Report to J. Robert Galvin, MD, MPH
Department of Public Health Commissioner

on
School Based Health Centers

Submitted by
The Ad Hoc Committee to Improve Health Care Access
(Convened by SB 317, §51)

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in Collaboration with
Members of the Ad Hoc Committee

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EXECUTIVE SUMMARY

In response to §51, Committee to Improve Health Care Access of Senate Bill 317, An Act Concerning Revisions to Department of Public Health Statutes, the Commissioner of the Department of Public Health established an Ad Hoc Committee for assistance in improving health care through access to School-Based Health Centers (SBHC), particularly by underinsured or uninsured people or Medicaid recipients.

The Ad Hoc Committee has representatives from the Departments of Public Health, Social Services, Mental Health and Addiction Services, Children and Families, Education; the Office of Policy and Management, and School Based Health Centers. In order to accomplish the tasks assigned, the Committee met six times between June 28 and the end of November 2006.

The group was charged with researching and recommending responses to the following three questions:

- Would statutory and/or regulatory changes improve healthcare through access to SBHC, particularly by persons who are underinsured, uninsured or receiving services under the state Medicaid program?
- What is the status of the current SBHC system and what recommendations are needed to improve resources, access to care, and fiscal support to achieve the Level V Model, which is the DPH Standard Model for a SBHC?
- What supportive processes are necessary to expand the current SBHC system (new sites) with respect to resources, access to care, and fiscal support?

Presentation of the findings and recommendations respond to the three charges outlined above and specifically address resources, access, and fiscal support for the current SBHC system and for future SBHC. These recommendations are based on additional funding through the appropriations process, if made available.

Recommendations in Response to Charge One:

- The Committee does not suggest any statutory or regulatory changes to improve access to SBHC at the present time. However, to assure the sustainability and proper expansion of Level V Model SBHC in Connecticut, statutory and/or regulatory changes may be warranted in the future.

- To move this agenda forward, the Committee recommends that a group consisting of representatives from SBHC, state agencies that provide direct services, Department of Social Services (Medicaid), as well as other appropriate identified entities, such as behavioral health providers, should continue to meet to revisit this charge as well as to facilitate ongoing, timely problem solving. Potential areas for further exploration by this committee include, but are not limited to, third party reimbursement, expansion of the Level V Model, stable funding sources, resource leveraging, and licensing requirements. This mechanism of sharing expertise and resources will help to promote an effective and efficient SBHC program in CT.

Recommendations in Response to Charge Two:

- If increased funding were available, bring all currently operating SBHC up to a Level V. In order to be considered a state-funded Level V SBHC in CT, the center must operate full time during the academic year including all hours of school operation. It must also operate as a Comprehensive SBHC, which is defined as a unique service delivery model that concurrently blends medical care with preventive and behavioral health services provided by a team of licensed inter-disciplinary professionals (at minimum, medical and behavioral) with particular expertise in child/adolescent health who work side-by-side to address and coordinate a broad spectrum of students' health needs and routinely offer to students time-intensive anticipatory guidance and health education. This model represents the highest standard of care available (National Gold Standard) with respect to the range and quality of SBHC services.

Note: This recommendation takes priority over the establishment of new sites. *It costs $471,603 per year to operate a Level V SBHC, with comprehensive dental services, during the academic year. The cost to have the 66 currently operating SBHCs at a Level V, with comprehensive dental services, during the academic year is $31,125,798.*

  - A mechanism should be developed by DPH to award additional funds based on need documented through criteria such as District Reference Groups (DRG), Health Professional Shortage Areas (HPSA), Medically Underserved Areas (MUA), Priority School Districts (PSD) and schools making inadequate progress in achieving No Child Left Behind (NCLB) goals. (See more information on these criteria under Recommendations in Response to Charge Three.)

- Consider core funding of 75% of SBHC budgets through the Department of Public Health's SBHC line item. Currently SBHC receive $7,286,531 ($6,998,435 in state dollars, $288,096 in federal funds) through the SBHC line item via the Department of Public Health. *Seventy-five percent of the cost to operate 66 SBHC at a Level V, with dental services, during the academic year is $23,344,348. New cost to the state would be 16,057,817. ($23,344,348 - $7,286,531.)*

- Consider increased funding to those sites that justify the value of operating beyond the school year. *It costs $517,727 per year to operate a Level V SBHC, with comprehensive dental services, on a year round basis*.

- Convene a meeting of MCO and other insurers to address how to maximize reimbursement to SBHC.

- Assess the current capacity of SBHC to offer dental services. Base the need for oral health care within each community in order to determine the best way to meet the need, i.e., within a center, through a freestanding dental clinic, or through a dental van service. A budget would then be developed for providing the dental service.

- Assess and assure that adequate DPH staff resources are in place to fully support the level of oversight and technical assistance required if additional sites are brought on board.

- If increased funding were available, increase funding to the SBHC training line item in order to provide adequate technical assistance in areas such as:
  - Best practices in the delivery of health care services
  - Coding and reimbursement
  - Practice management

- Follow the recommendations to enhance the Management Information System outlined in the CT Department of Public Health School Based Health Centers' Report, "Evaluation of Data Collection System", prepared for DPH by a data consultant. *The cost to implement the recommendations related to software and DPH staffing is $150,000 ($60,000 for software, $90,000 to establish a dedicated SBHC data management staff position.)*

Recommendations in Response to Charge Three:

- If increased funding were available, increase the number of new SBHC sites in order to expand safety net services to more students in Connecticut.

- All awards to new sites should be conducted through a competitive RFP process.
  - Require new grantees to conduct a needs assessment and develop a strategic plan for ongoing sustainability and community support.

