



Rural School-Based Health Centers: A Framework for Success



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Introduction

As more rural school districts attempted to establish and maintain school-based health centers (SBHCs) in Colorado, the Colorado Association for School-Based Health Care (CASBHC) recognized that the challenges they face are very different from those of urban districts. Unlike most urban SBHCs, some rural centers have no formal ties to an established health care system. In addition, rural SBHCs in Colorado must deal with extreme geographic isolation. Long driving distances, mountain passes, and harsh winter weather during the school year prohibit collaboration, information sharing, networking, and problem solving. Therefore, each new rural school-based health center develops without the insight or direct support from those with past experience. To address lack of systems and isolation, and test a framework for supporting the growth and sustainability of rural SBHCs in Colorado, CASBHC created the Rural Health Consortium (RHC).

The RHC was formed in 2007 to bring together individuals managing or providing care in school-based centers in rural areas of Colorado for the following purposes: 1) develop opportunities for networking and professional support; 2) identify essential and common elements among Colorado's rural SBHCs; 3) recognize challenges encountered in developing rural SBHCs; and 4) identify successful strategies and methodologies for sustaining a variety of rural models.

Membership in the RHC includes representatives from communities planning or operating a rural SBHC. Current members live and work in the counties of La Plata and Montezuma in southwest Colorado, Mesa and Montrose in the west central part of the state, Prowers in far southeastern Colorado, and Pitkin, Lake, Teller and Summit in the mountains west of Denver. Salida was chosen as the most central meeting location in Colorado (still a three to seven-hour drive for participants). Also present at meetings are representatives from the Colorado Department of Public Health and Environment, The Colorado Health Foundation, and the Colorado Rural Health Center. These organizations are keenly interested in supporting growth of SBHCs in rural areas to address the need for increased health care access for Colorado's children.

Rural Health Consortium Communities



Salida



Rural Health Consortium Participants

Growth of School-Based Health Centers

School-based health centers first began as an initiative of the American Academy of Pediatrics in the 1960s and expanded slowly in the 1970's with funding from the Robert Wood Johnson Foundation. Between 1988 and 2005, SBHCs grew from 100 centers nationwide to more than 1700. SBHCs provide prevention programs, comprehensive health assessments, treatment of acute illness, immunizations, management of chronic conditions, behavioral health assessment and treatment and, sometimes, dental screening, cleaning and sealants. SBHCs are now recognized as an important safety-net in children's health care for the uninsured, underinsured and in particular, adolescents, who have the lowest usage of primary health care of any age group in the United States.¹

The fastest growth of SBHCs nationally during the last decade has occurred in the southwest and the Rocky Mountain states. This indicates a need for the centers in rural communities.² While 59% of the nation's SBHCs are located in urban communities,³ the number of rural centers is increasing. They are playing a pivotal role in the provision of health care where access is limited. Barriers to care for the rural school-aged population include long distances to reach available providers, lack of transportation, competing parental work demands, increasing poverty, lack of health insurance, and the increasing cost of health care.

Although few differences have been found in overall physical health between urban and rural children, the greatest unmet needs of this population are mental health, reproductive health, and substance abuse treatment. Another major area of concern for rural youth is unintentional injuries and safety. Rural teens are less likely to use seat belts or motorcycle helmets, and are at twice the risk for motor-vehicle accidents involving alcohol use.⁴ Rural youth not only have higher alcohol use, but twice the methamphetamine use of urban youth and the more rural the area, the higher the rate of substance abuse.⁵

Currently in Colorado there are 46 SBHCs operating in 19 school districts providing access to physical and mental primary care.⁶ Thirty-five of the school-based health centers are located along the Front Range, an urban area extending along the east side of the Rocky Mountains from Fort Collins to Pueblo. This is also where 84.5 % of the state's population resides. The other eleven SBHCs are located in rural or frontier areas of the state where 15.5 % of the population lives.⁷

The Colorado Children's Campaign reported in 2008 that 14% of children in Colorado are uninsured because of unaffordable private plans or unattainable public programs. Colorado is 38th out of 50 states in the percentage of children who receive needed preventive dental care. Even more alarming is that Colorado currently has the fastest growth rate in the nation of the number of children in poverty.⁸ Colorado's rural counties in southern and eastern areas tend to have higher uninsured rates than more affluent suburban and urban communities, except for Denver County.

Supporting Rural School-Based Health Centers

As the number of rural SBHCs increased, CASBHC found it imperative to support their growth and sustainability by bringing together key players from existing SBHCs and rural communities in the planning phase of opening a SBHC. Simply introducing the RHC participants to each other created an overwhelming sense of support and decreased the feeling of isolation. Upon convening in Salida, the RHC participants sited four general needs: 1) networking and support; 2) training; 3) creative problem solving; and 4) joint advocacy. The following list of objectives was developed by the group to guide their efforts.

