licensed medical providers are ideal sponsoring agencies for SBHCs, since they have staff who have experience in health care administration and have systems in place for handling medical records, insurance billing, and government regulations. As the sponsoring agency, these organizations relieve the school district from handling most of the day-to-day operations of the SBHC. In addition, these organizations are often accustomed to leveraging federal, state, and private funds to provide cost-effective and culturally competent health care to underserved areas and populations.

School District as SBHC Sponsor

Some school districts prefer to be the SBHC sponsor because they feel it gives them more control over services provided in their buildings. However, school districts should consider the following when assessing their capacity to accomplish certain functions:

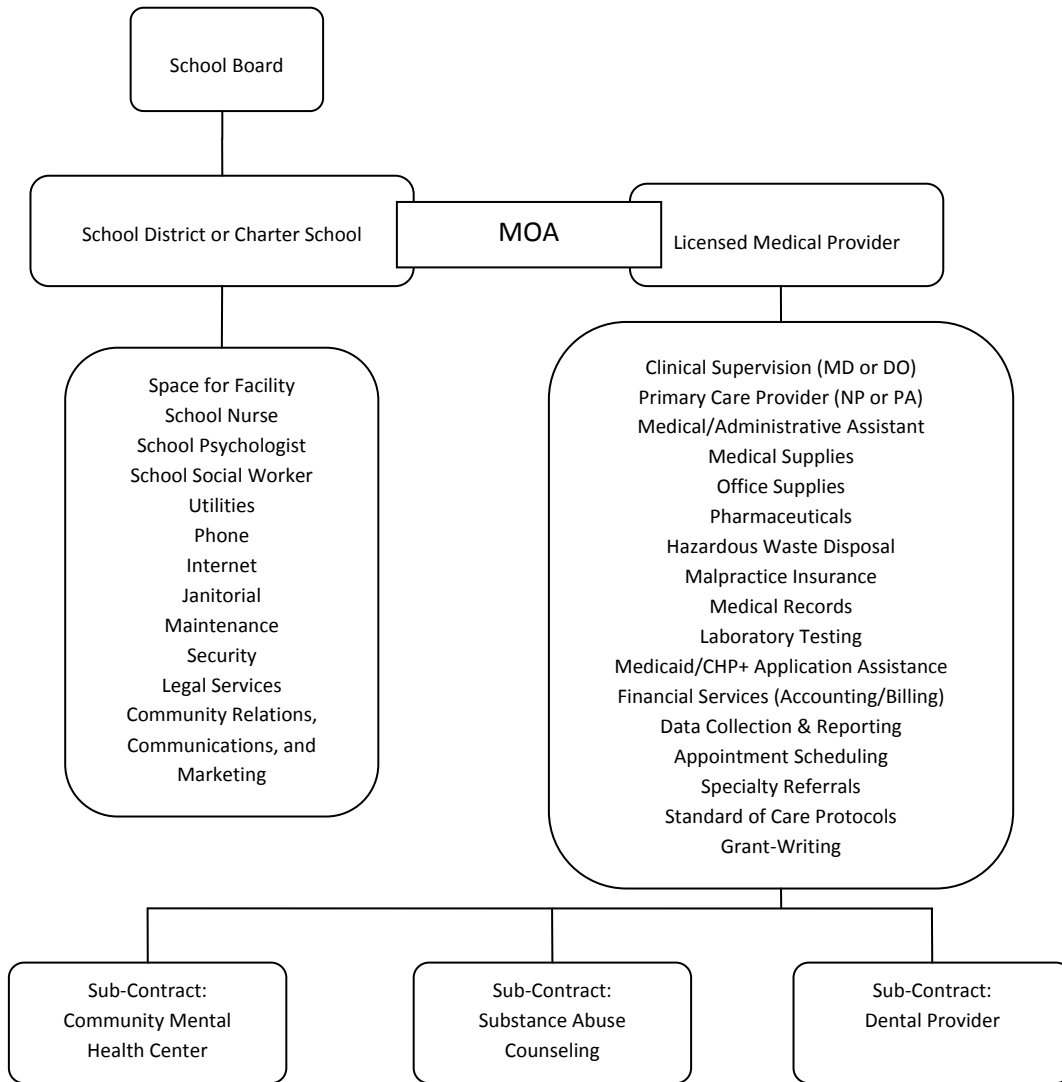
- Schools districts may find it difficult to hire their own health staff, especially when the positions are part-time and the school district does not have similar position descriptions. A licensed medical provider is often able to provide full-time employment, filling the remaining hours of a clinician at other sites. Further, licensed medical providers are equipped to assess a potential practitioner's medical qualifications and provide oversight for medical staff.

- School Districts may not have experience with medical billing, which is complex and requires special expertise.
- School administrators must focus on adhering to their own education-related regulations and may not have the time to learn about state and federal health regulations governing lab tests, patient confidentiality, pharmacy licensures, etc.

Sub-Contractors/Partners in Delivering Care

In addition to the services provided by the school district and licensed medical provider, the SBHC may decide to partner with other organizations to provide certain services or programs. For example, the sponsoring agency may decide to contract with a local mental health organization to provide mental health and substance abuse services rather than hire these providers directly. An existing local behavioral health agency has existing infrastructure (including supervision, psychiatric consultation, access to hospital and rehabilitation beds) to provide access to a range of services. Lines of authority, roles, responsibilities, record sharing, and plans for formal communication between providers need to be clearly detailed in these contracts with other agencies.

Sample Management Structure for SBHC Operation



Staffing Requirements

Typical Staffing

When deciding on an SBHC's staffing configuration and the number of administrative and provider hours, planners should take into consideration the size of the host school and the total target population of students in feeder schools with access to the SBHC (if any).

The Health Resources and Services Administration (HRSA) found that demand for primary care services is a function of age, gender, and geographic location (urban versus rural). In an analysis done in 2003, HRSA lists the average outpatient utilization for each age category by gender and geographic location.³¹ A number of other studies have been done to identify the number of primary care providers needed for a given population based on practice type (fee-for-service versus health maintenance organization), patient mix, and insurance status. These studies are often considered by health entities when determining the size of patient panels and clinic staffing needs.³²

Clinical providers of primary physical and mental health care need to be licensed and/or supervised in accordance with discipline-specific requirements published by the Colorado Department of Regulatory Agencies. Generally, a nurse practitioner or physician assistant (PA) handles primary medical care, and licensed therapists provide behavioral health services. Ideally, SBHC staff members should reflect the ethnic diversity of the community, and at least one staff member should speak the predominant language of the target population.

Level of Service

Below is a chart with staffing hours based on level of service as defined in the *Quality Standards for Colorado School-Based Health Centers*.³³ See Chapter 6 of this manual for salary ranges for these positions.

Level of Service	NP/PA/MD	Mental Health Provider	Support Staff (Medical Assistant)	Physician Medical Director
Level 1	≥15 hrs/week	≥10 hrs/week	≥15 hrs/week	As needed
Level 2	≥20 hrs/week	≥10 hrs/week	≥20 hrs/week	As needed
Level 3	≥30 hrs/week	≥20 hrs/week	≥30 hrs/week	As needed

Job Descriptions

SBHC Coordinator

The coordinator of an SBHC is the lead administrator. This person is responsible for overseeing operational procedures, including preparation of the annual budget, purchasing, supervision of staff, grant writing, and continuous quality improvement. The coordinator is also responsible for maintaining a good relationship with the school and community and advocating for the SBHC. This role of community and school liaison includes communication and coordination of services with the sponsoring agency, managing the Community Advisory Committee, ensuring that SBHC services are delivered in culturally appropriate ways, and communicating with school administration, faculty, and staff. Duties may also include periodically conducting a needs assessment, coordinating health promotion activities, organizing health fairs and risk reduction activities such as tobacco cessation, suicide awareness, physical activity, and nutrition.

Physician Medical Director

The medical director is a physician who may or may not work at the SBHC but who provides clinical oversight to the SBHC and medical consultation to the mid-level provider.

Primary Care Provider - Nurse Practitioner/Physician Assistant/Physician

The licensed primary care provider provides a full range of primary and preventive medical services for patients at the SBHC. The scope of services provided must be congruent with her/his training and licensure. The primary care provider may also be involved with school-wide or classroom-based health promotion activities.

Behavioral Health Provider

Behavioral health providers in SBHCs help students who are experiencing stress, depression, substance abuse issues, family trouble, or other behavioral health problems. Specific services include: primary prevention; crisis intervention; individual and family assessment, treatment and referral; and group counseling. The behavioral health provider is typically a licensed clinical social worker or licensed professional counselor qualified to provide psychotherapy.

Support Staff Position

The title and duties of this position vary from SBHC to SBHC. This position supports SBHC operation and the providers. Most commonly the position title is receptionist, health technician, or billing clerk. This position performs such functions as answering phones, making appointments, following up on non-respondents (no-

shows), taking inventory, ordering supplies, recording health information, and entering data into the computer. This individual might also process “patient encounter forms” to generate insurance claims and generate utilization and outcome reports for the sponsoring and state agencies.

If this position is filled with a certified medical assistant, he/she may also assist the primary care provider by performing health screenings, taking vital signs, and providing first aid to patients with minor injuries. It is important that the person who fills this position relates well to children and adolescents and has an understanding of the local community, as he or she will serve as the day-to-day liaison with parents and school staff and will be the first person the student encounters at the SBHC.

Additional Staffing Options

Depending on the SBHC’s resources, it may be able to hire the following types of additional staff members, often on a part-time or contract basis:

- Outreach and enrollment technician to assist families with the Medicaid application
- Health educator for student, school, and community education and outreach
- Psychiatrist or psychologist
- Addiction counselor
- Dietician to provide clinical assessment, education, and counseling for students and families
- Dental hygienist to provide oral health education, screenings, and prophylaxis (i.e. fluoride and sealants)
- Case manager to link students to school, community, and social services agencies that support their academic, health, and social needs
- Staff to provide and/or support youth development services such as mentoring, youth advocacy training, peer education, and youth conferences

School Health Personnel

School Nurses

School nurses are employed or contracted by the school district, not the health center. They are vitally important to comprehensive health care for students, and their partnership is highly valued by health center staff. Their work is defined in part by federal statute and state regulations and includes conducting vision, hearing, and other screenings. They provide counseling regarding health-related matters and make referrals as needed. School nurses also conduct follow-up care and monitor students with chronic conditions and special needs, including staff training and delegation. They are also responsible for the related services provided in the Individualized Education Program (IEP) for students with disabilities.

In addition, school nurses administer medications and often track immunization records. Unlike SBHC practitioners, school nurses do not have prescriptive authority. They do not provide primary care but can bill Medicaid under the Medicaid Extended School Health (MESH) program for the services they provide at school. The school nurse/SBHC partnership focuses on increasing compliance with treatment plans, facilitating access to care, monitoring outcomes of care, assessing care needs, and providing case management. In some cases, school nurses work in collaboration with the SBHC. Schools may choose to have the school nurse’s office within the SBHC facility to enhance collaboration for comprehensive care of the students.

In 2001, the National Association of School Nurses, the National Assembly on School-Based Health Care, and the American School Health Association, School Nurse Section issued a joint statement on the school nurse/SBHC partnership (see Appendix E).

Counselors/Psychologists/Social Workers

Like school nurses, counselors, psychologists, and social workers are employed or contracted by the school district. They too work in partnership with SBHC staff. The school counselor at the high school level, among many duties, provides academic skills support and planning as well as career counseling. The school psychologist assesses learning disorders and is also responsible for the documentation of IEPs. The school social worker duties vary from school to school. They may address student welfare, family, and discipline issues. Because of the contact with students and parents, the school counselors, psychologists, and social workers are often the first to become aware of behavioral health problems and serve as an important source of referrals to the SBHC.

Communication between SBHC Staff and School Personnel

SBHC staff work in partnership with school personnel, including the school nurses, counselors, school psychologists, school social workers, classroom teachers, coaches, principals, and physical, speech and occupational therapists, to provide a continuum of care for students. SBHC staff do not replace any school personnel, but rather, they complement services already being provided by placing additional resources in the schools. SBHC staff function as an integral component of a school's comprehensive health program. It is vital that the SBHC and school staff communicate regularly to optimize services.

There are also two federal laws that impact the sharing of confidential health information and education records, the Health Insurance Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA). SBHCs are subject to HIPAA regulations while school personnel are subject to FERPA (see Chapter 5 and Appendix H).

Chapter Five



*Olathe Elementary SBHC, courtesy of
Montrose County School District*

Business Plan: Operations

Chapter 5: Business Plan - Operations

The operations plan describes how the SBHC will be run and includes the physical setup. Many SBHC planners find it helpful to visit an operational SBHC in the area to tour the facility and observe the operation of the center. Operational aspects of an SBHC business plan include: location, floor plan; furniture and equipment; medical record keeping, third-party billing systems, and other information technology; hours of operation; patient confidentiality, consent and enrollment; service delivery, including laboratory and pharmaceutical services; and standards of care. The business plan financial pro forma, which includes the projected income statement, will be discussed in Chapter 6.

Location and Facilities

Location of the SBHC

SBHCs can be located either in the school building or in a separate building on the school campus. By Colorado law, an SBHC is “a clinic established and operated within a public school building, including charter schools and state sanctioned GED programs associated with a school district, or on public school property.”³⁴ The SBHC occupies dedicated space used exclusively for the provision of SBHC services.

In the School Building

The SBHC should be located where it will be visible and easy to find by students and parents. The ideal arrangement is co-location with the school nurse, school psychologist, and other student support services. An entry door that provides direct access to the space from outside the school building allows the health center to be open in summer months and other times when the remainder of the school is closed.

In a Separate Building on Campus

When schools do not have space available for an SBHC, an option is to place a modular building on school grounds. There are companies that design, construct, and install modular clinic space. However, water, electricity, and sewer hookups must be available.

SBHC Floor Plan

The physical space must be adequate to accommodate staff, to afford client verbal and physical privacy, and to allow for ease in performing necessary clerical, laboratory, and clinical activities.

At a minimum the SBHC should include a waiting/reception room, one or more exam rooms with a sink, a counseling room preferably with space large enough for group counseling, bathroom, office/clerical area, secure medication storage area, designated lab space, secure medical records storage area, private telephone and fax lines, and internet access/data connection. The Colorado Department of Public Health and Environment (CDPHE) has detailed the facility requirements for SBHCs receiving state funding in their *Quality Standards for Colorado School-Based Health Centers*.³⁵ Sample floor plans can be found in Appendix I.

Furniture and Equipment

SBHCs must have the necessary furniture and office and medical equipment to provide services and to operate efficiently. Medical equipment, such as scales and laboratory equipment, must be maintained and calibrated regularly as recommended by the manufacturer (see Chapter 6 for a listing of medical and office equipment typically needed to operate an SBHC).

Medical Record Keeping and Information Technology

SBHCs must maintain a medical record for each student seen in the SBHC. This is essential for quality care. The service data is used for billing purposes. The medical record includes the patient's medical history and all services provided or ordered, including results of laboratory tests and imaging exams. There are many ethical and legal issues concerning the medical record, including third-party access and the appropriate handling, storage, and disposal of these records.

The medical record may be a paper chart. If so, there must be systems in place to assure that referrals, external lab tests, and imaging exams are followed up in a timely manner. There also need to be prompts or reminders for the provider to perform indicated preventive services and administer needed vaccines.

More and more, however, SBHCs across the country have begun to implement electronic medical/health records. These systems include practice management tools, which allow users to capture patient demographics, schedule appointments, maintain lists of insurance payers, perform billing tasks, and generate reports. They provide a platform for health information collection and information exchange as well as coordinated scheduling and billing systems.

Third-Party Billing

SBHCs should maximize revenue for services provided to insured patients by billing third-party payers. This requires obtaining a Medicaid and Child Health Plan *Plus* provider number and billing for services provided to enrollees. SBHCs should also seek reimbursement from commercial insurance companies and establish contracts with commercial payers when necessary. Federal Medicaid policy requires providers who bill Medicaid to also bill other responsible third parties. To do this, SBHCs must have a process in place for ascertaining student insurance information. Commonly this information is requested on the parental consent form with an explanation to parents of SBHC billing practices.

Hours of Operation

Each SBHC operates differently, based on the needs of the student population it serves. In general, this means that a full-time SBHC may operate during school hours and also provide access for a period of time before and/or after school. Some SBHCs are also open during the summer months. It is preferable that part-time centers are open each school day for a minimum of two hours in order to provide access to acute care. Parents and students should be informed of arrangements for referral and emergency care when the health center is closed, through signage, printed materials, and the telephone answering machine.

Patient Confidentiality, Consent, and Enrollment

SBHCs require the parent or legal guardian to sign a consent form before their minor child may receive services in the SBHC. Once signed, the consent form becomes part of the child's medical record. Because SBHCs take the approach that the clinician, parents, and children should work together to resolve health problems, the staff promote strong family communication.

Colorado Minor Consent Laws

SBHCs should be familiar with state laws regarding the ability of minors to consent to various types of treatment. Minors are youth less than 18 years of age. Although no minimum age is specified in these laws, minors under the age of 12 are typically considered unable to give informed consent.

Sexually Transmitted Infection Services: C.R.S. 25-4-402 states "any physician, upon consultation by a minor as a patient and with the consent of the minor patient, may make a diagnostic examination for sexually

transmitted infection and may prescribe for and treat the minor patient for sexually transmitted infection without the consent of or notification to the parent or guardian of the minor patient or to any other person having custody of or parental responsibilities with respect to the minor patient. In any such case, the physician shall not be civilly or criminally liable for making the diagnostic examination or rendering the treatment, but the immunity from liability shall not apply to any negligent acts or omissions of the physician.”

HIV Testing: C.R.S. 25-4-1405 states “any local health department, state institution or facility, medical practitioner, or public or private hospital or clinic may examine and provide treatment for HIV infection for any minor if such physician or facility is qualified to provide such examination and treatment. The consent of the parent or guardian of such minor shall not be a prerequisite to such examination and treatment. The physician in charge or other appropriate authority of the facility or the licensed physician concerned shall prescribe an appropriate course of treatment for such minor. The fact of consultation, examination, and treatment of such a minor under the provisions of this section shall be absolutely confidential and shall not be divulged by the facility or physician to any person other than the minor except for purposes of a report required under sections 25-4-1402 and 25-4-1403 and subsection (8) of this section and a report containing the name and medical information of the minor made to the appropriate authorities if required by the "Child Protection Act of 1975", part 3 of article 3 of title 19, C.R.S. If the minor is less than sixteen years of age or not emancipated, the minor's parents or legal guardian may be informed by the facility or physician of the consultation, examination, and treatment. The physician or other health care provider shall counsel the minor on the importance of bringing his parents or guardian into the minor's confidence about the consultation, examination, or treatment.”

Substance Abuse Treatment: C.R.S. 13-22-102 states “Notwithstanding any other provision of law, any physician licensed to practice in this state, upon consultation by a minor as a patient, with the consent of such minor patient, may examine, prescribe for, and treat such minor patient for addiction to or use of drugs without the consent of or notification to the parent, parents, or legal guardian of such minor patient, or to any other person having custody or decision-making responsibility with respect to the medical care of such minor patient. In any such case the physician or any person acting pursuant to the minor’s direction shall incur no civil or criminal liability by reason of having made such examination or prescription or having rendered such treatment, but this immunity shall not apply to any negligent acts or omissions by the physician or any persons acting pursuant to the physician’s direction.”

Contraceptive Services: C.R.S. 13-22-105 states “except as otherwise provided in part 1 of article 6 of title 18, C.R.S., birth control procedures, supplies, and information may be furnished by physicians licensed under article 36 of title 12, C.R.S., to any minor who is pregnant, or a parent, or married, or who has the consent of his parent or legal guardian, or who has been referred for such services by another physician, a clergyman, a family planning clinic, a school or institution of higher education, or any agency or instrumentality of this state or any subdivision thereof, or who requests and is in need of birth control procedures, supplies or information.”

Prenatal Care: C.R.S. 13-22-103.5 states “notwithstanding any other provision of law, a pregnant minor may authorize prenatal, delivery, and post-delivery medical care for herself related to the intended live birth of a child.”

Mental Health: C.R.S. 27-10-103 states “notwithstanding any other provision of law, a minor who is fifteen years of age or older, whether with or without the consent of a parent or legal guardian, may consent to receive mental health services to be rendered by a facility or a professional person. Such consent shall not be subject to disaffirmance because of minority. The professional person rendering mental health services to a minor may, with or without the consent of the minor, advise the parent or legal guardian of the minor of the services given or needed.”

Federal Laws

There are also two federal laws that impact the sharing of confidential health information and education records. A paper summarizing these laws and their application to SBHCs is available on the Colorado Association for School-Based Health Care (CASBHC) website at <http://www.casbhc.org/publications/Impact%20of%20HIPAA%20and%20FERPA%20on%20the%20SBHCs%2011-19-09%20%20FINAL.pdf> (see Appendix H)

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law enacted in 1996 to address the problem of health insurance confidentiality in the era of electronic information. Under HIPAA, individually identifiable health information is protected and specific authorization is required for transfer of that information. HIPAA allows health care providers to share health information, without written release, with other health care providers (or other covered entity) for purposes of diagnosis, treatment, or payment. In other cases, authorization must be obtained from the patient (if able to consent) or the parent using a HIPAA compliant release of information form. In addition there is a “minimum necessary disclosure” limitation, requiring covered entities to limit the amount of information released to only that information absolutely necessary for the job at hand—i.e., billing or patient care.

SBHCs are subject to HIPAA regulations. HIPAA regulations are detailed and carry both financial as well as criminal penalties for non-compliance. For more information on HIPAA, visit: www.hhs.gov/ocr/hipaa.

FERPA

The Family Educational Rights and Privacy Act (FERPA) is a federal law that requires schools receiving federal funding to hold as confidential the information in a student’s education records, making it available only to parents or students over the age of 18 years or to those within the school who have a “need to know” in order to provide adequate education. FERPA is administered and enforced by the U.S. Department of Education’s Office for Civil Rights. School districts have been operating under FERPA for many years and all school districts should have standards in place to comply with the requirements of this law. For more information on FERPA visit <http://www2.ed.gov/policy/gen/guid/fpco/ferpa/index.html>.

Service Delivery

Scope of Services

SBHCs provide a full range of services, targeted to the health needs of children and adolescents as outlined in the first chapter of this manual. The comprehensive SBHC provides primary and preventive physical and behavioral health services and health education, as well as basic laboratory services and prescriptions. When resources are available, SBHCs also provide preventive dental care, such as hygiene education, screening, and sealants. SBHCs refer students to needed services not available at the SBHC and provide appropriate follow-up. Services must be available to all students, regardless of their ability to pay.

The *Quality Standards for Colorado School-Based Health Centers*³⁶ lists the scope of services that are required by CDPHE to be provided on-site or through direct referral in order to obtain state funding. Optional services are also listed. SBHCs are a community-driven initiative, and local communities decide what optional services their SBHCs will offer.

Integration of Services

“Integrated school health services” means comprehensive, coordinated, continuous, and age-appropriate physical, behavioral, and oral health services, provided by a multidisciplinary team to students while they are in school, using a process of care that includes direct delivery, co-management, and referral.

Service integration refers to the process of coordinating the delivery of all services provided to the patient. This includes the coordination of medical, dental, mental health, substance abuse, and community-based services. This is important to avoid overlap, unnecessary testing, contradictory treatment, and other inefficiencies. This assures that all providers are working together to meet the physical and emotional needs of the patient.

SBHCs are staffed by a multidisciplinary team and are well positioned to provide integrated services. SBHC staff work closely with each other, the school's nurses, psychologists, and counselors, as well as the student's primary care provider to coordinate services. Formal policies and procedures should be developed that outline communication methods for sharing information, including regular interdisciplinary team meetings and case conferencing, to assure integrated services.

Some SBHCs serve as the primary care provider or "medical home" for students. Colorado state law (C.R.S. 25.5-1-103) defines medical home as "an appropriately qualified medical specialty, developmental, therapeutic, or mental health care practice that verifiably ensures continuous, accessible, and comprehensive access to and coordination of community-based medical care, mental health care, oral health care and related services for a child." In Colorado, to be a medical home, certain criteria must be met, including the provision of after hours and weekend access to medical consultation. SBHCs that meet the criteria of a medical home may be eligible to receive supplemental payments for well-child check-ups provided to students enrolled in Medicaid and Child Health Plan *Plus*. Additional information on medical homes can be found at <http://www.coloradomedicalhome.com/>.

