NATIONAL HEALTH/EDUCATION CONSORTIUM

&

THE CONSERVATION COMPANY

Elementary School-Based Clinics:

Expanding on a Success

A Feasibility Study

December 1992

by

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I. INTRODUCTION

America's school-aged children are falling through the cracks: one in every five children lives in poverty, a 25-year high (National Center for Children in Poverty, 1991); one in eight children under the age of 12 does not get enough to eat (Food Research and Action Center, 1991); thirteen percent of all births are to teenage mothers (National Center for Health Statistics, 1992); and between 9 and 11 million children have no health insurance (Children's Defense Fund, 1991). As childhood poverty increases and child health indicators worsen, our future generation is less able to learn and to become productive citizens.

Compounding the health and education problems today is a health and human service delivery system that is fragmented, crisis oriented and difficult to access, particularly for those most in need. Unable to respond adequately to the rapidly increasing societal and demographic demands, communities increasingly look to schools to provide comprehensive services.

We all know what works: a sustained, preventive and early intervention approach where various health, education, and human services are integrated to provide increased access for children and families. Further, as revealed in recent cost-benefit studies of programs such as Head Start and WIC, preventive interventions more than pay for themselves. The earlier and longer children and families have access to preventive and early intervention services, the less need there will be for more costly services later on.

Faced with rapidly increasing societal and demographic demands, communities have increasingly looked to schools to provide early intervention through comprehensive, preventive services. Schools, it is increasingly felt, have direct and unparalleled social penetration within local communities and can reach many more children and families than any other institution.

By the mid-1980s, led by a variety of public and private initiatives, a handful of school-based health clinics (SBCs) began to offer basic health services to adolescents. By 1989, 150 SBCs existed; by 1991 over 300 existed in 33 states. This growth reflects not only the need for such

services but also the success many communities have had providing much needed health care to youth, many of whom are uninsured. It has been shown that approximately 50 percent of students who use school-based and school-linked health services do not have access to another source of health care (Center for Population Options, 1991). Typical activities for a comprehensive adolescent SBC include the treatment of minor illnesses, drug and alcohol counseling, eye-care and dental screening, treatment of sexually transmitted diseases, and provision of mental health services. SBCs also provide a dependable source of referrals to health professionals in the community, help develop more effective health education programs in the school, and often gain access to the families in greatest need.

Based upon the widely held belief that sustained early intervention and prevention are the most clinically appropriate and cost-effective ways to reach underserved children and families, The Conservation Company and the National Health/Education Consortium conducted a six month feasibility study of elementary school-based clinics (eSBCs). Building upon the success and experiences of adolescent school-based clinics around the country, we believe that establishing a network of clinics on the elementary level will provide the mechanism critical for early intervention.

To support the initiative, The Conservation Company and the National Health/Education Consortium have conducted a systematic, thorough review of relevant models. We have held numerous meetings with informed professionals involved in health and education, as well as school-based services. We travelled the country to talk directly with the people currently administering the handful of elementary school-based clinics in existence. We reviewed hundreds of publications that document the lessons learned from adolescent school-based clinics and studied funding mechanisms to sustain local endeavors. As a result of this review, we have discovered that there is growing support to integrate services for families and children. From our research, we are ever more convinced that the time is right to launch a national elementary school-based clinic initiative. Time after time, in all regions of the country, at all professional levels, in both the public and private sectors, policymakers, service providers, civic leaders and others offered unqualified support for this project. We present here our initial recommendations for an effective model and approach, as well as guidelines for implementation of a national elementary school-based clinic initiative.

Rationale

Given the unmet and growing needs of so many school-aged children, the success of adolescent school-based clinics, and the emerging interest in school-based services, it appears that the stage is set for moving to a new plateau. The new plateau is elementary schools.

The statistics cited above should be enough justification to support the growth of this model. A short list of compelling reasons to pursue it would include the following:

1. health and health-related needs of children, especially disadvantaged children

2. public health needs related to inadequate immunizations, emergence/reemergence of contagious diseases (measles, TB, AIDS, etc.)

3. the need to integrate services for purposes of better serving the whole child in context, leading to better health, educational and psycho-social outcomes

4. the pressure at all levels of government to ensure access to health care, especially for the poor and uninsured children

5. the success of a similar model in high schools and middle schools

6. it is cost-effective, comprehensive, and continuous

7. it is <u>not a deficit model</u> serving only "problem children and families."

An important question which has often been raised is, "why in elementary schools?" Again, the following key points provide a compelling answer:

1. that is where the children are

2. their parents and care-givers still accompany them to school, or interact with the school during the year (something worth encouraging)

3. this is an ideal place to address the needs of the whole child because of the ongoing range of existing services and a known environment for the child

4. prevention and early intervention are key in alleviating the need for more costly and stigmatizing services later on

5. in order to maintain the benefits and gains of earlier programs (i.e. Head Start, WIC, etc.) which will dissipate without reinforcement.

In many poor communities, the local elementary school is the one potential community-based

organization. In many places we visited, it is the hub of activity for longtime residents as well as immigrants not knowing where else to turn. It is often a safe haven for children and adults alike in some very desolate areas. These are communities with limited or no accessible health care, no physicians who serve Medicaid clients, and poor or nonexistent public transportation. Yet, there are public schools that have a social penetration unlike any other institution in the community. The need exists, the desire on the part of many schools to broaden their responsibilities exists, and the experience on which to build exists. Our goal is to begin to support fledgling efforts and to bring the concept to scale.

At a meeting in January 1992 at the New York Academy of Medicine, "School-Based Primary Care: Issues and Options", Dr. Robert Haggerty, just retired president of the W.T. Grant Foundation and renowned pediatrician, made an eloquent case for building on the success of school-based health clinics and the need to develop some visibility and public presence:

> My perception is that people in this important field are fairly isolated. Most of the clinics are fairly small. . . People in this field do not have the sense that there are many other people in the same field, and they don't have the mechanisms of communication with those who are. And particularly, they have not had the mechanism for making the case with the public for the appropriate support of their clinics.

By 1990, the following organizations had all adopted statements in support of the continued development of school-based health centers:

American Academy of Pediatrics
American Medical Association
American School Health Association
American Nurses Association
National Association of State School Nurse Consultants
National Association of Pediatric Nurse Practitioners

On the state level, our feasibility study documents numerous creative initiatives and growing political support. This activity ranges from high-level support from Governors and cabinet members to restructuring of Medicaid payments and processes.

For example, in October of this year, a major conference sponsored by the Commonwealth of Pennsylvania, "Prescription for Success: Enhancing School-Health Services", drew more than 400 educators and health professionals. Our feasibility study confirms that there is substantial interest in this concept, a base of experience from which to learn, and programs upon which to build.

The Report Which Follows

This report reviews the elementary clinics and programs we observed, and provides a set of

recommendations regarding what the future of this concept might be. Following this introduction is a discussion of four types of elementary school-based clinics, followed by a hypothetical model which combines many of the strengths and essential characteristics which we have observed. The next section (section III.) describes some of the major federal and state programs which complement or might directly support these types of projects.

The fourth section describes the potential uses of existing public funds and is, in effect, a preface to thinking about the future and bringing this concept to scale. The experiences of others in looking at decategorization of public funding streams, as well as creative uses of entitlement funds are reviewed.

The final two sections focus on recommendations for implementation and the potential for foundation support. Obviously, these last two sections are the real culmination of the feasibility study. We are confident that this tested model is entirely feasible, the need for it is almost a given, and support from the many stakeholders is easily documented. We have the makings of a program with significant impact.

II. MODELS FOR ELEMENTARY SCHOOL-BASED CLINICS

Although between 300 and 400 adolescent school-based clinics exist in the United States, there are very few clinics operating in elementary schools which meet the criterion of comprehensive on-site health services. An important part of this feasibility study was visiting those elementary programs to see how closely they fit the type of comprehensive elementary school-based clinic envisioned. In addition, a site visit was made to one established adolescent high school clinic (Cambridge, MA) for purposes of comparison and discussion of permutations of the model. Site visits were made to elementary school-based clinics in:

Dallas	San Diego
New Haven	San Fernando
New York	New Brunswick

An abbreviated description of the programs appears in Table 1. A more complete description of these site visits appears in the appendix. In reviewing this information, one can discuss our findings around four emerging models. Each, by definition, fits well in its community. None can be taken lock-stock-and-barrel into another community. But there are many elements in common, and particular elements which should be given a high priority. These will be discussed in the second half of this section.

The four existing models that provide the framework for an analysis of the site visits are:

A. medical model
B. expanded school nurse model
C. comprehensive service center model
D. neighborhood health center model

A. Medical Model

In its purest sense, the term "clinic" alone conjures up the notion of a medical model. In fact, very few of the elementary school-based clinics we visited truly approach the medical model. One of the oldest and most impressive, however, did: the Carver Health Clinic in West Dallas, Texas.

The Carver Health Clinic operates much like a neighborhood health center, but it is located at an elementary school. It is run by Parkland Hospital and staffed full-time by Parkland physicians. Complete backup is provided by the hospital on evenings and weekends and services are reimbursed primarily by Medicaid. The clinic is housed in a separate facility on the school grounds, easily accessible from the school itself and the surrounding housing project. It has a busy waiting room, and a Class D pharmacy. The staff provides health and mental health services for both children and adults. These include primary care, preventive services, acute care, chronic care, laboratory services, dental services, and some social services. The clinic registration rate approaches 80% of the student population.

The clinic, open year-round, is staffed by full-time physicians, nurse practitioners, nurse's aids, and social workers. The school nurse, mandated by the Dallas Independent School District (DISD), is an integral part of the school/clinic relationship. Located in the school itself, the school nurse is primarily responsible for the record keeping, initial diagnosis, and tracking. Through the clinic, the school and the hospital, children are tracked from birth to high school with a Unix computer tracking system.

The clinic's close working relationship with both the school and the community are seen as essential for its long-term success. The initial support of the superintendent was essential and now, with the emergence of more school-based management, the support of the local administrators becomes even more central. Given the obvious need in poor communities, school-based clinics currently existing in elementary schools have not had difficulty in galvanizing local support.

When the Dallas clinic first began more than 20 years ago, an important part of the partnership between DISD and the hospital was a loan from the school district for clinic construction. The support for this and the original funding came from the (now defunct) Dallas County Children and Youth Project working with the Dallas Children's Medical Center and the University of Texas Southwest Medical School. In 1989, the Community Oriented Primary Care Program (COPC) was created to develop an integrated system of community-based health centers with a link to the only public hospital in Dallas -- Parkland.

Currently, COPC supports two elementary school-based clinics and one adolescent clinic, with a combined budget of $1.4 million. Sources of support include an MCH block grant, MCH Healthy Tomorrows, Title XX, Medicaid, EPSDT, the Texas Department of Health, the Dallas County Hospital District, DISD, United Way, and patient fees.

B. Expanded School Nurse Model

As a clear expansion of the role of the school nurse, this model adds staff and services on-site to provide primary care to all students. An example of this model is the Katherine Brennan Elementary School in New Haven, CT.

Since 1905, the city health department has administered the school health program. The program now in place at Katherine Brennan Elementary School relies primarily on the health department, but is linked to the education and social services departments as well. It is staffed by the school nurse, a nurse practitioner, and a social worker. A physician is on-site once a week. In addition to examination rooms and a waiting room, there is a full dental clinic staffed by a part-time dental hygienist. (It should be noted that the dental equipment often remains wrapped in plastic because there are no funds for a dentist.) The clinic is linked to both Hill Health Center and the Hospital of St. Rayfield.

Although only one year old, the clinic has registered 85% of all students, and will soon serve all siblings as well. The need for establishing an on-site clinic had been documented in a study

by the New Haven Foundation, but it is also fairly obvious upon visiting the community. The school is located in an isolated part of the city with limited access to public transportation. There are no drug stores, few physicians, and very limited resources for three public housing projects.

The report of the New Haven Foundation was the catalyst for bringing the community together to discuss school-based clinics, and for attracting funding. A representative committee, chaired by the Superintendent of Schools, met six times and created interdepartmental support for this effort. An important part of this support for establishing an elementary school-based clinic was the city's successful experience with adolescent school-based clinics, first funded by the Robert Wood Johnson Foundation ten years ago. Following the completion of that grant period, the state of Connecticut and the city health department assumed support of the clinic. The success of this effort also demonstrated that agencies could work together and that jobs for school nurses were not in jeopardy. To the contrary, school nurses continued to perform state mandated services and their work was supplemented by other health and health-related professionals such as physicians, nurse practitioners, and social workers.

In this particular school, the principal played a key intermediary role between the parents, the teachers and a range of outside players. Having been a teacher in the school for 20 years, she knows the community well. When asked "What would happen to the clinic space if space was needed for another classroom?", the principal replied, "It wouldn't come from here!"

Support for the clinic now comes from the city health department and the federal Healthy Tomorrows program. The current annual budget for the clinic is approximately $275,000. In next year's budget, Governor Weicker has increased funding for school-based clinics (see "Connecticut'" in Section III., below).

C. Comprehensive Service Center Model

In the exploration of school-based clinics, a central defining characteristic has been access and referral to a range of services at one location. Although our original notion had health and health-related services at the core with other services added on, an alternative model would be other services at the core with health services added on. This alternative is best exemplified by the New Beginnings program in San Diego.

New Beginnings is a model of integrated services for families and children. It is located at Hamilton Elementary School because this is one of the few community institutions where both children and adults come. The center provides school registration; information about public assistance, health, mental health, adult education, job training; parenting classes; child care, housing, and other community resources.

