California School-Based Health Alliance
Strategic Plan
2016 - 2018

CALIFORNIA
SCHOOL·BASED
HEALTH ALLIANCE
Putting Health Care Where Kids Are

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Executive Summary

The California School-Based Health Alliance (CSHA) is the statewide association dedicated to expanding and improving health services in schools. *Our mission is to improve the health and academic success of children and youth by advancing health services in schools.*

The most comprehensive school-based health model is a school-based health center (SBHC). As of June 2016, there were 243 SBHCs in 90 different school districts in California. SBHCs emphasize:

- **Enhanced access** by bringing health care directly to where students and families are and engaging the school community as the "eyes and ears" of the health care system.
- **Stronger prevention** by integrating health promotion throughout the school in classrooms, campuswide events, or parent activities.
- **Intensive support for the highest-need students** by being present on a daily basis to manage chronic disease, deal with crises, and help families access resources.
- **A shared mission with the school to improve academic achievement** by working together to address absenteeism, school climate, classroom behavior, and academic performance.

Schools that do not have comprehensive SBHCs, may offer other health services including mental health programs, school nursing, dental screenings, etc. We believe that comprehensive SBHCs are the optimal model for meeting the health needs of students, but when an SBHC is not feasible, all schools can implement other school-based health models to ensure that health needs are not a barrier to learning.

Over the past decade, the number of SBHCs in California has almost doubled. Health care reform and changes in California's school financing system open possibilities for further growth and, ultimately, a chance to make school-based health an integral part of both health care delivery and education. Our strategic priorities for the next two years address the challenges of scaling up school-based health, maximizing its unique value-added, and ensuring its sustainability.

> **Organizational Strategies**
> CSHA advances SBHCs and other school-based health models through three core strategies:
> - Communications and Outreach
> - Programs and Training
> - Policy
>
> Stong staff, financing, and operations create the organizational foundation for effectively advancing our mission.

- ✓ **Priority 1: Strengthen grassroots advocacy for school-based health.** To further advance the movement for school-based health, more community members, grassroots organizations, and youth must know about school-based health and become advocates for it in their communities.
- ✓ **Priority 2: Better integrate SBHCs into schools and strengthen their impact on educational outcomes.** The unique value of SBHCs lies in their partnerships with their host schools, so it is a priority to help more SBHCs and schools work closely together and to demonstrate their success in improving educational outcomes.
- ✓ **Priority 3: Improve financing for school-based health services through health plans, hospitals, Medicaid, and public health.** Financing from the health sector is an important component of a financing model that will ultimately make school-based health services sustainable, and health care reform makes this an important time to pursue these financing strategies.
- ✓ **Priority 4: Improve school mental health services.** Mental health continues to be a need that is inadequately addressed in both health care and education and, therefore, is a top priority for the development of school-based programs.

As a result of CSHA's, we expect to achieve *more* SBHCs/school health and *great* SBHCs, which will ultimately lead to improved access to care for children and youth and improved health and educational outcomes.

Introduction

The California School-Based Health Alliance (CSHA) is the statewide association dedicated to advancing the delivery of health services in schools. Our staff of 13 is based in Oakand with a field office in Fresno. We coordinate our work closely with regional affiliates in Los Angeles and Alameda County. *Our mission is to improve the health and academic success of children and youth by advancing health services in schools.*

The Challenge

Keeping kids engaged in school and achieving at their full potential is critical to California and the nation's future. But no matter how engaging the curriculum, a child who suffers from low energy because of untreated diabetes cannot learn optimally. No matter how dynamic the teacher, a child who has untreated depression is at a disadvantage. These problems are not uncommon—in a typical California classroom with 25 students:

- 3 students have a mental health disorder
- 4 students have untreated dental cavities
- 4 students have asthma
- 7 students are overweight or obese
- 8 students will be sexually active by 9th grade

In low-income communities, these numbers are even higher and students are more likely to have high rates of violent injury, poor nutrition, physical inactivity, substance use, and sexually-risky behavior. They are also less likely to have health insurance or reliable access to health and mental health services.