- The RFP process should use standardized criteria to document need. Standardized criteria recommended for consideration are:
  - District Reference Groups (DRG) from CT State Department of Education - consist of three indicators of socioeconomic status; three indicators of need; and enrollment status. (For more information on DRG go to: http://www.ctkidslink.org/pub_detail_303.html.)
  - Priority school districts (PSD), which are school districts with the greatest academic need.
  - Schools not making adequate progress on No Child Left Behind goals. (For more information on NCLB go to: http://www.csde.state.ct.us/public/cedar/nclb/index.htm.)
  - Health Professional Shortage Area (HPSA) designations, which indicate a shortage of providers within geographic areas, population groups or facilities. A HPSA designation can be in primary medical care (HPSA-P); dental (HPSA- D) and/or mental health (HPSA-M). (For more information on HPSA go to: http://bhpr.hrsa.gov/shortage/)
  - Designations of Medically Underserved Areas (MUA) which are geographic areas in which residents have a shortage of personal health services. (For more information on MUA go to: http://bhpr.hrsa.gov/shortage/)
  - Community support for the SBHC service delivery model
    - Inclusive of ability to assure at least a 25% funding match

- Consider annual funding of different types of grants --
  - Planning grants of $50,000
  - Enhanced School Health Clinical Services at 75% of their costs ($152,144 for academic year; $176,882 for year round)
    - Offering Enhanced School Health Clinical Services is a first step toward the establishment of Level V SBHC; especially in those communities that have completed a planning process.
  - New Level V SBHC (with comprehensive dental services) at 75% of their costs ($353,702 for academic year; $388,295 for year round)

SUMMARY COMMENT

It is the hope of the Ad Hoc Committee that the work done between July and November 2006 is seen as a beginning process that has informed the Department on DPH-funded school based health centers. The intent of this report, especially the recommendations, is to strengthen and expand the delivery of care provided through SBHC to Connecticut children, their families and their communities.

SECTION I

THE ESTABLISHMENT OF AND CHARGE TO THE AD HOC COMMITTEE

In response to §51, Committee to Improve Health Care Access of Senate Bill 317, An Act Concerning Revisions to Department of Public Health Statutes, the Commissioner of the Department of Public Health established an Ad Hoc Committee for assistance in improving health care through access to school-based health centers (SBHC), particularly by underinsured or uninsured people or Medicaid recipients. (See Appendix A for full text of §51 of the SB317.)

The Committee was charged with researching and recommending responses to the following three questions:

- Would statutory and/or regulatory changes improve healthcare through access to SBHC, particularly by persons who are underinsured, uninsured or receiving services under the state Medicaid program?
- What is the status of the current SBHC system and what recommendations are needed to improve resources, access to care, and fiscal support to achieve the Level V Model? (See Appendix B for a description of the Level V Model.)
- What supportive processes are necessary to expand the current SBHC system (new sites) with respect to resources, access to care, and fiscal support?

Following the guidance on committee membership outlined in §51, the Ad Hoc Committee has representatives from the Departments of Public Health; Social Services; Mental Health and Addiction Services; the Office of Policy and Management and school based health centers. Membership was expanded to include representation from the State Department of Education and the Department of Children and Families. (See Appendix C for a listing of Ad Hoc Committee members.) In order to accomplish the tasks assigned, the Committee met six times between June 28 and the end of November 2006.

In addition to reviewing the regulations relevant to SBHC, the Committee was presented with information compiled by the State Department of Public Health, including SBHC data obtained from quarterly, midyear and yearly reports and a summary of the SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis that the SBHC Coordinators completed at the request of the Committee. The SBHC representatives provided an orientation session for the other Committee members and were a key source of information throughout the process.

State specific information was supplemented with material from a number of national sources including the National Assembly on School Based Health Care (NASBHC); the Robert Wood Johnson Foundation's School Based Health Center Initiative, *Making the Grade (MTG): State and Local Partnerships to Establish School-Based Health Centers*; and The Center for Health and Health Care in Schools at George Washington University School of Public Health and Health Services.

The Ad Hoc Committee's findings and recommendations are in Section IV of this report. It is preceded by background information on school-based health centers and an overview of SBHC in CT.

SECTION II

BACKGROUND INFORMATION ON SCHOOL BASED HEALTH CENTERS (SBHC)

Since the early 1980's, school based health centers have served as safety-net providers of comprehensive medical and behavioral health care within a school facility or on school grounds. They are found in high, middle, elementary and mixed schools (Mixed schools are combinations of elementary and middle schools and middle and high schools.) SBHC are staffed by multi-disciplinary teams of providers including, but not limited to, nurse practitioners, social workers, dentists, dental hygienists, health educators, prevention specialists, nutritionists, outreach workers and other ancillary staff as needed.

The acceptance of SBHC is evident by their growth throughout the country. According to the National Assembly of School Based Health Care's (NASBHC) 2004-2005 census, there are 1,735 SBHC operating in this country.

NASBHC, a national membership organization that does advocacy and public policy; training and technical assistance; and evaluation and research, compiled the following principles and goals as guidance for defining the essential elements of school based care. They also provide a framework for accountability and continuous improvement.

- Supports the School

The SBHC is built upon mutual respect and collaboration between the school and the health provider to promote the health and educational success of school-aged children.

- Responds to the Community

The SBHC is developed and operates based on continual assessment of local assets and needs.

- Focuses on the Student

Services involve students as responsible participants in their health care, encourage the role of parents and other family members and are accessible, confidential, culturally sensitive and developmentally appropriate.

- Delivers Comprehensive Care

An interdisciplinary team provides access to high quality, comprehensive, physical and mental health services emphasizing prevention and early intervention.

- Advances Health Promotion Activities

The SBHC takes advantage of its location to advance effective health promotion activities to students and the community.

- Implements Effective Systems

Administrative and clinical systems are designed to support effective delivery of services incorporating accountability mechanisms and performance improvement practices.

- Provides Leadership in Adolescent and Child Health

The SBHC model provides unique opportunities to increase expertise in adolescent and child health, and to inform and influence policy and practice.

These principles and goals provide the framework upon which a range of services is offered to students.