Many programs are provided on-site, and staff at the center speak English, Spanish, Hmong, Thai, Vietnamese and Lao. In addition to being a poor community, the language barriers are significant. The center works integrally with the school staff and, although the school is large

(1300 students), the adults and children appear to be familiar with each other.
Although the New Beginnings Center opened in September 1991, the health clinic was just completed this summer, with anticipation of full services by September 1992. Staffed by two nurse practitioners and a psychologist, the center's staff also includes four family advocates, a secretary, an administrative assistant, and the center director.

The history of the New Beginnings Center is somewhat unique. It grew out of an extensive planning phase that began in 1988 and involved the City of San Diego, the County of San Diego, San Diego Schools, San Diego Community College District, and the San Diego Housing Commission. The goal of this interagency collaboration was to complete a needs assessment and tailor a new system of service delivery focused on prevention and integration of services. As the goals of the program have been clarified, a close working relationship has been formed with the University of San Diego Medical School and Children's Hospital.

As of September 1991, the elected boards of the New Beginning partnership agencies approved a governance agreement which defines the rationale, organizational structure, purpose, and responsibilities of each agency. The agreement also defines an executive committee which consists of the:

City Manager
Community College District Chancellor
Unified School District Superintendent
Commission Executive Director
County Chief Administrative Officer
County Health Services Director
County Director of Social Services Housing
County Chief Probation Officer

The Center is administered by the San Diego School District, but participating agencies maintain involvement and actually have staff located on-site at the school. The annual budget for the program is approximately $597,000 with support coming from local, county, and state agencies as well as from private foundations.

D. Neighborhood Health Center Model

The resources and strengths of a particular community will dictate how it can best address its needs. Building on an impressive statewide program of school-based youth services for adolescents and a nearby neighborhood health center, Roosevelt Elementary School (K-8) in New Brunswick, NJ has created a program of on-site comprehensive services. Although many services are provided on-site, primary health care is provided by the Eric B. Chandler Neighborhood Health Center, part of the University of Medicine and Dentistry of New Jersey (UMDNJ).

The staff at the two institutions have a close working relationship and significant support from

a range of local agencies. A key role has been played by New Brunswick Tomorrow (a nonprofit, city-wide planning agency, established in 1980) working with the New Brunswick Board of Education, UMDNJ, and the New Brunswick Youth Services System. Acting as a catalyst, they have fostered a series of coalitions to address educational, medical, employment, child care, recreational, teen pregnancy, cultural, and youth services issues. The expansion and linking of services to elementary students is a logical and needed extension of this overall plan.

The goal is to provide a school-based program in 5 local elementary schools, with Roosevelt serving as the administrative link to the high school program and the point for coordinating clinical, medical, career development, recreational, social and cultural programs for these 5 schools.

Services will be provided on-site, with the exception of dental and medical care which will be carried out by the Chandler Neighborhood Health Center. Chandler is a full-service community health center which itself will be moving to a new facility in the near future. It is New Brunswick's only Federally Qualified Health Center (FQHC) and the only source of medical care for many families in the community.

In addition to services provided at Chandler, health care workers are brought into the schools to help educate students about developing healthy life styles and reducing health risks. Our discussions with staff reveal that mental health and dental services remain the most pressing needs. One staff member confessed, "We uncover so much more than we ever thought!"

The budget for this 5-school model is almost $430,000 plus $40,000 in renovation and start-up costs. Support comes primarily from the state human services department, supplemented by local education funds.

A Hypothetical Model

In less than ten years we have seen the concept of adolescent school-based clinics blossom from only a handful to almost 400 throughout the country today. Having reviewed that experience and success, we believe it appropriate to consider expanding the model into elementary schools. Toward that end, our review of the few existing elementary school-based clinics and the permutations which exist have led us to characterize four current models (described in the previous section). All have particular strengths, and all grow out of the local environment and landscape. Each, in other words, fits its own community.

Having reviewed the forest as well as the trees, we recommend building a program around the following hypothetical model.

Characteristics:

1. located in an elementary school

2. serves students and their families (on a voluntary basis)

3. provides comprehensive health and health-related services including health education and social services

4. open longer than school hours (ideally 8 a.m. to 6 p.m., plus some evening, weekend and vacation hours)

5. close working relationship with (if not a satellite of) a local hospital or clinic, plus other community-based agencies

6. at least some full-time staff

7. works with school to emphasize prevention and health promotion

8. relies on home visiting where appropriate/needed.

Services provided:

1. routine health screenings and checkups, including preventive care (immunizations, well-child checkups, etc.)

2. diagnosis and treatment of common illnesses

3. screening, referral, and follow-up of more complex health problems which require additional diagnostic and therapeutic interventions

4. management and monitoring of chronic health conditions, including referrals when needed

5. mental health services including guidance, counseling, and therapy as needed for individuals and groups

6. specific attention to child abuse, substance abuse, and domestic violence

7. children's dental screening and treatment

8. health education programs such as nutrition for children and parents

All of these characteristics and services are important. We recommend them based on the needs which exist and the successful programs which we have analyzed. This is not to say that every characteristic and service listed must be provided in every elementary school-based clinic. Depending on local needs and resources in a given community, a case might be made for eliminating one or more of the recommended services or characteristics. We would caution

against eliminating any of these, however, for our experience points to the central import of these elements. Nonetheless, services must be predicated upon local priorities, needs and resources.

In addition to these specifics, there are several important, maybe even self-evident truths which a community and its stakeholders must accept in order to embrace this type of program. First, prevention and early intervention are essential if greater suffering and costs are to be avoided further down the road. Second, long-term strategy and commitment reap greater payoffs than episodic and ad hoc responses. Third, universal access to health and health-related services should be a priority for all children in this country. Fourth, public schools are the original (and in some cases the only) community based organizations undergirded by an underlying philosophy of equality and universal access.

One of the most important underpinnings of this model is that it is comprehensive and does not focus on individual problems, failings, or handicaps. It provides services to children and families served by a given school and many of these services are preventive (i.e. before the onset of a problem). Health education, screenings and checkups-- these are services the middle class often takes for granted. There is no stigma attached. A key to an effective elementary school-based clinic is that it is not a deficit model.

Staffing and Budget

High quality staff is unquestionably the linchpin of a high quality clinic. The high quality must exist in health/medical skills as well as interpersonal skills. Continuity of staff is also important so that users can be comfortable in what is typically a rather daunting context. Continuity also helps to foster integration of services and the development of trust between provider and consumer.

As a minimum, the following staffing pattern is recommended for each clinic:

Clinic director	3/4 time
Nurse practitioner	full-time
Social worker/psychologist	1/2 to full-time
Physician	part-time; on-call
Receptionist/administrator	full-time

It is important to consider the role of the school nurse. In schools where a good school nurse is already present, this might be the ideal person to become the clinic director. Given the health and school credentials, and knowledge of the community, the school nurse is able to provide the overall management and operation of the clinic. In some of the larger elementary school-based clinics we visited, the school nurse remains in that job monitoring referrals and tracking student health status, and working closely with the school-based clinic which actually provides primary care.

On-site services provided by local public or nonprofit agencies is an option to be explored in each community. For example, the local mental health association might locate one of its psychiatric social workers in the clinic, or the local department of human services might place a case manager on site. From the consumer's point of view, they are part of the clinic staff. Yet, their salaries are paid by their home agency. With respect to this option, the key to success comes with achieving seamless continuity and integration within the eSBC.

A hypothetical budget reflecting the assumptions described above is presented here. Obviously, there are significant regional variations in costs and salaries and thus this budget must be reviewed with that in mind. This is neither a bare-bones budget, nor a luxurious one. In addition, note that there is some discrepancy between this sample budget's bottom-line and those presented in Table 1. More specifically, most of the budgets presented in Table 1 are more costly than our example. This is primarily due to the additional staffing (and hence services) that most of the clinics provide.

Elementary School-Based Health Clinic
One Year Sample Operating Budget

Budget		Amount (school year)	Amount (year-round)
I.	**PERSONNEL**		
	Staff Personnel:		
	Nurse Practitioner (1.0 FTE)	$ 37,000	$ 44,000
	Receptionist/Administrator (1.0 FTE)	$ 19,000	$ 22,800
	Physician ($50/hr x 5 hrs/week)	$ 10,000	$ 12,500
	Clinic Director (.75 FTE)	$ 20,000	$ 24,000
	Social Worker (.50 FTE)	$ 10,000	$ 12,000
	Fringe Benefits:		
	Fringe @ 14%	$ 13,500	$ 16,200
II.	**MATERIALS AND SUPPLIES**		
	To replace supplies used (most medications, serums, etc. covered by public $)	$ 2,000	$ 2,500
III.	**FACILITY COST**		
	a) rent (average 3 rooms)	$ 20,000	$ 22,000
	b) utilities (usually in-kind)	$ 1,000	$ 1,200
	c) maintenance (usually in-kind)	$ 500	$ 600
IV.	**EQUIPMENT RENTAL AND REPAIR**	$ 1,000	$ 1,200
V.	**TRAVEL** (For meetings, local mileage, etc.)	$ 500	$ 600
VI.	**TRAINING** (In-service training, etc.)	$ 500	$ 600
VII.	**RENOVATION/ALTERATION**	$ 1,500	$ 1,800
VIII.	**OTHER COSTS** (Insurance, data collection, etc.)	$ 2,000	$ 2,400
	TOTAL OPERATING BUDGET	$138,500	$164,400

Assumptions:

- This sample budget is for operating expenses only. Capital, renovation, construction, and added administrative start-up costs are not included.

- The clinic is open 40 hours per week (eight hour days).

- The rental (III. Facility Costs) calculation was made assuming 2000 square feet of space at $1.00 per square foot per month. This assumes some in-kind contribution.

III. FEDERAL AND STATE-LEVEL INITIATIVES

The issue of school-based health services has received varying degrees of attention at the federal and state levels. Federal activity until recently has consisted primarily of a few proposed but never passed programs and legislation. On the other hand, some states have been quietly implementing programs for years. And, of course, health care professionals around the country have been expressing concern and undertaking smaller-scale community initiatives in this area for over 100 years.

Most of the activity, however, at all levels has focused almost exclusively on adolescents. It is only in the last few years that Congress and federal agencies have turned a significant amount of attention to improving access to comprehensive health services for younger children. While state governments have a slightly longer history of including elementary-aged children in their initiatives, most state-level programs focusing on elementary school-based early intervention and preventive health services are in fairly early stages of implementation.

Since the mid-1980s, school-based health services have received national attention because of the widespread growth of school-based clinics (SBCs) in public high schools. Many districts faced stiff opposition to the clinics because of the belief that their main purpose would be related to teen pregnancy (dispensing of contraceptives, abortion counseling, etc.). In fact, usage data has shown that approximately 12% of visits to adolescent SBCs involve reproductive health (Lear, 1991).

During this period, several federal reports and initiatives began to reflect changing national attitudes toward school-based health services. For example, in June 1991 the U.S. Office of Technology Assessment released a report on adolescent health care that endorsed SBCs as an effective intervention. A shift in emphasis from adolescents to younger children is evidenced in a December 1991 report from the Advisory Council on Social Security, or the "Steelman Commission," that recommended the appropriation of $6 million in federal money to establish school-based health clinics for children ages 3-12.

In addition, the U.S. Public Health Service in 1990 released "Healthy People 2000," that included objectives relating to early childhood health and school-based health services (see "Reports and Recommendations," below). Finally, Goal #1 of the National Education Goals developed by the President and the nation's governors has contributed to turning national attention to the need for early and comprehensive health care for children. As reflected in the objectives for the "School Readiness" goal, good health is a major factor in ensuring that children enter school with a strong physical and emotional foundation for learning.

These factors, combined with stagnating or worsening health conditions for many young children, plus the positive results from existing SBCs, have come together to produce growing national momentum toward increasing access to early, comprehensive, and continuous health care services for children. Several new pieces of legislation have been introduced, and federal agencies have begun to involve themselves more substantively in the issue of school-based health

services. This momentum, in turn, has translated in several cases into initiatives at the state level, through legislatures and governors' offices. Finally, President Clinton has indicated his support for school-based and preventive services for children; this will likely have a positive effect on federal attention to these issues.

An examination of existing federal and state initiatives relating to elementary school-based clinics (eSBCs) will be invaluable as we explore approaches and resources in establishing a national network of eSBCs. Pending and planned legislation may provide access to new funding streams at both the federal and state levels; programs at the state level provide insights into the innovative use of existing funding streams; and lessons learned through present initiatives shed light on possible new approaches.

A. FEDERAL-LEVEL ACTIVITY AND INITIATIVES

Federal-level activity in the area of school-based health services can be divided into three categories -- legislation, federal programs, and agency and commission reports. Recently, several interagency committees have been formed around the subject of school-based health; several pieces of related legislation have been proposed; and a major eSBC project was developed through the U.S. Public Health Services. The national health and education objectives and reports mentioned above have played a large part in fueling legislative and agency attention to the issue of school-based health services for elementary-aged children.

Although there has been recent attention to school-based health services, evidence points to a conspicuous lack of definitive action on the part of the federal government. The interagency committees have no programmatic power, but rather are convened to "explore the issues." New legislative initiatives await reintroduction in the next session of Congress, with uncertain prospects for passage. Appropriation of $6 million for the proposed Ready To Learn School Health program developed by the U.S. Public Health Service was rejected by both the House and Senate.

Although concrete developments at the federal level in elementary school-based health services are scarce, interest is building, and the federal government is poised to enter this arena. Along with the clear interest of the new administration, conventional wisdom and political strategies point with increasing frequency to public/private partnerships as the most effective means through which to achieve national objectives, such as health and educational reform. An overview of federal activity will serve as context to a discussion of potential federal involvement with and support of a national eSBC initiative in the future.

1. Legislation:

From a historical perspective, legislative activity has mostly consisted of unapproved school-related health legislation. For example, in 1987 the **School-Based Adolescent Health Act** was defeated. This act would have established a grants program to set up school-based adolescent health services demonstration projects.