Laboratory Services

Clinical Laboratory Improvement Amendments (CLIA) are a set of federal requirements that ensure quality laboratory testing. To perform laboratory tests in an SBHC, some form of CLIA certificate is needed. SBHCs most commonly obtain a certificate of waiver, which allows sites to perform only tests that have been designated as CLIA-waived. CLIA-waived tests include:

- Blood glucose
- Hemoglobin/hematocrit
- Urinalysis
- Urine pregnancy test
- Rapid strep screen
- Mononucleosis test

To perform certain microscopy procedures, such as wet mounts and potassium hydroxide (KOH) preparations, a CLIA certificate for provider-performed microscopy procedures (PPMP) is necessary. This certificate allows qualified providers to perform both waived testing and certain microscopic examinations during patients' visits.

To apply for either certificate, the SBHC must complete the CLIA application (Form CM-116). Additional information on CLIA-waived testing and certificates for PPMP, including a list of waived tests and PPM procedures, can be found at <http://www.cms.hhs.gov/clia/>.

Colorado CLIA Contact Person:

Certification Program Manager, Laboratory Service Division
Colorado Department of Public Health and Environment
8100 Lowry Boulevard
Denver, CO 80230-6928
Tel: (303) 692-3681 Fax: (303) 344-9965

For other lab tests that cannot be performed on-site, arrangements are made to have collected specimens sent to a qualified lab for analysis. The SBHC's licensed medical provider may already have a contract in place with a lab that can be extended to the SBHC (see Chapter 4). The following are lab tests that are typically sent out for processing:

- Throat cultures
- Urine cultures
- Pap smears
- Chlamydia and gonorrhea tests
- Thyroid tests
- Lipid profiles

CDPHE performs Chlamydia, gonorrhea, and other sexually transmitted infection lab tests at an affordable price. They have a courier service that picks up at designated sites. A complete listing of lab tests run by CDPHE with prices can be found at <http://www.cdphe.state.co.us/lr/services/>

To get additional information about CDPHE lab services, contact:

Supervisor, Public Health Microbiology and Serology Laboratory Services Division
Colorado Department of Public Health and Environment
8100 Lowry Boulevard
Denver, CO 80230-6928
Tel: (303) 692-3484

Pharmacy Services

Written Prescriptions

SBHC primary care providers (nurse practitioners and physician assistants) have the ability to write prescriptions that can be filled at local pharmacies.

Administration of Medications

The administration of medications is defined in Colorado law as the “direct application of a drug to the body of a patient by injection, inhalation, ingestion, or any other method.”³⁷ SBHCs often administer over-the-counter and prescription medications to students in the SBHC. For example, Tylenol may be administered to a student for a headache, or a nebulizer treatment might be administered to a student with asthma. Vaccinations are also administered on-site (see below).

Dispensing of Medications

In Colorado, dispense “means to interpret, evaluate, and implement a prescription drug order or chart order, including the preparation of a drug or device for a patient or patient’s agent in a suitable container appropriately labeled for subsequent administration to or use by a patient.”³⁸ In order to dispense prescription medications from a clinic, it is necessary to first submit an application to the Colorado Department of Regulatory Agencies (DORA) and be established as an “other outlet pharmacy.”

The most important part of establishing an “other outlet pharmacy” is to identify a licensed pharmacist to provide consultation and assist with the process. The pharmacist becomes largely responsible for the application to the Colorado Board of Pharmacy and overall operation of the SBHC pharmacy. The consultant pharmacist will be responsible for requesting an application, writing protocols, conducting annual compliance reviews and quarterly inspections, as well as documenting all actions carried out.

For further information regarding the “other outlet pharmacy” application process, visit <http://www.dora.state.co.us/Pharmacy/bus/otheroutlet.htm>

Vaccinations and Vaccines for Children Program

In general, SBHCs administer vaccinations on-site. SBHCs are encouraged to become Vaccines for Children (VFC) providers. The VFC Program is a federally-funded program administered in each state by the state health department. Through the VFC program, government-purchased vaccine is available at no charge to enrolled health care providers for eligible children.

Children through 18 years of age who meet at least one of the following criteria are eligible to receive VFC vaccines: Medicaid-enrolled, uninsured, or American Indian or Alaskan Native. Underinsured children through 18 years of age are eligible to receive VFC vaccines at local health departments, federally-qualified health centers or rural health clinics. “Underinsured children are defined as those children who have health insurance but coverage does not include vaccines. Children whose health insurance covers only select vaccines or caps the vaccine cost at a certain limit are categorized as underinsured.”³⁹

It is advantageous for SBHCs to become VFC providers because it reduces the cost of purchasing vaccine, allows the SBHC to provide all vaccines recommended by the Advisory Committee on Immunization Practice (ACIP), and saves patients the expense (and inconvenience) of getting school-mandated vaccines elsewhere.

To become a VFC provider, contact Colorado’s Immunization Program Director:

Director, Immunization Program
Colorado Department of Public Health and Environment
DCEED-IMM-A4
4300 Cherry Creek Drive South
Denver, CO 80246-1530
Tel: (303) 692-2363
Fax: (303) 691-6118

Medicaid/Child Health Plan Plus Application Assistance

SBHCs generally assist families of uninsured children and adolescents in applying for Medicaid and Child Health Plan *Plus*. Child Health Plan *Plus* is low-cost health insurance for Colorado’s uninsured children whose families earn too much to qualify for Medicaid and yet cannot afford private health insurance.

Often families who have children eligible for Medicaid or Child Health Plan *Plus*, do not know they qualify or they do not know how to sign up. SBHCs should consider having at least one staff member trained to help people apply for Medicaid and Child Health Plan *Plus*. To learn more about Medicaid and Child Health Plan *Plus* application assistance, contact the local Department of Human Services. Contact information for each Colorado county can be found at <http://www.cdhs.state.co.us/servicebycounty.htm>

In 2009, CASBHC was the recipient of a two-year federal Children’s Health Insurance Program Reauthorization Act (CHIPRA) Outreach and Enrollment grant from the U.S. Department of Health and Human Services. The grant supports efforts to find and enroll children who are uninsured but eligible for either Medicaid or Child Health Plan *Plus*. There are five Colorado SBHC sponsors participating in the grant. It is hoped that the outreach model utilized will eventually be replicated in other SBHCs. The Colorado Health Foundation (TCHF) is interested in the replication of CASBHC’s model and would consider supporting similar projects in other school districts throughout the state.

Standards of Care

Policies and Procedures Manual – Administrative and Clinical

Every SBHC is different, but some elements – such as maintenance of basic equipment and credentialing medical providers – are similar across the board. The following table lists content areas for which policies and

procedures are needed when operating an SBHC. Some have already been discussed. Most licensed medical providers will already have policies and procedures in place that can be adopted for SBHC use (see Chapter 4). The National Assembly on School-Based Health Care (NASBHC) has a wealth of resources to assist in this area. Visit their website at <http://www.nasbhc.org>.

Suggested Content Areas for Policies & Procedures Manual

Administrative Content Areas:

FACILITY & SAFETY ISSUES

- Facility meets OSHA requirements (<http://www.osha.gov/>)
- Ongoing compliance with safety and fire codes and regulations for schools (lights, exit signs, ventilation)
- Facility compliant with *Quality Standards for Colorado School-Based Health Centers*⁴⁰ if state funded
- Dedicated and private telephone, fax, email accounts
- System for reporting incidents and follow-up
- Privacy policies

HIRING & PERSONNEL

- Discrimination free hiring practices (<http://www.eeoc.gov/>)
- Job descriptions for SBHC personnel
- SBHC providers are licensed and/or supervised in accordance with discipline-specific requirements published by Colorado Dept of Regulatory Agencies, credentialing and re-credentialing clinical providers (<http://www.dora.state.co.us/> and <http://www.ncqa.org/tabid/378/Default.aspx>)
- Time sheets, check disbursement
- Maintaining personnel files and performance evaluation
- Staff orientation, on the job training, mandated reporting requirements, handling suicidal/homicidal ideation, infection control, CPR/Basic Life Support, assisting with Medicaid/Child Health Plan *Plus* applications, etc.
- Continuing medical education and professional development per discipline-specific licensing requirements

SUPPLIES & EQUIPMENT

- Maintaining and ordering supplies/inventory, disposing of outdated materials
- Maintenance, sterilization, calibration of equipment
- Regular inspection of emergency medical equipment
- Medication refrigerator/freezer temperature logs

ENROLLMENT & CONSENT

- Student outreach efforts to encourage use of SBHC
- Enrollment practices; collection of demographic, parent/guardian contact, third-party billing and primary care provider information; obtaining parental consent, consent as part of medical record
- Services provided regardless of race, national origin, religion, immigration status, sexual orientation, handicap, gender, insurance status, or ability to pay

PARENTAL INVOLVEMENT

- Family participation in planning/implementing care
- Client/family right to refuse services
- Addressing complaints

HOURS OF OPERATION & SCHEDULING

- Hours of operation –posted and available on phone message
- Clinical appointment schedule that is responsive to emergency and unscheduled appointments
- No show and/or cancellation system that documents in medical chart when client does not keep appointment

TRANSPORTATION

- Transportation arrangement of students from other schools to SBHC
- Transportation of students by SBHC personnel

DATA

- Electronic data collection, management, storage, and backup

FISCAL

- Collection of co-payments and deductibles
- Billing policies
- Handling confidential visits (Explanation of Benefit will be sent to the parents if confidential services billed except for Medicaid)
- Fiscal record keeping

COMMUNITY ADVISORY COMMITTEE

- Community Advisory Committee (CAC) established
- Roles and responsibilities
- Meetings/minutes, etc

Clinical Content Areas:**INFECTION CONTROL & HANDLING MEDICAL WASTE**

- Infection control (<http://www.osha.gov/>)
- Medical waste handling and labeling
- Disposable needle container present and labeled

CONFIDENTIALITY AND HIPAA

- Release of client information and access to medical records in accordance with HIPAA regulations with measures to ensure confidentiality, privacy, and security of personal health information established (<http://www.hhs.gov/ocr/privacy/>)
- Exchange of information between SBHC provider staff and school health staff in accordance with HIPAA and FERPA
- Restrict access to computer files/logs, schedules/appointment books, medical records, data, etc.

SERVICES

- Evidence-based or best practice clinical guidelines followed for primary and mental health to include acute, chronic, and preventive health care services
- Delineation of roles and responsibilities of the SBHC and school nurses and mental health professionals
- Arrangements for 24 hour per day, 7 day a week coverage
- Services for non-enrolled students
- Emergency kit available/plans for handling medical emergencies during center hours
- SBHC role in school emergency or disaster, role in crisis response plan and on crisis response team
- Policies/procedures for handling child abuse and neglect, handling psychiatric emergencies, including suicidal and homicidal ideation
- Interdisciplinary team conferencing
- Care coordination with school nurses, school mental health professionals, and primary care providers
- Medicaid and Child Health Plan *Plus* outreach and application assistance to families
- Referral system for services not available on-site

PHARMACEUTICALS

- Safe and secure storage of medications

- Compliance with Colorado pharmacy licensing and health care provider licensing regulations (<http://www.dora.state.co.us/Pharmacy/bus/otheroutlet.htm>)
- Checking for outdated medications monthly and disposing of expired drugs

LABORATORY

- Compliance with Clinical Laboratory Improvement Amendments for all lab tests performed
- Arrangements for labs sent out for processing, including follow-up

REFERRALS

- Offsite referral and follow-up
- Referral for confidential services
- Internal referrals
- Sharing information and care coordination with primary care provider/ medical home

MEDICAL RECORDS

- Standardized chart format
- Charting standards regarding who can document in the chart
- Maintain and store records in manner that restricts access in accordance with HIPAA

QUALITY IMPROVEMENT & EVALUATION

- Continuous quality improvement plan developed and maintained that monitors and evaluates services
- Satisfaction surveys performed routinely, gathering feedback of students, parents, school staff
- Periodic chart auditing

Clinic Forms

In addition to policies and procedures, SBHCs will need to develop a variety of forms for clinic use, including a consent form, referral form, encounter form, and various chart forms if an electronic medical record (EMR) is not utilized. CASBHC maintains a library of document templates and sample forms that can be accessed by calling CASBHC at (303) 399-6380. Examples of consent forms can be found on CASBHC's website: <http://www.casbhc.org/>.

Cultural Competence Issues

The United States health care system is caring for an increasingly diverse nation. There is concern that some health care providers offer services that do not take this diversity into consideration.⁴¹ It is essential, therefore, to consider the impact of cultural issues on students and their parents.

Culture impacts people's views about general health care, reproductive health care, and consent issues. Pachter illustrates cultural competence through his description of a culturally sensitive health care system:

A culturally sensitive health care system is one that is not only accessible, but also respects the beliefs, attitudes, and cultural lifestyles of its patients. It is a system that is flexible – one that acknowledges that health and illness are in large part molded by variables such as ethnic values, cultural orientation, religious beliefs, and linguistic considerations. It is a system that acknowledges that in addition to the physiological aspects of disease, the culturally constructed meaning of illness is a valid concern of clinical care. And finally, it is a system that is sensitive to intra-group variations in beliefs and behaviors, and avoids labeling and stereotyping.⁴²

According to the Kaiser Family Foundation, it is also important to take into account other population groups, such as those defined by social class, religious affiliation, and sexual orientation, because they may also have unique perspectives that should be incorporated into the definition.⁴³

The Office of Minority Health defines cultural competence as follows:

Cultural and linguistic competence is a set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors and needs presented by consumers and their communities.⁴⁴

Culture and language have considerable impact on how patients access and respond to health care services.⁴⁵ To ensure equal access to quality health care by diverse populations, SBHCs should:

- Promote and support the attitudes, behaviors, knowledge, and skills necessary for staff to work respectfully and effectively with patients and each other in a culturally diverse work environment.
- Have a comprehensive management strategy to address culturally and linguistically appropriate services, including strategic goals, plans, policies, procedures, and designated staff responsible for implementation.
- Involve the Community Advisory Committee in designing culturally competent service delivery.
- Develop and implement a strategy to recruit, retain, and promote qualified, diverse, and culturally competent administrative, clinical, and support staff that are trained and qualified to address the needs of the racial and ethnic communities being served.
- Require and arrange for ongoing education and training for administrative, clinical, and support staff in culturally and linguistically competent service delivery.
- Provide all limited English proficiency (LEP) clients with access to bilingual staff or interpretation services.
- Translate and make available signage, commonly used written patient educational materials, and all SBHC forms.
- Ensure that the clients' primary spoken language and self-identified race/ethnicity are included in the medical record.

Chapter Six



Rachel Noel SBHC, courtesy of Denver School-Based Health Centers

Business Plan: Financial Pro Forma and Sustainability

Chapter 6: Business Plan - Financial Pro Forma & Sustainability

What is a Financial Pro Forma?

Business plans typically include financial projection statements, also called a financial pro forma, which are developed for at least one year and perhaps up to five years of future operations.⁴⁶ These statements are used “to manage and report a business’s financial operation.”⁴⁷ A financial pro forma is developed to answer two questions:

1. What will this project cost for start-up and ongoing operations?
2. Is an SBHC in this school/community sustainable over time?

The pro forma includes the following:

- **Income Projection Statement** is similar to a budget. It is a financial document that estimates the gross income and expenses, and the resulting net gain or loss of the program over a specified period of time.
- **Monthly Cash-Flow Forecast** is a financial projection that demonstrates whether the money coming in will cover the money going out each month.

The financial pro forma is given serious review by funders. This chapter will first address the critical elements of long-term sustainability and then outline things to consider when developing the financial pro forma for a new SBHC program.

Sustainability

Sustainability, in the case of SBHCs, is defined as the ability to maintain operation over time. SBHC sponsors are in the business of providing needed health services to children and adolescents in underserved communities. In general, SBHCs do not generate sufficient revenue from billing for services rendered because a large proportion of the population served is uninsured and low income. In 2008—2009, 46 percent of Colorado SBHC users were uninsured. Therefore, to finance their operations, SBHCs need support from sources other than insurance reimbursement.

SBHCs should consider long-term sustainability when developing a business plan. Four critical elements to long-term sustainability include:

- Diversified funding (multiple sources of revenue)
- Stable and supportive leadership
- Strong community partnerships
- Medicaid and Child Health Plan *Plus* outreach and enrollment

Diversified Funding

The funding mix for each SBHC in Colorado is different, due to the unique resources and needs in each community. Diversity of funding is central to long-term sustainability. Most SBHCs in Colorado are funded with three or more sources and over half are funded with five or more sources of revenue. Sources of revenue include: federal, state, and local government dollars, private grants and donations, insurance billing, and in-kind support. The following is a list of potential funding sources for Colorado SBHCs.

Federal Government Funds

SBHCs that are sponsored by federally qualified health centers (FQHCs) may be eligible to receive support through Section 330 of the Public Health Services Act. In addition, SBHCs that are designated as FQHCs or rural health clinics (RHCs) are eligible to receive enhanced Medicaid reimbursement (see *Insurance Billing* below).

Other special circumstances may qualify an SBHC to receive federal funding for specific services.

- Health Resources and Services Administration (HRSA)– Rural Health – Outreach Grant Program and Network Development Program: <http://www.ruralhealth.hrsa.gov/>
- Substance Abuse & Mental Health Services Administration (SAMHSA): <http://www.samhsa.gov/>
- Office of Juvenile Justice and Delinquency Prevention (OJJDP): <http://ojjdp.ncjrs.gov/grants/safeschool/contents.html>
- U.S. Department of Agriculture - nutrition grants: <http://www.usda.gov/wps/portal/usdahome>

It is anticipated that federal funds will soon be available specifically for SBHCs. The Patient Protection and Affordable Care Act that was signed into law by President Barack Obama on March 23, 2010, includes language authorizing a federal SBHC grant program and an emergency appropriation that would provide \$200 million for SBHCs over four years.

State Government Funds

- **Colorado Department of Public Health and Environment/SBHC Program:** <http://www.cdphe.state.co.us/ps/school/index.html>

The Colorado Department of Public Health and Environment (CDPHE) distributes legislatively appropriated general fund dollars for SBHCs through contracts with local organizations. Most SBHCs in Colorado receive some funding from CDPHE's SBHC Program.

- **Medical Home Initiative:** <http://www.ColoradoMedicalHome.com>

Colorado state law defines medical home as “an appropriately qualified medical specialty, developmental, therapeutic, or mental health care practice that verifiably ensures continuous, accessible, and comprehensive access to and coordination of community-based medical care, mental health care, oral health care and related services for a child.”⁴⁸ The Colorado Department of Health Care Policy and Financing is working to find medical homes for every child on Medicaid and Child Health Plan *Plus*. Primary care practices that participate in Medicaid and Child Health Plan *Plus* and qualify as medical homes are eligible to receive supplemental payments for well-child check-ups.

- **Colorado Indigent Care Program:** <http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1214299805914>

The Colorado Indigent Care Program, which is administered by the Colorado Department of Health Care Policy and Financing, distributes federal and state dollars to medical providers serving the indigent population. SBHCs are reimbursed for part of the cost of services provided to uninsured or underinsured students who are not eligible for Medicaid or Child Health Plan *Plus*.

- **Elementary & Secondary Education Act**

The Elementary and Secondary Education Act (ESEA) is a federal statute that funds elementary and secondary education. While being sensitive to the funding challenges that local school districts face, SBHCs should discuss with their local school district administration the possibility of using these funds to support SBHC services, particularly funding tied to the following titles of the ESEA:

- Title I, Improving Academic Achievement of the Disadvantaged
- Title IV, Part A, Safe & Drug Free Schools
- Title IV, Part B, 21st Century Community Learning Centers
- Title V, Part D, Subpart 14, Mental Health Services

Local Government Funds

- **Medicaid Extended School Health (MESH) Program**

Colorado law allows school districts to contract with the Colorado Department of Health Care Policy and Financing to receive federal matching funds for amounts spent in providing health services through the public schools to students who are receiving Medicaid benefits.⁴⁹ In a few districts, revenues from this source have been used as a source of funding for SBHC services.

- **Temporary Assistance for Needy Families (TANF)**

Temporary Assistance for Needy Families (TANF) is a federal block grant given to states and tribes to support programs that move people of extremely limited means into the work force. States must contribute money to help TANF-eligible families. Counties may also contribute to these funds. SBHCs may be eligible to apply for these funds to support comprehensive reproductive health services offered in SBHCs. SBHCs should contact their local Department of Human Services to learn more about the availability of TANF dollars. Additional information on TANF and SBHCs can be found at: <http://www.casbhc.org/publications/index.asp>. Click on: *TANF Dollars for SBHCs*.

- **Other Local Sources**

Other potential local sources of SBHC funding include city and county governments as well as health districts (supported by voter-approved local taxes). The origin of these funds varies considerably from the Temporary Aid to Needy Families Program to local tax revenues.

Private Grants and Donations

In Colorado, private grants and donations make up over one third of revenue for SBHC operation. Many foundations support the important work of SBHCs in providing services to underserved populations.

- **National Foundations**

- W.K. Kellogg Foundation: <http://www.wkcf.org/>
- The New York Life Foundation: <http://www.newyorklife.com/foundation>
- Prudential Foundation: <http://www.prudential.com/view/page/public/12373>
- The Commonwealth Fund: <http://www.commonwealthfund.org/>
- Robert Wood Johnson Foundation: <http://www.rwjf.org/>

- **State Foundations**

- The Colorado Health Foundation: http://coloradohealth.org/school-based_health_care.aspx
- The Colorado Trust: <http://www.coloradotrust.org/>
- Caring for Colorado Foundation: <http://www.caringforcolorado.org/>
- Rose Community Foundation: <http://www.rcfdenver.org/>
- El Pomar Foundation: <http://www.elpomar.org/>

- **Fundraising**

In addition to writing grant proposals, many SBHCs actively fundraise. Donations from local businesses, corporations, and individuals are solicited. In addition, local health care organizations will often donate durable or reusable medical equipment, such as exam tables and wheelchairs, to SBHCs.

Insurance Billing and Patient Revenues

SBHCs should pursue third-party reimbursement, from both public and private insurance, as a means of continuous funding and sustainability of the SBHC. As mentioned above, SBHCs that are designated as FQHCs or RHCs receive cost-based (enhanced) Medicaid reimbursement. Variances in utilization, payer mix, and

reimbursement rates can all affect the financial health of an SBHC program. It is critical to maximize patient revenue.

In-Kind Support

In-kind support is the donation of goods or services to support the program as opposed to cash. In 2008—2009, 20 percent of SBHC revenue was in the form of in-kind support. In-kind support has value beyond its estimated financial worth. It can be an indicator of the SBHC's value to the community. Therefore, many potential funders take an interest in the amount of in-kind support that an SBHC is able to generate.

The vast majority of SBHCs receive in-kind support from their school district. This includes facility space in the school, telephone and fax, internet service, other utilities, janitorial services, general liability insurance, maintenance of the facilities, and security. School districts may also provide staff to assist with clinic operation.

Community partners are also an important source of in-kind support. Community in-kind support might include the construction/renovation of the facility; SBHC staff; furniture, equipment, pharmaceuticals, and supplies; legal, financial, and billing services; Medicaid application assistance; and lab testing or x-ray exams for uninsured students.

Database Websites

The following websites provide searchable databases of potential funding sources and grant-writing tips. Some of these websites allow users to sign-up to receive email notices of grant alerts.

- School Grants: <http://www.schoolgrants.org/>
- Center for Health and Health Care in Schools: <http://www.healthinschools.org/>
- Foundation Center: <http://foundationcenter.org/>
- Center for Disease Control and Prevention: <http://www.cdc.gov/about/business/funding.htm>
- Foundations Online Directory: <http://wwwFOUNDATIONS.org/>
- Grantwriters.com: <http://www.grantwriters.com/>
- Federal Grants: <http://www.grants.gov/>
- National Assembly on School-Based Health Care: <http://www.nasbhc.org/site/c.jsJPKWPFJrH/b.2564543/apps/s/content.asp?ct=3875935>

Stable and Supportive Leadership

In addition to diverse funding streams, stable and supportive district and licensed medical provider leadership are essential for sustainability. SBHCs that have successfully operated for years have leaders who are strong and vocal advocates of school-based health care. They understand the many benefits of these services and can articulate these advantages to policy-makers, funders, and others within their own organization whose support is critical for ongoing success.

The financial health of the sponsoring agency is also of critical importance in terms of long-term sustainability. The balance sheet best describes the financial condition of an organization. It is a summary of the assets, liabilities, and equity of the sponsoring agency at a given point in time. It is included as an appendix in a business plan to show that the organization has the financial capacity to successfully operate the SBHC and is given strong consideration by funders.