Networking & support

- Provide an opportunity for people interested in planning and implementing school health services in rural districts to network and learn from each other
- Use facilitation by CASBHC as a way to relieve isolation and link rural health providers to each other, and to resources, training opportunities, best practices, etc.
- Encourage sharing of knowledge and resources
- Develop a joint vision

Training

- Learn how to invest limited resources to best meet unmet needs and produce good outcomes
- Determine what “integrated systems of care” means for rural areas
- Identify the unique access issues for children living in rural areas

Creative problem solving

- Develop messages/tools for addressing rural community concerns regarding the provision of sexual health education and reproductive health services to reduce teen pregnancy rates
- Learn how to address concerns that a new SBHC may take business from private practices
- Share what has worked and lessons learned regarding combining efforts for economies of scale (billing and collection of patient revenue, grant writing)

Joint advocacy

- Advance sustainability and simplify the state funding process

Essential Elements of Rural School-Based Health Centers

In Colorado, there is no state-authorized licensure of school-based health centers. Therefore, there is no widely agreed upon definition or standards. We rely, instead, on general descriptions put forth by national and state organizations, state laws related to funding and reimbursement, and private foundation guidelines. Although sometimes frustrating, this dynamic structure may contribute to the success of school-based health centers in meeting the varying needs of communities, schools, parents and children.

Certain principles and goals set forth by the National Assembly on School-Based Health Care (NASBHC) are considered fundamental to providing a framework for planning, implementation, and evaluation of school-based health centers. These principles are broad and allow for flexibility to meet unique needs. They state in general that a SBHC:

- supports the school
- responds to the community
- focuses on the student
- delivers comprehensive care
- advances health promotion activities
- implements effective systems
- provides leadership in adolescent and child health

In addition to these principals set forth by NASBHC, the RHC participants, after sharing successes and failures among SBHCs in rural Colorado, identified the following elements as essential to high quality care and sustainability:

- location in the school or on school grounds
- community buy-in and strong local partnerships
- support of the school district superintendent, school principal and school staff
- minimum two hours per school day staffing with a provider who has prescriptive authority
- services available to all students enrolled in the school without regard to ability to pay

- secure medical records and confidentiality of all communication
- capacity for data collection regarding utilization and financing
- integration of physical and behavioral health with a focus on the “whole child”
- cultural competency
- diverse income streams

The list created by the RHC participants can be used by new rural SBHCs during the planning process. Documentation and sharing of how essential elements are achieved will prevent each new rural SBHC from starting from scratch.

Challenges in Rural Colorado

The RHC provided opportunities for SBHC administrators and providers to identify challenges they felt were specific to rural areas. The common challenges agreed upon were:

- Recruiting mid-level providers. Providers recruited from larger towns or less expensive bedroom communities outside of resorts sometimes have to commute 20 -50 miles one way on rural roads which can be treacherous and may be closed in winter. Salaries are low and benefits are few; back up and after-hours coverage is often limited to 911.
- Providing mental health care to adolescents. Mental health services are limited or non-existent in rural areas and providers with child/adolescent-specific training and experience are hard to find, especially for long-term treatment and medication management.
- Developing partnerships and community resources. Some rural SBHCs operate independently. Lack of integration into a system of care makes issues such as after-hours coverage, provider vacation coverage, provider supervision, and referral or consultation on complicated cases, very difficult. In addition, issues sometimes arise regarding obtaining malpractice insurance coverage.
- Sustainable funding. Financial stability may be affected when there is a lack of capacity to do billing and collections from third parties.

After identifying challenges, participants were able to share strategies and learn from one another. This information sharing proved to be very effective and will reduce the need to re-invent the wheel each time a rural SBHC encounters a challenge. Documenting the strategies will also help reduce the isolation rural SBHCs experience because they will have access to information shared by their peers. Below are some of the stories and strategies shared by rural SBHC providers in the RHC to date:

The Southwest Open School (SWOS) School-Based Health Center is located in Montezuma County in the far southwest corner of Colorado and serves students from Cortez, Dolores, Dove Creek, Mancos and Towaoc. This community borders two reservations, the Ute Mountain Ute Reservation and the Navajo Reservation. The Cortez area is geographically remote and has been designated a Medically Underserved Area. The closest community health center or Indian Health Service clinic is over 20 miles away over mountain roads with no available public transportation. Currently there are no pediatricians in Cortez and family practice providers are not accepting new Medicaid patients. Since April of 2006, four primary care physicians have left the area. SWOS is a charter high school that enrolls approximately 165 students per year. Ninety percent of the SWOS students are considered socially or academically “at risk”. Last year, 30 of these teens were in their 1st or 2nd pregnancy. Historically, 60% of SWOS students are at or below 185% of the federally established poverty level based on the application for free or reduced lunch.