In addition, the **Office of Comprehensive School Health Education Act of 1987** was intended to establish an Office of Comprehensive School Health Education within the Department of Education. The department would have promoted various programs and policies at the Federal, state and local levels to establish and support comprehensive school health education. This bill also was defeated.

More recently, several new pieces of health-related legislation were introduced in the 102nd Congress. Following is a brief description of proposals most relevant to this report:

Health Promotion and Disease Prevention Act of 1991 (S.1944; Sen. Kennedy) and **Preventive Health Amendments of 1991** (H.R.3635; Rep. Waxman)

> Title II: For coordination of health promotion and disease prevention activities, establishes an interdepartmental group for coordination and cooperation regarding multidimensional school health programs.
>
> STATUS: S.1944 was passed by the Senate Labor and Human Resources Committee on October 4, 1992; will be reintroduced for Presidential signature in the next Congress. H.R.3635 was signed into law and is now known as Public Law 102-513.

Healthy Students-Healthy Schools Act of 1992 (S.2191, Sen. Bingaman; and H.R.4361, Rep. Andrews, M.)

> Establishes a "Healthy Students-Healthy Schools" Office in the federal Centers for Disease Control and Prevention to encourage and support programs that stress physical health, well-being, and disease prevention as regular parts of the school day. The office would work with other federal agencies to coordinate school health and physical education programs and provide these programs with up-to-date information. Also ensures that the Department of Education's drug-free school money could be used in conjunction with comprehensive school health education programs.
>
> STATUS: S.2191 hearing held March 19, 1992, but no vote was taken; would have to be reintroduced in the 103rd Congress. H.R.4361 was referred to House Subcommittee on Elementary, Secondary and Vocational Education; would have to be reintroduced in next session of Congress.

Comprehensive Services for Youth Act of 1992 (S.3088; Sens. Kennedy, Simon, Adams, Inouye, Bradley, etc.)

> Awards grants to eligible local community partnerships to coordinate and deliver comprehensive education, health, and social services to children or youth in

school-based, school-linked or community-based locations.

STATUS: Hearing was held July 28, 1992; referred to Senate Labor Committee; will be reintroduced in next session of Congress.

The Link-Up for Learning Act (H.R.812, Rep. Lowey; S.619, Sen. Bradley)

Establishes a demonstration grant program to provide coordinated human and social services for youth within the primary and secondary schools.

Allows school districts to take the lead in determining the best method for coordinating and organizing social, educational, and health services within schools.

STATUS: H.R.812 was referred to the House Education and Labor Committee and later much of it was incorporated into H.R.4323 (see below); H.R.812 will not be acted upon individually. S.619 was defeated by the Senate Labor, Health and Human Services, Education, and Related Agencies Subcommittee of the Senate Appropriations Committee; however, pieces of the legislation were incorporated into S.3088 (see above) and the Elementary and Secondary Education Reauthorization Act, which will be considered in the next Congress.

Neighborhood Schools Improvement Act of 1992 (H.R.4323, Rep. Kildee)

A bill to provide a ten-year authorization to help states and local public schools reach the National Education Goals.

Amended version of H.R.4323 (under Title I, "Comprehensive Restructuring") includes a clause giving local education agencies (LEAs) subgrants to establish broadly representative committees to develop and oversee (in conjunction with the local school boards) the implementation of local plans. The bill mentions that an LEA receiving a subgrant may use funds toward coordinating health and social services with education. The bill, however, emphasizes that the language authorizing such coordination "is not intended to support projects or activities which provide family planning or reproductive health services."

STATUS: H.R.4323 passed House August 12, 1992; Senate version (S.2) defeated in conference October 2, 1992; would have to be reintroduced in next session of Congress.

2. <u>Programs and Initiatives</u>:

Federal Interagency Ad Hoc Committee on Health Promotion Through the Schools: Formed in 1984, the committee has been co-chaired since 1990 by staff from the U.S.

Department of Education (Office of Education Research and Improvement) and the Department of Health and Human Services (Office of Disease Prevention and Health Promotion). The committee convenes mid-level agency staff and nongovernmental representatives bimonthly for information sharing purposes related to health promotion through the schools.

Interagency Committee on School Health (ICSH): Chaired by assistant secretaries from the U.S. Department of Education and the U.S. Department of Health and Human Services, this committee was formed to improve communication, planning, coordination, and collaboration among Federal agencies engaged in ongoing activities of relevance to school health, or planning such activities. Invited participants are fairly high level officials, including assistant secretaries of the various agencies. They plan to meet at least semiannually, while staff work on certain projects in the interim.

National Coordinating Committee on School Health (NCCSH): Convened by the U.S. Department of Health and Human Services and the U.S. Department of Education, the mission of the NCCSH is to provide a national forum for the discussion of school health issues, between national education, health, social service organizations and others interested in promoting school health and relevant Federal agencies involved in programming or other activities related to school health. The NCCSH will serve in an informal advisory capacity to the Interagency Committee on School Health. The committee plans to meet two times a year; the National Health/Education Consortium is a member of the Committee.

U.S. Department of Health and Human Services:

Maternal and Child Health Bureau:

MATERNAL AND CHILD HEALTH BLOCK GRANTS: Title V of the Social Security Act was established in 1981 as a consolidation of seven separate programs begun in 1935 which were designed to serve children and pregnant women. States are given block grants and then, within broad federal guidelines, set their own program criteria and priorities. Title V is intended to enable each State to improve the health of, and assure access to health services for mothers, infants, children, adolescents, children with special health care needs, and their families. While most block grant funds are awarded to local health departments, the funds have been a reliable source of long-term funding for eSBCs, since in most states at least some block grant funds finance services delivered by a range of providers in the state, including schools.

HEALTHY TOMORROWS PARTNERSHIP FOR CHILDREN: A collaborative program between MCHB and the American Academy of Pediatrics, Healthy Tomorrows is authorized through Title V of the Social Security Act. The Healthy Tomorrows program supports special projects that demonstrate how States, local agencies, organizations, businesses and communities can work together to improve the health status

of mothers and children. Each grant lasts five years. Last year "Healthy Tomorrows" funded 28 programs nationally including several that involved school-related services in San Diego, New Haven, Lansing, and Dallas.

PUBLICATIONS: MCHB has helped publish and disseminate dozens of publications related to school health including "ACCESS to Comprehensive School Based Health Services for Adolescents" (quarterly newsletter, School-Based Adolescent Health Care Program), *Bringing Health to School: Policy Implications for Southern States* (Southern Center on Adolescent Pregnancy Prevention, June 1991), and *Improving Access to Comprehensive Health Care Through School-Based Programs* (Fox Health Policy Consultants, January 1992).

Facilitation of Local Service Integration Planning: The Office of Planning and Evaluation has awarded six grants to assist some thirty communities build networks and relationships across program boundaries. Most of the communities have chosen to focus their efforts around schools.

National Resource Center for Service Integration: Through the Office of Planning and Evaluation, a grant has been awarded to the National Center for Children in Poverty (Columbia University) to provide information and technical assistance to communities and organizations engaged in planning and implementing health and human services on an integrated basis. A clearinghouse has been established.

Urban Community-based School Readiness Service Integration Coalition: A strategic plan, through the Office of Planning and Evaluation, includes eleven pilot projects which demonstrate holistic social service strategies for linking the efforts of schools, and county and community agencies. Institutional barriers to school/social service coordination and collaboration will be identified.

Coordinated Services for Children With Disabilities: Working with the Office of Special Education and Rehabilitative Services in the U.S. Department of Education, the HHS Office of Planning and Evaluation is assisting States and localities in coordinating the provision of health, education, social services and mental health services for preschool and school-aged children with disabilities.

Community Integrated Services System: A joint project between the Health Resources Services Administration and the Maternal and Child Health Bureau, this project sets aside funds to examine important areas for community-based service integration efforts. This is the first year funds have been available.

Bureau of Primary Health Care:

READY-TO-LEARN SCHOOL HEALTH PROGRAM: The Bureau of Primary Health Care (U.S. Public Health Service) had proposed a $6 million project to establish full-

service health clinics in elementary schools around the country. The premise was to link schools with existing federally-funded and federally qualified health centers to provide health care and prevention services for at-risk children and their families. The program would be targeted to 3-12 year-olds living in communities with a high incidence of poverty, poor health status indicators, and lack of access to primary care. The Bureau held a number of regional conferences during 1992 to inform potential applicants of the proposed program and to gain input from health and education professionals.

Funding for this program was included in the President's budget request to Congress, but appropriation was rejected by both the House and Senate; the House has requested re-submission of the proposal in next year's budget. In the meantime, the program has been transferred to the Division of Special Populations (U.S. Public Health Service), and a resource document is being prepared which will list all community and migrant health centers that are currently affiliated with school health programs. In addition, program staff hopes to secure $750,000 - $1 million from other federal agencies or foundations to begin a few pilot sites.

SECTION 330: Section 330 of the Public Health Service Act established the community health center (CHC) program and provides another source of potential Federal funding for school-based clinics. The approximately 600 CHCs operate over 2000 clinics in most of the states. Many of these clinics operate smaller satellite clinics in order to attain the greatest access and impact for underserved people. Some clinics have established satellites in schools. Several of the requirements for Section 330 funding, in fact, reflect the goals of many eSBCs -- clinics can be established only in areas deemed "medically underserved;" they must provide comprehensive services; and they must have boards representing "a majority of users of the center's services."

3. Reports and Recommendations:

"Healthy People 2000: National Health Promotion and Disease Prevention Objectives": Released in 1991 by the U.S. Public Health Service. Identifies school-based and school-linked health programs as models that could help achieve national health goals for young people.

"Adolescent Health: Volume III -- Crosscutting Issues in the Delivery of Health and Related Services": Released in June 1991 by the Office of Technology Assessment (OTA) of the U.S. Congress. Makes same recommendation as above.

"Critical Issues in American Health Care Delivery and Financing Policy": Released in December 1991 by the Advisory Council on Social Security. The Council, chaired by presidential adviser Deborah Steelman, recommended a plan to establish a nationwide system of clinics in or near elementary schools for children ages 3-12. These clinics would provide preventive and primary health care and basic dental care to all preschool and elementary school children.

B. STATE-LEVEL INITIATIVES

State-level initiatives in elementary school-based health services have increased in number over the past decade. These projects are in varying stages of development-- many are small-scale demonstrations or pilots; some are still being planned; and some are elaborate school health programs but not actually comprehensive on-site clinics. Most initiatives, however, seek to increase access through the enhancing of and/or linking with existing services, such as expanding school nurse services and/or linking with community health centers to establish formal referral arrangements.

Regardless of chronology and program type, however, the planning and implementation processes for all these initiatives is instructive as we examine options for a multi-site network of elementary school-based health clinics. State governments and agencies have been grappling with issues such as start-up and long-term funding options; the development of requirements for RFPs; staffing of clinics; and effective involvement of key players at each site. For example, most state-level projects require participating sites to establish intersector planning and implementation teams, to access existing funding streams, and to explore long-term funding options.

In addition, a detailed knowledge of current efforts by states will serve as a basis to explore options for potential sites for a national eSBC initiative. States which have begun planning and/or implementing programs in this area are likely candidates for participation in a national network to establish and/or enhance eSBCs.

CALIFORNIA: The "Healthy Start" Initiative

"Healthy Start" is the cornerstone of Governor Wilson's three-part initiative to develop an effective statewide system of access to comprehensive human support services for children and youth and their families. The first component of the initiative is to enhance participation in the federal Medicaid program for coverage of health services currently provided in the schools (see "Funding Streams," below). Healthy Start is the second component. The third component and long-term goal of the initiative is the development of a statewide integrated, comprehensive school-linked service delivery system.

The Healthy Start Support Services for Children Act is California's first statewide effort to place comprehensive support services at or near schools. Healthy Start authorized $20 million in 1992 for planning and operational grants to school districts and county offices of education to provide school-based or school-linked integrated health, mental health, social and other support services for children and their families.

Healthy Start is based on the premise that schools are in a unique position to integrate services and to ensure that children and youth have access to the services they need. Requirements for Healthy Start funding include:

- o the establishment of a working local interagency collaborative team;
- o an assessment of community needs and resources;
- o the provision of a minimum of four support services for students and their families;
- o family and community participation;
- o individualized case management; and
- o inclusion of an evaluation component to show measurable improvements in outcomes for students and their families in such areas as school attendance and performance, physical and social health indicators, and family functioning.

Under Healthy Start, planning grants are for one or two years and are for a maximum amount of $50,000; operational grants are for a three-year period, and for a maximum amount of $300,000, and may include an additional onetime start-up amount of $100,000. A 25% local match is required of all grantees. An ongoing annual appropriation of at least $20 million will be requested for Healthy Start sites in successive year budget proposals.

In order to assist grantees in planning and implementation, the state will be creating an external Center for School-Linked Services. Healthy Start targets low-income and at-risk children, youth and families, although the overall goal of the program is to make all services available for all children. In keeping with the early intervention and preventive focus of Healthy Start, half of all program grants were set aside for elementary school sites; the other half were awarded to middle and high school sites.

CONNECTICUT: A Statewide System of School-Based Health Care

In 1984, the Connecticut State Legislature began funding a statewide program of school-based health centers. The program is coordinated through the State Health Department. Over the past eight years, funding has gone from $493,000 to $2 million; for this coming fiscal year, the appropriation was increased by 400%.

The State Health Department has nurtured this program at the state level by working with other state agencies and organizations to build a wide base of support. They have been careful to keep all interested and influential parties apprised of plans and progress (legislators, professional associations, government agencies, etc.).