Strong Community Partnerships

Community partnerships are critical to the success and sustainability of SBHCs. With a shared mission to keep students healthy, in school, and ready to learn, community groups contribute generously, allowing SBHCs to

maximize their resources and serve more children. Community support is also essential for advocacy, which will be discussed further in Chapter 9.

Medicaid and Child Health Plan Plus Outreach and Enrollment

The fourth critical element to long-term sustainability is successful Medicaid and Child Health Plan *Plus* outreach and enrollment. Assisting families of eligible students to enroll in Medicaid and Child Health Plan *Plus* must be a key priority and service offered at SBHCs.

Developing the Financial Pro Forma

Integrated Budget

SBHCs should develop an integrated budget as the starting point for completing a financial pro forma. An integrated budget is the basis for a projected income statement. An integrated budget identifies:

- All sources of anticipated income, including both cash and in-kind contributions of all partners in the SBHC
- All anticipated expenses, both fixed and variable
- Projected net gain or loss from operations

To be functional, the integrated budget needs to tie to the sponsoring agency's accounting system, utilizing the same chart of accounts, definitions, and allocation system. When developing an integrated budget also keep in mind whether the funding from each revenue source is flexible, or whether it must be spent for a particular purpose within a particular time frame.

When completed, the integrated 12-month budget illustrates all expenses, and the sources of revenue that will be used to fund each expense. It calculates the total dollars needed to operate the SBHC and projects whether there will be an overall surplus or deficit. It specifically illustrates for each expense category whether there will be enough funds to cover that expense or whether additional funding must be secured. For additional information on integrated budgeting, contact the Colorado Association for School-Based Health Care at (303) 399-6380.

Estimating Insurance Revenues

The following projections regarding utilization, mix of care, and insurance coverage are needed to assist with estimating insurance revenue as part of the financial pro forma.

Utilization

Utilization is the use of the center by the students. As discussed in Chapter 3, utilization of services is affected by a number of factors, including the age, gender, and geographic location (rural versus urban) of the center. The cost of services, (collection of co-payments, deductibles, fees), and the student's access to other providers will also influence utilization.

Nationally, the average student body enrollment rate (students who registered with the SBHC and had a consent form on file) was 64 percent, and the average SBHC utilization rate was 84 percent of enrollees.⁵⁰ National benchmarks for an SBHC target population do not exist, but work by the National Assembly on School-Based Health Care (NASBHC) suggests that there be a minimum of 600 users per SBHC staffed with one primary care provider.⁵¹ In Colorado during the 2008—2009 school year, student users made an average of three visits per year. This is true in other states as well.

The following utilization projections will vary from SBHC to SBHC:

- Number of students with access to the SBHC
- Number of student users
- Number of visits/year

Service Mix, Case Mix, and Average Collection per Visit

“Service mix” refers to the proportions of types of care provided, e.g., medical, mental health, substance abuse, health education, dental. Projections of service mix must be made, because reimbursement for the different types of services varies. Not all types of services are covered. For example, SBHCs may be reimbursed for medical care, but not for health education or mental health visits. Reproductive health services, when delivered confidentially as required by law, are generally not billable because of insurers’ practice of sending Explanations of Benefits to the policyholder, which is often the parent. Decisions must also be made regarding whether or not cash payments made directly by patients at the time of service will be required, encouraged, or not allowed because of security and cash handling requirements of the school district.

“Case mix” refers to the proportions of patients who are uninsured or are covered by public (Medicaid, Child Health Plan *Plus*) or private insurance. Projections are needed regarding insurance coverage of students in order to accurately estimate revenue from billing.

Finally, once service mix and case mix are projected, and average collection per visit can be estimated. SBHC sponsorship can affect reimbursement rates. For example, FQHCs are reimbursed by Medicaid at a higher rate for medical services than non-FQHCs. Once these projections have been made, the income portion on the financial pro forma can be developed.

Determining Start-up Costs and Operating Expenses

Start-up costs include one-time costs for construction or renovation of space for the SBHC facility as well as the cost of furniture and equipment. Equipment needs vary depending on the age of the students served. Operating expenses are those expenses that are recurring such as salaries, office supplies, medical supplies, and hazardous waste disposal. Expenses to consider include:

ONE-TIME CAPITAL EXPENSES
Construction/Renovation of Facility
Architectural blueprints
Permits and inspections
Construction/renovation materials
Labor
Durable Equipment-Medical
TRIAGE AREA
Height/Weight scale
Snellen Eye Chart
EXAM ROOM(s)
Exam table (1/room)
Exam stool (1/room)
Side table (Mayo stand) (1/room)
Light, exam, gooseneck (1/room)
Privacy screen with caster (1/room)
Sharps container (1/room)
Covered trash can (1/room)

ONE-TIME CAPITAL EXPENSES
Blood pressure cuff-wall mount (1/room)
Oto/ophthalmoscope-wall mount (1/room)
Transformer for oto/ophthalmoscope (1/room)
PORTABLE EQUIPMENT
Stethoscope
Reflex hammer
Blood pressure cuff-automated
Audiometer-hand held
Thermoscan
Peak flow meter (1/room)
UV Woods lamp
Nebulizer
Wheelchair
Oxygen canister w/face mask, tubing, cart
Emergency kit that includes Ambu bag, adult & pediatric
Automatic external defibrillator
LABORATORY
HemoCue Glucose or glucometer
HemoCue Hemoglobin
Microscope
Refrigerator & freezer for vaccines
Durable Equipment- Office
Copier/Fax/Printer
Computer w/ internet access and software
Telephones-private & public lines
Furniture-desks, files, chairs, storage cabinets, etc.

ANNUAL OPERATING (RECURRING) EXPENSES	
Medical Supplies	Lab Expenses
Gowns and exam drapes	CLIA -waived or PPMP certificate fee
Gloves	Courier
Tongue blades	Hazardous waste disposal
Ear speculums	Salaries and Related Benefits
Vaginal speculums	Contractual Services
Biohazard bags and labels	Other Professional Services
BMI Wheels/percentile graphs	Legal
Cerumen spoons, ear syringes	Accounting
IV start kits, tubing	Billing and collecting
Canister suction and tubing	Payroll
Fluorescein strips	Marketing
Glass slides & cover slips	Printed material
Normal saline	Advertising
KOH and VIP stain for wet-preps	Promotional items
Urine collection cups	Website maintenance
Urine multistix	
Serum tubes	Pharmacy Expenses
Syringes & needles	Pharmaceuticals
Aptima specimen collection kits	Vaccines

ANNUAL OPERATING (RECURRING) EXPENSES	
Strep A test kits	Oxygen refills
HemCue hemoglobin cuvettes	Pharmacist consultant
HemoCue glucose cuvettes	Other Operating Expenses
Pregnancy test kits	Lease
Scissors	Utilities and maintenance
Bandages, gauze pads, kerlix, tape	Property Insurance
Ace wraps, splints	Telecommunications
Suture removal kits	Malpractice insurance
Office Supplies	Staff development
Pens, paper, stapler, paper clips, etc.	Travel
Calculator	Postage and shipping
Charts, dividers	Depreciation
Rx pads	Dues and subscriptions
Student educational materials	Electronic health record maintenance

Sample Personnel Expenses

Salary Range Guidelines for SBHC Staff			
SBHC Staff	Hourly Salary Range	Annual Salary Range	10-month Salary Range
Manager/Coordinator	\$17 - \$33	\$35,360 - \$68,640	\$29,390 - \$56,970
Mid-Level Provider (NP or PA)	\$30 - \$55	\$62,400 - \$114,400	\$51,790 - \$94,950
Mental Health Professional	\$20 - \$35	\$41,600 - \$72,800	\$34,530 - \$60,420
Clerk/Receptionist	\$8 - \$15	\$16,640 - \$31,200	\$13,810 - \$25,900

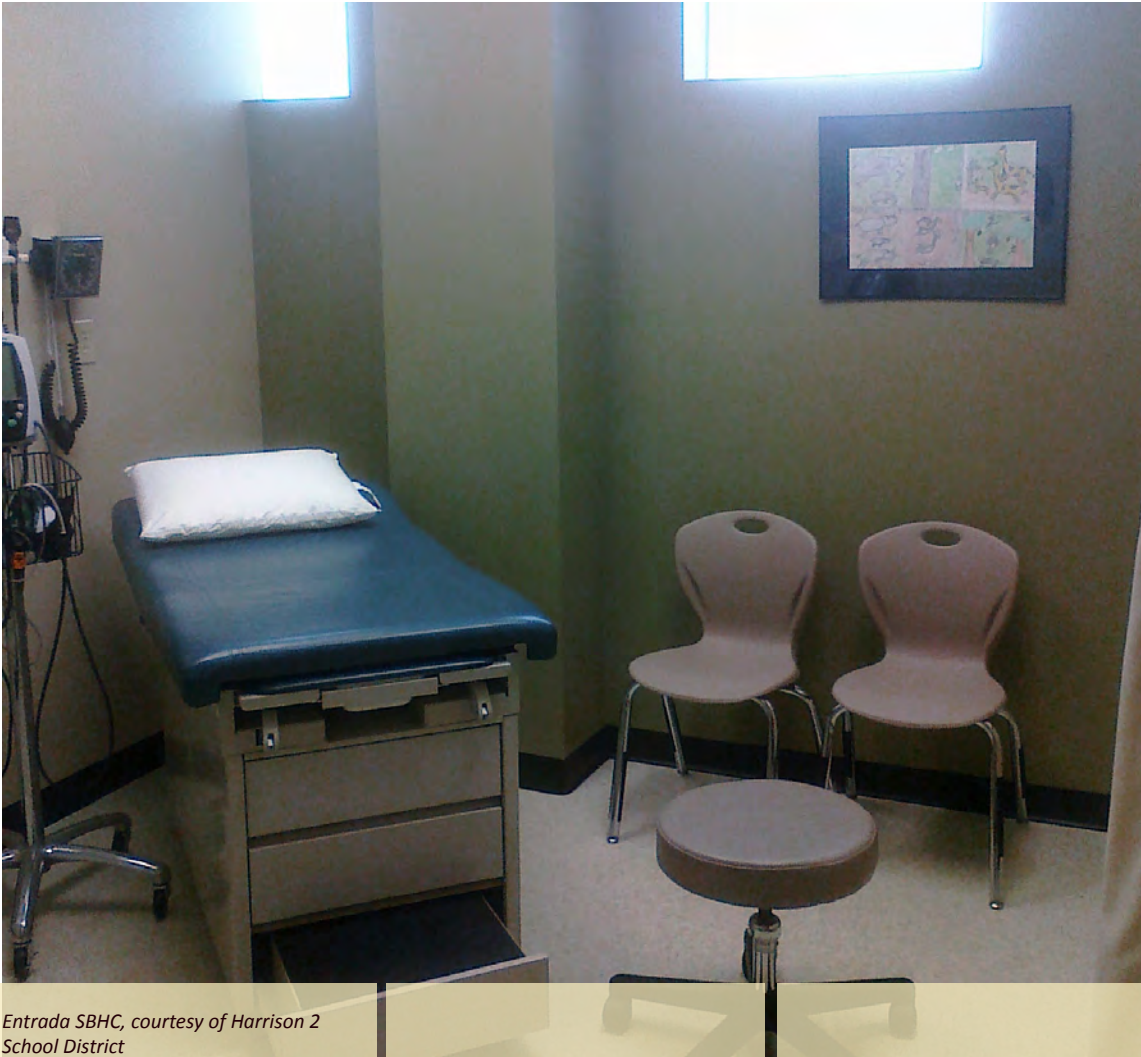
Notes: 1) These salaries do not include benefits, which vary but may be estimated at an additional 26 percent of the salary. Malpractice insurance would be an additional cost for medical providers. 2) School districts have specific pay scales for technical, non-technical, and managerial positions; therefore, these estimates need to be adjusted if the school district chooses to direct hire for these positions. If the school district contracts with a licensed medical provider to provide all SBHC staff, the licensed medical provider takes responsibility for salaries, benefits, and any other personnel issues. 3) Eight hours of services/week would correlate with .2 of the 10-month salary; 16 hours would correlate with .4 of the 10-month salary; 40 hours would correlate with the full 10-month salary. 4) Ten-month salaries are based on .83 of the annual salaries.

Projected Income Statement

A projected income statement should include the following elements.

	Year1	Year 2	Year 3	Year 4
Revenue				
Federal				
State				
Local Government				
Private grants/contributions				
In-kind				
TOTAL NON-PATIENT REVENUE				
Gross Patient Revenue				
Medicaid				
Child Health Plan <i>Plus</i>				
Private Insurance				
Uninsured				
TOTAL GROSS PATIENT REVENUE				
Unreimbursed Portion				
Medicaid				
Child Health Plan <i>Plus</i>				
Private Insurance				
Uninsured (fees if applicable)				
TOTAL UNREIMBURSED PORTION				
Net Patient Revenue				
Medicaid				
Child Health Plan <i>Plus</i>				
Private Insurance				
Uninsured				
TOTAL NET PATIENT REVENUE (TOTAL GROSS PATIENT REVENUE minus TOTAL UNREIMBURSED PORTION)				
TOTAL ALL REVENUE (TOTAL NON-PATIENT REVENUE plus TOTAL NET PATIENT REVENUE)				
EXPENSES				
Salary and Benefits				
Program Costs				
Administrative Costs				
In-kind Costs				
TOTAL EXPENSES				
NET REVENUE (EXPENSES) (TOTAL REVENUE minus TOTAL EXPENSES)				

Chapter Seven



Entrada SBHC, courtesy of Harrison 2 School District

Business Plan: Marketing

Chapter 7: Business Plan - Marketing

Why Is Marketing Important?

Marketing enables communication about the SBHC. It is important for SBHCs because it informs students and families of the services that are offered and lets them know how to access these services. Marketing is also used to generate support for the SBHC within the community. Advocacy, which is a tool for reaching policy-makers in order to influence policy, is discussed in Chapter 9.

When discussing marketing, the term “social marketing” is often used. “Social marketing is the systematic application of marketing, along with other concepts and techniques, to achieve specific behavioral goals for a social good.”⁵² Rather than dictating the way that information is conveyed from the top-down, social marketing urges public health professionals to listen to the needs and desires of the target audience and build a program from there. This focus on the “consumer” involves in-depth research and constant re-evaluation of every aspect of the program and its marketing materials. One of the benefits of a social marketing approach is that the materials will more likely reflect the cultural values of the community.

Before marketing can begin, the following questions need to be answered:

- What “business” is the SBHC in?
- What services are offered and why are they being offered?
- Who is the competition?

For example, people in the field of school health are in the “business” of providing quality health care that is child- and/or adolescent-friendly, parent- and community-friendly, culturally sensitive, easily accessible, comprehensive (including health education, mental health services, and primary care services), and prevention-focused. They are also in the business of promoting child, adolescent, and family development, improving the health and well-being of their communities, building a healthier future for society, and reducing disparities in health outcomes and access to care. The job is to figure out how to communicate all these aspects of SBHCs to the different audiences.

Marketing the SBHC is a year-round project. Schools are rapidly changing environments. Students, teachers, and even administrators change frequently. Therefore, it is necessary to continually get the word out about SBHC services.

Good Times to Market the SBHC

At School

- School registration
- Faculty meetings
- Teacher in-services
- Coach meetings
- School board meetings
- Awards banquets
- Sporting events
- Parent meetings
- Student groups, such as team athletics and student government
- Orientations

- Classroom presentations

In the Community

- Sporting events
- City council meetings
- Community association meetings, such as Rotary, Lions and Elks Clubs
- Health fairs
- Provider gatherings, such as local medical association and nursing chapter meetings and conferences
- Festivals and other cultural events

As part of the marketing plan, it is a good idea to set up a yearly schedule of events at which to promote the SBHC. Make a list of the materials that will be needed in advance. This approach will give time to adapt the materials to the different target audiences.

Marketing Tools

Many tools can help market the SBHC. In the current marketing climate, utilizing a variety of these tools is necessary to reach diverse groups. To be most effective, many of these materials should be developed in English, Spanish, and any other language commonly spoken in the community:

- **Brochures** can be handed out at the beginning of the year and periodically thereafter to explain what services the SBHC offers.
- **Fact sheets** can provide interesting and persuasive information about the need for a health center, the effectiveness of the health center, and the health care needs of the school and community.
- **Flyers** advertise timely health care services offered by the center such as sports physicals. They can be displayed at school or in the community.
- **Press releases** can be distributed to media outlets to notify the public about a specific event or special programs offered by the health center.
- **Social marketing tools**, such as Facebook and Twitter, can be used to keep students, parents, business leaders, and other “friends” updated about the SBHC. Social marketing venues can be an effective means of issuing invitations to events and sending reminders, such as the importance of getting the flu shot, to students and families. They are also useful for monitoring any concerns that arise regarding the SBHC and provide an opportunity to intervene early.
- **SBHC webpage** can be developed and maintained to provide general information about the student health center, such as hours of operation, services, staffing (biographies and photos) , accessing services, enrolling children in Medicaid and Child Health Plan *Plus*, as well as health alerts.
- **Public service announcements**, on the radio, television and in newspapers and other publications, alert the public about specific services offered at the health center as well as health education activities sponsored by the health center, such as a “Bike to School” day.
- **Robo-Calls** can be made through the phone system of some school districts. These are automated calls that leave messages for parents on their home phones. These can be used to remind parents of special events offered by the SBHC such as immunization clinics or dental sealant opportunities.
- **Presentations at public events** enlist support for the SBHC by making people more aware of key facts about the center (such as the number of students serviced, health education activities, etc.).

Marketing Audiences

To ensure that the marketing materials are effective, it is important to tailor them to the specific audience to be reached. Different audiences often need to hear different messages about the SBHC. For example, a brightly colored, youth-designed flyer might be used to draw students into the health center, but a simple one-page fact sheet might be given to parents attending school orientation. In most cases, the message will be to: 1) encourage personal use of the SBHC; 2) encourage others to use the center; or 3) support the services financially and politically.

Parents

This important group influences students' support of and decision to use the health center. Marketing messages for parents might focus on the services the health center offers, the benefit to parents of not missing work every time their child needs a medical appointment, and the level of control they have over their child's use of health services.

Students

This audience's knowledge about the health center and perceptions about the program will definitely influence their use of its services. The messages to youth might include what services are provided, which ones are confidential, and when the center is open.

School Staff

Teachers and other school employees have a significant role in the success of the SBHC. In order to build support from the school staff, communicate the message that healthier young people learn better and often score better on standardized tests, that the SBHC reduces absenteeism since students do not have to leave school for medical appointments. SBHC staff can make teachers' jobs easier by providing some of the support that high-needs students require.

Community Leaders

This important audience has the capacity to influence parents' and policy-makers' support for the SBHC. These leaders, which can include civic and religious leaders, often affect local and state policy. To garner their support, communicate the message that the SBHC is striving to support the successful education of the community's children by improving the health status of young people, supporting families by providing valuable assistance to working parents, and helping to build a stronger community.

Local Health Care Providers

This group needs to know that SBHCs do not take away their business. Local providers also like to know that they will receive some form of communication about services provided to their patients and that the SBHC will refer students back to them for additional treatment. Further, medical practitioners want assurance that the providers at the SBHC are qualified and licensed.

Chapter Eight



*Southwest Open School SBHC, courtesy of
Southwest Open School*

Business Plan: Data Collection, Reporting, and Evaluation

Chapter 8: Data Collection, Reporting and Evaluation

Data Collection

SBHCs must have a system in place for the collection, storage, and analysis of encounter data. As discussed in Chapter 5, some SBHCs have begun to use electronic health records (EHRs) that also serve as databases. The data from patient encounters is aggregated and used for evaluation purposes. The SBHC will have to determine what electronic database system will be used. The *Quality Standards for Colorado School-Based Health Centers*⁵³ requires SBHCs that receive state funding to maintain an electronic data collection system that includes the following minimum data variables:

- Unique patient identifier
- Date of birth
- Gender
- Race
- Ethnicity
- Grade
- Insurance status
- Date of visit
- Location of visit
- Provider type
- Current Procedural Terminology (CPT) visit codes(s)
- Diagnostic code(s) (ICD-9 or ICD-10 & DSM IV)

Why Evaluation Is Important

Evaluation is important for several reasons. Evaluation is necessary for monitoring the program and determining if the program goals are being met. Evaluation is useful for assessing the quality of service delivery, including client satisfaction, and taking steps to continually improve the program. Evaluation provides evidence to funders, policy-makers, the school community, and others that the SBHC is a wise investment. Lastly, evaluation is needed for developing future grant proposals to support the program.

First Steps in Evaluation

Obtain Baseline Data

It is important to collect some data before the SBHC opens in order to document change that occurs as a result of the health center. For example, SBHCs are often successful at decreasing the number of students being sent home from school because of illness or injury. SBHCs can also decrease absenteeism, particularly for students with asthma; decrease the number of disciplinary referrals; improve immunization rates; etc. It is very helpful to request this information from the school before the SBHC opens in order to have baseline data with which to compare future measurements.

Data collected during the planning phase may also be suitable for including as an element in the evaluation. For example, planners may find that 75 percent of students surveyed during the needs assessment had not seen a doctor or nurse in the last 12 months. On a repeat survey one year after the SBHC opens, this percentage may have declined to 50 percent or less. Such information will be of interest to stakeholders.

Some SBHCs have been able to show that access to SBHC services decreases the number of visits made by children and adolescents to the local emergency room and/or urgent care provider. If the licensed medical provider is the local hospital, this data may be readily available.

The SBHC may want to consider surveying students, parents, and school staff and faculty before and annually after opening the SBHC to demonstrate improved access and satisfaction with SBHC services.

Consider Who Uses Evaluation

When planning the evaluation and data collection, consider the groups who have a stake in the SBHC. What will they want to know about the SBHC and its impact on students? Compile a list of the information based on their needs and interests. The evaluation plan can be crafted from the list. Below is a list of the various groups who use evaluation and the information that is likely to be important to them. Many of the statistics listed are important to more than one group. Consider involving funders directly in designing the evaluation plan.

Policy-makers and Funders

Policy-makers – including legislators and other elected officials – have an obligation to their constituents to ensure that tax dollars perform the greatest possible good. The best way to maintain funding for the work of the center is to provide concrete evidence that the services improve health. Data of interest to this group include:

- Number of children with access to SBHC services
- Number of children served
- Insurance status of children served
- Number of uninsured students assisted by the SBHC to enroll in Medicaid and Child Health Plan *Plus*
- Reduced Medicaid expenditures related to emergency department use and hospitalizations
- Health care outcomes, such as immunization rates, before and after the SBHC opens
- Community support for the SBHC, including businesses, religious leaders, and other influential community members

School Administrators and Board Members

Schools are in the business of educating children. They are interested in services and programs that positively impact academic achievement. Parent satisfaction is very important to them as well. Data of interest to this group include:

- Number of students leaving school due to illness or injury
- School attendance
- Rates of graduation
- Number of suspensions, expulsions, and drop-outs
- Number of referrals for disciplinary problems and any other related outcomes
- Improvement in grades or other academic outcomes
- Parent and student satisfaction

Government Administrators

Government administrators are responsible for making sure programs are run effectively and improve health. These administrators are required to demonstrate that government funds are used in the manner intended. Data of interest to government administrators might include:

- Users by ethnicity, gender, and age
- Access to/utilization of primary and preventive services, including comprehensive health screenings
- Access to/utilization of reproductive health services
- Access to/utilization of mental health services

- Access to/utilization of oral health services
- Immunization rates
- Tobacco, alcohol, and other substance abuse prevention programs
- Obesity prevention and management programs
- Sources of revenue, including insurance and in-kind revenues

Student Users and Parents

Student and parent satisfaction is critical to the success of the SBHC. If they are not satisfied with the services, they are unlikely to use the SBHC. Therefore it is important to include their assessment of the SBHC in the evaluation plan and respond to the feedback with meaningful changes. Evaluation data of importance to students and parents include:

- Hours of operation
- Wait times
- Types of services provided
- Privacy and confidentiality
- Courteousness and friendliness of staff
- Answers to student and parent questions
- Quality of services
- Convenience for student and parent
- Parent communication with SBHC providers

SBHCs

The manager of the SBHC is the person who is in a position to make the best use of the evaluation data collected at the facility. This information is used to raise funds, demonstrate to local officials that the health services are valuable, make staffing and budgetary projections, and verify client satisfaction. SBHC managers find that good data make their jobs much easier.

Types of Evaluation

There are different types of evaluation. The approach taken will depend on the questions that are to be answered. Two common types are *process* evaluation, which assesses strengths and weaknesses of the SBHC as a whole, versus *outcome* evaluation, which tracks the health impacts of the program on clients.