The SWOS SBHC was started 12 years ago by a Licensed Practical Nurse, Shannon Wells, and is the only health care safety net for underinsured/uninsured adolescents in the Montezuma- Cortez school district. The SBHC is located in one of the modular units that provide classrooms for SWOS students. Skunks can be a nuisance in the spring. Staff includes Shannon, who grew up in Cortez and works full time, and a part-time nurse practitioner. For many years, Shannon has filled multiple roles to maintain operation of the SBHC. These include providing patient care, grant writing, fund raising, and management. All services, including family planning, are provided free of charge to students through in-kind contributions and grant funding. A dental hygienist brings equipment into the center twice a year to clean teeth. Shannon finds resources to provide restorative dental care when needed. “To see a child walk into the center with a big smile because his mouth is finally pain free; to witness the pride of students who are the first members of their family to graduate from high school; these are the moments that make it all worthwhile” says Shannon.

Lessons Learned:

- Multitasking is essential for success, especially in small rural SBHCs. Nurses often serve as administrators, bookkeepers, grant writers and clinicians.
- Thinking outside the box allows students to access more services. Despite not being able to provide preventive dental services all the time, Shannon has made it possible for a dental hygienist to work in the SBHC at least twice per year.

Lamar High School SBHC is located in Prowers County in extreme southeast Colorado. The rural county is considered a Health Provider Shortage Area with 30% of the population at or below 200% of the Federal Poverty Level. The average adult income is \$29,900/year. The population is 30% Hispanic, 70% Caucasian, and conservative with strong religious evangelical roots. The SBHC sees a need for reproductive health services for teens but is unable to overcome community resistance in spite of numerous unintended pregnancies. Partnering with local agencies has not been easy because of mistrust regarding the role of the SBHC in the community. A nurse practitioner from the local community health center provides care at the SBHC two mornings per week.

Lessons Learned:

- Time is often necessary to gain community support. After being open one year, the SBHC is being utilized more, the community is gaining trust, and the SBHC may need to expand hours.

Basalt School Health Center officially opened in November 2007 in Basalt High School and has since opened sites in the elementary and middle schools. Staff and students are seen in the three schools by two nurse practitioners on a sliding scale basis. Basalt is typical of small rural resort

towns in Colorado. It is 20 miles from Aspen to the southeast and Glenwood Springs to the northwest. Surrounded by mountains, it is accessed by one highway and has a unique cultural and economic mix. Home to many immigrant families, Basalt was once an inexpensive alternative to Aspen but average homes now sell for \$1 million. It is nearly impossible to find affordable housing. People have poor living conditions and no health insurance. Spanish is the primary language for over 50% of students in Basalt schools. A lack of interpreters makes communication with parents difficult.

The biggest hurdle for the Basalt SBHC has been space. The SBHC is sharing small offices in the high school and middle school with the part-time school nurse and health aide. Staff has worked through the space issues and is now very good at open communication and referrals. Another hurdle is providing reproductive health services. Last year a 10th grader came in for a sore throat. Through a trusting relationship, it was discovered that there was a need for birth control. Because of the current policy disallowing distribution of contraceptives in the SBHC, a referral to another local agency was made. However, the student did not follow through and was pregnant by year's end. If the SBHC had the ability to provide reproductive health services, this and other unintended pregnancies might be prevented.

Lessons Learned:

- Space can look different than expected. Through not having their own clinic space, the providers in the Basalt SBHC have improved communication with school staff.
- Integration of school nursing and SBHC services is an effective strategy to improve student health and increase referrals to the SBHC.
- Facing controversy can help students stay healthy and in school. Even though some parents may object to family planning services in the SBHC, providing these services when needed can help prevent unintended pregnancies among adolescents in the community.

Northside Child Health Center opened its doors in October of 2007. This SBHC is located on an elementary school campus in Montrose, about 60 miles from Grand Junction, the closest urban community. The area has wintry weather but snow accumulation is minimal. The SBHC serves Montrose County children ages three to twelve years. Many of these children have unmet health care needs due to low-income and lack of documentation of legal residence. There is a free clinic in town, Mission Clinic, which is open one night a week, but the SBHC is the only option available for most uninsured and undocumented children. Initially the SBHC was managed by the Montrose County School District. However, between February and August of the first year of operation, the SBHC struggled due to lack of a full time provider. This led to the decision to contract with Rocky Mountain Youth Clinics, located in Denver, as the medical sponsor. Rocky Mountain

Youth Clinics employs a pediatric nurse practitioner and sub-contracts with a local pediatric practice to provide oversight.

The school district is still making efforts to work with the medical community in Montrose. Personnel continually work on developing professional partnerships. The most important tactic used to solve problems is turning to community resources that are supportive and have helped in the past.