SBHC serve children and their families as well as the schools and communities in which they are located. Access, convenience, focus on learning, continuity and assurance of care are the hallmark characteristics of SBHC that function as unique safety net providers. (See Appendix D for a fact sheet by NASBHC on school based health centers as a child focused safety net strategy.) The Committee on School Health of the American Academy of Pediatrics cites several sources to support their claim that "Increasingly, schools are used as health access sites for students to receive increased and improved access to care

that they are not receiving elsewhere".[1] Numerous studies reinforce the efficacy of SBHC as access points to care and include the following:

- A 4-year retrospective study of student visits found that teens attending SBHC had higher rates of visits for health and medical care than those using traditional sources of medical care.[2]
- A number of studies, including the most recent from 1992 and 1993, comparing SBHC users to SBHC non users report that students at high-risk for medical and psychosocial problems use the centers, or are more willing to use them, for both routine and sensitive issues. [3,4]
- Studies comparing students enrolled in a managed care organization with students enrolled in both a SBHC and managed care organization underscore the value of providing teenagers an additional access point to services. It was found that while they had more health visits per year, overall the SBHC-enrolled cohort had more health supervision visits, particularly at the SBHC site.[5]

There are also numerous studies that document the cost effectiveness of SBHC. The following three reports are examples:

- A study by Johns Hopkins University found that school-based health centers reduced inappropriate emergency room use among regular users of school-based health centers.[6,7]
- A study of school-based health center costs by Emory University School of Public Health attributed a reduction in Medicaid expenditures related to inpatient, drug and emergency department use to use of school-based health centers.[8]
- In FY2002, SBHC in CT had 2044 student visits with a primary diagnosis of asthma. Eighty-six percent of those students were treated by the SBHC and returned to class. Those SBHC site interventions alone saved $1,684,164 in additional health costs.[9]

The pediatric health care delivery system must not only address morbidity and mortality related to illness, but also health concerns with root origins related to the more complex issues of behavior and lifestyle. The interdisciplinary team approach embedded in the SBHC model enables practitioners to respond to the full range of contemporary medical, behavioral and dental needs of children and adolescents, especially those at high risk for health problems.[10]

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[1] Committee on School Health, the American Academy of Pediatrics. School Health Centers and Other Integrated School Health Services. Pediatrics. Vol. 107. No1. January 2001.
[2] Anglin TM, Naylor Ke, Kaplan DW. Comprehensive school-based health care: High school students use of medical, mental health and substance abuse services. Pediatrics 1996;97:318-30
[3] Adelman HS, Barker LA, Nelson P. A study of school-based clinics: Who uses it and who doesn't. J Clin Child Psychol 1993:22:52-9.
[4] Fisher M. Juszcak L. Friedman SB, et al. School-based adolescent health care: Review of Clincial service. Am J Dis Child 1992;146;615-21
[5] Kaplan DW, Calonge BN, Guernsey BP, Hanrahan MB. Managed care and school-based health centers: Use of health services. Arch Pediatr Adolesc Med. 1998;52:25-33.
[6] Key JD, Washington EC, Hulsey TC, Reduced emergency department utilization associated with SBHC enrollment, *J Adol Health 2002; 30:273-278.*
[7] Santelli J, Kouzis A, et al. SBHCs and adolescent use of primary care and hospital care. *J Adol Health 1996; 19: 267-275*
[8] Webber MP, Carpiniello KE, Oruwariye T, Yungtai L, Burton WB, and Appel DK. Burden of asthma in elementary school children: Do SBHCs make a difference? *Arch Pediatr Adolesc Med. 2003; 157: 125-129.*
[9] CASBHC Special Studies, 2003.
[10] Millennia Consulting. School-Based Health Centers in Chicago, Current Status and Challenges for the Future. October 28, 2004. Available at: http://www.consultmillennia.com/documents/School-BasedHealthCentersInChicago.pdf. Accessed November 2006.

The following vignette illustrates how SBHC serve as a safe access point for troubled students.

JANICE

Janice is eleven years old and lives with her parents and two younger brothers. She is in the seventh grade. In October, the School Based Health Center sponsored a school-wide stress management day. Students and faculty were invited to participate by visiting a table outside the cafeteria and taking a short quiz about their feelings. Janice quietly filled out her quiz. She answered "yes", that she would like to talk to someone about her sad feelings. The Health Center social worker made an appointment to see Janice the next day and then spoke to her teacher about her. Janice's teacher had noticed that she was tired quite a bit and had very few friends.

After becoming comfortable with the social worker, Janice said that her Dad was "too sick to work" and that he "stayed in bed all day". She also said she had been thinking of ways to hurt herself as she was so sad and didn't want to "bother" her mother.

The worker met with Janice's mother and found that her father was mentally ill, suffering from depression so debilitating it had forced him to leave his job three years ago. Janice's mother was very overwhelmed as she attempted to raise three children and keep the bills paid. Janice never told her mother about how she felt, as she didn't want to worry her.

The health center social worker immediately referred Janice for a psychiatric evaluation. She was hospitalized for depression that day and when she returned to school she was already connected to a community agency for continued counseling. She continues to see the social worker in the school based health center and is currently in a girls group, which deals with self-esteem issues. She is slowly beginning to make friends and enjoys many of the group activities at the health center.

Note: Provided by a CT SBHC. The name has been changed to protect confidentiality.

According to a fact sheet on children's mental health needs and school based services prepared by the Center on Health and Health Care in Schools:

- Research suggests that schools may function as the de facto mental health system for children and adolescents.
- Only 16 percent of all children receive any mental health services. Of those receiving care, 70 – 80 percent receive that care in a school setting.
  (See Appendix E for a copy of the fact sheet.)

Tooth decay (dental caries) is one of the most common chronic childhood diseases. It is five times more common than asthma and seven times more common than hay fever. Children living in poverty suffer twice as much tooth decay as their more affluent peers, and their disease is more likely to be untreated. More than 61 million school hours are lost each year to dental-related illness. [11] Just as with medical health and behavioral health care, SBHC that offer dental services eliminate barriers to care including the lack of insurance coverage, dentists, transportation and juggling schedules to accommodate inconvenient appointment times. (See Appendix F for a fact sheet by The Center for Health and Health Care in Schools on children's dental health needs and how SBHC are addressing those needs.)

[11] US DHHS. Oral Health in America: A Report of the Surgeon General. Rockville, MD: US Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institute of Health, 2000.

Another vignette describes how a serious dental problem was handled by a SBHC that managed the emergency and ensured that the required follow up care was also obtained.