The clinics in this program place a strong emphasis on linking with other services and teaching students and families how to access care through the existing system. All clinics are staffed by a multi-disciplinary team and licensed by the State of Connecticut as outpatient facilities. Clinics are located in 6 districts. One site, Bridgeport, currently has 2 eSBCs and 3 high school SBCs; they have submitted a proposal to open a third eSBC. The other sites operate exclusively

in middle and high schools.

FLORIDA: A Full-Scale Interagency Agreement and Several Resulting Initiatives

An Interagency Agreement was signed in 1990 by the Florida Education Commissioner and the Florida Secretary of Health and Rehabilitative Services. The purpose is to provide a mechanism for interagency collaboration to develop and support joint initiatives. The initiatives must facilitate the provision of a comprehensive system of care which meets the health, educational, vocational, social, and mental health needs of Florida's youth and children. Following are some relevant initiatives that have come as a result of and/or are supported by the Interagency Agreement:

Supplemental School Health Services Act: Enacted in June 1990, the Act requires school districts to develop and implement supplemental school health services projects based on one of the following models:

- School Health Improvement Pilot Project (SHIPP): Full-time school nurse and nurse's aide on-site; serves mostly as a referral mechanism to community health care providers.
- Student Support Services Team Program (multi-disciplinary).
- Full-Service Schools: Integrated health and education services provided at the school-site.

First year funding ($2.6 million) supported 28 school health services projects in the state. In the second year of funding ($9 million), Florida added 21 new projects. Projected 1992-93 funding stands at $9 million to support existing projects. Approximately 75 elementary schools are provided with primary health care services through this program.

Florida State Health/Education Consortium: Established in 1992, the Consortium is co-chaired by Governor of Florida, Lawton Chiles, and the Florida Education Commissioner. The Consortium was established under the aegis of the National Health/Education Consortium to facilitate collaborative activities between the health and education communities in Florida. Its first priority is to develop a statewide effort to improve school-based services in underserved areas.

Florida Healthy Kids Corporation: In 1990 the State of Florida, at the urging of the state commissioners of insurance and education, legislated the creation of the Healthy Kids Corporation. The Corporation was created to demonstrate the School Enrollment-Based Health Insurance (SEBHI) concept. The concept uses public schools as a grouping mechanism for negotiating comprehensive and affordable group health coverage. The first phase of project implementation, consisting of the enrollment of six thousand Florida children in Volusia County, was begun in early 1992.

The health insurance plan covers preventive, primary and selected long term care services. The full cost per year is $720 per child for children residing in families with incomes over 185% of the federal poverty level. Free and subsidized coverage are available for children with lower family incomes. All children, ages 5-19, regardless of health status, who are regularly attending school, who have been uninsured for at least 6 months, and who are ineligible for public insurance programs, such as Medicaid, can be covered through this program.

KENTUCKY: Family Resource and Youth Services Centers

Section 18 of Kentucky's Education Reform Act of 1990 mandates the establishment of Family Resource and Youth Services Centers across the state, modeled on New Jersey's School-Based Youth Services Program (see below). An Interagency Task Force has developed a five-year implementation plan for this initiative. By 1995, all Kentucky public schools will have Centers.

Family Resource Centers focus on elementary-aged children and their families, while Youth Services Centers work with middle school, junior high, and/or high school students and their families. Combined centers are also permitted. Centers must be located in or near a school. School districts in which at least 20 percent of the student body are eligible for the Federal School Lunch Program can participate.

The provision of health services or referral to health services is only one of the required components of the Family Resource Centers. Other required services are: (1) full-time preschool child care for children two and three years of age; (2) after-school child care for children ages four through 12, with the child care being full-time during the summer and on other days when school is not in session; (3) "families in training," an integrated approach to home visits, group meetings and monitoring child development for new and expectant parents; (4) parent and child education (PACE) program; and (5) support and training for child day care providers.

In fiscal year 1992, 133 centers were funded in 75 school districts representing 232 schools. Of these, 73 were Family Resource Centers, 34 were Youth Services Centers, and 26 were Combined Family Resource and Youth Services Centers. Each eligible district receives between $10,000 and $90,000 to establish a center and may subcontract with outside organizations. Approximately 100 new centers will be funded during fiscal year 1993.

NEW JERSEY: The School-Based Youth Services Program

The School-Based Youth Services Program (SBYS) was originally designed to enable adolescents to complete their education, obtain skills that either lead to employment or to additional education, and lead a mentally and physically healthy life. The program, which is run by the New Jersey Department of Human Services, offers services in or near secondary schools in areas of need throughout the state. In its first phase, $6 million was allocated to establish 29 sites. A 25% local match requirement is usually met through in-kind services or contributions.

In fiscal year 1991, an additional $500,000 was provided to develop pilot sites in middle and elementary schools. The first two elementary level programs funded through SBYS are in New Brunswick and Newport. Downe Township Elementary School in Newport has a "Kids' Center," which provides an array of health and social services. Newport is a rural community, and the clinic is managed by a private agency, Bridgeton Area Health Services. In New Brunswick, services include referral to and delivery of primary and mental health care as well as academic assistance, employment counseling for parents, and social and recreational activities.

In addition, New Jersey has several initiatives which address the need for linking school districts with health and human services agencies and programs. For example, "Family Net" creates linkages between various service agencies and the 30 neediest school districts in New Jersey.

A bill is currently pending before the New Jersey legislature to expand community resource centers to encourage "one-stop shopping" for various services including health. A statewide network of Family Development Centers provides an integrated referral system for services and is linked with schools. Finally, six schools in New Jersey are now participating in the "Success for All" initiative developed at Johns Hopkins University. This program, which is based on ameliorating school failure and dropout by ensuring reading skills in the early grades, is moving toward the provision of primary health care.

NEW YORK: Two Statewide Initiatives in School-Based Health Services

New York State has a relatively long history of involvement with school-based health services. Two programs are running in the state, one coordinated through the State Department of Education and the other through the State Department of Health.

In 1978, legislation was passed that allowed nurse practitioners to deliver primary health care services through the schools. Based on this legislation, the Department of Education in 1979 began coordinating expanded school health services programs in eight school districts, mostly in upstate New York. The state did not provide funding for this program; original funding was from the Robert Wood Johnson Foundation. Although this private funding was gradually phased out, all sites are still in existence, funded through other sources on a site-by-site basis. Matching funds were provided by the state to one site (Buffalo), which has retained this support. State involvement with the program has mainly to do with the fact that all sites must be officially designated by the state as eligible for certain regulation waivers. All sites serve children K-12, but only some have clinics actually located in elementary schools.

The second initiative in New York State is run by the Department of Health. The department in 1981 received state funding for school-based health services to be provided by community health care providers. These sites serve K-12 and are currently funded through a variety of sources. Most activity at this point is concentrated in New York City, where nearly 100 elementary schools have various on-site school health services.

PENNSYLVANIA: An Array of Programs for Healthy Children and Families

Over the last two years, Pennsylvania has mounted and sustained a significant array of programs to enhance the health of young children and their families. In a variety of ways, these efforts are designed to provide quality and accessible health care that is coordinated, flexible and child and family-centered.

The initiative most relevant to this report is the School-Based Primary Health Care program. Pennsylvania, after sending an RFP to approximately 150 school districts, is funding six school districts to establish school-based primary health care centers in elementary schools. These districts, which have high percentages of students on the federal Aid to Families with Dependent Children (AFDC) program or are located in sparsely populated areas of the state, will make available to students a range of health services, including physical exams, immunizations, assessments of growth and development, and on-site diagnosis and treatment for common illness. Schools also will make arrangements for off-hour and follow-up care.

There is no legislative mandate or new money appropriated by the State for this pilot program; the initiative will use $350,000 in existing MCH Block Grant funds for its first-year support. The state hopes to extend funding next year. The target date for opening all six clinics is February 1993.

Another important initiative is Pennsylvania's effort to link Medical Assistance (MA or Medicaid) with public schools. Pennsylvania has instituted the ACCESS program to help school districts receive MA reimbursement for eligible special education programs, services, and equipment. Further, Pennsylvania is working to inform all school districts with significant numbers of MA-eligible students that these children are entitled to health services, and that, depending on how the services are delivered, the schools might be eligible for MA reimbursement if the services are delivered by certified Medicaid providers employed by or under contract to the schools.

The other components of Pennsylvania's program to address health care for children and their families are briefly described below:

Healthy Beginnings Plus and Medicaid Expansion: This type of expansion has been undertaken by virtually all states over the past 5-6 years. In Pennsylvania, Healthy Beginnings Plus adds a variety of services to the basic set of prenatal health care services provided to low-income women through Medical Assistance. The expansion of the Medicaid program increases income eligibility for children and pregnant women, and increases fees for physicians providing preventive health care services to low-income children.

Child Immunization: In order to expand its efforts to have all low-income children immunized, Pennsylvania will provide free vaccines to Medical Assistance providers and provide for the costs of physician office visits, equipment, and staff.

The Governor's Uninsured Children's Health Care Initiative: This legislation has just been passed and signed into law. It will provide voluntary health coverage to uninsured children

who are not poor enough to qualify for Medical Assistance, but whose families cannot afford to buy private health insurance. State-subsidized insurance, available for young children from families with annual incomes of up to 300% of the federal poverty level, will be purchased on a sliding fee scale. Funded through a tax on cigarettes, the primary focus of the program is children ages 0-6; a possible expansion would cover children 7-18.

Pennsylvania's comprehensive approach to child well-being is characterized by strong interagency collaboration. The recently established Children's Cabinet, comprised of the Secretaries of Education, Health and Public Welfare, and senior officials of the Governor's Office, has a broad mandate to coordinate all cross-agency efforts relating to children, and will be particularly important in continuing progress toward establishing a coordinated and accessible system of health care for children and their families.

VIRGINIA: School/Community Health Clinics

The Virginia Department of Education and the Office of Medical Assistance Services are in the early stages of developing a two-year pilot program for school/community health centers. The Virginia General Assembly in 1992 appropriated $300,000 for the first year (1992-1993).

All grantee school districts are required to be or become eligible Medicaid providers. Applicants were asked to develop proposals based on one of three models: (1) screening and referral by school nurses; (2) nurse practitioners providing primary care; or (3) school-based clinics. Schools also were required to work with their local health department in the development of their proposals.

Six sites were funded for planning grants. The program hopes to get approximately $250,000 appropriated in the next fiscal year for each site for the first year of operation, including start-up costs. Once the clinics are established, the program hopes to phase out state funding. The state wants localities to capitalize on existing funding streams for long-term funding; thus, the Medicaid requirement. The state will also encourage sites to become qualified to provide services under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, thus enhancing the Medicaid funding source.

Other States of Note:

Michigan is well-known for its "Michigan Model for Comprehensive School Health Education," targeted to grades K-8. Following the adoption of the State Board of Education definitions of the Michigan School Health Program and School Health Education, the Department of Public Health in 1981 published the "Comprehensive School Health Plan," which emphasized cooperative planning and implementation to achieve the comprehensive school health program. Additional planning and legislative endorsement led to the enactment of the Michigan Model in 1984. The Model is now reaching approximately 95 percent of Michigan's school districts, and plans to expand to the high school and preschool levels. In addition, the Governor has recently announced the "Communities First" initiative which will increase the number of school-based,

non-education services.

The **"Texas Comprehensive School Health Initiative"** (TCSHI) was established in 1990 as a cooperative venture between the Texas Association of School Administrators and the Texas Center for Comprehensive School Health, funded by the U.S. Department of Education. TCSHI has expanded its scope to serve as the Texas State Health/Education Consortium, which was initiated by the National Health/Education Consortium. Its focus has been largely on improving school health education and a healthy school environment. Activities have involved data collection and evaluation of statewide services, providing training on curriculum models, and evaluating the impact of health promotion conferences on comprehensive school health implementation. Upon expanding its scope, TCSHI broadened its mission to include improving school-based services within the state.

Although not on a statewide level, there has been much recent activity in **Washington State.** As a result of a recent $50 million levy, the Seattle Department of Health has taken over all school-related health and social services. Coupled with recent grants from the Kellogg and Robert Wood Johnson Foundations, Seattle has taken major steps toward the expansion of school-based health services. Although there is no state funding or legislation regarding these activities, the state legislature and agencies are highly supportive of all school-based initiatives, especially given the low levels of EPSDT screenings in Washington.

In **West Virginia**, Governor Caperton established a Cabinet of Children and Families, which has recently chosen early childhood health as its primary concern. Further, the West Virginia School Health Committee trained over 200 elementary school teachers in how to implement comprehensive school health programs this year. The state also received a federal grant from the U.S. Department of Health and Human Services to develop a statewide plan to increase their school health program. And finally, the state recently deemed its school nurses and speech/hearing/vision specialists as certified Medicaid providers, which will bring more funds to the schools for the health services they provide.

FEDERAL AND STATE INVOLVEMENT: CONCLUSIONS AND IMPLICATIONS

Following the successes of adolescent school-based clinics, and taking the recent "ready-to-learn" movement one step further, state and federal governments are poised to address the "missing link" in providing comprehensive, continuous care to children -- the elementary school years.

While current evidence indicates a dearth of federal legislation and specific programs regarding elementary school-based clinics, it is also clear that interest in the issue of school-based services is quickly growing. A project establishing a national network of eSBCs would be able to capitalize on this interest to engender support at the federal level. In addition, pending federal legislation regarding school-based health services may soon provide at least some concrete opportunities for federal involvement.

More importantly, it is at the state level where we see much more activity and leadership to promote collaboration between health and education, using schools as the focal point. We are seeing an emergence of programs targeted toward elementary schools. These trends suggest that various jurisdictions are acknowledging that many children are in desperate need of health care services and that schools can be an effective partner in delivering services and assuring that children are as healthy as possible and are ready to learn. In many instances, it is through such systems of care that children are able to gain access to services that they might otherwise not be able to receive. However, the absence of adequate state and school district budgets have prevented the growth of school health services at a rate that is compatible with the growing needs of our nation's children and youth.