Process Evaluation

This type of evaluation focuses on the operations and dynamics of a program in an attempt to understand its strengths and weaknesses. Process evaluation examines how the program is being implemented. It helps answer such questions as the following:⁵⁴

- What is happening at the SBHC and why?
- Are the students receiving the intended services?
- How do clients experience the SBHC?
- How does the staff feel the program is going?
- How do the parts of the program fit together?
- Are the school health, behavioral health, and primary care providers in the SBHC collaborating on the delivery of care to students? If so, how?

Outcome Evaluation

Unlike process evaluation, which focuses more on the program, outcome evaluation tends to look at the actual clients. Outcome evaluation quantifies improvement in the health of the students. Outcomes must be measurable. Outcome evaluation can examine these changes in the short term, intermediate term, and long term. It helps answer questions such as the following:⁵⁵

- Did asthma clients who used the SBHC miss fewer days of school than in years past or compared to other students with asthma who did not use the SBHC?
- Are students with SBHC access more likely to have their vaccinations up-to-date than students without?
- To what measurable degree are clients satisfied with the services they receive?
- Are there measurable improvements in SBHC students' health that are not found among students who do not use or have access to an SBHC?
- To what measurable degree do the school's absentee and checkout rates change in the first three years after the SBHC opens? (Or, how do the rates compare with those of a similar school without an SBHC?)

Evaluation Tools

Data Collection

Each SBHC is unique in its funding and community reporting needs, so each one will determine what information to collect. However, advocacy for school health care is stronger and better coordinated when data can be combined from multiple sites. For that reason, the Colorado Association for School-Based Health Care encourages all Colorado SBHCs to collect the following information and complete the annual CASBHC survey:

- Number of students enrolled in the school(s) served
- Number of English language learners in the school(s) served
- Number of students enrolled in the free and reduced lunch program at school(s) served
- Cash revenue by source
- Type and value of in-kind support received from school district and from other agencies
- Total number of SBHC users
- Number of SBHC users by insurance status, age, gender, and zip code
- Number of SBHC users eligible for the Colorado Indigent Care Program (CICP)
- Number of visits by type: primary care, mental health, substance abuse counseling, dental care, immunizations, health education

Satisfaction Surveys

These types of surveys collect feedback from clients, parents, school staff and faculty, and practitioners about how to improve SBHC services. This type of data can also be useful for policy-makers, funders, and administrators. Sample satisfaction surveys can be found in Appendix B. Sample parent and student satisfaction surveys can also be found on the Colorado Department of Public Health and Environment /SBHC Program website at <http://www.cdphe.state.co.us/ps/school/>.

Chapter Nine



Coalition Building and Advocacy

Chapter 9: Coalition-Building and Advocacy

What is Advocacy and Why is it Important?

Advocacy aims to influence public policy. Some people consider advocacy a form of marketing or education. For the purpose of this manual, *marketing* is defined as a way to reach clients whereas *advocacy* is a tool for reaching policy-makers. Advocacy can include public speaking at meetings, letter-writing, issuing press releases, and other strategies for getting the message to policy-makers. Of course, many marketing materials can be easily tailored for this audience.

Lobbying is an attempt to influence specific legislation. It is a form of advocacy. The Internal Revenue Service distinguishes between direct lobbying and grassroots lobbying. Direct lobbying “is any attempt to influence any legislation through communication with a member or employee of a legislative or similar body; a government official or employee who may participate in the formulation of the legislation, but only if the principal purpose of the communication is to influence legislation; or the public in a referendum, initiative, constitutional amendment, or similar procedure.”⁵⁶ Grassroots lobbying “is any attempt to influence any legislation through an attempt to affect the opinions of the general public or any part of the general public.”⁵⁷ For the communication to be grassroots lobbying, it must encourage a specific action to be taken regarding the legislation.

It should be noted that federal and state funds cannot be used for lobbying and foundations can only support certain amounts of direct lobbying. SBHCs may be asked by funders to quantify the amount of direct and grassroots lobbying they are conducting.

Who to Consider When Advocating

School Boards

School boards are responsible for planning and setting a school’s goals, setting district policy, adopting an annual operating budget, approving the instructional program, approving building plans, and ratifying contracts negotiated with local bargaining units. A local school board must approve the establishment of an SBHC in any of its schools.

City and County Government

Often, public health offices are controlled by city or county governments, so advocating for the SBHC to city or county officials may be useful to tap the resources of the local public health department.

Tribal Governments

Tribes are sovereign nations, so relationships must be established with tribal leaders just as with other local or state leaders. Many tribes have both an executive and local system of government. Often there is a governor or president of the tribe as well as village or chapter officials.

Since each tribal structure is different, it is important for SBHC staff working in Native American communities and reservations to learn how local tribes are structured. Tailor the advocacy to the appropriate leaders. Another potential audience for advocacy is Bureau of Indian Affairs administrators. This federal agency, among other responsibilities, runs some schools on tribal lands.

In addition to their systems of government, tribes’ legal codes and judicial systems vary, so advocates must also familiarize themselves with applicable tribal law. In most cases, federal but not state law applies on tribal land. State law applies if the tribe has adopted state law into tribal law.

For more information on tribal governments, visit the following websites:

- American Indian Policy Center: www.airpi.org/pubs/indinsov.html
- U.S. Department of the Interior/Bureau of Indian Affairs (which contains a Tribal Leaders Directory): <http://www.bia.gov/>

State Government

The Colorado General Assembly, i.e., the Colorado Legislature, consists of the House of Representatives and the Senate. There are 65 representatives and 35 senators. Members of the House of Representatives are elected every two years, and senators are elected every four years. Regular legislative sessions are held annually and begin no later than the second Wednesday in January. They last no more than 120 days and are held at the state Capitol in Denver. Special sessions may be called at any time by the governor or upon written request of two-thirds of the members of each house. Special sessions are infrequent.

SBHCs may want to invite their local senator and/or representative to become a member of the Community Advisory Committee (CAC). At the very least, SBHCs should invite their local senator and representative to tour the SBHC and learn more about the services it offers.

Colorado school health professionals may find themselves advocating in Denver at some point because the legislature controls the Colorado Department of Public Health and Environment /SBHC Program budget. Most SBHCs in Colorado depend on this funding source for at least part of their annual budget.

Future legislation may address SBHC issues concerning funding or services. It is important as an advocate to be aware of the issues discussed in the state legislature. The Colorado Association for School-Based Health Care is the state advocacy organization for SBHCs in Colorado and is responsible for coordinating SBHC advocacy efforts. It closely tracks legislation that impacts school health care.

Information on pertinent health care issues, major legislation being considered, and legislators who sit on health and education committees can be found on the Colorado General Assembly website, <http://www.leg.state.co.us/>.

National Government

Nationally elected officials make decisions and set policies for a wide range of issues related to child and adolescent health, including health care access, reproductive health services, substance abuse issues, sexuality education, etc. As a school health advocate it is important to have the center's voice heard at the national level. There are seven representatives and two senators representing Colorado in the United States Congress. The National Assembly on School-Based Health Care is the national advocacy organization for SBHCs. NASBHC and its state partners were instrumental in seeing that there was funding appropriated for SBHCs in the Patient Protection and Affordable Care Act of 2010.

Coalition-Building

Advocacy is often most effective when organized by a group instead of an individual. Coalition-building and partnership development in the community are effective ways to create support for the SBHC. Collaborating with organizations such as CASBHC, NASBHC, and local health care coalitions will strengthen advocacy efforts and increase their effectiveness.

LiveWell Colorado outlines steps to building a successful coalition in their white paper "Understanding Your Community: The Key to Building an Impactful, Sustainable Coalition."⁵⁸ They advise comprehensive research and careful planning as a first step. The issue being addressed needs to be thoroughly understood. Advocates need to do their homework on SBHCs and understand the complexities. The community, its needs, concerns,

cultural make-up and history must also be understood. Through the research, resources and potential collaborators can be identified to achieve goals.

Next, it is important to anticipate potential sources of resistance to the advocacy efforts and prepare for them. Common *false* arguments raised against SBHCs include:

- Students can access services without parental consent thus usurping parental control over their children.
- SBHCs encourage sexual activity by providing reproductive health services.
- SBHCs are a waste of tax dollar investment, providing a duplicative service that families already have access to through private means.
- SBHCs take money from schools that should be used for education.
- Schools should not be in the business of delivering health care.

Once the issue and community homework has been done, the organizational and operational structure of the coalition can be defined and members recruited. Local businesses, non-profits, cultural groups, and religious organizations can all be strong advocates as well as benefactors of the SBHC.

The message should be framed to incorporate “the expressed concerns of the community stakeholders” based on the information gathered.⁵⁹ Messages should be simple. The central message is generally student need and the fact that an SBHC is a positive development for schools. The impact of health on education should be demonstrated and the point made that healthy children keep parents at work, reduce absenteeism, and increase student performance.

Coalition-building can be very effective. In 2008, CASBHC and SBHCs statewide worked together to successfully advocate at the Capitol to increase the line item in the state budget for SBHCs from \$500,000 to \$1,000,000.

Advocacy Strategies

The goal of advocacy is to build positive knowledge and recognition about SBHCs and to promote policies that support their operation.

Letter-Writing or Email Campaigns⁶⁰

As an individual, one might make a difference by writing or calling a local politician. A bigger impact can be made by organizing a campaign where *many* people call or write. Here are some steps for making that happen:

- Before starting, contact related organizations to see if they are already organizing a campaign. If so, ask if the SBHC can help. If not, ask if they can help the SBHC.
- Put together a short handout telling people about the issue, what they need to know, and all necessary addresses or phone numbers. Include a sample letter and script for phone calls. Many will be distributed, so the handout should be brief, 2-3 pages at the most. (In the instructions, ask people to also send a copy of their email or letter to the coordinating group so that the number of policy-maker contacts can be tracked.)
- Distribute the information as widely as possible. For example, perhaps the SBHC wants people to write their state legislator in support of a new bill to expand SBHC funding. Packets of flyers might be delivered to parents and students, non-profit organizations, and school personnel. A popular street corner might be chosen and flyers handed out to passers-by. (If information is being distributed out on the street, don't be overly aggressive. Expect that many people will decline the flyer. And remember: never work alone or after dark.)

- Ask other groups to announce the campaign in their own newsletters and at meetings.
- After a couple of weeks, follow-up with all partner organizations, checking on their progress. Call and remind. Call and remind. Call and remind.
- In the meantime, be working on the follow-up strategy. Options include: a press release announcing the number of letters, calls, and emails generated by the campaign; a meeting (or series of meetings) with elected officials; or a public rally.

Letters to the Editor & Editorials

Letters to the editor and editorials are good advocacy tools.⁶¹ They are used to influence readers to think or act a certain way. They also reach a wide audience. Editorials and letters to the editor can tell readers how to contribute to the SBHC or express an opinion related to a school health topic, such as why junk food should be banned in schools.

About Editorials

Editorials (also called “guest editorials” or “op-ed pieces”) are well-researched articles that present a particular opinion. They are submitted to newspapers or other publications. They are different than regular newspaper articles in that the author is not expected to remain unbiased; instead, the author is typically someone who is an expert about a particular cause and wants to advance that cause. To get editorials published, one generally must:

- Contact the editorial page editor of the newspaper in advance to learn their policies on accepting outside editorials. Be prepared to tell the editor why the cause is important and why the author of the guest editorial is the right person to write about it (i.e., their authority or expertise on the matter). Depending on the size of the publication, the editorial editor may decline to accept the editorial but may decide to write about the cause herself. If this happens, don’t be offended; instead be glad as this will bring attention to the cause.
- If given the thumbs-up by the editorial editor, write a clear, well-researched editorial.
- After the editorial is published, send copies to other organizations, the school newspaper, local elected officials, and others that the SBHC would like to influence. Also consider adding a link to the editorial on the SBHC website.

About Letters to the Editor

Generally, letters to the editor are shorter than editorials and require less research. They are also easier to get published. They might contain a short call to action, make a public announcement, or respond to a previous newspaper article or public decision. Many smaller newspapers publish all credible letters to the editor, so one stands a good chance of getting the information in print. The downside is that letters to the editor typically get less attention than editorials.

Writing Tips

Below are some tips to help get the letter or editorial printed.

- **Get to the point.** The first paragraph should usually be a concise summary of what is going to be told to the reader audience.
- **Establish credibility.** The author should establish himself or herself as an expert on the topic. For example, if arguing for more funding for the SBHC, the author might say: “As the coordinator of the school’s health center, I know how important it is to keep students healthy and in class. In the six months since our center opened, we have handled over 300 student appointments – double what we

had expected. I now realize how helpful it would be if we were open full-time, instead of just three days a week.”

- **Do the homework.** Research the issue well before starting to write. The article should support the claim with a few statistics, facts, examples, or quotes. The editorial should be clear and forceful but should avoid attacking others. Be honest and accurate.
- **Mention the opposition.** If there is “another side” to the issue, one gains credibility if it is acknowledged – although a lot of detail is not necessary. *“We know that some people oppose the idea of SBHCs because they fear the health centers will take money from the school. We respectfully disagree with that position because...”*
- **Be brief.** Try to limit the editorial to 300-500 words (about one or two double-spaced, typed pages) and a letter to the editor to 100-200 words. Keep the paragraphs brief and direct. Unlike regular academic writing, the paragraphs should be short (2-3 sentences).
- **Look for a “hook.”** The editor is more likely to print the letter if it refers to something currently in the news. For example, if the letter pertains to policy issues concerning legislative action, the editorial should be timed to correspond to the legislative session and mention that in the piece.

Face-to-face Meetings with Policymakers

Before Going⁶²

- Do a little research. Has this official supported SBHCs or other health issues in the past?
- If talking with more than one official on the same day, do not schedule the meetings too close together. Due to busy schedules, politicians are sometimes late, so plan on the meeting ending later than expected. However, always be early.
- Develop in advance a short written summary of the group’s mission, cause, and request for action. Bring extra copies in case the official invites extra staff members to sit in.

When Getting There

- If meeting with a busy politician, know that the meeting can happen anywhere: in the official’s office, in a committee room, in the hall, in the reception area – don’t be surprised.
- Anticipate changes in who attends the meeting. A politician may assign a staff member to meet instead of him/herself. If this happens, do not feel bad; the staff member might actually prove more helpful.
- Always begin the conversation by thanking the person for taking time to meet. If she/he has supported the cause in the past, be sure to express appreciation.
- Make important points clearly and succinctly. If a community needs assessment or other research was done, mention it. It is important to demonstrate the need for school health care.
- Be honest, candid, and relaxed. Use a conversational tone. Do not be defensive or argumentative. Do not read a prepared statement and risk boring the official.
- The total presentation should take no more than 5 minutes.
- Be prepared to answer questions about the SBHC.
- Expect a neutral reaction. Politicians rarely make firm commitments on the spot.
- Never talk about an official or staff member while in public buildings.

After Leaving

- Follow-up with a polite thank you letter.
- Take some notes about what was discussed for future reference.

Social Media Tools

Social media tools, such as Facebook and Twitter, can also be used to advocate for school-based health care. It is a particularly effective strategy for grassroots lobbying, when supporters need to be mobilized quickly.

appendices A-L



Adams City Middle School SBHC, courtesy of Community Health Services

Appendix A: Sample Data-Based Needs Assessment Information

Chapter 3 of this manual explained that there are several types of needs assessment strategies. One of the most basic is collecting existing statistics. Once this data is collected, move on to other types of needs assessment strategies that involve community members, such as surveys or focus groups. Sample surveys and results of a sample youth focus group are presented in Appendices B and C.

Sample Data-Based Needs Assessment

_____ High School serves the suburban and/or rural areas of _____ County. The demographics of the students are: Hispanic ____, Anglo ____, African American ____, Native American ____, and Asian _____. (Source: _____ High School)

Income and Employment:

The volume of enrolled students for the school year 2009-2010 is ____; ____percent of the students are eligible for free and reduced lunch. (Source: _____ High School)

In 2007, ____percent of children under 19 lived in poverty in _____ County. (Colorado Children's Campaign)

In 2009, ____percent of the labor force in _____ County was unemployed. (Source: CO Dept of Labor & Employment)

Depression and Suicide

In 2007, ____ percent of _____ School students felt sad and hopeless every day for two weeks in the past year, and ____percent made a suicide plan. (Source: CO Youth Risk Behavior Survey -CO YRBS)

In 2007, ____percent of _____ School students surveyed attempted suicide in the past year, and ____percent suffered injuries as a result. (Source: CO YRBS)

Physical Activity and Nutrition

In 2007, _____percent of _____ students surveyed did not do the minimum recommended moderate or vigorous physical activity. (Source: CO YRBS)

In 2007, ____ percent of _____ students surveyed were overweight, and _____percent were at risk of being overweight. (Source: CO YRBS)

Risk Behavior

In 2008, ____percent of births were to teens 19 years and younger. (Source: CO Dept of Public Health & Environment)

In 2007, ____percent of the _____ students surveyed had their first sexual experience at age 12 or younger. (Source: CO YRBS)

The dropout rate (and/or retention, suspension, expulsion rates) for the _____ School District in 2008-2009 was ____percent compared to the state rate of ____percent. (Source: CO Department of Education)

Substance Abuse

In 2007, ____ percent of students surveyed had smoked a cigarette, and ____percent were current smokers.

In 2007, ____percent of _____ students surveyed had consumed alcohol, and ____percent were current drinkers.

In 2007, _____ percent of _____ students surveyed were current users of marijuana.

(Source for all: CO YRBS)

Violence and Crime

In 2007, ____percent of students surveyed had been in a physical fight in the past 12 months, and _____percent of the males had carried a weapon at school in the previous 30 days. (Source: CO YRBS)

Appendix B: Sample Surveys

Parent Survey

Dear Parent:

The **INSERT SCHOOL DISTRICT** and **INSERT LICENSED MEDICAL PROVIDER** are thinking about opening a School-Based Health Center. Children attending **INSERT NAME OF SCHOOL(S) TO BE SERVED** would be eligible to receive services at the School-Based Health Center. Services might include immunizations, physical exams, care of minor illnesses (earaches, sore throats, cuts and bruises) and related family support services. The cost of services would be based on a sliding-fee scale, and no one would be refused service because of inability to pay.

To help us plan for the School-Based Health Center, we would like to ask a few questions about the health needs of your child. This information will help us decide what types of services and programs to offer at the Center. **Your answers are completely confidential.** You do not need to put your name anywhere on this form. Thank you for your help.

1. What physical health problems or needs has your child had in the past month? Check all that apply.

- a. Headaches
- b. Toothaches or dental problems
- c. Sore throat or strep throat
- d. Stomachaches
- e. Colds/fever
- f. Skin problems or rashes
- g. Often feeling really tired
- h. Diarrhea or vomiting
- i. Earaches or ear infections
- j. Problems with eating or weight
- k. Injuries or accidents
- l. Bedwetting

2. Have you been told by a doctor that your child has any of the following chronic health problems?

- a. Asthma
- b. Attention deficit or hyperactivity
- c. Diabetes
- d. Seizures
- e. Allergies
- f. Other _____

3. Where do you regularly take your child for health care? Check all that apply.

- a. Family doctor or clinic
- b. Emergency room
- c. Regular source of health care
- d. Other _____

4. Do you have a regular source of dental care for your child?

Yes No

5. Do you have someone you could go to for counseling services for behavioral problems? (e.g., unusual or extreme fears, depression, nervousness)

Yes No

6. How do you currently pay for health services?

- a. Private insurance or belong to an HMO
- b. Medicaid, Child Health Plan *Plus*, or social security
- c. Armed Services medical plans
- d. No insurance and generally pay out-of-pocket
- e. Other _____

7. If we opened a School-Based Health Center, how likely would you be to take your child there for service? Check one.

- a. Would definitely use the Center
- b. Would probably not use the Center
- c. Would probably use the Center
- d. Would definitely not use the Center

8. At what hours would you be most likely to use the clinic? Check all that apply.

- a. Before school
- b. Evenings
- c. During school
- d. Saturdays
- e. Immediately after school

THANK YOU!

Teacher Survey

Dear Teacher and/or Staff Member:

[Same basic introduction as on previous survey.]

1. On a scale of 1-5 (1 being major, 5 being minor) rate each of the physical health problems listed below for children in your classroom.

- | | |
|--------------------------------------|---|
| a. Headaches _____ | g. Toothaches or dental problems _____ |
| b. Sore throat or strep throat _____ | h. Stomachaches _____ |
| c. Colds/fever _____ | i. Skin problems or rashes _____ |
| d. Often being really tired _____ | j. Diarrhea or vomiting _____ |
| e. Earaches or infections _____ | k. Problems with eating or weight _____ |
| f. Injuries or accidents _____ | l. Bedwetting _____ |

2. We would like your perception on chronic health conditions. Please rate each of the problems listed below on a scale of 1-5 (1 being major, 5 being minor) for children in your classroom.

- | | |
|----------------------------|-----------------------------|
| a. Asthma _____ | e. Emotional problems _____ |
| b. Diabetes _____ | f. Seizures _____ |
| c. Allergies _____ | g. Other: _____ |
| d. Behavior problems _____ | |

3. Please comment on anything you think we need to keep in mind as we plan for the School-Based Health Center:

Services _____

Hours _____

Prevention _____

Other _____

Parent Satisfaction Survey

Dear Parent/Guardian,

Date _____

The _____ School Health Center is conducting an evaluation of our services to your son or daughter. We are interested in your opinions about our services. Your participation in this survey is voluntary. All your answers will remain private, and no one other than the administration of the health center will see your survey. Thank you for your participation. We appreciate your sharing your thoughts about your child's health care.

If your child <u>has</u> been to the Wellness Center, please answer the following questions.					
1. What services did your child receive at the Center? (Check all that apply.)					
<input type="checkbox"/> Illness (flu, cold, stomachache or something more serious)	<input type="checkbox"/> Counseling for personal or emotional problems				
<input type="checkbox"/> Chronic health problem (asthma, depression, headaches)	<input type="checkbox"/> Yearly physical or sports physical				
<input type="checkbox"/> Vision or hearing exam	<input type="checkbox"/> Treatment of injury or accident				
<input type="checkbox"/> Immunizations (vaccines)	<input type="checkbox"/> Care for girls with menstrual problems				
<input type="checkbox"/> Dental exam	<input type="checkbox"/> Pregnancy test				
<input type="checkbox"/> Acne or skin problem	<input type="checkbox"/> Services for pregnant teens				
<input type="checkbox"/> Nutrition counseling	<input type="checkbox"/> Information for parents about your child or health care in general				
<input type="checkbox"/> Drug/alcohol prevention	<input type="checkbox"/> Other, please tell us _____				
<input type="checkbox"/> Counseling for substance abuse (tobacco, alcohol, drugs)					
2. How much do you think your student was helped by the Center? <input type="checkbox"/> A great deal <input type="checkbox"/> Somewhat <input type="checkbox"/> Very little <input type="checkbox"/> Not at all <input type="checkbox"/> Don't know					
3. Did you feel that the staff was courteous to you? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know, I never met the staff					
4. Did the staff at the Center explain your child's medicine or treatment clearly? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> My child did not receive medicine or treatment					
5. Did the staff at the Center refer you to other services not provided by the Wellness Center? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know					
6. How would you rate the following aspects of the SBHC?	<u>Excellent</u>	<u>Good</u>	<u>Fair</u>	<u>Poor</u>	<u>Don't know</u>
Communication with parents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appearance of the clinic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Convenience of the location	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hours that it is open	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality of medical care received	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you agree or disagree with the following?	<u>Agree</u>	<u>No opinion</u>	<u>Disagree</u>		
The Center encourages students to be more responsible for their health.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Students miss less school because of the Center.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
The care at the Center is confidential (private).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
The Center has saved you a trip to the doctor, the school or the hospital.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
The Center is a valuable service to the school community.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
8. Are there any services that you would like the Center to provide? <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Yes If yes, please describe _____					
THANK YOU					

Student Satisfaction Questionnaire (High School)

Grade level _____

Male Female

Date _____

Is this your first visit to the health center this year?

Yes No

If no, how many times have you visited the health center?

0-1 2-5 more than 5

It is very important to us to know how you feel about the services you received today. Your answers to the following questions help us know how we are doing and how to improve our services.

During my visit.....

1. The clinic staff was courteous and friendly to me.

Yes No Don't Know

Comments _____

2. All of my questions were answered by the health care provider.

Yes No Don't Know

Comments _____

3. My privacy was respected.

Yes No Don't Know

Comments _____

4. I waited too long to be seen by the health care provider.

Yes No Don't Know

Comments _____

5. Did you receive medication or a prescription?

Yes No Don't Know

If yes please answer #6.