WILLIE

Willie is a 15 year old 11th grader from South America who waited for a month for his first appointment at the dental clinic. When he arrived on a Friday morning the dentist found that he had an infection so severe he could not open his mouth or turn his head. While it had begun in his gum, the infection had traveled to his bone and he was in danger of it infecting the tissues in his brain. With no health insurance he had no options for health care in the community. The SBHC dentist used an interpreter to speak to Willie's father and made arrangements for him to go directly to the emergency room where he was placed on IV antibiotics for the next 24 hours. While this treatment saved his life, once discharged he was left with the need for oral surgery to remove the tooth that became infected and the bone that had been infiltrated by the infection. Again the SBHC dentist and the clinic coordinator arranged for a local oral surgeon to see Willie on a pro bono basis for the oral surgery and subsequent follow up visits.

Note: Provided by a CT SBHC. The name has been changed to protect confidentiality.

SECTION III

SCHOOL BASED HEALTH CENTERS IN CONNECTICUT

History

CT's first SBHC was started in the early 1980s in Wilbur L. Cross, a New Haven high school. The establishment of that SBHC started what has become a rich history in understanding the importance of SBHC and establishing them in communities throughout the state. CT was one of twelve states selected through a competitive process by the Robert Wood Johnson Foundation to receive a 12-18 month -- Making the Grade: State and Local Partnerships to Establish School-Based Health Centers (MTG) -- planning grant to develop a plan to expand the number of SBHC in CT and improve conditions for sustaining them. CT then went on to be one of nine states to participate in the Foundation's MTG demonstration program. It was during this time that the Level V Model was created and adopted as the Standard Model (See Appendix B for full description of the model.)

Connecticut SBHC have grown exponentially over the years. When the MTG demonstration program began in 1994, there were 29 state-funded centers in operation. Today there are 66 state supported centers located in 20 towns. This represents a 128 percent increase. The following chart provides a breakdown of the SBHCs by town and type of school in which they are located.

Chart 1: Number of School Based Health Centers by Town and Type of School

Town	Type of School					
	Pre-K	Elementary	Elementary/ Middle	Middle	Middle/ High	High
Ansonia						1
Bloomfield					1	
Branford				1		1
Bridgeport		1	5			3
Danbury				1		1
East Hartford		1		1		1
Groton		2		1		1
Hamden						1
Hartford		2		1		2
Middletown		1		1		
New Britain						1
New Haven		5	2	3		2
New London		5		1		1
Norwalk						3
Norwich		1		2		1
Stamford			1		1	2
Stratford				1		
Waterbury		1				
Waterford	1					
Windham				1		1

Note: The Department of Public Health also funds three Expanded School Health Services Programs for a combined grant total of $248,026. They are located in Meriden, Madison and the Region 11 School District. See the Glossary for more information on Expanded School Health Services Programs.

SBHC operate under the sponsorship of a variety of organizations representing community health centers, hospitals, municipalities, boards of education and regional education councils, local health departments, and community based organizations. A mix of funding sources support SBHC activities including state, federal, local and private dollars.

Primary and preventive medical and behavioral health care services, along with age appropriate health promotion/education activities, are the cornerstone services provided at each center to address the many threats affecting the health of Connecticut's youth. Poverty, violence, psychosocial problems, substance abuse, unplanned pregnancies and sexually transmitted diseases and myriad mental health problems are among the most prevalent.[12,13] To address these contemporary health threats, Connecticut's school based health centers offer child and adolescent focused care in a comprehensive, family centered and culturally sensitive manner. An often-underappreciated value of SBHC is their ability to utilize a preventive community health approach to address the "root" causes of ill health. Because each site is embedded in the community in which their targeted population interacts on a daily basis, they can simultaneously address both the medical and community factors that affect the health outcomes of their students. This health care delivery model is a recognized approach to reducing health disparities. [14]

SBHC provide a safe and confidential haven for those who need help in making positive health supporting decisions while managing the stresses of their lives. Many SBHC patients, especially adolescents, are forced to balance taking care of themselves with some or all of the following: family issues, cultural differences, poverty and barriers to accessing the help and care that may be needed.

The following vignettes are examples of how SBHC provide care to students as well as their ability to network with other systems on behalf of their patients.

HELENE

In March, the nurse practitioner referred a junior, Helene, to the social worker. Helene was being seen by the nurse practitioner for muscle pain, headaches, and neck aches; it was suspected that she might be experiencing emotional stress as well. She started attending sessions with the social worker on a weekly, then twice-weekly basis. The issues she brought to treatment ranged from feelings of abandonment due to her mother's departure from her life around age 7; a conflictual relationship with her father; questions about her own sexual identity; and intense feelings of mistrust towards others. Helene is an unusually insightful student who has been able to form a strong alliance with the social worker. She has been able to improve her grades, in part because she can concentrate in class, knowing that she will discuss her problems in treatment. She is relying less on friends to fulfill all of her emotional needs, and as result, she is in fewer fights and feels less isolated. Due to lack of funds and family support, Helene would not be able to receive mental health services at an outside agency. However, she is making good use of the services at the SBHC and, it is hoped that she may be able to explore a corrective emotional experience through her work with the social worker.

Note: Provided by a CT SBHC. The name has been changed to protect confidentiality.

[12] Planning Branch, CT Department of Public Health. CT School Health Survey. 2005. Available online at: http://www.dph.state.ct.us/PB/HISR/cshs.htm. Accessed November 2006.
[13] CT Department of Public Health, CT School Based Health Centers, Annual Report RY 2004-2005. Unpublished.
[14] The Prevention Institute. The Imperative of Reducing Health Disparities through Prevention: Challenges, Implications, and Opportunities. October 2006. Available online at: http://www.preventioninstitute.org/documents/DRA_ReducingHDthruPrx.pdf. Accessed November 2006.

JOHNINA & KAROLINA

Johnina and Karolina, ages 6 and 9, arrived in Connecticut last year following their emigration from Kosovo. Their family is living with relatives until they can make enough money to secure their own apartment. Both of their parents have taken jobs as laborers but currently have no health insurance for either of the girls. After screening in their elementary school by one of the public health dental hygienists, the girls were referred to the school based dental clinic.