A positive school climate is academically-challenging, caring, participatory, safe, and healthy—and is associated with higher levels of student academic performance. Unfortunately, many of California's schools have not yet achieved such an environment. Fewer than 50% of 9th graders experience high levels of three key features of positive school climate: high expectations (47%), caring adult relationships at school (30%), and meaningful school participation (13%). In addition, 42% of 9th graders do not think of school as a safe or very safe place for them to spend their time.

These risk factors lead to poor health and educational outcomes and pronounced disparities between racial/ethnic and socioeconomic groups. For example:

- Latina teens were four times more likely to give birth than their white peers in 2013.[1]
- Three-quarters of African American and Latino students report drinking one or more sugar-sweetened beverages a day compared to only 18% of white students.[2] Not surprisingly, Latino and African American adolescents are two to three times more likely to be obese than their white peers.[3]
- African Americans have 40 percent higher asthma prevalence, four times higher asthma emergency department visit and hospitalization rates, and two times higher asthma death rates than whites. [4]

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[1] California Department of Finance (2015). *Race/Ethnic Population with Age and Sex Detail, 1990-1999, 2000-2010, 2010-2060.* Retrieved http://www.dof.ca.gov/Forecasting/Demographics/; California Department of Public Health, Center for Health Statistics, Birth Statistical Master Files.; Centers for Disease Control & Prevention. *Natality data*. Retrieved from http://wonder.cdc.gov/; Martin et al. (2015, January 15). *Births: Final Data for 2013* (United States, US Department of Health and Human Services, Centers for Disease Control and Prevention). Retrieved from http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_01.pdf

[2] Babey, S. H., Wolstein, J., & Goldstein, H. (2013). *Still bubbling over: California adolescents drinking more soda and other sugar-sweetened beverages.* Retrieved http://www.publichealthadvocacy.org/stillbubblingover.html

[3] California Department of Public Health, Nutrition Education and Obesity Prevention Branch. (2014). *Obesity in California: The Weight of the State 2000, 2012*.

[4] Milet M, Lutzker L, Flattery J. (2013). *Asthma in California: A Surveillance Repor*t. California Department of Public Health, Environmental Health Investigations Branch. Retrieved http://www.californiabreathing.org/asthma-data/cal-asthma-report

- African American children are much more likely to have two or more "adverse childhood experiences" (45% compared to 18% of white or Latino children ages 0-17 in California).[5]
- Over 70% of California children with mental health needs never receive treatment. For youth in poverty or with non-English speaking parents, this figure is over 80%.[6]
- High school completion rates also vary greatly by race and ethnicity. For the class of 2015, graduations rates were as follows: Asian, 93%; white, 88%; Latino, 79%; and African American, 71%.[7]
- These dispartities are predicted in the earlier years by rates of chronic absenteeism (missing more than 10% of the school year).[8] Low-income students are far more likely to be chronically-absent than their higher-income peers.[9]

Number of School-Based Health Centers in California, June 2016
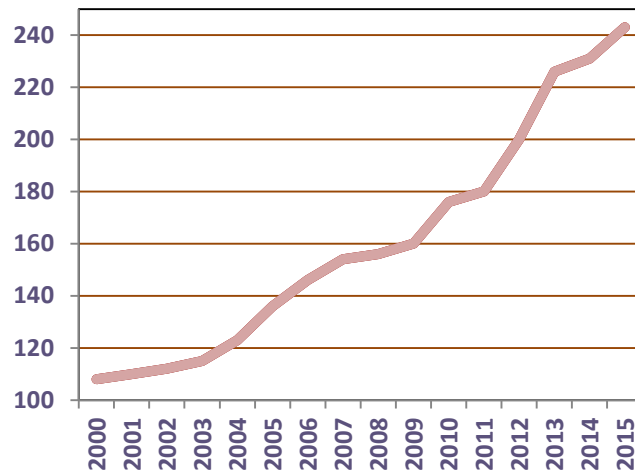
School-based health: Part of a comprehensive solution

Bringing health services directly onto school campuses is part of a comprehensive approach to advancing equity. School-based health services emphasize:

- **Enhanced access** by bringing health care directly to where students and families are and engaging the school community as the "eyes and ears" of the health care system.
- **Stronger prevention** by going beyond a traditional doctor's visit to integrate prevention throughout the school and address social determinants of health.
- **Intensive support for the highest-need students** by being present on a daily basis to manage chronic disease, deal with crises, and help families access resources.
- **A shared mission with the school to improve academic achievement** by working together to address absenteeism, school climate, classroom behavior, and academic performance.