The range of interest, activity, and experience in this area at the federal and state levels has many implications for the proposed eSBC project. The fact that federal, state and local budget constraints have prevented the growth of elementary school-based services suggests the need for innovative financing strategies to support these initiatives. Clearly, the need to establish public-private partnerships at the federal, state and local levels is a promising mechanism for sharing the burden of cost. Public-private partnerships demonstrate a national cross-sector investment. Public sector partnerships between various governmental levels provide a leveraging mechanism for securing private-sector support. These types of partnerships may also encourage legislative activity related to school-based services.

The use of existing funding streams is a common theme among state-level eSBC programs. Given budget constraints, the redirection of existing monies and the leveraging of reimbursement dollars, particularly Medicaid, creates a long-term, albeit often complicated, method of supporting school-based services. A detailed discussion of funding streams follows in the next section of this study.

There also are many programmatic lessons to be learned from existing initiatives, especially those at the state level. For example, we have found that most up-and-running programs are so involved in day-to-day activities that they do not engage in substantial evaluation and/or keep detailed written information (annual reports, descriptions, etc.). Some programs have begun to address this issue by requiring new proposals to include an evaluation plan; however, the emphasis is still on securing funding and delivering services. A national eSBC project, therefore, will have to collect data and evaluate progress through its national administrative structure and/or an outside evaluator.

We have also learned that eSBC programs in different states and often in the same state are fairly isolated from one another. More than one contact expressed the need for exchange of information, best practices, etc. among eSBC directors. This finding provides evidence of the need for a national network of eSBCs; a national demonstration project would be enhanced by including a networking function among project and existing eSBC sites.

Linkages with existing community services and addressing specific community needs are also paramount to a successful eSBC initiative. As we have seen, most state initiatives (and the

proposed federal program) require interagency planning teams, community needs assessments, and/or working relationships and arrangements with existing service delivery systems. These requirements are designed to avoid or ameliorate potential problems having to do with "turf," confidentiality, and ownership. Experiences of existing initiatives and input from frontline practitioners can provide a valuable framework for developing the most promising mechanisms for establishing an effective, as well as demographically representative, eSBC demonstration project.

Overall, it is clear that states are ahead of the federal government in encouraging and even mandating school-based services at the elementary level. Preventive and early intervention approaches to children's health and education are gaining widespread support, and programs at the state level serve as a bellwether for the direction in which the federal government is moving. The need for a national eSBC initiative is clear, and the time is right. This proposed project rides the crest of the wave in ensuring that children receive continuous, comprehensive health care, thereby encouraging each child to reach his or her full potential to learn and succeed.

IV. PUBLIC FUNDING STREAMS FOR eSBC INITIATIVES*

The purpose of this section is to illustrate the range of public funding streams available to eSBCs and how they may be accessed. It was found that although a variety of public funding streams exist, they are often difficult to access and do not supply a significant amount of clinic income. A discussion of the barriers to accessing public funding is included, as well as some possible solutions. Despite the difficulties posed in utilizing public funding streams, they can become a significant source of future eSBC income if properly and aggressively tapped.

There is no single answer to the financing challenge. A variety of funding strategies and sources exist, and thus the most desirable plan is that which most effectively accommodates the needs of both the children served and other stakeholders involved. Despite the lack of a single answer, several general truisms about financing eSBCs exist. First, the process can be most accurately characterized as the piecing together of funding streams that either already exist or could be cultivated. Several sources of funding may be accessed at the federal, state and local levels, each having different availabilities and restrictions.

Secondly, it is imperative that the financing plan be an integral part of both the eSBC program design and political consensus building processes. In other words, an eSBC must be developed with the requirements of public funding streams in mind and must be responsive to the political context. If it is not, the project runs the risk of alienating the community it intends to serve and jeopardizing the long-term stability of its financial base.

Finally, one must consider the financing of an eSBC within the broader context of health/social service system reform. Often this involves a wide-scale health and social service integration and restructuring project among local school districts and county, state and city health, education, and human services departments. Of course, an eSBC may be implemented without such a large scale undertaking, but as this report has illustrated, there are several instances where eSBCs have been the product of systemic reform (NJ, KY, CA, etc.). The financing discussion here is geared primarily toward a focused eSBC effort, but it may well be applied in the broader service integration and systemic reform context.

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*Much of the discussion in this section relies on work done by the Center for the Study of Social Policy, in particular: "Refinancing in Kentucky: Expanding the Base for Family Resource and Youth Service Centers", January 1991; and "Leveraging Dollars, Leveraging Change", September, 1991. Other key works cited include: Harriette B. Fox, et. al., "Improving Access to Comprehensive Health Care Through School-Based Programs," Washington, DC: Fox Health Policy Consultants, Inc., January, 1992; Frank Farrow, Tom Joe, "Financing School-linked, Integrated Services," The Future of Children: School-Linked Services, Los Altos, CA: Center for the Future of Children, The David and Lucile Packard Foundation, Spring, 1992.

The Finance Planning Process

The Center for the Study of Social Policy has identified two important issues to consider in the finance planning process. First, program and fiscal goals should be a product of an accurate definition of the problems in the community. This is a crucial step and often the result of a thorough community health and social service needs assessment. The assessment will confirm the health and social service needs of the community, and thus shape the goals and eventual eSBC program sought for the community's children and families.

Secondly, eSBC financing goals should be tied directly to eSBC program content (services provided, staffing needs, administrative requirements, etc.). More specifically, eSBC programmatic rationale should be the basis of the financing strategy, rather than the financing strategy determining program content. If the latter should occur, the effectiveness of the clinic might be seriously compromised.

The Overall Financing Strategy

The Center for the Study of Social Policy proposes a general framework for financing eSBCs which rests upon three pillars, all of which aim to take advantage of existing public funding. The elements of each pillar and how they may be used to sustain eSCBs are discussed here.

1. Maximize state and local program funds available for children's health and social services.

2. Maximize federal entitlements, including all medical and non-medical funding streams.

3. Reallocate local and state dollars from other government agencies and programs to support preventive, community-based and family oriented service systems.

Pillar 1: Maximize State and Local Program Funds

State Insurance Plans

State health insurance plans are becoming an important method to increase the availability of health care to low-income people. Most of them provide coverage to low-income children and families who are not eligible for Medicaid but cannot afford private health insurance. Several states have taken the lead with this increasingly popular idea, while the federal government has moved more slowly with its own versions of health care reform.

A key characteristic of state health insurance plans is affordability. The programs must be priced to reflect the purchasing capacity of low-income families. Some of the plans described

below have ensured affordability by designing insurance products that are subsidized on an income-based sliding scale.

Arkansas--Project ACCESS: This is a proposed statewide program aimed at providing affordable well-child care, primary care, and prevention services through a single, common enrollment mechanism in order to facilitate access to either Medicaid, a private basic benefit insurance policy, or a publicly subsidized basic policy for children. Project ACCESS will draft legislation requiring employers who do not already provide health insurance benefits to allow qualified employees to assign monthly income from the Earned Income Tax Credit as premiums to the Project ACCESS insurance carrier. The program is working in conjunction with the Arkansas Medicaid program to implement the Arkansas Eligibility Verification Claims System (AEVCS) which will allow electronic eligibility and benefit verification and claims transmission. As the first state to use such a system, Arkansas predicts saving from $1.5 to $2 million in four years. Project ACCESS will explore the possibility of extending AEVCS to serve as an "all payer" system by including Blue Cross/Blue Shield, Medicare, and Project ACCESS claims.

Hawaii--State Health Insurance Program (SHIP): Funded by the Hawaii state legislature in 1989 and implemented in April 1990, SHIP is a basic health benefit program that provides preventive and primary care services to families and children. Hawaii residents whose gross family income does not exceed 300% of the federal poverty level, who are ineligible for Medicaid, Medicare, Champus or other government programs, and who aren't eligible for insurance through their employers can participate in the plan. People eligible for SHIP can purchase insurance on a sliding scale, with individual contributions for children ranging from $0 to $20 per month. Outreach efforts to encourage enrollment include brochures, display posters, radio announcements, television spots, and specific outreach to school children and preschool children.

Maine--Maine Health: Administered by the Maine Department of Human Services, this program provides Medicaid-like benefits to low-income adults and children. Children 19 years of age and younger are eligible for benefits if they live in a household with an income (assets excluded) at or below 125 percent of the federal poverty level. Families with incomes between 100 and 125 percent of the federal poverty level pay a small premium, but no more than 3 percent of their income, to participate in the program. If the household income increases to more than 125 percent of the federal poverty level, children may remain in the program for a transitional period of 24 months. Participants may move from the transitional component of the program back into the basic component if their income again declines. Although the program was entirely state funded when it began in October 1990, the child component of Maine Health has since been partially funded by Health Care Financing Administration (HCFA) demonstration monies.

Minnesota--Children's Health Plan (CHP)/MinnesotaCare: Created in 1987, the plan provides preventive and primary care to children up to age 18 with family incomes below 185% of the federal poverty level. Recently folded into the "MinnesotaCare" plan (October 1, 1992), the plan now allows for enrollment of parents and siblings of CHP-eligible children. Future

plans include expansion of coverage to individuals with income up to 275 percent of federal poverty level as well as provision of coverage for inpatient services. The program is administered by the Commissioner of Human Services. Outreach efforts target health care provider offices, local health and human services agencies, schools, and WIC program sites. Funding is provided by proceeds from state cigarette taxes, the state's general fund, and small family contributions.

New York--Child Health Plus (CHP+) Insurance: Administered by the state Department of Health, the plan provides coverage for subsidized primary and preventive health care services for children age 12 and under with family incomes at or below 222 percent of the federal poverty level. Households with income above this level may purchase coverage for uninsured or underinsured children. Participating providers in selected health maintenance organizations will offer CHP+ covered services. Funding is provided through New York's bad debt and charity pool and from premiums. Eligible children are recruited through outreach efforts targeting community-based organizations such as day care centers, schools, parent organizations, hospitals, homeless shelters, churches, newspapers, government relief programs and employment sites.

Pennsylvania--The Caring Program for Children: The Caring Program is a public/private initiative that was established in mid-1985 by Western Pennsylvania Blue Cross/Blue Shield as a response to the primary health care needs of children from low-income families. Through a grant from the U.S. Department of Health and Human Services' Maternal Child Health Bureau, the program has been replicated in 20 states. A second grant called Project Caring provides coordination services to a target population with special health care needs. Eligibility is extended to children eighteen years of age or younger whose families do not qualify for Medicaid but have an income below 133-100 percent (depending on the particular state) of the federal poverty level. The program is funded through donations from state government, religious organizations, community groups, businesses, private foundations, and individuals. Blue Cross and Blue Shield plans match contributions dollar-for-dollar and provide administrative support.

Pennsylvania--The Children's Health Care Plan: This comprehensive health plan which was recently signed by Governor Casey (December 1992) will provide free and subsidized health care to uninsured children. The minimum benefit package includes preventive care; diagnosis and treatment of illness or injury; injections and medications; outpatient surgery; emergency care; full dental, vision and hearing care and inpatient hospitalization up to 90 days per year. Children under six years of age whose family income does not exceed 185% of the Federal Poverty Income Guidelines (FPIG) will have free insurance for the services above, as will children six to eighteen years of age whose family income does not exceed 100% of the FPIG. A Children's Health Fund will provide subsidized insurance to children less than six years of age whose family income is between 185 and 300% of the FPIG.

Washington--Washington Basic Health Plan: This demonstration project is designed to provide health care coverage for 24,000 uninsured Washington residents under age 65 whose

gross family income does not exceed 200% of the federal poverty level. The plan covers doctor visits and hospital care; lab tests and x-rays; emergency care and ambulance services; and preventive care such as immunizations and routine checkups. Premiums are based on a sliding scale determined by family size and income. The program is administered by private managed health care systems and paid for through a mixture of participant premiums and state revenues.

Vermont--Doctor Dynasaur: This state-funded health insurance program is designed to provide health care for children up to age 18 with family incomes at or below 225% of the federal poverty level and pregnant women with incomes at or below 200% of the federal poverty level. Like Minnesota, Vermont has taken advantage of recent Medicaid changes that have allowed coverage expansions for pregnant women and children.

Wisconsin--WisconCare: Administered by the Wisconsin Department of Health and Social Services, the plan covers individuals at or below 150% of the federal poverty level who are unemployed (or work less than 25 hours). The plan also covers dependents up to age 18 who are not eligible for other health care coverage or don't have health insurance coverage with outpatient/maternity benefits. WisconCare covers primary care and inpatient maternity care and is funded mostly through state revenues.

Local Government Programs/Funds

Local government funds for eSBCs can come from several sources, but those most often utilized are city or county health department and school district funds. In most cases local government contributions to eSBC budgets are not substantial, however there are some notable exceptions that illustrate how local funds can be stable and long-term.

The Fort Worth Independent School District's (FWISD) Connections Program is one such example of a school district that has taken the lead in providing children's health and social services in its schools. The effort is primarily funded by existing FWISD funds, while a United Way grant accounts for the balance of revenues. Connections (see Table 1) is a comprehensive services model that provides referrals to community organizations rather than having on-site service provision. For example, most students in the five participating elementary schools are transported to one of the county's fifteen community health centers for primary care. This has allowed FWISD to keep costs low and service standards high.

Special Taxing Districts: A special district is defined as an "independent, limited-purpose, local government unit that exists with substantial administrative and fiscal independence from general purpose governments." (Porter, 1992) Most special districts were created to finance urban infrastructure, such as hospital, airport and flood control districts. Today there are over 29,487 special districts in the United States, with every state claiming at least six (Porter, 1992).