With no fluoridation in the water in their village in Kosovo, both children had extensive tooth decay. Their parents were barely able to meet their financial obligations and were trying to save the money needed for a security deposit and rent for their own apartment. As a result, they did not have the money to take the girls to a private dentist.

The hygienist in the dental clinic cleaned their teeth and the dentist repaired their cavities. The staff at the dental clinic gave the parents information about CT's HUSKY insurance program and referred them to the HUSKY application assistance program at the local health department.

Note: Provided by a CT SBHC. The names have been changed to protect confidentiality.

DANIELLE

Danielle is a twelve-year-old girl in the 9th grade that presented to the SBHC frantically requesting an HIV test. She explained that she had had sexual contact with a boy, who she heard through rumors, was also sexually involved with a girl known to be HIV-positive. After commending her for coming forward and being open about her situation, STD testing and counseling was performed. Danielle was then referred to the HIV prevention counselor from the health department. Danielle was not HIV infected and was immediately referred to the SBHC social worker. Danielle spoke extensively with the nurse practitioner and social worker about a variety of extreme family problems.

In addition to her mother's disabling chronic medical condition and her older sister's substance abuse, Danielle's parents' marriage was wrought with conflict and sometimes violence. Danielle received on-going supportive counseling and medical follow-up at the SBHC. Despite all her stresses, Danielle has maintained good grades and now has goals and plans for her future.

Note: Provided by a CT SBHC. The name has been changed to protect confidentiality.

Current Information from SFY 04-05

There were 43,900 SBHC enrollees in SFY 04-05. Of that total number of enrollees, 19,881 (45%) utilized SBHC services. Of 127,674 total contacts, there were 89,121 actual clinic visits. The remainder were collateral contacts (for example, a call to a provider or a parent to organize services). Of the 89,121 actual clinic visits, the distribution of diagnosis codes can be seen in Appendix G, SBHC Visits by Reason for Visit 2004-2005.

The insurance status of the children who obtained SBHC services is as follows: 44% Medicaid (HUSKY A); 29% no insurance; 26% private insurance; and 1% unknown. Note that these figures represent a snap shot of insurance status that can change for a number of students during the course of the year. It is also important to note that the insurance status of SBHC patients does not necessarily translate into funding sources that cover the cost of their care. SBHC have a lower Medicaid reimbursement rate than community health centers and other providers. The reimbursement only covers a fraction of the cost of care. Behavioral health services offered are often not billed due to the low acceptance rate, especially for the provision of preventive behavioral health care, and the concern that Explanation Of Benefits (EOB) are sent to the family, potentially compromising patient-provider confidentiality. Obtaining reimbursement from private insurance sources for the 26% of the students who have private insurance coverage is also problematic. Many private insurance companies have refused to recognize and accept billing from SBHC.

Additionally, some of the core SBHC services, especially case management, care coordination and health education, are not covered services and billable at all. To make matters more complex, the contract terms between the SBHC sponsoring agency and third party payers' are not the same. These reimbursement issues are acknowledged under challenges and provide the basis for some of the funding recommendations outlined in Section IV.

Challenges

Despite the significant progress and overall success of SBHC in CT, many challenges remain. As safety net providers, CT SBHC need ongoing reliable sources of funding and an adequate infrastructure to support their work. As previously stated, the uniqueness of CT's SBHC service delivery model provides an especially taxing system for garnering 3rd party reimbursement. These challenges have been documented nationally and are best summarized by the National Assembly on School-Based Health Care statement:

> ***School based health care represents an intersection of public health, medical care, mental health and education. Its survival depends on a policy and financing structure that adequately rewards this intersection and the unique clinical opportunities including group and population-focused services, that are not part of standard health care reimbursement.***[15]

Nationally, and in a number of states, policymakers are seeking information similar to that requested by CT legislators and introducing legislation to support SBHC. Senator Dodd has introduced legislation – the School Based Health Clinic Establishment Act of 2006 --to amend the Public Health Service Act to establish the School Based Clinic Program. The bill would fund SBHC in: 1) acquiring and leasing building and equipment; 2) training; 3) managing SBHC; and 4) paying staff. This proposed legislation is based on an understanding of SBHC as safety net providers and a recognition of their contribution to the public health of the communities in which they are located. It supports their need for infrastructure and a stable base of funding.

In addition to reliable sources of funding and adequate infrastructure, a third challenge facing CT's SBHC is a possible "dilution" of the Comprehensive SBHC Model (See the Glossary for more information on the Model). All three of these issues are discussed in more detail below.

Reliable Sources of Funding

One of the findings of the initiative, Making the Grade: State and Local Partnerships to Establish School Based Health Centers, is the need to have a mix of public/private financing strategies that include federal, state and local sources of support. Early on, billing third party insurers, including Medicaid, for services provided by SBHC practitioners, was seen a major ongoing and reliable funding source. However, that expectation has fallen short. While it remains an appropriate source of income to be included in the overall funding mix, the amount that can be generated from third party sources has been ratcheted down considerably.[16] The literature indicates that billing for services needs to be more realistic and take into account the cost (time and personnel) involved; the low reimbursement rates; the number of services that might be covered, but will not be billed due to issues of confidentially; and services billed but not paid for due to a change in a child's coverage status.[17]

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[15] National Assembly on School-Based Health Care. Critical Issues in School-Based Health Care Financing. September 1999.

[16] The Robert Johnson Foundation. Making the Grade: State and Local Partnerships to Establish School-Based Health Centers. November 2003. Available online at: http://www.rwjf.org/portfolios/resources/grantsreport.jsp?filename=MakingGrade.htm&iaid=132&gsa=1. Accessed November 2006.

[17] National Assembly on School-Based Health Care. Creating Access to Care for Children and Youth: School Based Health Center Census 1998-1999. June 2000.