Lessons Learned:

- The community may have more resources than you think. Asking for help can make the SBHC successful.
- Partnerships are essential and can take time to establish. Working with medical partners is an ongoing process.

Durango High School SBHC is also located in southwest Colorado. Like many resort towns in Colorado, wages are low and the cost of living is extremely high. The most accessible urban area is Albuquerque, NM, which is four hours south. Extreme weather and high mountain passes can limit travel in the winter. There is only one high school in Durango which has 1500 students.

The SBHC opened in October of 2007 with a part-time nurse practitioner and behavioral therapist. Because of the high demand for services, the behavioral therapist now works four days per week and a pediatrician was added two days a week. The SBHC has unique features to promote integrated health care. One is the integration of school nursing, primary care and behavioral health. All rooms in the center were remodeled with connecting doors to facilitate communication. Students are often interviewed by the primary care provider and the behavioral therapist together. The center is part of the larger Coordinated School Health Program within the school district. This creates a close working relationship between the SBHC, the school, and the school district. Community partnerships are also an integral part of services that are offered. The behavioral therapist is employed by the community mental health center. This increases opportunities for psychiatric consultation and referral. As a designated satellite of the local health department, the SBHC offers reproductive health services under the federal Title X program. Working once again with our community partners, another SBHC is planned to open in 2009 in an elementary school.

Lessons Learned:

- Start-up SBHCs, especially those with funding for renovation, can make the physical space of the clinic integration-friendly. This improves efficiency and quality of care.
- Partnering with a Title X funded agency to provide family planning services facilitates accessibility and affordability.

Opportunities in Rural Colorado

The Rural Health Consortium also helped CASBHC advocate for new funding that has recently been secured to expand school-based health centers. The \$500,000 appropriated by the Colorado legislature in 2006 grew to \$1,000,000 in 2008. These dollars, combined with funding from the federal Maternal and Child Health Block Grant and The Colorado Trust, a private foundation, will be administered by the Colorado Department of Public Health and Environment and disbursed to SBHCs throughout the state. The Colorado Health Foundation is also making a significant investment in SBHCs to meet its goals to improve healthy living, health coverage and health care.

Passage of Colorado House Bill 07-1292, regarding adoption of science-based content standards for instruction in human sexuality, legally establishes comprehensive sex education as the best practice in Colorado schools and further opens the door for reproductive health care. The law focuses on preventing unintended pregnancy and reducing sexual transmitted infections in adolescents.

Conclusion

The Colorado Association for School-Based Health Care has tested a framework for decreasing isolation among rural school-based health centers in Colorado. That framework - the Rural Health Consortium – has proved to be valuable in supporting networking, information sharing, creative problem solving, and advocacy. The development of a log-in section on the CASBHC website and a list-serve will assist with dissemination of information. Further improving communication tools will strengthen the links among rural centers and between rural and urban centers.

In addition to supporting the Rural Health Consortium, CASBHC must continue its advocacy role, provide training and technical assistance, and promote the development of practice management systems in Colorado's rural school-based health centers. Automated and standardized data collection will strengthen CASBHC and the Rural Health Consortium's ability to promote a health policy agenda that increases care for children where the children are – in school.

End Notes

¹ American Academy of Pediatrics, Committee on Adolescence. Achieving Quality Health Services for Adolescents. *Pediatrics*. 2008;121:1263-1270. Available at: www.pediatrics.org. Accessed on June 5, 2008.

² Lear JG, Eichner N, Koppelman J. The Growth of School-Based Health Centers and the Role of State Policies: Results of a National Survey. *Arch Pediatr Adolesc Med* 1999;153:1177-1180. Available at: www.archpediatrics.com. Accessed on November 12, 2007.

³ Scudder L, Papa P, Brey L. School-Based Health Centers: A Model for Improving the Health of the Nation's Children. *The Journal for Nurse Practitioners* 2007; Vol 3, 10, 713-720.

⁴ Sells W, Resnick M, Walker J. School-Based and School-linked Clinics in Rural America: A Report Prepared for the Office of Rural Health Policy. National Adolescent Health Resource Center, 1995. University of Minnesota: Minneapolis, MN.

⁵ Lambert D, Gale J, Hartley D. Substance Abuse by Youth and Young Adults in Rural America. *Journal of Rural Health* 2008;24;3:221-228. Available at www.wiley.com/bw/journal.asp. Accessed on August 19, 2008.

⁶ Colorado Association for School-Based Health Centers. Directory of School-Based Health Centers in Colorado. 2008-2009. Available at www.casbhc.org.

⁷ Colorado Rural Health Center. Available at www.coruralhealth.org

⁸ Colorado Children's Campaign. 2008 Kids Count in Colorado! www.coloradokids.org.

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Keeping children **healthy**, in school, and ready to learn



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