Theoretically, a special district could offer program funds or entitlement funds, depending upon how it was created by law. However, most special districts do not provide funding for

community-based programs, as local jurisdictions usually lack the tax base or political will to provide for such innovations. Nevertheless, the examples below illustrate how a special taxing district can be used as a vehicle to provide children's services program funds.

Two special districts that are dedicated to children's health and social services are in Florida. Florida's Pinellas County created a special district over forty years ago for the establishment of the Juvenile Welfare Board, which now operates over 70 programs and has a budget of nearly $14 million. Palm Beach County, Florida has also enacted a special taxing district that is a dedicated funding source for children's services. Florida law required the passage of both a state law creating the special district and a referendum of county voters approving it. The Children's Services Council of Palm Beach County, funded solely by the special district, now coordinates the planning, funding and evaluation of children's programs. Program areas include substance abuse, education, recreation, child care, juvenile justice, developmental disabilities, dependency and health.

Special taxing districts dedicated to children's interests are not common. A simple explanation for this is that many local administrators have not considered special districts for such purposes. Another explanation is that it is relatively difficult to galvanize political support for special taxing districts. Nevertheless, special taxing districts are a powerful revenue generating source that should be considered for any eSBC effort.

Pillar 2: Maximizing Federal and State Entitlements

By maximizing federal and state entitlements, a state or local government can increase funds earmarked for children's health or social services. The idea is to tap federal funding streams that already exist, for many state governments are not fully accessing funding streams that they are entitled to by law. Millions of dollars in reimbursements could be available if funding streams were properly accessed. Federal reimbursements would free state funds that normally would pay for certain services (such as special education, case management and assessment costs). The newly freed state funds could then be applied to eSBC costs or children's services reform.

Medicaid

Medicaid is a jointly financed federal and state program in which states determine eligibility, provider requirements, covered services and reimbursement levels within relatively broad federal guidelines.

Eligibility: Medicaid eligibility varies among states, but most tie benefits to AFDC (Aid to Families with Dependent Children) or SSI (Supplemental Security Income) eligibility. Unfortunately, many states have become more restrictive with eligibility requirements by setting income levels for these programs so low. With greater constraints in place, Medicaid now

covers only 40% of those living below the federal poverty level (Lipson, 1987).

Conversely, Congress has amended the Medicaid statutes to expand coverage for some groups, namely children and pregnant women. Currently states must cover pregnant women and children up to age six with incomes below 133% of the federal poverty level. States also have the option to cover pregnant women and infants (up to age 1) with incomes up to 185% of poverty. Finally, and most significantly for an eSBC project, states are being required to phase in coverage of children up to age 19 with incomes below 100% of the federal poverty level. The phase-in process is occurring on a yearly basis; states this year are covering children under ten years of age. In 1993, states will be required to cover all children under the age of 11. The upper age limit of 19 will be reached by October 1, 2002. (National Governor's Association, 1992).

Provider Requirements: Provider requirements vary from state to state as well. State laws generally mandate licensing standards, reimbursement rates, and the reimbursable services allowable for different types of health facilities.

In general, the provider must be certified by the state in order to bill Medicaid. There are over 40 different types of providers; three are relevant to our discussion in that they are the most compatible with eSBCs: 1) Outpatient clinics, which deliver preventive, diagnostic, therapeutic and rehabilitative services to patients on an outpatient basis in a facility not part of a hospital, 2) Hospital outpatient departments, which are units of a hospital (not necessarily in a hospital) that perform the same functions found in an outpatient clinic, and 3) Physicians (Wells, 1992).

In addition to these three, some states are beginning to expand their provider categories in an effort to improve access to services. Most notably, twenty states have made provisions to allow schools and/or school districts to become Medicaid or EPSDT providers (National Governor's Association, 1992). Despite these efforts, most states still do not have such policies in place. Consequently, most SBCs have difficulty becoming Medicaid certified because they cannot obtain a license that designates them as one of the above provider types, or because they do not possess the billing capabilities necessary to handle complex Medicaid billing procedures.

Covered Services and Reimbursement Levels: Much like eligibility and provider requirements, covered services and reimbursement rates vary from state to state. However, there are several services, such as EPSDT (discussed below), that all states must cover.

States have the option to cover certain clinic services, which most often include outpatient services provided by a nurse practitioner and supervised by a physician. Usually states limit the amount, duration and scope of various procedures to contain costs. States also have leeway in setting reimbursement rates for specific services and payment plans for certain providers (Lipson, 1987).

EPSDT: The Early and Periodic Screening, Diagnostic and Treatment Program is the core component of Medicaid that is most applicable to eSBCs. The general goals of the EPSDT

program are to assess a child's health needs through initial and periodic examinations and assure problems are diagnosed and treated early. All states participating in Medicaid are required to offer EPSDT services to all Medicaid eligible children under 21.

EPSDT covers several activities and services, such as outreach, screening and health prevention services that are in most cases already provided by the schools. For example, EPDST covers services such as height and weight, ears, nose, throat, teeth, gums, vision, urine and hearing checks. In addition, EPSDT also pays for TB and sickle cell tests and checks for cardiac abnormalities.

In 1989 Congress amended the Medicaid statute to significantly strengthen the EPSDT program. The law now requires states to provide all medically necessary health care treatment identified through an EPSDT screen regardless of whether the services are currently covered under the state's Medicaid plan. However, the services do have to fall within the scope of the federal Medicaid statute.

EPSDT also pays for outreach, case management activities and related services for special education programs. As a result, schools could use EPSDT to help pay for activities to find and enroll eligible children into the program. Outreach is classified as an administrative activity and is thus reimbursed on a 50/50 federal/state basis. Case management activities, such as student record tracking and monitoring, can be either classified as an administrative function or as an actual service (with respect to federal and state reimbursement proportions, reimbursement for services differs from administrative functions). Finally, EPSDT administration funds may be used to finance related services for special education programs such as case management and planning services.

Rehabilitation Services: Medicaid covers a range of optional medical and remedial services that are intended to reduce physical and/or mental disability. Services such as assessment, treatment planning, therapy, and counseling are available to the physically or mentally disabled who receive treatment according to a licensed physician's plan of care. The treatment plan is outlined in an Individualized Education Plan (IEP) and approved by a licensed practitioner.

It is possible for a state to expand its use of rehabilitation services by allowing local school districts to become eligible rehabilitation service providers. In order for this to occur the state Medicaid plan, which states must submit to the federal Health Care Financing Administration on a yearly basis, must be amended to extend the rehabilitation option to public schools and define the services and providers. The program would allow a state to bill for a variety of services not presently reimbursable under the regular Medicaid program. For example, Medicaid could be used to pay for medical services outlined in an IEP.

Non-Medical Funding Streams

o Title IV-E of the Social Security Act allows states to reimburse for costs incurred in

maintaining children in foster care, as well as programs designed to prevent foster care. Title IV-E primarily covers maintenance costs, administrative costs and training of staff, but can also be used to pay for preschool and day-care expenses and those costs associated with case planning and management.

- o Federal funding under Chapter 1 of the Elementary and Secondary Education Act supports disadvantaged students by providing for a variety of supportive services.

- o Most states often have several special-purpose education funding streams for remedial learning, substance abuse and preschool programs.

- o Title IV-B of the Social Security Act is usually earmarked for services for abused or neglected children.

- o Title IV-A of the Social Security Act provides for emergency assistance funds for families in crisis.

- o Federal juvenile justice funds provide for community-based youth services for delinquent children.

- o Title IV-F of the Social Security Act provides funds for child care, supportive services and case management for children of parents participating in the federal JOBS program.

- o The Child Care and Development Block Grant provides funds for affordable, quality child care. States receive funds according to a formula, but one-fourth of the funds must be dedicated to quality improvements and early education and latchkey programs. The remainder of the funds are to be used for assisting families in paying for child care and for programs increasing the supply of child care.

Barriers to Increased Use of Federal Entitlements

Although there are many benefits to maximizing federal funds, there are a number of obstacles that impede entitlement optimization. These are:

- o Categorical Funding: Entitlements are invariably defined in narrow terms. Organizational culture reinforces these specialized perspectives.

- o Difficulty in Making Application: Bureaucratic red-tape is unavoidable and often detrimental to program participation. However, most states have taken steps to streamline the process for children and pregnant women.

- o Immigrant Status: In some schools, a high percentage of the children are illegal immigrants, and thus ineligible for federal funds.

- Billing: Many SBCs will have to develop a 3rd party billing system which is often difficult given limited resources and experience. Arrangements with a partner medical facility or local HMO should be pursued.

- Managed Care Systems: Usually these programs require that all Medicaid recipients in a certain geographic area be enrolled. This may exclude an SBC from Medicaid participation entirely. Fortunately, SBCs can, in some cases, subcontract with the managed care plan for a certain segment of services.

Pillar 3: Reallocate Resources to Children's Services

This pillar is perhaps most important for those communities engaged in system-wide, broad-based social, education and health services reform. The concept is based upon the idea that funds can be used more efficiently and effectively if services are structured in a more client-friendly fashion. Given the notion of bringing services to where the clients are, it may be more cost-effective to centralize programs and services in a school-based health and social service center. This serves to bolster preventive services, as opposed to reactive treatments, and to increase the efficiency of service delivery and decrease the need for more costly services in the future.

Strategies

One state strategy is to tie new funds to a plan for integration of the systems serving children and families. As previously noted, several states have employed such a strategy. For instance, Kentucky's Family Resource and Youth Services Center Program offers state grants of up to $90,000 to communities that couple county/city-wide children and youth services system reform with school-based health and social service centers in elementary schools.

The redirection of existing funds may take several forms:

- Staff Reassignment/Relocation: For example, station public health nurses in schools. Similarly, rotate nurse practitioners and other health professionals from local clinics or outpatient departments into schools.

- Budget Reallocation: Transfer money from other uses or from new reimbursement funds to children's services.

- Decategorization: It will often take state level legislation, changes in Medicaid regulations, and/or changes in local government organizational structures to mandate a "client-centered" approach rather than a "funding-stream" driven system. If successful with such an approach, local jurisdictions will have greater discretion with respect to funds allocated (Center for the Future of Children, 1991).

- In-kind Contributions: The school or hospital will often be able to contribute space, equipment, staff, and/or administrative support.

New Beginnings: An Example of Reallocation of Resources: The New Beginnings Project in San Diego, CA is an example of system-wide reform that is refocusing its children and youth service delivery in the schools. The City of San Diego, San Diego City Schools, the County of San Diego, UCSD Medical Center and the San Diego Community College District have come together to develop plans that will radically restructure the delivery of services to children and their families.

The implementation plans call for "...waivers, policy changes and staffing changes; funding flexibility; the development of an agency network; and agency collaboration that is client-centered" (San Diego City Schools, 1990). Staff from the participating agencies are housed in the New Beginnings Center, which is located on the campus of Hamilton Elementary School, in order to provide greater continuity and effectiveness of service.

The relocated staff remain on their home agency's payroll. In addition, school counselors and nurses, County Department of Social Service workers, and County Public Health Nurses take on new or expanded roles to better serve children at the New Beginnings Center.

New Beginnings also required federal legislative and regulatory change from the Department of Health and Human Services. New Beginnings has requested the following waivers (Kirst, 1992):

- Reimbursement for case management services (Title IV-E and Medicaid)
- A unified system for determining program eligibility
- The ability to designate New Beginnings staff as an interdisciplinary team for case information and confidentiality exchange
- The ability to allow Child Protective Services workers to spend more time on cases without penalty
- The ability to use existing funds more flexibly
- The ability to give priority to the Center's families for service and treatment
- The ability to cross-train the Center team from the best funding source.

The Financing Strategy: Implications

Based on the preceding discussion of potential sources of funding, it is clear that the sources of funding are numerous but typically restricted in scope. It is the task of each clinic to review the

relevant options on the federal, state and local levels to create a tailored funding package.

In reviewing the budgets from the sites visited, it was found that in addition to health department funds, education and human service dollars are also used. The following chart illustrates the sources of income for several of the clinics visited.

The Katherine Brennan Elementary School, New Haven, CT:

New Haven Department of Health:	82%
Healthy Tomorrows Grant (Federal):	18%

The Vaughn Street Family Center, Vaughn Street Elementary, San Fernando, CA:

LA Unified School District	62%
Healthy Start Grant (State)	27%
United Way	7%
Nabisco Foundation (NJ)	4%

The Community Oriented Primary Care Program, (3 clinics) Dallas, TX:

MCH Block Grant	53%
Texas Department of Health	12%
Medicaid	11%
United Way	7%
Title XX	6%
Patient Fees	5%
Healthy Tomorrows Grant (Federal)	4%
Dallas Hospital District	2%

New Beginnings Center, Hamilton Elementary School, San Diego, CA:

Reallocation of local funds	55%
State and foundation grants	45%

Roosevelt Elementary School, The School-Based Youth Services Program, New Brunswick, NJ:

New Jersey Department of Human Services	51%
UMDNJ (Medical Center)	14%
New Brunswick Tomorrows	13%

New Brunswick School District	22%

The Cambridge Teen Center, Cambridge, MA:

Cambridge Hospital (This includes Department of Public Health, Community Development and United Way funds.)	65%
Medicaid	24%
Blue Cross/Blue Shield	9%
HMOs	2%

Non-Health Department Public Funding: Although health dollars (to varying degrees) are used in all sites, long term funding is available from other sources as well. The New Brunswick, NJ clinic, for example, illustrates how a clinic can be sustained by a line item in a state human services department budget. Of course, health departments do contribute to many clinics, some of which are stable state budget line items (see chart below).