An Adequate Infrastructure

An adequately supported infrastructure at multiple levels, state (CT DPH) and (CASBHC, individual SBHC sites) is key to the success of SBHC. This is reinforced by the information shared by SBHC Coordinators in their SWOT analysis and 1996 recommendations of the Public Health Subcommittee based on a survey of CT's safety net providers, which includes the following, "DPH must intensively monitor each safety net provider's financial status, identify providers at risk of closing or reducing services, determine the potential impact on that community, perform a needs assessment and develop a plan to address those needs.[18]"

The Threat of the "Dilution" of Comprehensive SBHC Model

The value of CT's comprehensive SBHC model to the overall mission of public health is often overlooked. SBHC deliver population-based approaches to health by providing interventions directed at multi-level factors -- interpersonal, intrapersonal, societal and environmental -- all which affect individual behaviors, lifestyle choices and ultimately health status. Potential "dilution of the model", due to funding constraints, remains a significant threat to the success of this holistic approach of delivering health care to at-risk populations. Limited funding often forces SBHC to cut back on services. Many times diminished services include limited SBHC hours and cuts to behavioral health and health education services. In many instances, oral health services are not offered at all. The comprehensive model is thus "diluted".[19]

The unique Comprehensive SBHC Model offers a valuable service. Data obtained through the 2005 CT School Health Survey indicate that youth are practicing risky behaviors that include tobacco use and substance abuse. It also reports inadequate levels of physical activity and poor eating habits. Behaviors that contribute to intentional and unintentional injuries, including violence, were reported as well as sexual behaviors that can lead to unplanned pregnancies and infectious diseases.[20] SBHC perform health risk appraisals to identify many of these risky behaviors and allow prompt interventions. Culturally sensitive, age-appropriate health education is also delivered to assist youth in the adoption of healthy behaviors. During the 2005-2006 school year, individuals (not only SBHC enrollees, but other students who attend the school as well as staff and parents) participated in educational sessions provided through school based health centers. These sessions covered a wide array of timely topics such as: bullying, violence prevention, reproductive health, substance use, anger management, dental, diabetes, sexual assault, asthma, healthy relationships, suicide prevention, domestic violence, stress, self esteem, etc.

Projecting into the Future

A significant contributor to the ongoing success of CT's SBHC is the CT Association of School Based Health Centers (CASBHC). CASBHC was formed (1994) and incorporated as a private non-profit agency (1995) during MTG's implementation grant period. It is a membership organization of 65 SBHC. This advocacy organization monitors legislation, provides testimony and increases awareness of SBHC through marketing. Over the years, it has worked to establish a strong base of support for SBHC through the delivery of community-based quality services. At the same time the Ad Hoc Committee was meeting, CASBHC did some strategic planning for themselves as an organization and for the state's SBHC. (See Appendix H for CASBHC vision for SBHC in Connecticut.) While the goals are broader in scope than the recommendations outlined in the following section, CASBHC will advocate and support them as stepping stones to achieving their longer-term goals for SBHC.

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[18] The Status of Safety Net Providers in CT: A Survey. Recommendations of the Public Health Subcommittee. 1996. Available on online at: ttp://www.cga.ct.gov/ph/medicaid/mmcc/ph/study/phstu3.htm. Accessed November 2006.

[19] The Robert Johnson Foundation. Making the Grade: State and Local Partnerships to Establish School-Based Health Centers. November 2003. Available online at: http://www.rwjf.org/portfolios/resources/grantsreport.jsp?filename=MakingGrade.htm&iaid=132&gsa=1. Accessed November 2006.

[20] Planning Branch, CT Department of Public Health. CT School Health Survey. 2005.

The future of SBHC in Connecticut will also depend upon the dedication and efforts of SBHC staff and their community-based partners as well as guidance and funding from the state, via the Department of Public Health.

The following Ad Hoc Committee's findings and recommendations are offered as guidance to decision making that will ensure the enhancement and sustainability of SBHC.

SECTION IV

FINDINGS AND RECOMMENDATIONS

The recommendations support school based health centers as safety net providers for CT children and adolescents, especially those who are uninsured, underinsured and Medicaid recipients.

Presentation of the findings and recommendations respond to the three charges outlined in §51 of Senate Bill 317 and specifically address resources, access, and fiscal support for the current SBHC system and for future SBHC. These recommendations are based on additional funding through the appropriations process.

Charge One

Would statutory and/or regulatory changes improve healthcare through access to SBHC, particularly by persons who are underinsured, uninsured or receiving services under the state Medicaid program?

The Ad Hoc Committee examined and evaluated CT state statutes and regulations relevant to SBHC. Key findings are as follows:

- All state funded SBHC in Connecticut must hold a State of Connecticut License for Outpatient Clinics as outlined in the Public Health Code, Sections 19-13-D45 through 19-13-D53, or a Hospital Satellite License as outlined in the Connecticut General Statutes, Section 19A-493.

- All medical, behavioral and dental professionals who deliver care in state-funded SBHC must be licensed by the State of Connecticut.

- Senate Bill 317 under §84 expands the Loan Repayment Program to include SBHC. Section 84 states "The law authorizes DPH to establish, within available appropriations, a program providing three-year grants to community-based, primary care service providers to expand access to health care for the uninsured. The grants may be awarded to recruit and retain primary care clinicians and registered nurses through salary subsidies or a loan repayment program. . . The act specifies that these providers can also provide nursing services in a school-based health center." This expansion of the Loan Repayment Program to include SBHC can be used as a marketing tool to recruit advanced practice nurses (APRN).

- The value of exploring possible statutes or regulations related to SBHCs including, but not limited to, licensing, certification, accreditation, and insurance reimbursement needs is warranted.

Recommendations in Response to Charge One:

- The Committee does not suggest any statutory or regulatory changes to improve access to SBHC at the present time. However, to assure the sustainability and proper expansion of Level V Model SBHC in Connecticut, statutory and/or regulatory changes may be warranted in the future.

- To move this agenda forward, the Committee recommends that a group consisting of representatives from SBHC, state agencies that provide direct services, Department of Social Services (Medicaid), as well as other appropriate identified entities, such as behavioral health providers, should continue to meet to revisit this charge as well as to facilitate ongoing, timely problem solving. Potential areas for further exploration by this committee include, but are not limited to, third party reimbursement, expansion of the Level V Model, stable funding sources, resource leveraging and licensing requirements. This mechanism of sharing expertise and resources will help to promote an effective and efficient SBHC program in CT.