6. The health care provider explained to me **why I needed** the medicine and **how to take it**, using words I understood.

Yes No Don't Know

Comments _____

7. Would you recommend the health center to your friends?

Yes No Don't Know

Comments _____

8. Could you have gone somewhere else in your community to receive the same type of service provided here at the school health center?

Yes No Don't Know

9. Why do you like to come to the health center at your school? (Check all that apply)

- I like its location I don't have insurance I don't want people to know about my medical care
 It's free (no cost to me) I trust the staff Other _____

10. What other information or services would you like available in the health center?

Thank you for completing the questionnaire.

Student Satisfaction Questionnaire (Middle School)

Grade level _____

Male Female

Date _____

Is this your first visit to the health center this year?

Yes No

If no, how many times have you visited the health center?

0-1 2-5 more than 5

It is very important to us to know how you feel about the services you received today. Your answers to the following questions help us know how we are doing and how to improve our services.

During my visit.....

1. I waited too long to be seen by the health care provider.

Yes No Don't Know

Comments _____

2. The health center staff was friendly to me.

Yes No Don't Know

Comments _____

3. All of my questions were answered by the health care provider.

Yes No Don't Know

Comments _____

4. My privacy was respected.

Yes No Don't Know

Comments _____

5. I received the services I wanted today.

Yes No Don't Know

Comments _____

6. Would you recommend the health center to your friends?

Yes No Don't Know

Comments _____

7. Were you satisfied with the health center?

Yes No Don't Know

Comments _____

8. Please tell us about any improvements you would like to see, or things you do not like.

Thanks.....You're Awesome!!

School Staff/Teacher Satisfaction Survey

Date _____

We are evaluating our role at your school in providing health care services to the students. We are very aware of your commitment to the students and how hard you all work at your school and are concerned about your perception regarding the availability of our services, which include the physical health and mental health of the students. We want to communicate more effectively with you, so that services are not duplicated and we can better serve the students.

Please take a moment to fill out this questionnaire and return it to the health clinic or put it in the school nurse's mailbox.

1. Have you ever referred a student to the School-Based Health Center?

Yes No Didn't know about this service

Comments: _____

2. If yes, did you receive any feedback stating the student was seen?

Yes No

Comments: _____

3. Do you know that providers are available to discuss issues regarding students with you?

Yes No

Comments: _____

4. Would you like the school health center staff to do a presentation in your class next year?

Yes No

If yes, name of teacher _____ Extension _____

5. Do you know the difference between the School Nurse and the School-Based Health Center?

6. Do you have additional suggestions for us?

Thank you!

Appendix C: Sample Youth Focus Group Results

The following focus group results provide an example of another type of needs assessment strategy or evaluation tool. It is also a useful example of youth-led research. *The following recommendations came from a series of youth-led focus groups conducted in seven California communities.*

Forum Participants' Suggestions for SBHCs

Youth Recommendation #1: Advertise School Clinic Services More Broadly

Many students did not know what services their clinic offered nor its hours of operation. Some did not know their high school even had a health clinic. Forum participants suggested the following ideas for promoting SBHCs:

- Advertise the clinic on the loud speaker at school.
- Tell people about the clinic when they first come to the school.
- Make presentations in class and explain what happens when a student visits the clinic.
- Hold assemblies and rallies to introduce the clinic and staff.
- Promote the "FREE" aspect of school-based health care.
- Let students know that having a school clinic means their parents don't have to miss work to take them to the doctor.
- Build a website for each school clinic.

While the majority of students said their parents support SBHCs, students believe that some parents oppose them because they worry about their children getting health services without their parents' knowledge. The students suggested that school clinics should develop a special advertising effort for parents and the community about the benefits to having a school clinic.

Youth Recommendation #2: Continue To Strive To Be Teen-Friendly

Youth cited fear as a barrier to seeking health care at the school clinics. They all agreed that clinics should be welcoming, not intimidating. Youth made the following observations:

- Employing teens or young workers in the health center would help reduce the intimidation of an adult-only staff. (This suggestion came out in *every* youth forum.)
- The clinic's outside appearance should not be "scary-looking."
- Music, television, music videos or video games will help students relax while waiting.
- The clinic should be roomy and colorful.
- SBHCs should consider providing drinks and food.

Many youth also said they would not want to miss class to go to the health center; they suggested keeping clinics open every day of the week and during after-school hours. The youth seemed to believe that if clinics increased their availability and continued to work toward providing a teen-friendly environment, students would be likely to go there for help.

Youth Recommendation #3: Focus On Services That Are Important To Teens

Youth agreed that first and foremost clinics should provide general health services, but they also recommended that clinics provide more specialized health services, such as:

- Physical therapy for people to recover from injuries
- An athletic/ fitness trainer
- Counseling for family problems and psychological problems such as depression

- Health counseling to help students maintain good diets
- Sexual health services and education materials

Youth Recommendation #4: Emphasize Confidentiality

Above all, students wanted absolute assurance that their privacy was protected when they visit the school clinic. They suggested promoting the clinic's privacy policy, including the details about how information is protected. The types of details they wanted included:

- Whether clinic files are locked
- Whether parents or teachers are notified if a student visits the clinic
- What type of employee policies the clinic staff – including youth staff members – must adhere to regarding student privacy
- Whether clinic records and files use students names (versus student ID numbers or other ways to track student health data)

Additional Findings

Mental Health

Most students reported that school clinics that provide mental health services were very helpful but that students did not use these services as much as they should, in some cases because they were not aware of them. Others thought talking to a counselor carried a stigma that teens would want to avoid.

Recommendations listed earlier in this document regarding teen-friendliness and confidentiality might eliminate barriers to teens seeking mental health services.

Health Coverage

The majority of youth agreed that, when they did not use the school health center, the cost of health care was the largest barrier to getting care. Another top barrier was location/transportation (because parents have to miss work). Most students reported having to miss class to visit a doctor. Some said missing class for health care reasons made it difficult to make up coursework, but the bigger problem was for their parents who had to miss work to take them to the doctor.

Appendix D: Sample MOAs Between School District and Licensed Medical Provider

Sample #1

(SAMPLE)
Memorandum of Agreement
Between
(insert name of) School District or Charter School
And
(insert legal name of Medical Sponsor)
For the Provision of School-Based Health Care

This Memorandum of Agreement (MOA) is made and entered into this _____ day of _____, 20____ by and between _____ School District, hereinafter "District," and _____, (insert "a Colorado non-profit corporation" or other legal designation applicable to Medical Sponsor), hereinafter "Medical Sponsor," to formalize our agreement regarding the implementation and operation of a school-based health center on District property.

The parties hereby agree to collaborate on the implementation and operation of a school-based health center (hereinafter "SBHC") at _____ (name of school) located at _____ (address of school).

Obligations of District:

1. Designate and renovate an interior space of approximately _____ square feet to be occupied by the SBHC rent-free. The space, as renovated, will have a reception/waiting area, one exam room with accessible hand-washing sink, one counseling/health education room, one provider office, a unisex bathroom, designated lab space with clean and dirty areas, a secure area for storage of supplies and medications, and a secure area for records storage. The space will also be electrical, phone and internet ready.
2. Provide all utilities, three telephones, internet access, janitorial services, routine maintenance and repairs, removal of non-hazardous waste, security services.
3. Actively promote the SBHC to school personnel, students, and families.
4. Designate the school principal as liaison between school personnel and SBHC personnel in planning and problem solving around issues concerning the SBHC. The principal will assist Medical Sponsor in developing an annual budget for SBHC operations to include the value of in-kind support from District.

5. Designate the school nurse and the school psychologist/social worker to participate in the development and implementation of joint protocols, policies, and procedures that ensure continuity, quality, and confidentiality of school nursing, school mental health, and SBHC services.
6. Provide information technology support.
7. Maintain appropriate records and strict accountability for all funds provided to or by District for implementation and operation of the SBHC.
8. At the time of annual school registration, obtain consent from the parents or legal guardians of children under the age of 18 years _____ (describe the eligible population to be served by the SBHC) who wish to be served by the SBHC. The wording of the consent form(s) will be agreed upon in advance by District and Medical Sponsor.

Obligations of Medical Sponsor:

1. Furnish, equip, and supply the SBHC as required to ensure quality and confidentiality of SBHC services.
2. Arrange for hazardous/biological waste disposal in compliance with federal and state laws.
3. Manage the operation of all services provided in the SBHC by any and all sub-contractors. Oversee contracts and performance expectations of sub-contracting organizations.
4. Provide the following health services to eligible children:
 - treatment of minor acute injury and illness
 - well-child/well-adolescent exams and sports physicals
 - immunizations
 - routine (CLIA-waived) laboratory tests
 - management of chronic illness
 - mental health assessment and treatment, including drug/alcohol treatment
 - case management and referral
 - age-appropriate reproductive health services
 - health education and health promotion
 - medications and/or prescriptions for medications
 - (add any dental services to be provided)

Services will not include hospitalization, after-hours emergency care, treatment of complex medical or mental health conditions, medical x-rays or any other medical procedure that cannot be performed by an advanced practice nurse or physician assistant under state law or that requires facilities beyond those available in the SBHC.

No health services shall be provided to a child under the age of 18 years by the Medical Sponsor or sub-contracting organization without the prior written consent of his or her parent or legal guardian, taking into account the Colorado Revised Statute's minor consent laws. However, in a life or health-threatening emergency, employees of the Medical Sponsor may provide life support services without written or oral parent or guardian consent.

5. Ensure that physician assistants and/or advanced practice nurses employed by the Medical Sponsor and providing services in the SBHC are operating within their scope of practice as defined by state law.
6. Ensure compliance with all applicable federal and state regulations regarding medical facilities and medical practice including those of the Occupational Health and Safety Administration (OHSA) and the Clinical Laboratory Improvement Amendments (CLIA) administered by the Centers for Medicare and Medicaid Services, and the Colorado Board of Pharmacy.
7. Designate one individual who will represent Medical Sponsor in its relationship with District under this MOA and will serve as the primary liaison to District to coordinate the exchange of information between the parties.
8. Ensure that employees and contractors treat all individuals in a nondiscriminatory manner, regardless of race, ethnicity, religion, national origin, citizenship, age, sex, sexual orientation, preexisting medical condition, physical or mental handicap, source of payment, economic status or ability to pay for services provided.
9. Assume responsibility for funding SBHC operations and serve as the fiscal agent for public and private grants and contracts. Develop an annual budget for SBHC operations. The annual budget will include all anticipated sources of revenue for the SBHC including grants, contracts, and donations, reimbursement for services collected from insurance carriers, and the value of in-kind support from District, as well as all anticipated expenses.
10. Maintain appropriate records and strict accountability for all funds provided to or by Medical Sponsor for implementation and operation of the SBHC.

Further Agreements of the parties:

1. The parties will jointly sponsor a Community Advisory Committee made up of representatives of each party to this MOA, representatives of the community at large, and SBHC users (parents and students). The District will convene and support meetings of the Community Advisory Committee at least twice each year. The Committee will review the use and coordination of shared resources for operation of the SBHC, utilization of services provided, need for additional services or programs, and coordination between school staff, SBHC staff, and any sub-contracting organizations.
2. Medical Sponsor will require its employees and the employees of all sub-contractors to undergo criminal background checks. Notwithstanding the foregoing, Medical Sponsor agrees that upon District's request and at District's expense, each employee of Medical Sponsor or sub-contractor who works in the SBHC may be subject to another criminal background check similar to that which District is legally obligated to perform on any new employee. Medical Sponsor agrees to cooperate with District in obtaining authorizations from such employees consenting to such background checks. Medical Sponsor agrees to honor any request by District to not use any individual to provide services in the SBHC based on the results of the background check.
3. The ownership and right to control of all medical records, test results and supporting documents prepared in connection with the delivery of services in the SBHC will vest exclusively in Medical Sponsor. However, Medical Sponsor agrees that copies of such medical records will be released to a

patient, parent or legal guardian, as applicable, pursuant to a valid consent or to a third-party as provided by applicable federal or state law. The parties expressly agree that such medical records will not be released to District nor will District have access to any of the contents of such medical records and such medical records will not be considered “educational records” as such term is defined in the Family Education Rights and Privacy Act of 1974. This section will survive termination of this MOA.

4. Medical Sponsor, at its sole expense, will secure prior to the provision of SBHC services, and will maintain during the term of this MOA: (i) commercial general liability insurance covering itself, its respective employees, contractors and agents, with commercially reasonable limits; and (ii) appropriate workers’ compensation insurance as required by Colorado law; and (iii) appropriate levels of professional liability insurance which covers the provision of the medical services furnished by the Medical Sponsor’s employees at the SBHC. Medical Sponsor will also ensure that sub-contractors and employees of subcontractors are likewise covered for general liability, worker’s compensation and malpractice.
5. Children receiving SBHC services shall be charged the usual and customary fee for said services by the Medical Sponsor. However, no eligible child shall be denied services due to an inability to pay. A sliding fee schedule will be implemented by the Medical Sponsor based on the ability of a child or his or her family to pay. It is expressly understood by and between all parties that the District shall, in no event, be liable for any charges for services rendered to its students by the Medical Sponsor, regardless of whether or not payment is made by student or student’s parents.
6. The Medical Sponsor will manage the submission of claims to the appropriate insurance carrier, i.e. Medicaid, Child Health Plan *Plus* and private insurers. Reimbursements collected either through co-pays or reimbursement by insurance shall be credited to the SBHC account.
7. The Health Insurance Portability and Accountability Act (HIPAA) and respective regulations guide management and protection of personal health information in medical records kept by Medical Sponsor and all sub-contractors providing health care in the SBHC. Medical Sponsor and all sub-contracting medical providers are HIPAA covered entities. The parties agree that personal health information in medical records maintained by Medical Sponsor in the SBHC will not be released to school personnel without required patient or parental consent.
8. The Family Educational Rights and Privacy Act (FERPA) guides management and protection of personal information in education records maintained by District employees including school nurses and school psychologists, social workers and counselors. Education records, including immunization records, are specifically exempted from HIPAA privacy regulations.
9. Colorado law and regulations allow minors to consent for and receive the following confidential health services: alcohol/drug abuse treatment, outpatient mental health treatment, contraceptives, pregnancy care, and STD/HIV diagnosis and testing.
10. Under HIPAA:

Medical Sponsor and sub-contracting health care organizations are permitted to disclose the following without parental consent:

- Personal health information related to a child’s immunization status may be provided to school nurses. School nurses are recognized under HIPAA as limited “public health entities” for the limited purpose of receiving immunization-related information to prevent and control disease.
- Personal health information may be provided to a medical provider, including a school nurse, who is providing care and treatment to the child if it is reasonable to believe that the provider will (i) take appropriate steps to protect the information and (ii) will not use or disclose the information for any purpose other than the delivery of health care to the child.

District employees may disclose the following to Medical Sponsor without specific parental consent:

- Personal health information may be released in any emergency when the information may be necessary to protect the health or safety of the student or other persons; FERPA allows for health information in student education records to be released to SBHC clinicians in an emergency or when the information is necessary to protect the health or safety of the student or other persons.
 - Personal health information related to a child's immunization status may be provided as school nurses are recognized under HIPAA as limited "public health entities" for the limited purpose of providing immunization-related information to prevent and control disease.
11. District and Medical Sponsor agree to use appropriate safeguards to prevent use or disclosure of personal health information consistent with HIPAA privacy rules and state regulations; District will not use or routinely disclose students’ health status information maintained in educational records in a manner that would violate the requirements FERPA or Colorado laws regarding provision of confidential services to minors.
 12. In the case of a medical emergency on school property outside the SBHC facility, the school nurse is the primary provider of first aid and is the first line of response. If the school nurse is not available in an urgent or emergent situation, other appropriate school personnel will respond to the situation. When necessary, SBHC clinicians may be called to the scene, but will follow Medical Sponsor’s direction and procedures regarding their involvement in response to urgent or emergent situations. Sub-contracting organizations will communicate information about their procedures and directions to SBHC clinicians, to the school nurse, and to the school principal so that these can be taken into account in emergency response planning.
 13. The parties agree to design and annually execute an evaluation of SBHC processes, students’ health status, and students' health needs. Both parties will identify, collect, analyze and share data necessary to perform the agreed upon evaluation. Evaluation results will be used to improve the SBHC’s efficiency, effectiveness, utilization and financing in order to increase students’ access to primary health care.

EXECUTION OF THIS MEMORANDUM OF AGREEMENT

The parties agree that:

1. This MOA shall not become effective or binding on any party hereto until it has been fully executed by all parties.
2. This MOA shall be binding on both parties, their successors and assigns.
3. Both parties shall review terms and conditions of the MOA during March of each year. Any amendment desired by one party to the MOA will be proposed to the other party by April 1, will be negotiated and decided upon prior to the last day of the school year, and will become effective and binding on the first day of the following school year.
4. The MOA reflects the entire understanding between the parties with respect to the subject matter hereof and supersedes all other prior oral or written statements, understandings or correspondence.
5. The persons signing the MOA have been fully authorized to execute this agreement and to validly and legally bind District and Medical Sponsor to all the terms, performances, and provisions herein set forth.
6. The effective date of this MOA shall be _____, 20 , and the MOA shall continue in effect until one party gives the other party written notice of its desire to terminate. This MOA may be terminated without cause by District or Medical Sponsor. The effective date of termination will be ninety (90) days after a party's written notice of desire to terminate is received by the other party, or upon a mutually agreed upon termination date.
7. Notwithstanding the above termination provision, if at any time any party is unable to perform its obligation under this MOA consistent with such party's statutory and regulatory mandates, the affected party shall immediately provide written notice to the other party and seek a mutually agreed upon resolution.
8. The notice of termination, and all other communication related to this MOA shall be mailed to the parties at the following addresses:

For District:

For Medical Sponsor:

IN WITNESS WHEREOF, the parties have caused this Memorandum of Agreement to be executed.

Dated: _____, 20

BY: _____
Medical Sponsor representative

Dated: _____, 20

BY: _____
District representative

If Dental Services are to be provided, consider adding:

Provision of Dental Health Services. Dental services may include oral hygiene education, oral health screenings, dental cleanings, sealants, and fluoride varnish. Dental services will be performed by licensed dental hygienists and licensed dental assistants. Dental services will not include the provision of dental fillings, extractions, or sedations or any other dental procedure that cannot be performed by a dental hygienist or a dental assistant under the Dental Practice Law of Colorado (C.R.S. 12-35-101 *et. seq.*), other applicable state law, or that requires facilities beyond those available in the SBHC.

Also consider adding language related to assistance with Medicaid and Child Health Plan *Plus* enrollment if this service is to be provided.

Sample #2

Purpose

The agencies described as [Licensed Medical Provider] and [School District (District)] are entering into this Memorandum of Agreement (MOA) for the provision of physical health care services for the [location] School-Based Health Center (SBHC) for the 2010-2011 school year.

Responsibilities of the Parties

Each party to this MOA understands that it must be able to fulfill its responsibilities under this MOA in accordance with the provisions of law and regulation that govern its individual activities. Nothing in this MOA is intended to negate or otherwise render ineffective any such provisions or operating procedures. If at any time any Parties are unable to perform their functions under this MOA consistent with such Parties statutory and regulatory mandates, the affected Parties shall immediately provide written notice to the others seeking a mutually agreed upon resolution.

[Licensed Medical Provider] will provide:

- Administration and oversight of all services related to the District SBHC in accordance with the Colorado Department of Public Health and Environment, *Quality Standards for Colorado School-Based Health Centers*.
- Physical health care services as described in *Quality Standards for Colorado School-Based Health Centers*.
- All licenses, waivers, certifications, and supervision for those services described in *Quality Standards for Colorado School-Based Health Centers*.
- Documentation of all required professional insurance.
- Management of claim and encounter submissions to Medicaid and commercial payers as described in contracts with these entities. Any reimbursements collected will be the property of the SBHC.

The District will provide:

- Appropriate referrals of students to the SBHC.
- Assistance to students in scheduling of appointments at the SBHC.
- All materials, supplies, equipment and other items necessary to the provision of said physical health care services.
- Facilities adequate for the provision of said physical health care services.

Confidentiality

Parties to this MOA agree to comply with the applicable sections of any appropriate statute or requirement to assure that:

- All applications and individual records related to services provided under this MOA, including eligibility for services, enrollment, and referral shall be confidential and shall not be open to examination for any purpose not directly connected with the delivery or evaluation of such services.
- No person will publish or disclose, use, or permit to be published, disclosed, or used, any confidential information pertaining to applicants, participants, or students overall.
- Each of the Parties will agree to abide by the current confidentiality provisions of respective statutes and shall share information necessary for the administration of the program including accountability. To the extent allowable and in accordance with each of the Parties governing state and/or federal laws and regulations, Parties, therefore, agree to share client information necessary for provision of services and accountability.
- Any information deemed confidential under state or federal law provided to or developed by any of the Parties in the performance of the duties described in this MOA shall be kept confidential and shall not be made available to any individual or organization without the approval of all Parties; however, the Parties shall make administrative, fiscal, program, and participant records available as required by law for audit purposes to assist in the performance of state/federal responsibilities.
- Parties shall notify remaining Parties promptly of any unauthorized possession, use, or knowledge, of any other Parties' data files or other confidential information and shall promptly furnish to those Parties full details of the unauthorized release of such confidential information and shall assist with the investigation or prevention of the further release of such information.

- All services described in this MOA will be delivered in compliance with Health Insurance Portability and Accountability Act (HIPAA) and *Quality Standards for Colorado School-Based Health Centers*.
- Results from any tests performed by [Licensed Medical Provider] that need to be sent to any of the Parties for their records will be sent only when a HIPAA authorization is received from the patient or patient's responsible party.
- The Parties hereto agree that they will not disclose results of any records unless such disclosure is authorized pursuant to the requirements of the Health Insurance Portability and Accountability Act (HIPAA) and state laws and, if necessary, will resist in judicial proceedings any effort to obtain access to the Medical Records, except as provided in the above-cited regulations.

Termination Provisions

Notification of termination shall be given to all Parties at least 30 days prior to the intended date of termination.

Extension

Parties to this MOA may extend the MOA for a specified time. Any notification of extension must be by mutual agreement and must be in writing. Notification of intention to extend the MOA must be given at least 30 days prior to the expiration of the MOA. Any extension of or amendment to this MOA will be pursuant to the terms stated herein.

Parties agree to review this MOA at least annually and provide written suggestions as to recommended changes, clarifications, deletions, or additions. An addendum signed by the authorized representatives of the Parties shall be sufficient to modify the MOA.

Amendment

This MOA shall not be altered, changed, or amended except by instrument in writing executed by the Parties hereto.

Notice of Failure to Perform

If any of the Parties to this MOA, are dissatisfied with the performance of any of the obligations imposed on the other Parties under the terms of this MOA, the dissatisfied Parties shall give written notice to the non-performing Parties of the duties which the dissatisfied Parties believe have not been performed. The non-performing Parties shall have 10 days in which to correct any failure to perform the duties so specified or to communicate with the dissatisfied Parties to resolve any disagreement between the Parties.

Scope of Agreement

This MOA incorporates all the agreements, covenants, and understandings between the Parties hereto concerning the subject matter hereof, and all such covenants, agreements, and understandings have been merged into this MOA. No prior agreements or understandings verbal or otherwise, of the Parties or their agents shall be valid or enforceable unless embodied in this MOA.

Assignment

Parties shall not assign or transfer any interest in this MOA or assign any claims for money due or to become due under this MOA without prior written approval from other Parties.

Funds Accountability and Accounting

The Parties hereto agree that each shall maintain appropriate records for strict accountability for all receipts and disbursements of funds transferred or expended pursuant to this MOA, pursuant to established federal and Colorado cost accounting requirements.

Liability

Parties shall each be responsible for their respective liability. None of the Parties shall be responsible for the liability of the other Parties as a result of acts or omissions in connection with the performance of this MOA. Licensed Medical Provider must maintain and present documentation of all required professional insurance. District affirms that it carries a liability

insurance policy sufficient in amount and coverage, which will apply to any personal injury or loss that may occur on the SBHC's property.

Subcontracting

Parties may not subcontract any portion of this MOA without obtaining the prior written approval of the remaining Parties.

Duration of MOA

This MOA shall be in force from August 1, 20__ – June 30, 20__.

Notice

Any notice required to be given pursuant to the terms of this MOA shall be in writing and shall be hand-delivered or sent by certified mail to the addresses listed in [Exhibit A: List of Addresses] attached hereto. Either party to this MOA may change the address to which notice is to be submitted by notice delivered pursuant to this section.