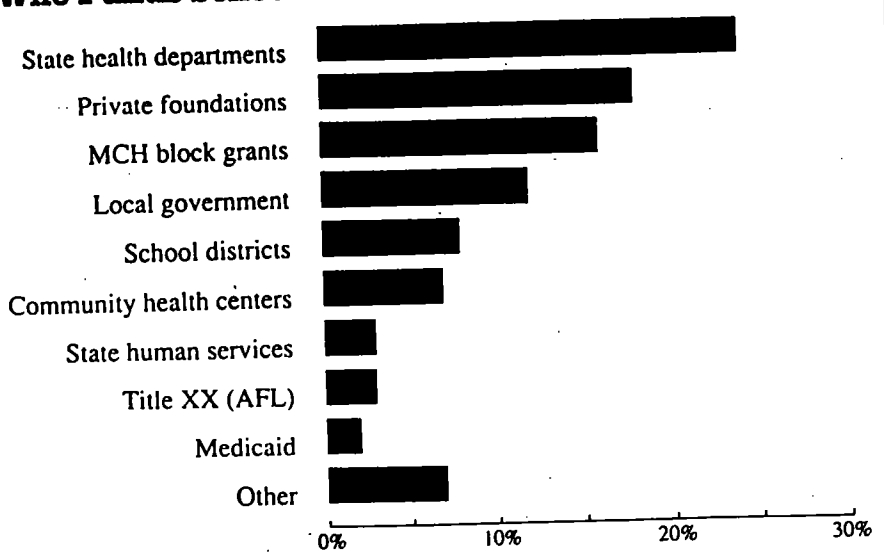
Funding with Reallocated Dollars: Several clinics in the feasibility study rely on reallocation of existing local resources coupled with state, federal and local funds. These clinics are perhaps the best examples of how school district, hospital, human service, public welfare and public health dollars can be utilized to fund a clinic providing health and health-related services. The New Beginnings Center in San Diego is perhaps most illustrative. The collaborative partners that provide over half of the Center's budget include San Diego City Schools, the County of San Diego, UCSD Medical Center, the City of San Diego, the San Diego Community College District, and various social service agencies.

The Katherine Brennan Elementary School clinic in New Haven serves as another example of how existing local funds may be reallocated. The clinic's part-time dental hygienist, hearing technician, health educator, administrator and accountant are all city employees whose salaries have been partially reallocated to the clinic budget.

Hospital/Neighborhood Health Center Funding: Hospital or Federally Qualified Health Center (FQHC) funds have also been used to support SBCs. Hospitals and FQHCs can provide professional staff, an existing Medicaid/3rd party billing system and the weight of an established community institution. They can also secure other funds, including tax dollars (if a public hospital), state grants and school district funds. For example, The Cambridge Teen Center is a satellite of The Cambridge Hospital. The hospital incorporates The Teen Center's budget and bills Medicaid and other 3rd parties for approximately 35% of The Teen Center's total budget--a significantly high 3rd party percentage. In fact, The Teen Center's 3rd party reimbursement is the highest of any clinic visited, and is far higher than the national average (see chart below).

Medicaid--Barriers and Solutions: Unfortunately, as the experience from most eSBCs

Who Funds School-Based Health Centers?



SOURCE: Center for Population Options, *School-Based and School-Linked Clinics, Update* 1991

illustrates, the use of Medicaid as a funding source poses many obstacles. As outlined previously in this section, the primary barriers include the ineligibility of many children, the complexity and high cost of administration, and low state reimbursement rates.

Eligibility and state reimbursement rates can only be altered via state-level statute or procedural change. This is not altogether impossible however, as the collaborative process nearly inherent in eSBC development will give the clinic planners the opportunity to voice these concerns and perhaps sway state leaders to change certification, eligibility, billing and/or record keeping requirements. This has been the case in California and Pennsylvania, where state leaders have altered Medicaid regulations to allow school districts to become Medicaid eligible providers if they meet certain requirements.

For a newly created entity such as an eSBC, it is worthwhile to create an arrangement with a local hospital or neighborhood health clinic already knowledgeable about computerized billing. As noted above, The Cambridge Hospital has such an arrangement with The Cambridge Teen Center. The SBC may also want to consider contracting the billing service to an outside provider. The Commonwealth of Pennsylvania has done so by contracting a private firm to be responsible for certifying clinic eligibility and billing processes.

The Future Prospects of Public Health Insurance: An additional 3rd party source that will have a substantial future impact is public health insurance plans. Particularly on the state level, public health insurance is a more likely reality than ever before. As previously mentioned, states such as Florida, Wisconsin, Arkansas, New York, Minnesota and Pennsylvania have either enacted an insurance plan or are on the verge of passing legislation to do so. This bodes well for school-based clinics, especially those with 3rd party billing systems, as it will become another potentially stable funding source for heretofore uninsured children.

The importance of state insurance plans should not be underestimated. It is likely that such developments will create a surge in demand for the kind of health care that eSBCs are positioned to provide. Most state plans will offer insurance to those not eligible for Medicaid but too poor to purchase private insurance. As a low-cost, prevention oriented provider, eSBCs will be poised to play a significant role in providing health and health-related services to these new consumers.

The Role of Private Funding: Although this section has focused on public funding streams, it is important to recognize the role played by private funders. It is a limited role, however, as it is most common for foundation funding to cease after a certain time period. As a result, the most common roles for foundation funds are start-up funds, or funds targeted for a specific purpose, such as the purchase of new equipment or capital projects.

Two additional types of private funds that have significant potential include patient fees and other 3rd party reimbursement plans. Patient fees come from families who either pay out-of-pocket for services or are covered by private health insurance. In typical communities where eSBCs are located, this is usually a very small proportion of children, sometimes no greater than 1-2%.

The most relevant examples of private 3rd party plans are prepaid, managed care systems, such as health maintenance organizations (HMOs). An HMO operating in a community with an existing or planned eSBC could potentially contract with a school or school system to provide on-site services to eSBC families. This service delivery strategy has not been tried in many locations, but with the growing emphasis on managed care and its central identity in the national health care reform debate, it is an important avenue to explore.

V. Recommendations for Implementation: Demonstration Strategies

Based on the extensive research which now documents the success of hundreds of adolescent school-based clinics throughout the United States, and our recent review of the few elementary school-based clinics which are currently operating, it is recommended that a program be launched to assist communities in developing first-class school-based clinics in elementary schools.

Given the neglected health and health-related needs of too many elementary school children, particularly in disadvantaged communities, an expansion of this model in a limited number of geographical locations is warranted. It is recommended that the program begin in just five cities (or geographical areas) but that support be given to ten elementary schools in each to develop the model.

By supporting several clinics in a given city (or geographical area), economies of scale will be achieved along with a critical mass to provide visibility for the concept. Through this visibility and eventual success, it is hoped that political support will be galvanized. The critical mass will also provide the opportunity for networking on the local level, sharing experiences, and learning from each other.

Based on what we have learned in the feasibility study, and on what we know about helping community-based programs take root, the following framework for bringing this concept to scale is recommended:

i. Support the development of ten elementary school-based clinics in a given city (or geographical area).

ii. Support these developments in five cities (or geographical areas).

iii. Provide up to $150,000 per clinic per year.

iv. Provide funding for at least two years.

Although this could not be construed as lavish support for each clinic, when taken as a whole it is a substantial program:

$150,000 X 10 schools per city = $1.5 million

$1.5 million X 5 cities = $7.5 million

$7.5 million X 2 years = $15 million

In conclusion, it is recommended that $15 million be obtained for direct support of 50 elementary school-based clinics. Given the nature of this type of project (i.e. service delivery

which in some cases will require renovation of physical space), it is also recommended that a separate pool of funds be available for limited capital costs. This pool might total $2.5 million.

Two additional elements to be factored into a program plan of this broad scope and import are costs for administration and for program evaluation. Without the specific details and design for each, at this stage it is recommended that a working figure of $1.0 million be allocated for each over the course of the 2-year project.

In summary, to fully fund, administer, and evaluate this nationwide effort the following budget is recommended:

direct program costs	$15.0 million
possible capital costs	2.5 million
administration	1.0 million
evaluation	1.0 million
	$19.5 million

Site Selection and Priorities

Based on the project site visits and program materials reviewed, a preliminary list of sites has been developed. These are cities or geographical areas with significant projects already underway and therefore have already dealt with some of the difficult and time-consuming issues related to pulling partners together and obtaining initial approvals. Since we have done site visits to most of them, we are confident there is a substantial base to build upon, yet the most unmet needs remain substantial. These initial cities are:

Dallas
New Brunswick/Newark
New Haven/Bridgeport
Philadelphia
San Diego

Combining what we have learned from site visits, and what we have learned about some very significant state-level activities, an alternative approach might be to select several states and then focus on selecting geographical concentrations within each. Given some creative financing, program planning and leadership selected in states, this approach also has promise. Some states to be considered might include:

Arkansas	Kentucky
California	Pennsylvania
Florida	Texas

Another approach to site selection would focus more on the availability of potential start-up funds, as opposed to already existing programs. Given the fact that the need for this type of program exists in all 50 states, this approach to site selection is not inappropriate. Based on the combination of significant need as well as the potential for significant funding, the following cities and states might be considered:

Cities	States
Detroit	Michigan
Indianapolis	Indiana
Milwaukee	Ohio
Miami	Washington

Organization and Support of the Initiative

To manage and administer this national program, a program office would be set up by the National Health/Education Consortium (NHEC) in Washington. While relying on existing or newly hired staff, NHEC would also continue to work closely with The Conservation Company, given their substantive expertise and significant experience with large-scale national programs. Rae Grad, a cofounder of NHEC and executive director of the National Commission to Prevent Infant Mortality, has been recommended to become Project Director of this effort.

An initial task will be to appoint an Advisory Committee with national and professional visibility. In addition, consideration will also be given to creating a targeted substantive work group as well.

VI. THE ROLE OF FOUNDATIONS

Although the key to success and longevity for a school-based clinic is long-term public support, early and crucial roles can be played by foundations. By virtue of their independence, they are unlike the public and nonprofit constituencies who are often their partners:

- They typically have no vested interest in existing public programs and policies.
- They typically have no vested interest in maintaining the status quo.
- They are, therefore, well suited to bridge the gaps between agencies, departments, levels of government, and disciplines to promote collaboration, new thinking, and even new paradigms.
- They are in a good position to encourage the creation and testing of new models.
- They have the potential to provide leadership.

In fact, it is really these characteristics rather than their dollars which exemplify their import. On the other hand, that is not to say that the dollars are unimportant. Most often their role in providing "seed money" can make the difference in the birth of a program versus another good idea on the shelf. Because private funds can be moved faster and more flexibly than public dollars, foundations can often provide the right timing as well as outside endorsement of the concept or project.

Expansion of Elementary School-Based Clinics

As described in the previous section, the conclusion of this feasibility study is that a limited national demonstration is the appropriate next step in building on this important concept.

If a five-city (or state), two-year program is considered (section V.), an estimated budget would be $15 million. Ideally, attracting three national funders to each contribute $5 million over the two-year period would provide the full program support needed as well as significant visibility for the funders. The more likely route would be that the Prudential Foundation plus other corporate funders would join with private and community foundations in support of this effort. In addition, these funders would be asked to share equally in the costs of program administration/technical assistance and program evaluation, totalling approximately $2.0 million.

Although of interest to a smaller group of funders, the program would benefit from a separate (and smaller) pool of funds earmarked for limited capital costs. A recommended sum of $2.5 million would be appropriate for this purpose.

Consideration as the lead program supporters might be given to:

The Prudential Foundation
The Robert Wood Johnson Foundation
The W.K. Kellogg Foundation
The David and Lucile Packard Foundation
other corporations

For the pool of capital support, it is recommended that the Kresge Foundation be approached because of their substantive interest in health and their almost exclusive support for capital projects. In addition, the Fannie Mae Foundation will be approached.

An Alternative

Rather than seeking full program support from such a limited number of large funders (as described above), another approach might be to seek half of that support from those national funders, matched by that same amount from large geographically-restricted foundations.

In this scenario, the funders mentioned above would collectively contribute approximately $7.5 million and local foundations would match that amount. The chart below provides some options:

POSSIBLE NATIONAL FUNDERS	2-year Support
Prudential RWJF Kellogg Packard Other corporations	$7.5 million

POSSIBLE LOCAL FUNDERS

State	Funder	1-year Support
Pennsylvania	Pew, Heinz	$1.5 million
Texas	Meadows, Richardson, Tandy	$750,000
California	Weingart, Ahmanson, N. California Consortium	$750,000
Michigan	Skillman, Mott, Dow	$750,000
Indiana	Lilly	$750,000
Kentucky	Humana, Brown, Lexington Foundation for Women	$750,000
Florida	Knight, Dade Community Foundation	$750,000
Minnesota	McKnight, Northwest, St. Paul Community	$750,000
New York	Diamond, Cummings, NYCT	$750,000

BACKGROUND

The National Health/Education Consortium

Nearly three years ago, in May 1990, the National Health/Education Consortium (NHEC) was formed under the leadership of the National Commission to Prevent Infant Mortality and the Institute for Educational Leadership. The mission of the Consortium, which includes 56 national health and education member organizations, totalling nearly 11 million individuals, is to bring together the health and education communities to better serve America's children. Despite the long history of health and education professionals not working together, or sometimes even working at cross purposes, the Consortium has successfully begun to change the way that the health and education systems work for children.

NHEC's commitment to emphasize, particularly at the grassroots level, the importance of improving cooperation between the health and education sectors has been demonstrated through a number of activities. The Consortium has held state and local forums all across the country to accomplish such collaboration, generating linkages among health and education practitioners, and political, business and community leaders. Some of these partnerships have led to new strategies and services on behalf of children and families, while others have increased the efficiency of services already in place. Publications targeted to professionals, policymakers and parents have been widely disseminated, raising public awareness of the inextricable links between children's health and their education.