Charge Two:
What is the status of the current SBHC system and what recommendations are needed to improve resources, access to care and fiscal support to achieve the Level V Model?

- CT has 66 state supported SBHC programs located in 20 towns.

- Approximately 50% currently operate as a Level V Model (full time & comprehensive)

- Types of services offered (vary by site)
  - Primary health care including:
    - Physical exams/health assessments/screenings for health problems
    - Diagnosis and treatment of acute illness and injury
    - Diagnosis and management of chronic illness
    - Immunizations
    - Health promotion and risk reduction
    - Nutrition and weight management
    - Reproductive health care
    - Laboratory tests
    - Prescription and/or dispensing of medication for treatment
    - Referral and follow-up for specialty care that is beyond the scope of services provided in the SBHC
  - Behavioral Health Services
    - Assessment, diagnosis and treatment of psychological, social and emotional problems
    - Crisis intervention
    - Individual, family and group counseling or referral for same if indicated
    - Substance abuse and HIV/AIDS prevention
    - Risk reduction and early intervention services
    - Outreach to students at risk
    - Support and/or psycho-educational groups focusing on topics of importance to the target population
    - Advocacy and referral for such services as day care, housing, employment, job training, etc.
    - Consultation to school staff and parents regarding issues of child and adolescent growth and development
    - Referral and follow-up for care that is beyond the scope of services provided in the SBHC
  - Oral Health Services (in certain sites)
    - Screenings
    - Prophylaxis
    - Fissure sealants
    - Diagnostic X-rays
    - Treatment for caries
    - Simple extractions

- All state-funded SBHC are designed to operate as a Level V Model. However, due to budget limitations, many SBHC are forced to close before the end of the academic year and/or cut back on needed services, such as: behavioral health, dental care, health education opportunities, and outreach to children and their families. Funding limitations also often prevent hiring full time staff and offering benefits, which limits the services offered. It also limits the pool of potential SBHC staff to those who can afford working less than full time and have other access to health care benefits.[21,22]

[21] 2005-06 year end reports submitted by the SBHC. CT Department of Public Health, 2006. Unpublished data.

- An expansion of the current SBHC system to operate at a Level V Model of care would support:
  - Full time hours of operation (open all times that school is in session) on either an academic calendar or year round coverage
    - Full time staff with health care benefits
    - Comprehensive SBHC services (medical and behavioral)
    - Oral health (where need established)
    - Preventive health care through risk appraisals and health education
    - Outreach and care coordination to high-risk students and their families
    - Additional inter-disciplinary professionals as needed (i.e., psychiatrists, nutritionists, health educators, etc.)
- A range of appropriate funding sources is needed to supplement the current core funding from DPH. This support compensates for otherwise uncompensated care including services offered to uninsured and underinsured students.
- SBHC contractors are currently required to provide at least 25% of in-kind support to operate their center(s). SBHC provide important services to the communities in which they are located. This value should be acknowledged with in-kind and/or financial support. However, since the relationships between SBHC and the communities that they serve are unique, local support (amount and type of in-kind) will vary.
- While financial returns from third-party payers are challenging and problematic, reimbursement efforts should continue to be conducted at all SBHC.
- Ongoing valid and reliable data produced in a timely manner is essential for tracking and monitoring SBHC activities, identifying needs and trends, and evaluating the provision of services offered and their impact on the health and well being of students. A comprehensive assessment on the current data collection system was conducted this past year. A detailed report was generated outlining specific recommendations for addressing the limitations and barriers identified.

Recommendations in Response to Charge Two:

- If increased funding were available, bring all currently operating SBHC up to a Level V (DPH Standard Model). Note: This recommendation takes priority over the establishment of new sites. (See Appendix B for a description of the model and Appendix I for a budget on the Level V Model of care.) It costs *$471,603* per year to operate a Level V SBHC, with comprehensive dental services, during the academic year. The total cost to have the 66 currently operating SBHC at a Level V, **with** comprehensive dental services, during the **academic year** is *$31,125,798.*
  - A mechanism should be developed by DPH to award additional funds based on need documented through criteria such as DRG, HPSA, MUA, priority school districts and inadequate progress in achieving NCLB goals.
- If increased funding were available, consider core funding of 75% of SBHC budgets through the Department of Public Health's SBHC line item. Currently SBHC receive $7,286,531 ($6,998,435 in state dollars, $288,096 in federal funds) through the SBHC line item via the Department of Public Health. *Seventy-five percent of the cost to operate 66 SBHC at a Level V, **with** dental services, during the **academic** year is $23,344,348. New cost to the state would be $16,057,817 ($23,344,348- $7,286,531.)* Making the Grade, the Robert Wood Johnson Foundation's School Based Health Center Initiative, advocates "obtaining state-level funds for "core or base" funding."[23]
  - Even those SBHC operating as a Level V have needs not addressed by current funding.

[22] Information from SWOT analyses done by SBHCs at the request of the Ad Hoc School Based Health Committee. Carey Consulting. October 2006. Unpublished data.
[23] Barents Group of KPMG Consulting LLC. Factors that Influence the Financial Sustainability of School-Based Health Centers. October 2002.

- If additional funding were available, consider increased funding to those sites that justify the value of operating beyond the school year. *It costs $517,727 per year to operate a Level V SBHC, with comprehensive dental services, on a year round basis*. (See Appendix I for budget.)

- Convene a meeting of MCO and other insurers to address how to maximize reimbursement to SBHC.

- Assess the current capacity of SBHC to offer dental services. Base the need for oral health care within each community in order to determine the best way to meet the need, i.e., within a center, through a freestanding dental clinic, or through a dental van service. A budget would then be developed for providing the dental service.

- Assess and assure that adequate DPH staff resources are in place to fully support the level of oversight and technical assistance required if additional sites are brought on board.