Signatures

IN WITNESS WHEREOF, the duly authorized representatives of the Parties have executed this MOA effective as of the date first above written.

Dated: _____, 20__

BY: _____

[Licensed Medical Provider] representative

Dated: _____, 20>>

BY: _____

[School District] representative

Appendix E: Joint Statement: School Nurse/School-Based Health Center Partnership



National Association of School Nurses

Joint Statement

School Nurse/School-Based Health Center Partnership

The *National Association of School Nurses*, the *National Assembly on School-Based Health Care*, and the *American School Health Association, School Nurse Section* have collaborated to develop the following statement about the role of school nurses and school-based health centers. It is the intent of all three groups that schools are best served when all health care providers in school settings work closely together to improve the health of students.

School nurses and school-based health center (SBHC) staff share an important mission: protecting and advancing the health and well-being of our nation's school-aged children. Although multiple health professionals in a school setting may have distinctive and complementary functions, funding, and accountability, their objectives are met effectively and efficiently through collaboration. Working as partners, school nurses and staff of school-based health centers are able to increase compliance with treatment plans, facilitate access to needed health and mental health care, monitor outcomes of care, uniformly document care, collect data about health needs and outcomes of care, and provide case management – all critical for improving the quality of health care and academic outcomes for school-aged children and youth.

The school nurse is responsible for managing the health of all students while they are in the school. The school nurse routinely assesses students' needs, utilizing and valuing the additional easily accessible, and user-friendly resource of the SBHC for students who need health, mental health, and social services. The staff of SBHCs either directly provides or makes available, to eligible students, age-appropriate primary services such as health, dental, mental health, social services, and health education. Research indicates that SBHCs provide a safe, efficient, and cost-effective way to deliver health services.

Both the school nurse and the SBHC have distinct roles and each contributes to students' health, academic outcomes, life-long achievement, and over-all student and staff well-being. One does not replace the need for the other. In support of successful school nurse-school-based health center partnerships, a shared vision of collaboration is characterized by:

- inclusion of students, their families, and school staff within the parameters of confidentiality
- well-defined roles and responsibilities that promote seamless and comprehensive care for students and their families
- mutual respect and support for each partner's contributions
- cooperative planning and implementation of school health services and programs to promote the health of the student body
- joint policies and procedures that ensure the quality and confidentiality of care received by students
- information sharing and exchange that protects student privacy and ensures continuity and coordination of care
- a collaborative focus on student academic outcomes

We call upon school and community health professionals to join with us in affirming our mutual responsibility to healthy, productive students.

Reference:

The Role of the School Nurse in School Based Health Centers, Position Statement, National Association of School Nurses, 2001, www.nasn.org

Adopted: October 2001

National Association of School Nurses, Inc.,
8484 Georgia Avenue
Suite 420
Silver Spring, Maryland 20910

1-240-821-1130
1-301-585-1791 Fax
<http://www.nasn.org>
nasn@nasn.org

Appendix F: CASBHC Position Statement on Delivery of Reproductive Health Services

Position Statement:

The Delivery of Preventive and Primary Reproductive Health Services In School-Based Health Centers

The Colorado Association for School-Based Health Care (CASBHC) promotes access to comprehensive health services for adolescents. Where there is a significant documented need to reduce the prevalence of at-risk behaviors and incidence of sexually-transmitted disease among adolescents, school-based health centers (SBHCs) should meet that need through providing preventative and primary reproductive health services. These services include human sexuality education, behavioral risk assessment, counseling, pregnancy testing, contraception or referral for contraception, and diagnosis and treatment of sexually-transmitted infection. Ultimately, the goal is to keep students healthy, in school, and ready to learn.

DOCUMENTING THE NEED FOR REPRODUCTIVE HEALTH SERVICES

TEEN SEXUAL ACTIVITY

The Centers for Disease Control and Prevention (CDC) conducted a nationwide survey to monitor health-risk behaviors among students in grades 9 to 12 from October 2004 to January 2006. Regarding reproductive health nationwide, 46.8 percent of students reported having had sexual intercourse. When broken down by ethnicity, 67.6 percent of blacks, 51.0 percent of Hispanics, and 43.0 percent of whites reported having had sexual intercourse.⁶³ Nationwide, 33.9 percent of students reported having had sexual intercourse with at least one person in the last three months prior to the survey. Of that 33.9 percent, 62.8 percent reported that either they or their partner used a condom during the last sexual intercourse and 17.6 percent reported that they or their partner used birth control pills before the last sexual intercourse.⁶⁴

In Colorado, 39.3 percent of students reported having had sexual intercourse. About 30 percent of students in Colorado reported being currently sexually active, and among these students, 69.3 percent reported condom use during their last sexual intercourse. Fifteen percent reported using birth control pills before their last sexual intercourse.⁶⁵

TEEN PREGNANCY

Nationally and across Colorado, teen pregnancy rates have declined since the early 1990s. Between 1992 and 2000, the nation saw a decrease in teen pregnancy of 24 percent.⁶⁶ Despite the decline, the United States teen pregnancy rate is still the highest among western nations. The pregnancy rate is twice as high

as the rates in England, Wales and Canada, three times as high as Sweden's⁶⁷ and eight times as high as the rates in the Netherlands and Japan.⁶⁸

Compared to the nation, Colorado saw a larger decline in teen pregnancy. Between 1992 and 2000 Colorado's teen pregnancy rate declined 26 percent among 14-19 year olds. Most of the decline occurred among the 18 to 19 year-olds, less among the 15 to 17 year-olds. Although there has been a decline, teenage pregnancy is still pervasive in Colorado. Every four hours, a baby is born to a Colorado teen between 15 and 17 years of age.⁶⁹

Colorado has the 22nd highest teenage pregnancy rate among the 50 states. There are approximately 12,130 teenage pregnancies each year in Colorado of which 62 percent result in live births.⁷⁰ The Colorado Organization on Adolescent Pregnancy, Parenting and Prevention (COAPPP), broke down Colorado's fertility rate by county for females 15-17 years old from 2003 to 2005. Lake County had the highest teen fertility rate at 56.9 per thousand, Otero was second at 54.1 and Denver was third at 53.5. The top ten also included Crowley with 48.4, Morgan with 46.3, Castilla with 45.6, Prowers with 42.0, Adams with 40.9, Rio Grande with 39.6, and Huerfano with 38.8 per thousand.⁷¹

The calculation of rates can be deceptive when the population being measured is small, as it is in many rural counties in Colorado. Therefore, COAPPP created a list of the state's most populated counties having the highest teen fertility rates. At the top of the list is Denver with 53.5. The fertility rates in other highly populated counties are: Adams 40.9, Pueblo 36.4, Weld 35.4, Arapahoe 20.0, El Paso 19.6, Boulder 15.4, Larimer 14.2, Jefferson 13.0, and Douglas 4.3.⁷²

SEXUALLY TRANSMITTED INFECTIONS

Studies show that persons who engage in sexual activity at a young age often have multiple sexual partners and frequent sexual encounters. Both behaviors can be attributed to increased risk of contracting sexually transmitted infections (STIs). Additionally, adolescent females may be more susceptible to STIs than older women. Teen girls have fewer antibodies to STIs and may have a higher risk of cervical infections.⁷³ In 2006, the highest rates of Chlamydia were in females age 15-19 at 347.8 cases per 100,000, a 5.6 percent increase from 2005.⁷⁴ Approximately nine million U.S. teens contract an STI every year.^{75,76} Compared to other states, Colorado ranks 22nd for Chlamydia, 32nd for gonorrhea and 24th for syphilis.⁷⁷

CONSEQUENCES OF TEEN PREGNANCY

ECONOMIC IMPACT

Children of teens born in Colorado cost taxpayers at least \$167 million in 2004 (\$9.1 billion nationally). Included in the taxpayer costs are medical care for the child, child welfare services, and lost tax revenue due to decreased earnings and spending of the parents. The average annual public cost associated with a child born to a mother 17 years of age and younger is \$4,056.⁷⁸

EDUCATIONAL IMPACT

Pregnancy is the main reason adolescent girls drop out of school.^{79,80} Young mothers are less likely to graduate.^{81,82} Although little research has been completed on adolescent fathers, it is known that, should they decide to support their child, they too are more likely to drop out of school.⁸³

HEALTH AND SOCIAL WELFARE IMPACT

Pregnancy disrupts adolescence, which is a time of transition between childhood and adulthood. There are several negative health and social impacts on a teenage parent. Pregnant teens are more likely to experience higher rates of pregnancy-related complications, such as toxemia and anemia; and, they are more likely to deliver low birth weight, premature,⁸⁴ and developmentally disabled babies.⁸⁵ Additionally, teen mothers are more likely to be single parents, have a greater reliance on public assistance, and have multiple children over a short time frame.⁸⁶

While teen mothers face difficulties, their children face even more hardships. Children of teen mothers often have poorer health, more developmental delays,^{87,88} and are more likely to be abused and/or neglected.^{89,90} As children of teen mothers age, they are predisposed to dropping out of school, obtaining low-skilled employment, being incarcerated,⁹¹ and becoming teen parents themselves.⁹² According to The National Campaign to Prevent Teen Pregnancy, if a child's mother gave birth as a teen, if the child's parents were unmarried when the child was born, and if the mother did not receive a high school diploma or GED, the child is nine times more likely to grow up in poverty compared to if none of these factors existed.⁹³

CONSEQUENCES OF SEXUALLY TRANSMITTED INFECTIONS

The most common STIs are Chlamydia, human papillomavirus (HPV), genital herpes, gonorrhea, syphilis and human immunodeficiency virus (HIV). Some STIs have painful and long-term consequences, including birth defects, blindness, cancer, heart disease, and death.⁹⁴ STIs can also lead to infertility, ectopic pregnancy, and long-term emotional suffering and stress.

CHLAMYDIA AND GONORRHEA

According to the Center for Disease Control and Prevention (CDC), in 2004, 929,462 cases of Chlamydia were reported from 50 states and the District of Columbia. However, the CDC approximates that 2.8 million people are infected with Chlamydia each year, most going unreported due the absence of signs or symptoms. Like Chlamydia, gonorrhea often presents with no symptoms; however, symptoms may occur within thirty days but be mistaken for other infections.⁹⁵ Roughly 75 percent of American gonorrhea infections occur in persons 15 to 29 years old. Additionally, in 1999, 75 percent of gonorrhea infections occurred in African Americans.⁹⁶

PELVIC INFLAMMATORY DISEASE (PID)

Left untreated, both Chlamydia and gonorrhea can lead to pelvic inflammatory disease (PID).^{97,98} Many organisms can cause PID; however, most cases of PID are associated with Chlamydia and gonorrhea.⁹⁹ Approximately one million women develop PID each year in the United States.¹⁰⁰ PID is more likely to occur in sexually active women under the age of 25 than in women older than 25. Due to the lack of

maturity, a younger woman's body is more susceptible to contract STIs that eventually lead to PID if left untreated. PID usually goes undetected and untreated due to its mild symptoms. Additionally, there are no specific tests to identify PID. However, untreated PID can damage the female reproductive system leading to infertility. One in eight women with PID becomes infertile.¹⁰¹

HUMAN PAPILLOMAVIRUS (HPV)

HPV is the most common STI in the United States¹⁰² affecting approximately 20 million people.¹⁰³ Roughly 50 percent of sexually active men and women will acquire genital HPV infection at some point in their lives. By age 50, approximately 80 percent of women will have acquired genital HPV infection.¹⁰⁴ HPV often presents with no symptoms for both men and women. Some people develop genital warts, and some may have pre-cancerous changes in their reproductive tract. According to the CDC, "Human papillomavirus is the name of a group of viruses that have more than 100 different strains. More than 30 of these viruses are sexually transmitted."

Currently, there is no cure for HPV infection. For most men, the virus will never cause any symptoms or health problems,¹⁰⁵ and for most women, the virus will go away on its own.¹⁰⁶ For 90 percent of women, cervical HPV infection becomes undetectable within two years.¹⁰⁷ However, about 10 of the 30 genital HPV types can lead to cervical cancer. Therefore, in 2006, the Food and Drug Administration approved the Gardasil vaccine, which prevents infection from four common types of HPV.¹⁰⁸

STIS AND HIV

All STIs have a link with HIV infection. According to the CDC, having an STI increases a person's susceptibility to HIV.¹⁰⁹ Women infected with Chlamydia are up to five times more likely to become infected with HIV if exposed.¹¹⁰

STIS AND PREGNANCY

STIs also pose consequences for pregnant women who can pass an STI to their babies before, during, or after birth. STIs in babies can cause stillbirth, low birth weight, conjunctivitis (pink eye), pneumonia, neonatal sepsis (infections of the baby's blood stream), neurological damage, blindness, deafness, acute hepatitis, meningitis, chronic liver disease and cirrhosis.¹¹¹

DEFINING PREVENTIVE AND PRIMARY REPRODUCTIVE HEALTH SERVICES OFFERED IN A SCHOOL-BASED HEALTH CENTER

Preventative and primary reproductive health services may be offered at school-based health centers in order to reduce the incidence of disease and prevalence of at-risk behaviors among adolescents. Although the services vary among centers, they most often include human sexuality education, a comprehensive behavioral risk assessment, counseling, pregnancy testing, contraception or referral for contraception, and diagnosis and treatment of sexually transmitted infections.

The services provided by each SBHC vary based on the age of students served, student need, community resources, available funding, and local school district policy. Most SBHCs located in high schools include a comprehensive behavioral risk assessment as part of a well-adolescent exam and follow-up with

health education and counseling when a need is identified. Sexually active students are counseled and informed about the risk of pregnancy and sexually transmitted infection. Some SBHCs provide contraception, while others refer students to another provider in the community. Most SBHCs provide pregnancy testing upon request. If a diagnosis of pregnancy is made, SBHCs provide non-directive counseling, support, and referral as needed. However, in rural areas of Colorado, lack of community resources and inadequate transportation may make referrals impractical and limit access to reproductive health services.

HUMAN SEXUALITY EDUCATION

Desired Outcome: Adolescents make informed, healthy decisions to delay sexual activity.

PROGRAM TYPES

The two main types of human sexuality education programs are Abstinence-Only and Comprehensive.

ABSTINENCE-ONLY PROGRAMS

There are two sub-types of abstinence-only programs; Abstinence-Only Education and Abstinence-Only-Until-Marriage Education. Abstinence-Only Education promotes abstinence as the “only morally correct option of sexual expression for teenagers.” Abstinence-Only-Until Marriage programs are similar but add a component regarding unmarried adolescents and/or young adults.¹¹² Both programs exclude information about using contraception as a way to prevent unwanted pregnancies and to prevent infections.¹¹³ Another commonly used name for abstinence-only programs is Abstinence-Centered Education.¹¹⁴

COMPREHENSIVE SEX EDUCATION PROGRAMS

Comprehensive sex education programs stress the importance of abstinence as the best way to prevent pregnancy and disease. These programs also provide information on various types of contraception, including their benefits, their success and failure rates, and possible side effects.¹¹⁵ Other names for comprehensive sex education programs are Abstinence-Based Education and Abstinence-Plus Education.¹¹⁶

A law passed by the Colorado General Assembly in 2007 (HB07-1292) requires that a school district or charter school that offers instruction in human sexuality must base the content on scientific research and must encourage parental involvement and family communication. The law states, in part, that “Comprehensive sex education programs that complement the involvement and instruction of parents and respect the diversity and values of the state provide Colorado’s youth with a foundation of information to help them make responsible, healthy, and informed decisions.”¹¹⁷

EVALUATION OF ABSTINENCE-ONLY PROGRAMS AND COMPREHENSIVE SEX EDUCATION PROGRAMS

Numerous studies have been completed about the effectiveness of abstinence-only programs and comprehensive sex education programs. These studies have conclusively shown that, while there are benefits to both, comprehensive sex education programs have been more effective in delaying the

initiation of sex, reducing the number of sexual partners, and reducing the frequency of sex.^{118,119} Additionally, comprehensive sex education programs do not increase sexual activity.^{120,121,122}

As cited in the statement of the American Psychology Association Committee on Psychology and AIDS:

The research on adolescents' sexual behavior shows that comprehensive sexuality education programs that discuss the appropriate use of condoms do not accelerate sexual experiences. On the contrary, evidence suggests that such programs actually increase the number of adolescents who abstain from sex and also delay the onset of first sexual intercourse. Furthermore, these programs decrease the likelihood of unprotected sex and increase condom use among those having sex for the first time.¹²³

In addition, "studies of schools with health clinics and schools with condom-availability programs have consistently shown that the provision of condoms and other contraceptives through schools does not increase sexual activity"¹²⁴

COMPREHENSIVE BEHAVIORAL RISK ASSESSMENT

Desired Outcome: Reduce the incidence of risk-taking behavior through collecting information about the type of behaviors in which the adolescent is engaged and educating the adolescent as part of the well-adolescent exam.

Comprehensive behavioral risk assessments are administered for the purpose of identifying unhealthy behaviors and providing appropriate interventions. One of the most widely used risk assessment tools is the Guidelines for Adolescent Preventive Services (GAPS). GAPS was developed by the American Medical Association to organize, restructure, and redefine health care delivery for adolescents. GAPS provides twenty-four recommendations to physicians and other health providers on how to best deliver preventative services.^{125,126} "The goal of GAPS is to improve health care delivery to adolescents using primary and secondary interventions to prevent and reduce adolescent morbidity and mortality"¹²⁷

COUNSELING

Desired Outcome: To support students in making healthy choices around reproductive health issues; to increase positive communication around reproductive health issues.

Counseling is an important aspect of providing reproductive health services as it is vital to understand the motivating factors behind adolescent choices to become sexually active. Clinicians and health educators encourage adolescents to involve their parents in reproductive health decisions. Within the scope of counseling services at SBHCs, staff may counsel adolescents regarding their developmental and/or emotional preparedness for having sex, peer influences, parental values, and self-esteem. If the adolescent is in a relationship, discussions may address the components of a healthy relationship.

CONTRACEPTION AND PREGNANCY TESTING

Desired Outcomes: To reduce the number of unwanted pregnancies; to increase knowledge around ways to prevent unwanted pregnancies and sexually transmitted infections; to encourage early prenatal care and improve the health of babies born to adolescent women.

Approximately 80 percent of teen pregnancies are unintended.¹²⁸ When teens use contraception during their first sexual experience, they are less likely to get pregnant. Forty-three percent of teen girls who did not use contraception during their first sexual experience reported pregnancy versus 27 percent of teen girls who used contraception. Likewise, 18 percent of teen boys who did not use contraception at first intercourse reported involvement in a pregnancy versus 12 percent who used contraception.¹²⁹ According to the National Campaign to Prevent Teen and Unwanted Pregnancy, many teens do not use contraceptives consistently and correctly. Of girls age 15 – 19 who use oral contraceptives, only 70 percent take a pill every day.¹³⁰

Pregnancy testing is performed in SBHCs upon request. If an adolescent has a negative pregnancy test, the clinician provides education and counseling and, if the adolescent indicates continuing sexual activity, contraception or a referral for contraception. If the pregnancy test is positive, the adolescent is strongly encouraged to inform and involve parents or other trusted adults in decision-making, and non-directive, family-centered counseling is initiated.

DIAGNOSIS AND TREATMENT OF SEXUALLY TRANSMITTED INFECTION

Desired Outcome: Early intervention to lower complications.

Upon request, adolescents are screened for sexually transmitted infections. Some SBHCs have the capacity to provide treatment for STIs; others refer to providers in the community. In addition to treatment, SBHCs provide education and counseling to address at-risk behaviors.

Antibiotics are most often used to treat bacterial infections such as gonorrhea, Chlamydia, and syphilis. Viral infections are commonly treated with antiviral medications as needed. Self-care can relieve some painful symptoms related to genital herpes or genital warts.

SCHOOL-BASED HEALTH CENTERS AND THE LAW

In the state of Colorado, a minor may consent to the following services: contraceptive services, STI services, prenatal care, and general medical care for the minor's child.¹³¹ According to 25-4-402 Colorado Revised Statutes, a minor may consent to examination and treatment of a "venereal" disease without the consent or notification of a parent, and a physician may provide an examination and treatment for a "venereal" disease without the consent or notification of a parent without penalty.¹³²

Additionally, in the state of Colorado, sexual contact is prohibited if the juvenile is under the age of 15 and the "actor" (other person) is more than four years older.¹³³ If SBHC personnel suspect sexual abuse, they are mandated to report the information to appropriate officials.

CONFIDENTIALITY

Privacy and confidentiality are of the utmost importance in providing medical care to adolescents. Teens are more likely to share important health-related information with trusted adults. SBHCs are bound by the Health Insurance Portability and Accountability Act (HIPAA). HIPAA guidelines regulate who can access medical records and personal health information and what information can be disclosed. Because Colorado allows minors to consent to reproductive health services, parents of minors are not allowed access to their child's medical records under HIPAA, unless the minor consents.¹³⁴ However, SBHC clinicians encourage adolescents to engage in open dialogue with their parents/guardians about all aspects of their health care.

CONCLUSION

The services provided in each school-based health center depend upon the age of students served, documented need, community resources, available funding, and local school district policy. Where there is a significant documented need among adolescents for comprehensive reproductive health services, school-based health centers should meet those needs through providing human sexuality education, behavioral risk assessment, counseling, pregnancy testing, contraception or referral for contraception, and diagnosis and treatment of sexually transmitted infection.

Appendix G: CASBHC Membership Form



COLORADO ASSOCIATION FOR
SCHOOL-BASED HEALTH CARE

Membership Application

1801 Williams Street, Suite 400
Denver, CO 80218

www.casbhc.org

Name:

Title:

Company:

Address:

City: **Zip:**

Please indicate if above address information is business or home Business Home

Email: **Phone:**

Sponsoring Organizational Membership

Sponsoring Organization members are primary sponsors of operational school-based health centers in Colorado. Dues are based on the organization's annual operating budget. If you are interested in becoming a Sponsoring Organization, please contact the CASBHC office at 303-399-6380 prior to completing the application form.

Collaborating Organization Membership

Collaborating Organization members have a contractual affiliation with an operational school-based health center in Colorado. Annual dues for a Collaborating Organization Member are \$100.

Associate Membership

Associate members are organizations or individuals who support CASBHC's mission and goals. Annual dues for an Associate Organization Member are \$100. Annual dues for individuals are \$35.00.

All memberships are renewed annually and run from January 1 through December 31 of each year.	
Please make checks payable to CASBHC. Mail with application form to:	<input type="checkbox"/> Collaborating Organization \$100.00
CASBHC 1801 Williams St., Suite 400 Denver CO 80218	<input type="checkbox"/> Associate Organization \$100.00
<i>For inquiries, call 303-399-6380</i>	<input type="checkbox"/> Associate Individual \$35.00
	Donation \$ <input type="text"/>

Appendix H: CASBHC White Paper on the Impact of Federal Privacy Laws on the SBHC

The Impact of Federal Privacy Laws on the School-Based Health Center

Research studies have documented that students will forgo health care due to doubts over privacy.^{1, 2} When children, especially adolescents, have concerns about the confidentiality of their health issues, they may avoid care, stop seeking care, or be less than forthcoming with clinicians about their health behaviors, symptoms, and concerns.³ From a health care provider's point of view, protecting confidentiality is critical to building trust so that the patient will seek needed care and divulge all information necessary to develop an accurate diagnosis and appropriate treatment options.

Beyond the practical benefits of confidentiality, there are many federal laws that protect an individual's health information. Well known are those that apply to health care providers, including the privacy regulations issued under the Health Insurance Portability and Accountability Act (HIPAA), the Title X Family Planning Program of the Public Health Service Act, and the laws governing drug and alcohol treatment. There are also federal laws that obligate educators to protect health information that becomes part of a student's educational record, including the Family Educational Rights and Privacy Act (FERPA), the Individuals with Disabilities Education Act (IDEA), and Section 504 of the Americans with Disabilities Act. Because school-based health center providers and educators interact frequently, it is important to understand the basic provisions of these laws.

State laws (such as minor consent laws, medical records laws, and other provisions) also regulate the privacy of personal health information. In addition, there may be policies of the school-based health center's medical sponsor and/or the host school district concerning record keeping or release of information. These policies may be designed as guidance in the implementation of federal and state laws, but may also be more stringent than those laws.

The focus of this paper is to examine the intersection of the two major federal privacy laws that regulate the interactions between school-based health center staff and personnel of the host school or school district. These two federal laws are HIPAA and FERPA. This paper provides general information about the scope of these laws and is not intended as legal advice. When developing policies, forms, or procedures for a school-based health center, it is best to consult legal counsel.

The Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act (HIPAA) was enacted by Congress in 1996. Its intent was to ensure continued health insurance coverage to those who change jobs and to establish security and privacy in the exchange of health information. In 2002, final privacy regulations were issued pursuant to HIPAA by the U.S. Department of Health and

Human Services (HHS). Implementation and interpretation of these privacy regulations (referred to throughout this paper as the HIPAA Privacy Rule) are the responsibility of the HHS Office of Civil Rights.

The HIPAA Privacy Rule protects all "individually identifiable health information" held or transmitted by a "covered entity" or its "business associate," in any form or medium, whether electronic, paper, or oral.^{4,5} The HIPAA Privacy Rule calls this information "protected health information" (PHI). PHI includes demographic data that relates to the patient's past, present, or future physical or mental health, as well as information about any care provided to the patient.⁴

"Covered entities" that are required to comply with the HIPAA Privacy Rule include health care providers (hospitals, clinics, individual practitioners), health plans, and health information clearinghouses.

Generally, authorization from a patient ("the individual") or a patient's personal representative is required for disclosure of PHI. However, PHI can be disclosed to a third-party without authorization in specific circumstances. These include sharing of information for the purpose of treatment (providing health care, consultations, coordinating care and making referrals); payment or health care operations; reporting of diseases to public health authorities; reporting of injuries and suspected child abuse; disclosing information in emergencies to lessen or prevent a serious and imminent threat to the health or safety of a person or the public; and for compliance with a court order. Patients are made aware of these instances of potential sharing of information when they acknowledge that they have received and read a copy of the provider's privacy notice.

Under the HIPAA Privacy Rule, a parent is usually the personal representative of a patient who is a minor. Therefore, parents generally have the right to make health care decisions for their minor children. Parents also have the right to view the health records of their minor children, and a parent's authorization is generally required for disclosure of PHI to another person. Under the HIPAA Privacy Rule, however, when a minor legally consents to health care – under state minor consent laws, for example – the minor is considered "the individual" and has access to and control over disclosure of his or her own PHI. There is one exception to this: whether a parent has access to a minor's PHI *when the minor has legally consented to the care* depends on "state or other applicable law,"^{5,6} so if state or other law either requires or prohibits disclosure to parents, that requirement controls. If state or other law permits disclosure or is silent, then the health care provider has discretion whether to give the parent access to the minor's PHI.^{5,6}

In Colorado, it is clear that minors may consent for contraceptive services, sexually transmitted infection services, drug or alcohol treatment, and mental health treatment. It is also clear that there is no requirement to notify parents when minors consent for these services. However, in the case of mental health treatment, Colorado law provides that a professional person providing services to a minor age 15 or older who has given his or her own consent for the services *may*, with or without the minor's consent, advise the parent or legal guardian of the

services given or needed.⁷ Therefore, if a parent asks for access to PHI about mental health care for which a minor has legally given consent, the provider may make a determination regarding release based on the particular case.⁸

Finally, the HIPAA Privacy Rule discusses whether “incidental disclosures” of protected health information violate HIPAA. An example of an incidental disclosure is when a third-party overhears a clinician reviewing a patient’s case. It has been decided that if “reasonable safeguards” have been implemented to reduce the likelihood of inappropriate sharing of PHI, then no violation has occurred.⁹

The Family Educational Rights and Privacy Act

The Family Educational Rights and Privacy Act (FERPA) was enacted by Congress in 1974 and has been amended nine times.¹⁰ The intent of the law is to protect the privacy of parents and students by controlling access to, and release of, information held in students’ “educational records.” The term “educational record” is broadly defined as information which is directly related to a student and is maintained by a public school, educational agency, or any person acting on behalf of a public school or agency.¹¹ These records include student health records and records maintained on special education students in accordance with the Individuals with Disabilities Education Act or Section 504 of the Americans with Disabilities Act.¹¹ Unlike HIPAA, FERPA applies only to official student information and does not cover casual communication or personal notes.

FERPA applies to all educational agencies and institutions which receive money from any program administered by the U.S. Department of Education. This includes virtually every public school, public school district, and all state Departments of Education. Most private and religious schools are exempt from FERPA because they do not receive U.S. Department of Education funding. State education record laws may still apply to nonpublic schools and provide privacy protection.

The main provisions of FERPA are: 1) a parent, legal guardian, or eligible student has the right to inspect and review the student’s educational records and seek to have them amended in certain circumstances; 2) a student’s educational records cannot be released to any party without a parent’s, legal guardian’s, or eligible student’s written consent; but 3) a student’s educational records can be released to school personnel who have a “legitimate educational interest,” without parental or student consent; and 4) records can be released in an emergency when the information is necessary to protect the health or safety of the student or others and also when requested during an investigation of an act of terrorism. An eligible student is a student who is at least 18 years of age. School districts must establish policies to determine “legitimate educational interest” to prevent the casual exchange of student information.

The Intersection of HIPAA and FERPA and School-Based Health Centers

A school-based health center (SBHC) is a health care facility located in a school or on school grounds and operated through a partnership between a school district and a licensed health care provider. Given this, SBHC personnel need to know whether the records of patients seen in the SBHC are considered educational records governed by FERPA or health records governed by HIPAA or both. The answer to this question is determined by who “owns” the records. In most cases, the SBHC is operated under a binding contract which specifies that the school district owns the facility in which the SBHC operates, but the health care provider owns the medical practice and the records. When the health care provider owns the records, the records are generally subject to HIPAA.

If, alternatively, a school district directly employs a health care provider to operate the SBHC, the records belong to the district and are governed by FERPA. This is not unlike the situation with school nurses. School nurses are employed by the school district and any records developed by the school nurse are part of the educational record and fall under the purview of FERPA. FERPA does not allow schools to protect student health information differently from academic information, making it available to parents and legal guardians regardless of state minor consent laws and to school personnel with a “legitimate educational interest.”

While FERPA permits disclosure of educational records, including health information contained in them, to parents and persons with a legitimate educational interest, it does not allow release to outside parties without parental consent or consent of a student who is age 18 or older. This creates barriers to the exchange of health information between the school and the SBHC. For example, a school nurse cannot release information contained in the educational record, such as a student’s health history, an individualized health care plan, medications administered during school hours, or recommendations related to screenings, to an SBHC provider unless parental consent is obtained. For this reason, at the beginning of each school year, SBHCs generally ask parents to sign a form allowing the school to release health information contained in the educational record to the SBHC and also allowing the SBHC to release health information to the student’s primary care physician, to specialists or community-based programs to coordinate care or to effect a referral, and to public or private third-party payers for billing purposes. Finally, the SBHC should require the parent to acknowledge that he/she has received, read, and understood the SBHC’s statement of HIPAA privacy protections and rights. Several samples of consent forms used by Colorado SBHCs are posted on the CASBHC website at www.casbhc.org.

To conclude, provider-patient confidentiality is paramount in the SBHC to ensure that students seek care and that providers have sufficient information from the patient for proper diagnosis and treatment. Providers, parents, and patients should all have a clear understanding about whether health information acquired by an SBHC is covered by FERPA or HIPAA, and accordingly, who may have access to it. The important differences in the two laws related to access to health information are outlined below:

Issue	FERPA	HIPAA
Parental access to information	Parents have the right to access their child’s health information maintained by the school in the child’s educational record unless the child is an “eligible student” age 18 or older.	Parents have the right to access their minor child’s PHI maintained by a health care provider in the child’s medical record, except for information pertaining to services covered by Colorado’s minor consent laws. Information about mental health treatment to which a minor has consented is generally confidential, but in some circumstances may be disclosed to parents based on the discretion of the health care provider. Once the child turns 18 years of age, consent of the child is required for parental access to PHI.
Access to protected health information by other persons (not the patient or parent)	Health information can be released to school personnel without parental consent when a legitimate educational interest exists	A minor child’s PHI cannot be released without parental consent except when necessary to coordinate treatment, meet legal or billing requirements, avoid harm to the patient or others, insure public health, and a few other specific circumstances.

Those working in SBHCs should be especially aware of the possibility of incidental disclosures because of their small facilities. Clearly, conducting interviews with students in an open cubicle where conversations can be easily overheard will not qualify as a “reasonable safeguard” as required under HIPAA.¹² Similar considerations for discretion or restriction of access must be taken into account for written and electronic notes or files.

Although HIPAA does allow limited disclosure of PHI for coordination of care between providers, questions concerning the appropriateness of communicating about a patient can arise, especially when providing integrated care. In the SBHC, for example, a pediatric nurse practitioner employed by one covered entity may work alongside a behavioral health specialist employed by a different covered entity. In this case, the SBHC should obtain a release signed by a parent or legal guardian so that information critical to patient care can be exchanged between the two providers.

To make integrated care easier and more efficient, SBHCs can create a structure called an Organized Health Care Arrangement (OHCA) under HIPAA.¹³ In order to qualify as an OHCA, the SBHC must be:

1. “A clinically integrated care setting in which individuals typically receive health care from more than one health care provider; and

2. “An organized system of health care in which more than one covered entity participates, and in which the participating covered entities (a) hold themselves out to the public as participating in a joint arrangement; and (b) participate in joint activities that include at least one of the following:¹⁴ utilization review, quality assessment and improvement activities, or payment activities.”¹⁵

Salud Family Health Centers in northern Colorado operate as an OHCA. Their presentation to the public as an OHCA is seen, in part, through a joint notice of privacy practices. Viewing Salud’s privacy notice may be helpful to better understand how OHCA’s might be organized. The privacy notice can be found at: www.saludclinic.org/policy2.html.

Because health information maintained by an SBHC can be subject to HIPAA or FERPA depending upon how the SBHC is legally structured, it is important for both school administrators and health care providers to thoroughly understand both federal laws as well as their relationship to state minor consent laws. In addition to the important confidentiality protections contained in both federal and state laws, all personnel should understand the exceptions which prevail in situations such as emergencies, threats of harm to self or others, and suspected child abuse. It is recommended that SBHCs review their operating documents (including any memoranda of understanding between the school district and medical providers) to insure that ownership of PHI is explicit. SBHCs should also periodically review their patient registration materials to make sure the Notice of Privacy Policy is current and clear, and consent forms are appropriate given the controlling law. Finally, it is critical that SBHCs provide training to both SBHC personnel and educators working in the school to ensure all parties understand the “ground rules” for communicating with each other for the benefit of students.

Useful Websites for Further Information and Examples

- Additional information on HIPAA may be found at the website of the US Office of Civil Rights at: www.hhs.gov/ocr/hipaa
- Additional information on FERPA may be found at the website of the US Dept. of Education at: www.ed.gov/policy/gen/guid/fpco/ferpa/index
- FAQs on the HIPAA-FERPA intersection compiled by both the U.S. DHHS and the U.S. DOE at: www.ed.gov/policy/gen/guid/fpco/doc/ferpa-hipaa-guidance.pdf
- For general information about the HIPAA Privacy Rule, go to: www.healthprivacy.org
- For information about the HIPAA Privacy Rule and public health, go to: www.cdc.gov/privacyrule/
- For an overview of patient rights and responsibilities under HIPAA, go to: hcpf.cdhs.state.co.us/HCPF/HIPAA/hipPrivacy.asp
- For a concise privacy notice, a statement of patient rights and responsibilities, go to: hcpf.cdhs.state.co.us/HCPF/HIPAA/UpdatedHIPAANotice0208.pdf
- For a copy of the University of Colorado Health Sciences Center’s HIPAA Policy, go to: www.uchsc.edu/hipaa/internal/docs/3.1.pdf
- For summaries of the Protection of Pupil Rights Amendment (PPRA), go to: www.ed.gov/policy/gen/guid/fpco/ppra/index.html, or www.ed.gov/policy/gen/guid/fpco/ppra/modelnotification.html

Citations

- (1) Lehrer, J.A., Pantell, R., Tebb, K., & Shafer, M.A. (2007.) Forgone health care among U.S. adolescents: associations between risk characteristics and confidentiality concern. *Journal of Adolescent Health*, 40: 218–226.
- (2) Ford CA, Bearman PS, Moody J. Foregone health care among adolescents. *Journal of the American Medical Association*. 1999; 282: 2227-2234.
- (3) Ford CA and English A. Limiting confidentiality of adolescent health services: what are the risks? *Journal of the American Medical Association*. 2002; 288: 752-753.
- (4) American Academy of Family Physicians. What is protected health information? Available at: www.aafp.org/online/en/home/practicemgt/regulatory-compliance/hipaa/hipaaprivacy/whatisphi.html
- (5) Rosenbaum, S., Abramson, S., MacTaggart, P. Health information law in the context of minors. *Pediatrics*. 2009; 123 Supplement: S116-S121. (5a)
- (6) English A and Ford CA. The HIPAA privacy rule and adolescents: legal questions and clinical challenges. *Perspectives on Sexual and Reproductive Health*. 2004; 36:80-86.
- (7) Colorado Revised Statute § 27-10-103.
- (8) Dailard C. New medical records privacy rule: the interface with teen access to confidential care. *Guttmacher Report on Public Policy*. 2003; 6: 6 –7.
- (9) Office for Civil Rights. Incidental Uses and Disclosures. Available at: www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/incidentallusesanddisclosures.html
- (10) U.S. Department of Education. Legislative History of Major FERPA Provisions. Available at: <http://www.ed.gov/policy/gen/guid/fpco/ferpa/leg-history.html>
- (11) U.S. Department of Health and Human Services and U.S. Department of Education. Joint Guidance on the Application of the *Family Educational Rights and Privacy Act* (FERPA) and the *Health Insurance Portability and Accountability Act of 1996* (HIPAA) to Student Health Records. Available at: <http://www.ed.gov/policy/gen/guid/fpco/doc/ferpa-hipaa-guidance.pdf>
- (12) The Center for Health and Health Care in Schools, InFocus, August 27, 2002. Available at: www.healthinschools.org/News-Room/InFocus/2002/Issue-4.aspx
- (13) Office for Civil Rights, U.S. Department of Health and Human Services. Uses and Disclosures for Treatment, Payment and Health Care Operations. Revised April 3, 2003. Available at: www.hhs.gov/ocr/privacy/hipaa/understanding/coveredentities/sharingfortpo.pdf
- (14) Association of American Medical Colleges. AAMC’s HIPAA Frequently Asked Questions #1. June 2003. Available at: www.asrm.org/Media/misc_announcements/aamc_hipaa.pdf
- (15) DiAntonio, J. Organized health care arrangements under HIPAA. *Health Law Alert*. Spring-Summer, 2003: 21-22.

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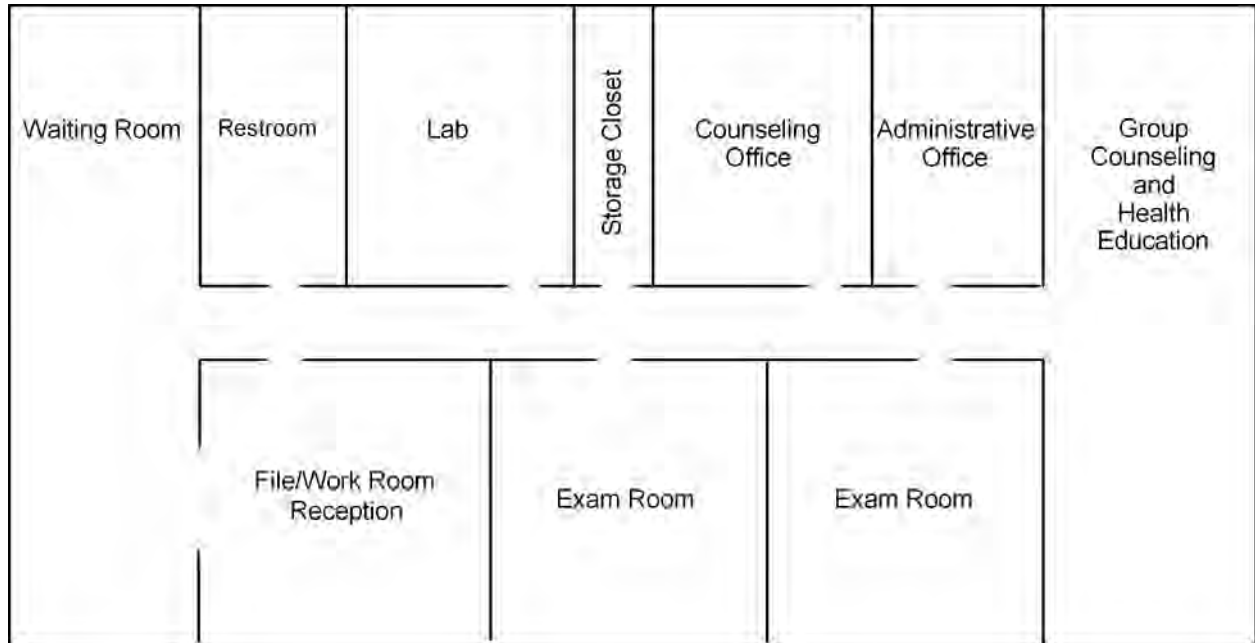
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Appendix I: Sample Floor Plans

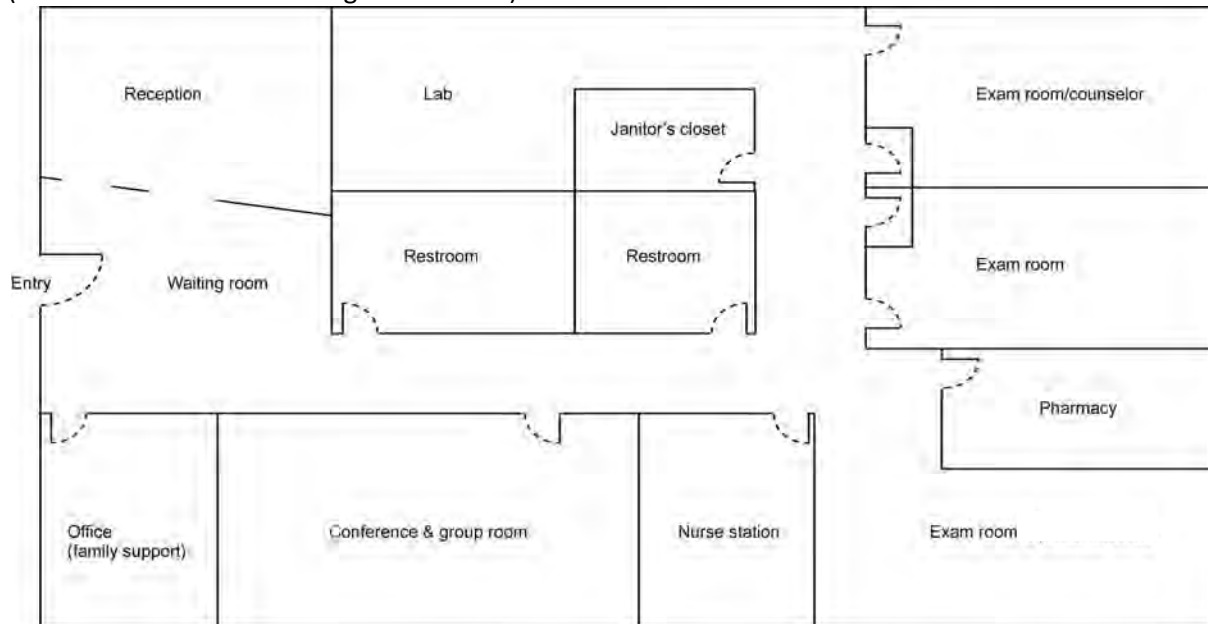
The floor plans that follow demonstrate different ways that schools may utilize existing space or create new space to house their SBHC. In Colorado, the average SBHC is 713 square feet. The size ranges from 200 to 2000 square feet.

Basic SBHC Floor Plan



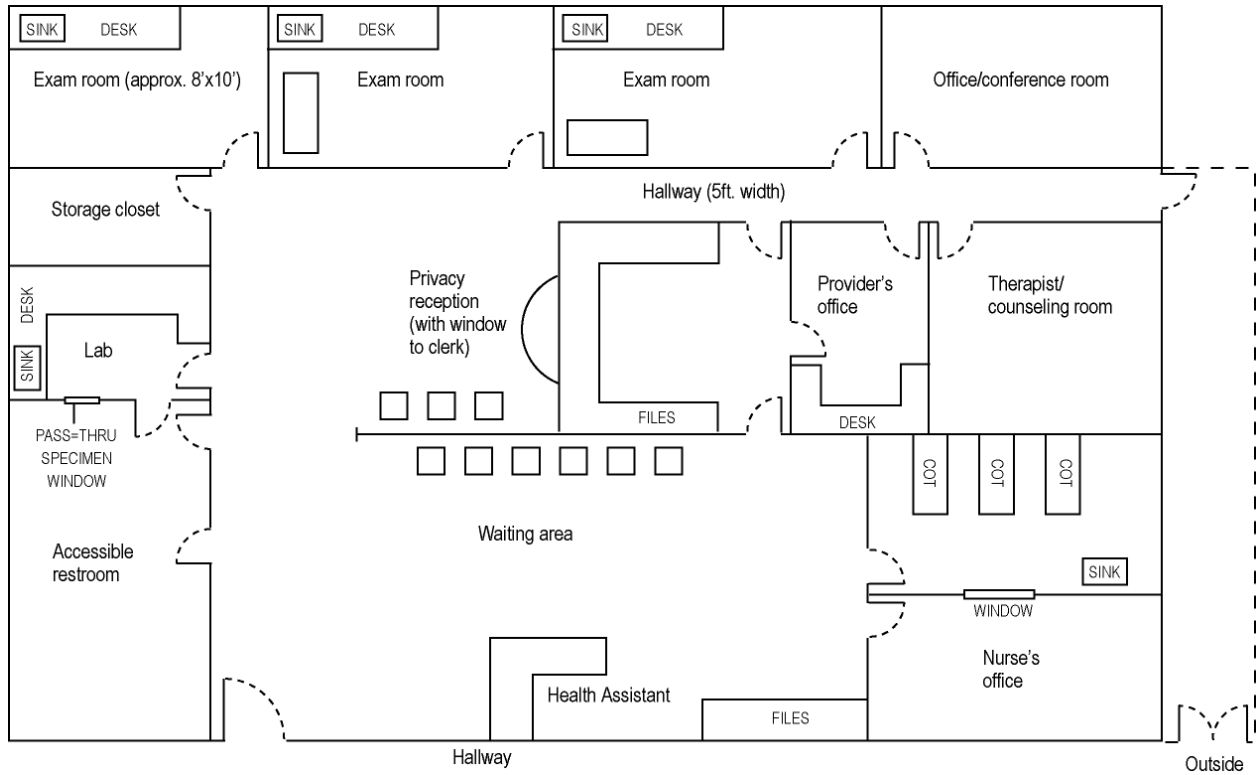
Silver City, NM SBHC Floor Plan

(SBHC converted from two large classrooms.)



Belen High School SBHC Floor Plan

(Space created by converting a large school nurse's office and bumping out the north and west exterior walls to add exam rooms and offices)



Appendix J: Resources

Advocates for Youth

<http://www.advocatesforyouth.org/>

American Academy of Pediatrics

<http://www.aap.org/>

Center for School Mental Health, University of Maryland School of Medicine

<http://csmh.umaryland.edu/>

Centers for Disease Control, Healthy Schools Healthy Youth

<http://www.cdc.gov/healthyyouth/>

Center for Health and Health Care in Schools

<http://www.healthinschools.org/>

Colorado Child Health Plan *Plus*

<http://www.cchp.org/>

Colorado Department of Public Health and Environment,

Child, Adolescent and School Health Unit

<http://www.cdphe.state.co.us/ps/cash/index.html>

Healthy Youth Colorado

www.healthyyouthcolorado.org

National Assembly on School-Based Health Care

<http://www.nasbhc.org/>

Robert Wood Johnson Foundation

<http://www.rwjf.org/>

School Mental Health Project - Center for Mental Health in Schools, UCLA

<http://smhp.psych.ucla.edu/>

The Colorado Health Foundation-School-Based Health Care Initiative

http://coloradohealth.org/school-based_health_care.aspx

U.S. Department of Health And Human Services

<http://www.hhs.gov/ocr/privacy/hipaa/understanding/coveridentities/hipaafferpajointguide.pdf>

Appendix K: Checklist for Starting an SBHC

- Identify stakeholders that would be supporters of an SBHC.
- Develop a community advisory committee.
- Educate the committee about SBHCs.
- Visit operational SBHCs in your area.
- Conduct a needs assessment of the population you wish to serve.
- Identify a licensed medical provider willing to operate the SBHC.
- Identify the school where the SBHC will be located. Identify specific space within the school. Make sure there is plumbing for hand-washing sink, patient bathroom(s), laboratory space.
- Will there need to be remodeling? If so:
 - Obtain architectural drawings
 - Obtain contractor
 - Obtain funding
 - Obtain formal approval from the school district.
- Create a business plan for operating the SBHC.
 - Who will be the legal owner/operator of the SBHC?
 - Who will carry the necessary liability/malpractice insurance?
 - Who will be responsible for financial sustainability (grant writing, budgeting, accounting, preparation of tax forms, payroll, financial policies, billing and collection of patient accounts)?
 - What is the mission of the SBHC?
 - Who will be eligible to receive services?
 - What will be the hours of operation?
 - What services will be offered?
 - Laboratory – CLIA waiver?
 - Pharmaceuticals – Other Outlet Pharmacy license?
 - Disposal of hazardous waste?
 - How will the facility be staffed?
 - Who will supply phones, internet, housekeeping, maintenance, security?
- Develop an MOA between the school district and the licensed medical provider that delineates the responsibilities of each party and how the SBHC will be governed.