The Conservation Company

The Conservation Company provides a variety of professional services to nonprofit organizations, public agencies, private agencies and corporate and private foundations throughout the country. The staff is thoroughly familiar with the internal workings and the diverse roles and missions of these organizations. The firm's special interest and competency lie in its history of working objectively within these environments. The Conservation Company is proficient in the design of new programs to meet a variety of institutional objectives. Members of the firm have years of experience in moving from concept, to plan, to prototype, to implementation. The firm has undertaken a number of assignments for private foundations and corporate giving programs, including Ford, Rockefeller, Pew, MacArthur, Mellon, Kraft-General Foods, GTE, Industrial Bank of Japan, and Bristol Myers Squibb.

APPENDIX A

INDIVIDUALS CONTACTED

INDIVIDUALS CONTACTED

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APPENDIX B

BIBLIOGRAPHY

BIBLIOGRAPHY

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NB: Numerous other site-specific reports, memoranda, RFPs, proposals, promotional materials, newspaper articles and statistical analyses were reviewed in addition to those works listed above.

APPENDIX C

SITE VISIT REPORTS

Cambridge, MA

Dallas, TX

Fort Worth, TX

New Haven, CT

Trenton, NJ

San Diego, CA

Los Angeles, CA

San Fernando, CA

(Site visit reports are printed as a separate volume and are available upon request from The Conservation Company in Philadelphia)

TABLE 1: SITE VISITS

CITY, PROGRAM, SCHOOL	CONTACTS	NATURE OF PROGRAM	START DATE	BUDGET	STAFFING (full-time unless otherwise noted)	SERVICES	HOURS OF OPERATION	VOLUME	FUNDING SOURCES	COLLABORATIVE PARTNERS/ LOCAL ADMINISTRATION	COMMENTS
CAMBRIDGE, MA: **The Cambridge Teen Center, Cambridge Rindge & Latin High School**	Lynn Shoeff, Teen Center Director Karen Friedman, Nurse Practitioner	Full service adolescent school-based clinic with on-site primary care and mental health services, and off-site referrals to other social services	1986	$311,584 per year	Program Director Medical Director/Physician (part-time) School Nurse 2 Nurse Practitioners Nurse Midwives (part-time) 3 Medical Assistants Various off-site counselors employed part-time	Primary health care provided by nurse practitioners and on-call or on-site physicians Mental health and other social services provided by subcontracted community non-profits Other services provided by Cambridge Hospital	8AM-5PM No evenings 12 months/year No weekends but 24 hour on-call back-up	2000 student visits per year	Cambridge Hospital Cambridge Department of Public Health United Way Medicaid Other 3rd party insurers Community Development Block Grant	Cambridge Hospital Cambridge Department of Public Health Local community non-profits Administered by Cambridge Hospital	Excellent model of adolescent clinic for comparison with elementary sites School busing complicates notion of community-based services
DALLAS, TX: **The Community Oriented Primary Care Program (COPC), Carver and Saldivar Elementary School-Based Clinics**	Stephen Rosser, COO, COPC James Sealey, Director of Clinic Operations, COPC	Two elementary and one adolescent school-based clinics, located on school grounds Full service medical model	1972	Average per site: $466,000 per year	Physician Clinic Manager 2 Nurse Practitioners Social Worker Case Aid Medical Assistant 2 Clerical Aids	Primary health care, preventive services, acute care, chronic problem care, laboratory services, dental services (Saldivar only) and some limited social services Linked with Parkland Hospital and Children's Medical Center for referral needs	8AM-5PM 2 weekday evenings 12 months No weekends 24 hour physician back-up	Carver Elementary: 3,719 students and family members Saldivar Elementary: 3,666 students and family members	MCH Block Grant Texas Department of Health MCH Healthy Tomorrows Grant Dallas County Hospital District Dallas Independent School District United Way Medicaid Title XX Patient fees	Parkland Hospital The Dallas Independent School District Texas Department of Health Parkland Hospital is the administering entity	No further expansion of services because of political climate High adult usage

TABLE 1: SITE VISITS

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ITY, PROGRAM, CHOOL	CONTACTS	NATURE OF PROGRAM	START DATE	BUDGET	STAFFING (full-time unless otherwise noted)	SERVICES	HOURS OF OPERATION	VOLUME	FUNDING SOURCES	COLLABORATIVE PARTNERS/ LOCAL ADMINISTRATION	COMMENTS
ORT WORTH, X: he Collaborative eadership evelopment rogram's (CLDP) PSDT S.S. illow Elementary chool	Jackie Thompson, Director of Health Services, FWISD Mya Coursey and T. Ware, CLDP Program Facilitators	Small pilot program EPSDT screenings were conducted on five Friday mornings on-site	1992	EPSDT reimbursement	Screenings were conducted by a visiting Ft. Worth Public Health Nurse Practitioner	EPSDT screenings	N/A	38 students	EPSDT reimbursement Collaborating partner contributions Local foundation support	CLDP members: local business and community groups, nonprofits, hospitals and city officials The FWISD and Ft. Worth Public Health Department administer the program	CLDP is testing this model of collaboration and service provision in hopes of expanding it in other elementary schools
ORT WORTH, X: he Coor rogram, The Ft. /orth Independent chool District WISD)	Pat Wright, Director of Early Childhood Development, FWISD	Elementary school-based comprehensive services program—social, education, family and health services Brokering of services on and off-site for five elementary schools	1992	$250,000 approximate added cost for five clinics	Central support from Department of Early Childhood, FWISD Each school may reallocate resources or personnel as they see fit Two schools have social service coordinators paid by United Way grant School principal, nurse and guidance counselors play administrative and/or service roles	Depending upon each school's stated needs: Social services– day care, drug counseling, housing, single parenting, job skills, food bank Education services– ESL, parent literacy, homework clinics, discipline classes, etc. Health services– primary health care, immunizations, eye care, nutrition	8AM-5PM Selected weekday evenings, depending upon school No weekends Most schools open 12 months for health and day care services No physician back-up	5 elementary schools, 1992-93 1800 total children and their families	Reallocation of existing FWISD and Ft. Worth Public Health Department funds to retrain and relocate staff United Way grant Local foundations	Education, business and community leaders, The United Way, parents, faculty, city and county officials Program administered by local school principals and existing school and school district staffs in conjunction with service providers	A very decentralized system with varying services according to demonstrated needs Connections supplements a strong NHC system All schools indicated desire for increased health services
EW RUNSWICK, NJ: he School-Based outh Services rogram, Roosevelt lementary School ee TRENTON, NJ so)	Gail Reynolds, Director, SBYSP for New Brunswick School District Lillian Thomas, Coordinator for School Health, New Brunswick School District	School-based comprehensive social services, recreational programs and referred primary health care School Nurse refers primary care to Eric B. Chandler Neighborhood Health Center (NHC) Free van service to NHC and other social service agencies	1991	Average per site: $86,000 per year	For 5 elementary sites, Roosevelt is head administrative office and houses: Assistant Director 4 Counselors/Clinicians Administrative Assistant (part-time) Youth Service System Site Facilitator	Referral primary health care, mental health, academic assistance, employment counseling, teen parenting, social and recreational activities	8AM-9PM 12 months/year Weekends	3,400 total students	NJ Department of Human Services NJ Community Mental Health Center at Piscataway New Brunswick Tomorrows New Brunswick School District	New Brunswick Tomorrow (nonprofit social planning agency) New Brunswick Public Schools Youth Service System UMDNJ Collaborative partners hire administrators	Upon visitation, health was the hook (as opposed to recreation, which is the hook in the adolescent SBYSP)

TABLE 1: SITE VISITS

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NEW HAVEN, CT: **Katherine Brennan Elem. School**	Muriel Oberg, Director, Public Health Nursing Dietria Wells, Principal Lynn Donahue, Nurse Practitioner	Primary care provided on site by nurse practitioner Referrals to physicians at Hill Health Center	1991	$275,152 per year	Nurse Practitioner Social Worker (part-time) Physician (part-time) School Nurse (part-time) Dental Hygienist (part-time) Administrator (part-time) Clerical Aids (part-time) Various part-time medically related specialists	Primary health care, screenings, social services and outreach	8AM- 3PM No evenings 10 months/year No weekends	532 students and their siblings	MCH Healthy Tomorrows Grant New Haven Department of Health	New Haven Departments of Health and Education The New Haven Foundation School parents' groups and teachers Site administered by New Haven Department of Health	The on-site NP only treats children Besides nurse practitioner, most clinic staff are New Haven Department of Health employees working with the clinic on a part-time basis
NEW YORK, NY: **Mt. Sinai Hospital: PS 83, PS 108 Elementary Schools The Alternative Education Center**	Gary Butts, MD Director, Division of Ambulatory Care Pediatrics, Mt. Sinai Hospital Ray Cornbill, Department of Community Medicine, Mt. Sinai Hospital	Hospital satellite school-based clinics administered and staffed by Mt. Sinai Hospital	1990	Average per site: $116,000 per year	Physician (part-time) Social Worker (part-time) 2 Health Aids	Screenings, immunizations, first aid, complete medical history and physical exams, diagnosis and treatment services, mental health counseling, health education Referrals to Mt. Sinai Hospital	8AM-4PM No evenings 12 months/year No weekends	2,497 total students for three schools	New York City Department of Health Mt. Sinai Hospital Medicaid	New York City Department of Education New York City Board of Education Local school administrators, teachers and parents New York State Department of Health New York City Department of Health Administered by Mt. Sinai Hospital	Mt. Sinai is one of several New York City hospitals to participate in the state funded School Heath Program that provides funding for hospitals or community health centers to establish school-based clinics in their neighborhood schools There are 44 elementary schools participating in this program Relies primarily on rotating staff

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TRENTON, NJ: **The School-Based Youth Services Program, New State Department of Human Services**	Ed Tetelman, Director, Legal and Regulatory Affairs, Department of Human Services Roberta Knowelton, Director, SBYSP Kay Riess, Assistant to the Director, SBYSP	School-based comprehensive social services, recreational programs and referred or on-site health care RFP issued by The NJ Department of Human Services Recreation serves as the hook	1987	Average per site: $200,000 per year	Typically: Project Manager (Administrator) Employment Specialist Nurse Practitioner Human Service Coordinator	Direct health services (nurse practitioner may/may not be on site), substance abuse counseling, recreational activities, job employment training, mental health and family counseling, academic assistance Other social services, depending on needs stated in proposal	Standard Hours: 8AM - 9PM 12 months/year Weekends	20,000 children state-wide (36 sites)	$6 million from the State ($250,000 max per site) 25% local matching contribution (usually in-kind) Reallocated district or local government funds Medicaid	State Departments of Human Services, Health and Education Local sites administered by local non-profits and/or community groups	Described as a state program which has become a model as opposed to a model trying to become an ongoing program
SAN DIEGO, CA: **The New Beginnings Center, Hamilton Elementary School**	Jeanne Jehl, Administrator on Special Assignment, Office of Deputy Superintendent Irma Castro, New Beginnings Center Coordinator Claudia Hildreth, RN, School Nurse Practitioner	Elementary school-based comprehensive service center with referral links to local hospital and social service agencies NPs will provide some primary care on-site beginning upcoming year Local social service nonprofits are tenants in New Beginnings Center	1991 Health Clinic opened summer 1992	$597,000 per year	Coordinator Receptionist/clerk Administrative Assistant 3.5 Family Service Advocates (counselors) Mental Health Worker (part-time) 2 Nurse Practitioners Supervising Physician (part-time) 2 Outreach Workers	An entire range of on-site and referral social services and counseling provided by the Family Service Advocates On-site primary health care will be in place this year Hospital and physician back-up	8AM-5PM No evenings 12 months/year No weekends	1300 students and their families	Existing local and state government funds Stuart Foundations Danforth Foundation Medicaid	City of San Diego San Diego School District County of San Diego San Diego Community College District UCSD Medical Center Children's Hospital Administered by San Diego School District	Interagency collaboration has been difficult but successful Model is a reorganizational effort, not merely a new program with new money

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SAN FERNANDO, CA: **The Vaughn Street Family Center, Vaughn Street Elementary School**	Yvonne Chan, Principal Yoland Trevino, Director, Vaughn Street Family Center Connie Dubin, Project Director, LA Educational Partnership	On-site elementary school-based comprehensive family service center A full range of on and off-site social services and educational programs for children and adults Part-time school district nurse practitioner visits to administer screenings Primary health care will be offered on-site in early 1993, complemented by a full health services referral network	1990	$361,560 per year	Center Director Family Case Manager Clinical Case Manager 3 Family Advocates (part-time) 12 Volunteer Block Leaders (part-time) Administrative Assistant School Readiness Coordinator (part-time) 2 Child and Family Education Specialists (part-time) 2 USC MSW Interns (part-time)	Health services include EPSDT exams, immunizations, referrals to dental screening and primary care Educational/social services--translation, legal, housing, employment, food bank, WIC clinics, parent education and adult skills, day care network, youth activities, family counseling	8AM-5PM No evenings 12 months/year No weekends	1200 students and their families	Los Angeles School District United Way Healthy Start Grant Nabisco Foundation In-kind volunteers	LA County, LA County Children's Planning Council, LA County School Health Services Committee, LA County Department of Education, service providers, public/private partnerships, school officials Locally administered by independent Program Commission, comprised of 50% parents and 50% service providers Los Angeles Educational Partnership is convener/fiscal agent/technical assistance provider	Has planned an extensive set of social services Primary health care component due to start in 1993 Attempting to develop a capitated HMO program with Blue Cross/Blue Shield for opening of on-site primary health care