- If additional funding were available, increase funding to the SBHC training line item in order to provide adequate technical assistance in areas such as:
    - Best practices in the delivery of health care services
    - Coding and Reimbursement
    - Practice Management

- Follow the recommendations to enhance the Management Information System outlined in the CT Department of Public Health School Based Health Centers' Report, "Evaluation of Data Collection System", prepared for DPH by Terry Zukerman.[24] *The cost to implement the recommendations related to software and DPH staffing is $150,000 ($60,000 for software, $90,000 to establish a dedicated SBHC data management staff position.)*

Charge Three:
What supportive processes are necessary to expand the current SBHC system (new sites) with respect to resources, access to care, and fiscal support?

- The documented efficacy of SBHC as cost effective safety net providers for children and adolescents warrants that CT increases its number of SBHC.

- Priorities for establishing new SBHC should be conducted in a thoughtful and consistent manner based on geographic need and information obtained through a community health care needs assessment.

- The Committee identified standardized criteria to help determine need. (See Appendix J for a listing of the criteria and a listing of towns in relation to the indicators of need.) Criteria of need include, but are not limited to:
    - District Reference Groups (DRG) from CT State Department of Education (DRG indicators consist of three indicators of socioeconomic status; three indicators of need; and enrollment status. (For more information on DRG go to: http://www.ctkidslink.org/pub_detail_303.html.)
    - Priority school districts (PSD) are school districts with the greatest academic need.
    - Schools not making adequate progress on No Child Left Behind goals. (For more information on NCLB go to: http://www.csde.state.ct.us/public/cedar/nclb/index.htm.)
    - Health Professional Shortage Area (HPSA) designations indicate a shortage of providers within geographic areas, population groups or facilities. A HPSA designation can be in primary medical care (HPSA-P); dental (HPSA- D) and/or mental health (HPSA-M). (For more information on HPSA go to: http://bhpr.hrsa.gov/shortage/)

[24] Zukerman,T. CT Department of Public Health School Based Health Centers, Evaluation of Data Collection System, May 29, 2006. Unpublished report.

- Designations of Medically Underserved Areas (MUA) area geographic areas in which residents have a shortage of personal health services. (For more information on MUA go to: http://bhpr.hrsa.gov/shortage/)
- Community support for the SBHC service delivery model
  - Inclusive of ability to assure at least a 25% funding match

Recommendations in Response to Charge Three:

- If additional funding were available, increase the number of new SBHC sites in order to expand safety net services to more students in Connecticut.

- All awards to new sites should be conducted through a competitive RFP process
  - Require new grantees to perform a needs assessment and develop a strategic plan for ongoing sustainability and community support
  - The RFP process should use standardized criteria, such as those listed above, to document need.

- Consider annual funding of different types of grants --
  - Planning grants of $50,000
  - Enhanced School Health Clinical Services at 75% costs ($152,144 for academic year; $176,882 for year round - See Appendix K for budget.)
    - Offering Enhanced School Health Clinical Services is a first step toward the establishment of Level V SBHC; especially in those communities that have completed a planning process.
  - New Level V SBHC at 75% of their costs ($353,702 for academic year; $388,295 for year round – See Appendix I for budget.)

SUMMARY COMMENT

It is the hope of the Ad Hoc Committee that the work done between June and November 2006 is seen as a beginning process that has informed the Department on DPH-funded school based health centers. The intent of this report, especially the recommendations, is to strengthen and expand the delivery of care provided through SBHC to Connecticut children, their families and their communities.

LIST OF ABBREVIATIONS

CASBHC	CT Association of School Based Health Centers
DPH	CT State Department of Public Health
HPSA	Health Professional Shortage Areas http://bhpr.hrsa.gov/shortage/
MTG	Making the Grade: State and Local Partnerships to Establish School-Based Health Centers
MUA	Medically Underserved Areas http://bhpr.hrsa.gov/shortage/
NASBHC	National Assembly on School Health Care
NCLB Legislation	No Child Left Behind Legislation http://www.ctkidslink.org/pub_detail_303.html
PSD	Priority school districts
SBHC	School based health centers
SWOT analysis	Strengths, Weaknesses, Opportunities and Threats analysis
SFY	State fiscal year

GLOSSARY

Expanded School Health **Services** Program	• Program designed to expand existing school health services. • Services vary by site and include, but are not limited to, counseling, health education, health screening, psychological care, prevention services and linkages to community services. • A clinic license is not required, as the program does not provide the full range of outpatient medical and behavioral health services such as those offered in a traditional SBHC. • The administration of these expanded services may be integrated in the administration that currently exists in the school.
Enhanced School Health **Clinical** Services	• Medical, behavioral, or dental services provided by licensed health professionals within or on the grounds of schools. • A clinic license and medical director may be required to deliver such services. • Usually only one type of service is provided at each site, such as just dental or just behavioral health, and therefore, it is not considered a true SBHC.
School Based Health Centers (SBHC)	• Freestanding medical centers, licensed by the State of Connecticut as clinics, located within or on the grounds of schools. • All SBHC as operate under the guidance of a medical director. • SBHC promote the **physical and mental health** (and oral health at some sites) of children and youth and ensure their access to comprehensive primary and preventive health care. • Services are aimed at, but not limited to, students who do not have access to a family health care provider or whose family has little or no health insurance. • SBHC staffs are a resource for both the school and the community and also deliver population-focused programs on wellness, disease prevention, health promotion and general health management. • State funded centers are designed to deliver services utilizing the **Comprehensive SBHC Model** (See definition below) however, clinic hours and services vary among sites due to funding constraints.
Comprehensive SBHC Model	• A unique service delivery model that **concurrently** blends medical care with preventive and behavioral health services. • Staffing **must** include a team of licensed inter-disciplinary professionals (**at minimum, medical and behavioral**) with particular expertise in child/adolescent health. • Staff works side-by-side to address and coordinate a broad spectrum of students' health needs. • Time-intensive anticipatory guidance and health education are routinely offered to students that utilize the SBHC. • This model represents the highest standard of care available (National Gold Standard) with respect to the range and quality of SBHC services. *(Making the Grade: State and Local Partnerships to Establish School Based Health Centers, 2003)*
Level V SBHC (DPH Standard Model)	The following criteria must be met in order to be considered a state-funded Level V SBHC in CT: • Operate full time during the academic year including all hours of school operation • Operate as a Comprehensive SBHC Model