- Develop MOAs between the sponsoring agency and partner agencies that will provide services in the SBHC (such as community mental health agency, local health department, etc.)
- Develop an annual parent consent form that is HIPAA compliant and promotes the integration of physical, mental, and dental care by allowing the appropriate sharing of medical records. How will the consent forms be operationalized?
- Develop administrative policies and procedures (child abuse reporting, confidentiality, appointments versus walk-ins, after-hours coverage, medical record-keeping, etc)
- Develop financial policies and procedures in compliance with Medicaid, Child Health Plan *Plus*, and other state and federal laws. If cash is to be collected from patients and kept in the clinic, policies to ensure security of the cash and personnel are required.
- Develop clinical protocols in compliance with physician assistant and nurse practitioner licensure and certification.
- Develop referral protocols between the SBHC and the school nurse and school psychologist, as well as between the SBHC and outside agencies.
- Develop and implement a plan for outreach and marketing.
- Develop and implement an evaluation plan.
- Order furniture, medical equipment, medical supplies, office equipment, and office supplies.
- Hire or designate a provider with prescriptive authority and experience in child and adolescent primary care.

Appendix L: References

- ¹ Walker, S.C., Kerns, S.E.U., Lyon, A.R., Bruns, E.J., & Cosgrove, T.J. (2010). Impact of school-based health center use on academic outcomes. *Journal of Adolescent Health*, 46:251-257.
- ² McCord, M.T., Klein, J.D., Joy, J.M., & Fothergill, K. (1993). School-based clinic use and school performance. *Journal of Adolescent Health*, 14: 91-98.
- ³ Kaplan, D. W., Calonge, B. N., Guernsey, B. P., & Hanrahan, M. B. (1998). Managed care and school-based health centers: Use of health services. *Arch Pediatr Adolesc Med* - spell out journal name, 152(1): 25-33.
- ⁴ Guo, J.J., Jang, R., Keller, K.N., McCracken, A.L., Pan, W., Cluxton, R. J. (2005). Impact of school-based health centers on children with asthma. *Journal of Adolescent Health*, 37: 266-274.
- ⁵ Juszczak L., Melinkovich P., & Kaplan D. W. (2003). Use of health and mental health services by adolescents across multiple delivery sites. *Journal of Adolescent Health*, 32(6 Supplement): 108-118.
- ⁶ Allison, M. A., Crane, L. A., Beaty, B. L., Davidson, A. J., Melinkovich, P., & Kempe, A. (2007). School-based health centers: Improving access to quality of care for low income adolescents. *Pediatrics*, 120(4): e887-e894.
- ⁷ Adams, K.E. & Johnson V. (2000). An elementary school-based health clinic: can it reduce Medicaid costs? *Pediatrics*, 105(3):780-788.
- ⁸ C.R.S. 25-20.5-502. Spell out CRS.
- ⁹ Ibid., 203.
- ¹⁰ Quality standards for Colorado SBHCs. (2009). Colorado Department of Public Health and Environment. Child, Adolescent, and School Health Unit. Available at <http://www.cdphe.state.co.us/ps/school/>
- ¹¹ Position statement: The delivery of preventive and primary reproductive health services in school-based health centers. Colorado Association for School-Based Health Care. Retrieved March 24, 2010, from <http://www.casbhc.org/publications/Reproductive%20Health%20Position%20Statement.pdf>
- ¹² Rural school-based health centers: A Framework for success (2009). Colorado Association for School-Based Health Care. Retrieved February 14, 2010, from <http://www.casbhc.org/publications/index.asp>
- ¹³ National survey: Executive summary. (January 2007). School-Based Health Care Program-W.K. Kellogg Foundation. Retrieved May 26, 2010, from <http://www2.wkkf.org/default.aspx?tabid=90&CID=316&ItemID=5000310&NID=61&LanguageID=0>
- ¹⁴ School-based health centers: Uniting education and health for success in the classroom and life. NASBHC. Retrieved June 17, 2010, from http://www.nasbhc.org/atf/cf/%7BCD9949F2-2761-42FB-BC7A-CEE165C701D9%7D/TA_AO%20fact%20sheet.pdf
- ¹⁵ Walker, S.C., Kerns, S.E.U., Lyon, A.R., Bruns, E.J., & Cosgrove, T.J. (2010). Impact of school-based health center use on academic outcomes. *Journal of Adolescent Health*, 46: 251-257.
- ¹⁶ McCord, M.T., Klein, J.D., Joy, J.M., & Fothergill, K. (1993). School-based clinic use and school performance. *Journal of Adolescent Health*, 14(6): 458-463.
- ¹⁷ Kahn, R., Lynn, J., Braga, A., Hoxworth, T., & Donovan, K. (2008). Engage Youth! Colorado's Guide to Building Effective Youth-Adult Partnerships. Denver, CO: Colorado Youth Partnership for Health, Colorado Department of Public Health and Environment. Available at <http://www.cdphe.state.co.us/ps/adolschool/healthyyouthcolorado/files/YPHGuidebookFINALVersion2.pdf>
- ¹⁸ Balas, H. (2003, March). Engaging youth in policymaking improves policies and youth outcomes. Center for Health Improvement. Retrieved May 11, 2010, from http://www.chipolicy.org/pdf/TEEN_BRF2.pdf
- ¹⁹ Campbell, K. & Haley, B. (2008, August). Business planning for non-profits: What it is and why it matters. Bridgespan Group. Retrieved February 21, 2010, from <http://www.bridgespan.org/LearningCenter/ResourceDetail.aspx?id=2382>
- ²⁰ Strategic planning: Not just for big business. (2009). Small Business Notes. Retrieved March 7, 2010, from <http://www.smallbusinessnotes.com/planning/strategicplanning.html>
- ²¹ McNamara, C. Strategic planning in non-profit and for-profit organizations. Free Management Library. Retrieved March 7, 2010, from http://managementhelp.org/plan_dec/str_plan/str_plan.htm
- ²² Brindis, C. D., Klein, J., Schlitt, J., Santelli, J., Juszczak, L., & Nystrom, R. J. (2003). School-based health centers: Accessibility and accountability. *Journal of Adolescent Health*, 32 (suppl. 1): 98 – 107.
- ²³ Task force on the future of Denver SBHCs. Final report. (2007, October). Any other info available?
- ²⁴ Making the Grade National Program Office and Rosenberg & Associates. (1995, September). Issues in financing SBHCs: A guide for state officials. The Center for Health and Health Care in Schools. Retrieved October 23, 2009, from <http://www.healthinschools.org/static/papers/issues-financing.aspx#4a>
- ²⁵ Ford, C. A., Bearman, P. S., & Moody, J. (1999) Foregone health care among adolescents. *JAMA*, 282: 2227-2234.
- ²⁶ Anglin, TM., Naylor KE, Kaplan DW. (1996). Comprehensive school-based health care: high school students' use of medical, mental health, and substance abuse services. *Pediatrics*, 97(3):318-30.
- ²⁷ Adapted from: Brindis, C., Kaplan, D., Phibbs, S. A guidebook for evaluating school-based health centers. National Assembly on School-Based Health Care. Retrieved February 4, 2010, from <http://www.nasbhc.org> (members only section)
- ²⁸ Adapted from: Brindis, C., Kaplan, D., Phibbs, S. A guidebook for evaluating school-based health centers. National Assembly on School-Based Health Care. <http://www.nasbhc.org> (members only section)
- ²⁹ Adapted from: Brindis, C., Kaplan, D., Phibbs, S. A guidebook for evaluating school-based health centers. National Assembly on School-Based Health Care. <http://www.nasbhc.org> (members only section)
- ³⁰ Comparison of the rural health clinic and federally qualified health center programs. (2006, June). HRSA. Retrieved March 3, 2010, from <http://www.ask.hrsa.gov/downloads/fqhc-rhccomparison.pdf>
- ³¹ Changing demographics
- ³² Sales, S. Determining provider panel size in a staff model HMO. (2006, October). MGMA. Retrieved February 15, 2010, from <http://www.mgma.com/>

-
- ³³ Quality standards for Colorado SBHCs. (2009). Colorado Department of Public Health and Environment. Child, Adolescent, and School Health Unit. <http://www.cdphe.state.co.us/ps/school/>
- ³⁴ C.R.S. 25-20.5-502.
- ³⁵ Ibid.
- ³⁶ Ibid.
- ³⁷ C.R.S. 12-22-102
- ³⁸ Ibid.
- ³⁹ Frequently asked questions about the Vaccines for Children Program. CDPHE. Retrieved May 20, 2010, from <http://www.cdphe.state.co.us/dc/immunization/vfc/vfcfaq.html>
- ⁴⁰ Quality standards for Colorado SBHCs. (2009). Health
- ⁴¹ Kurian, E. (2004). This land was made for you and me: Cultural competence in school-based health centers. The Center for Health and Health Care in Schools. Available at <http://www.healthinschools.org/sh/cultpaper.asp> (this document is no longer available on the CHHCS website).
- ⁴² Pachter, L. M. (1994). Culture and Clinical Care: Folk Illness Beliefs and Behaviors and Their Implications for Health Care Delivery. *JAMA*, 271 (9): 690-4.
- ⁴³ Ibid.
- ⁴⁴ What is cultural competency? The Office of Minority Health, U.S. Department of Health and Human Services. Available at <http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=11>
- Ibid.
- ⁴⁶ Financial management for the growing business. (1990). US Small Business Association. Retrieved April 5, 2010, from http://www.sba.gov/idc/groups/public/documents/sba_homepage/serv_capgrowth.doc
- ⁴⁷ Ibid.
- ⁴⁸ C.R.S. 25.5-1-103.
- ⁴⁹ C.R.S. 25.5-5-318.
- ⁵⁰ Brindis, C. D., Klein, J., et al. (2003). School-based health centers.
- ⁵¹ Task force on the future of Denver SBHCs. Final report. (2007, October).
- ⁵² Social marketing. Wikipedia. Retrieved May 27, 2010, from http://en.wikipedia.org/wiki/Social_marketing
- ⁵³ Quality standards for Colorado SBHCs. (2009). Colorado Department of Public Health and Environment. Child, Adolescent, and School Health Unit. <http://www.cdphe.state.co.us/ps/school/>
- ⁵⁴ Some questions drawn from Patton, M. (1997). *Utilization-focused evaluation*. (3rd ed.) Thousand Oaks, CA: Sage Publications, Inc.
- ⁵⁵ Some questions drawn from McNamara, C. Basic guide to outcome-based evaluation for non-profit organizations with very limited resources. Free Management Library. <http://www.managementhelp.org/evaluatn/outcomes.htm> and Brindis, C., Kaplan, D., Phibbs, S. A guidebook for evaluating school-based health centers. National Assembly on School-Based Health Care. <http://www.nasbhc.org> (members only section)
- ⁵⁶ Instructions for Schedule C. IRS. Retrieved June 15, 2010, from <http://www.irs.gov/instructions/i990sc/ch01.html>
- ⁵⁷ Ibid.
- ⁵⁸ Understanding your community: The key to building an impactful, sustainable coalition. (November 2009). LiveWell Colorado. Retrieved March 30, 2010, from <http://www.livewellcolorado.org/resources/white-papers>.
- ⁵⁹ Ibid.
- ⁶⁰ Adapted from materials in the *Youth Action League* manual developed by the California Center for Civic Participation
- ⁶¹ Adapted from materials developed by the National Small Business United online media center and Sebranke, P., Meyer, V., Kemper, D. (1990). *Write source 2000: A guide to writing, thinking, and learning*. Burlington: Write Source Educational Publishing House.
- ⁶² Adapted from Being an effective youth advocate. National Network for Youth. Available at <http://www.nn4youth.org/>
- ⁶³ Centers for Disease Control and Prevention. (2006, June 9). *Morbidity and Mortality Weekly Report: Youth Risk Behavior Surveillance - United States, 2005*. Retrieved December 2007, from Centers for Disease Control and Prevention: <http://www.cdc.gov>
- ⁶⁴ Ibid.
- ⁶⁵ Ibid.
- ⁶⁶ Colorado Organization on Adolescent Pregnancy, Parenting and Prevention. (2007). *The State of Adolescent Sexual Health in Colorado 2007*. Retrieved November 27, 2007, from <http://www.coapp.org>
- ⁶⁷ Kreipe, R., MacDonald, C., & McAnamey, E. (1991). Reproductive Health Care for Adolescents. *Journal of Adolescent Health*, Vol: 649-661.
- ⁶⁸ Guttmacher Institute. (2006, December). *Facts on Sex Education In The United States*. Retrieved December 13, 2007, from Guttmacher Institute: <http://www.guttmacher.org>
- ⁶⁹ Centers for Disease Control and Prevention. (2006, June 9). *Morbidity and Mortality Weekly Report: Youth Risk Behavior Surveillance - United States, 2005*.
- ⁷⁰ Guttmacher Institute. (2006, March). *Contraception Counts*. Retrieved November 29, 2007, from Guttmacher Institute: <http://www.guttmacher.org>
- ⁷¹ Centers for Disease Control and Prevention. (2006, June 9). *Morbidity and Mortality Weekly Report: Youth Risk Behavior Surveillance*.
- ⁷² Ibid.
- ⁷³ Nossel, I. (1996, October). *Pregnancy and Childbearing Among Younger Teens*. Retrieved December 3, 2007, from Advocates For Youth: <http://www.advocatesforyouth.org>
- ⁷⁴ Centers for Disease Control. *National Profile, STD Surveillance 2006*. Washington, DC, 2006.
- ⁷⁵ Elliott, A. (2007, March 29). *The Bell Policy Center*. Retrieved December 3, 2007, from The Bell Policy Center Web site: <http://www.thebell.org>
- ⁷⁶ Kreipe, R., MacDonald, C., & McAnamey, E. (1991). Reproductive Health Care for Adolescents. *Journal of Adolescent Health*, Vol:649-661.
- ⁷⁷ Centers for Disease Control. *National Profile, STD Surveillance 2006*.
- ⁷⁸ Centers for Disease Control and Prevention. (2006, June 9). *Morbidity and Mortality Weekly Report: Youth Risk Behavior Surveillance*.

- ⁷⁹ Brindis, C. & Philliber, S. (1998). Room to Grow - Improving Services for Pregnant and Parenting Teenagers in School Settings. *Education and Urban Society*, Vol:242-260.
- ⁸⁰ Freudenberg, N. & Ruglis, J. (2007). Reframing School Dropout as a Public Health Issue. *Preventing Chronic Disease: Public Health Research, Practice and Policy*, 4 (4): 1-11.
- ⁸¹ Kirby, D. (2001). *Emerging Answers Summary: Research Findings on Programs to Reduce Teen Pregnancy*. Washington, DC: National Campaign to Prevent Teen and Unwanted Pregnancy.
- ⁸² Gallagher, K. & Drisko, J. (2000, July). Building Community Capacity For Teen Pregnancy Prevention. *Evaluation of The Colorado Trust Teen Pregnancy Prevention 2000 Initiative*. City, Colorado.
- ⁸³ Centers for Disease Control and Prevention. (2006, June 9). *Morbidity and Mortality Weekly Report: Youth Risk Behavior Surveillance*.
- ⁸⁴ Kirby, D. (2001). *Emerging Answers Summary*. Page numbers would be appropriate on these references.
- ⁸⁵ Colorado Department of Public Health and Environment. (2002). *Unintended Pregnancy: Why it Matters*. Retrieved December 13, 2007, from Colorado Department of Public Health and Environment: <http://www.cdphe.state.co.us/pdf/upwebdoc2002.pdf>
- ⁸⁶ Kirby, D. (2001). *Emerging Answers Summary*.
- ⁸⁷ Ibid.
- ⁸⁸ Ibid.
- ⁸⁹ Ibid.
- ⁹⁰ Ibid.
- ⁹¹ Ibid.
- ⁹² Freudenberg, N. & Ruglis, J. (2007). Reframing School Dropout.
- ⁹³ The National Campaign To Prevent Teen Pregnancy. (n.d.). *Linking Teen Pregnancy Prevention to Other Critical Social Issues*. Retrieved November 28, 2007, from the National Campaign: <http://www.teenpregnancy.org>
- ⁹⁴ Haggerty, M. (2002, December). *Health A to Z*. Retrieved December 12, 2007, from Health A to Z Web site: <http://www.healthatoz.com>
- ⁹⁵ Centers for Disease Control and Prevention. (2006, April). *CDC Fact Sheet - Gonorrhea*. Retrieved December 12, 2007, from CDC: http://www.cdc.gov/std/healthcomm/fact_sheets.htm
- ⁹⁶ The National Campaign To Prevent Teen Pregnancy. (n.d.). *Linking Teen Pregnancy Prevention to Other Critical Social Issues*. Retrieved November 28, 2007, from the National Campaign: <http://www.teenpregnancy.org>
- ⁹⁷ Centers for Disease Control and Prevention. (2006, April). *CDC Fact Sheet-Chlamydia*. Retrieved December 12, 2007, from CDC: http://www.cdc.gov/std/healthcomm/fact_sheets.htm
- ⁹⁸ Haggerty, M. (2002, December). *Health A to Z*.
- ⁹⁹ Centers for Disease Control and Prevention. (2004). *CDC Fact Sheet-Pelvic Inflammatory Disease*. Retrieved December 12, 2007, from CDC: http://www.cdc.gov/std/healthcomm/fact_sheets.htm
- ¹⁰⁰ Centers for Disease Control and Prevention. (2006, April). *CDC Fact Sheet-Chlamydia*.
- ¹⁰¹ Haggerty, M. (2002, December). *Health A to Z*.
- ¹⁰² Alford, S. (2003, January). *Adolescents - At Risk For Sexually Transmitted Infections*. Retrieved December 5, 2007, from Advocates For Youth: <http://www.advocatesforyouth.org>
- ¹⁰³ Centers for Disease Control and Prevention. (2004, May). *Genital HPV Infections - CDC Fact Sheet*. Retrieved December 12, 2007, from CDC: http://www.cdc.gov/std/healthcomm/fact_sheets.htm
- ¹⁰⁴ Alford, S. (2003, January). *Adolescents - At Risk For Sexually Transmitted Infections*.
- ¹⁰⁵ Centers for Disease Control and Prevention. (n.d.). *HPV and Men - CDC Fact Sheet*. Retrieved December 12, 2007, from CDC: http://www.cdc.gov/std/healthcomm/fact_sheets.htm
- ¹⁰⁶ Alford, S. (2003, January). *Adolescents - At Risk For Sexually Transmitted Infections*.
- ¹⁰⁷ Ibid.
- ¹⁰⁸ United States Food and Drug Administration. (2008, January 14). *Product Approval Information*. Retrieved February 4, 2008, from FDA: <http://www.fda.gov/cber/products/gardasil.htm>
- ¹⁰⁹ Centers for Disease Control and Prevention. (2000). *The Role of STD Detection and Treatment in HIV Prevention*. Retrieved December 12, 2007, from CDC: http://www.cdc.gov/std/healthcomm/fact_sheets.htm
- ¹¹⁰ The National Campaign To Prevent Teen Pregnancy. (n.d.). *Linking Teen Pregnancy Prevention to Other Critical Social Issues*. Retrieved November 28, 2007, from the National Campaign: <http://www.teenpregnancy.org>
- ¹¹¹ Center for Disease Control and Prevention. (2004, May). *STDs and Pregnancy - CDC Fact Sheet*. Retrieved December 12, 2007, from CDC: http://www.cdc.gov/std/healthcomm/fact_sheets.htm
- ¹¹² Advocates For Youth. (n.d.). *Sex Education Programs: Definitions and Point-by-Point Comparison*. Retrieved December 6, 2007, from Advocates For Youth Web site: <http://www.advocatesforyouth.org>
- ¹¹³ Kirby, D. (2007). *Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases*. Washington, DC: National Campaign to Prevent Teen and Unwanted Pregnancy.
- ¹¹⁴ Advocates For Youth. (n.d.). *Sex Education Programs: Definitions and Point-by-Point Comparison*. Retrieved December 6, 2007, from Advocates For Youth Web site: <http://www.advocatesforyouth.org>
- ¹¹⁵ Freudenberg, N. & Ruglis, J. (2007). Reframing School Dropout as a Public Health Issue.
- ¹¹⁶ Advocates For Youth. (n.d.). *Sex Education Programs: Definitions and Point-by-Point Comparison*.
- ¹¹⁷ General Assembly of the State of Colorado. 2007. House Bill 07-1292. *Concerning The Adoption of Science-Based Content Standards For Instruction Regarding Human Sexuality*.
- ¹¹⁸ American Psychological Association. (2005, February 23). *Based On The Research, Comprehensive Sex Education Is More Effective At Stopping The Spread of HIV Infection, Says APA Committee*. Retrieved December 5, 2007, from American Psychological Association Online Web site: <http://www.apa.org/releases/sexeducation.htm>
- ¹¹⁹ Freudenberg, N. & Ruglis, J. (2007). Reframing School Dropout as a Public Health Issue.

-
- ¹²⁰ McKeon, B. (2006). *Effective Sex Education*. Retrieved December 2007, from Advocates For Youth: <http://www.advocatesforyouth.org>
- ¹²¹ Kirby, D. (2007). *Emerging Answers 2007*.
- ¹²² Marsiglio, W. & Mott, F. L. (1986). The Impact of Sex Education on Sexual Activity, Contraceptive Use and Premarital Pregnancy Among American Teenagers. *Family Planning Perspectives*, Vol: 151-154.
- ¹²³ General Assembly of the State of Colorado. House Bill 07-1292.
- ¹²⁴ Freudenberg, N. & Ruglis, J. (2007). Reframing School Dropout as a Public Health Issue.
- ¹²⁵ American Medical Association. (1997). *Guidelines for Adolescent Preventive Services (GAPS)*. Retrieved December 2007, from American Medical Association: <http://www.ama-assn.org>
- ¹²⁶ Montalto, N. J. (1998). Implementing the Guidelines for Adolescent Preventive Services. *American Family Physician*. Available at <http://www.aafp.org/afp/980501ap/montalto.html>
- ¹²⁷ American Medical Association. (1997). *Guidelines for Adolescent Preventive Services (GAPS)*.
- ¹²⁸ Weiss, D. G. (2007, September). *Pregnancy & Childbearing Among U.S. Teens*. Retrieved December 2007, from Planned Parenthood: <http://www.plannedparenthood.org>
- ¹²⁹ Suellentrop, K., & Flanigan, C. (2006, April). *Science Says: Pregnancy Among Sexually Experienced Teens, 2002*. Retrieved 20 December, 2007, from The National Campaign to Prevent Teen Pregnancy: <http://www.teenpregnancy.org>
- ¹³⁰ Kirby, D. (2007). *Emerging Answers 2007*.
- ¹³¹ Guttmacher Institute. (2007, November 1). *State Policies In Brief: An Overview of Minors' Consent Law*. Retrieved November 27, 2007, from Guttmacher Institute: <http://www.guttmacher.org>
- ¹³² The Committee on Legal Services for the State of Colorado and Matthew Bender & Company. (2007). *Colorado Revised Statutes*. C.R.S. 25-4402. Retrieved December 13, 2007, from Lexis Nexis: <http://www2.michie.com/colorado/lpext>.
- ¹³³ The Committee on Legal Services for the State of Colorado and Matthew Bender & Company. (2007). *Colorado Revised Statutes*. 18-3-402. Retrieved December 13, 2007, from Lexis Nexis: <http://www2.michie.com/colorado/lpext>.
- ¹³⁴ United States Department of Health and Human Services. (2006, May 16). *Medical Privacy - National Standards to Protect the Privacy of Personal Health Information*. Retrieved December 13, 2007, from United States Department of Health and Human Services: <http://www.hhs.gov/ocr/hipaa/>