As of June, 2016, there were 243 school-based health centers (SBHCs) in California, double the number ten years ago. SBHCs are medical clinics on school campuses designed to increase access to primary medical, dental, and mental health care by bringing care to a location that is convenient and trusted by students and families. In addition to SBHCs, many schools in California offer others types of health services

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[5] *Data Brief on Adverse Childhood Events Among California's Children*. (2014, April 2). Retrieved http://childhealthdata.org/docs/presentations-/californiadata.pdf

[6] Padilla-Frausto, D. I., Grant, D., Aydin, M., & Aguilar-Gaxiola, S. (2014, July). *Three Out of Four Children with Mental Health Needs in California Do Not Receive Treatment Despite Having Health Care Coverage.* Retrieved from http://healthpolicy.ucla.edu/publications/Documents/PDF/2014/childmentalhealthbrief-july2014.pdf

[7] California Department of Education. *Cohort Outcome Data for Class of 2014-2015*. Queried at http://dq.cde.ca.gov/dataquest/

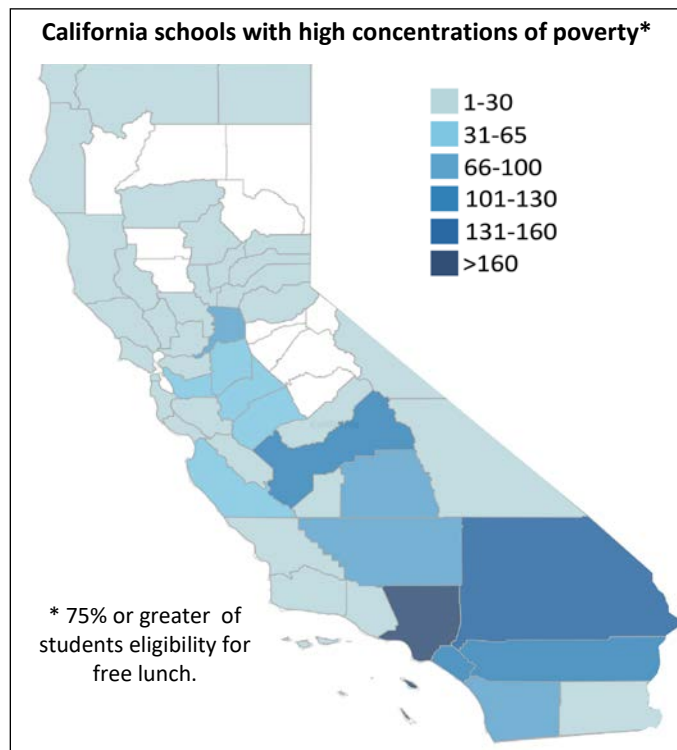[8] Attendance Works. (n.d.). Retrieved September 08, 2016, from http://www.attendanceworks.org/

[9] Attendance Works & Chronic Absence & Attendance Partnership. (2011, May). *The Attendance Imperative: Reducing Absences, Spurring Achievement.* Retrieved http://www.attendanceworks.org/wordpress/wp-content/uploads/2011/05/California-Policy-Handout_5-13.pdf

to students. These might include school mental health programs, school nursing, preventive dental programs or services through a mobile dental van, or asthma programs.

Unmet Needs

While the number of SBHCs in California has grown consistently, it is far from adequate to serve all of the children who could benefit from them. SBHCs provide benefits to children, families, and communities at all socioeconomic levels, however, we know that there is a particular need in low-income areas. An abundance of research connects poverty to poor educational and health outcomes, high rates of teen pregnancy, and greater risk of dropping out of school. SBHCs can significantly impact children living in the state's most distressed neighborhoods where children and families are uninsured; experience barriers to accessing preventive health care; and have high rates of emergency room visits, obesity, asthma, and exposure to violence and trauma.

California schools with high concentrations of poverty*

	1-30
	31-65
	66-100
	101-130
	131-160
	>160

* 75% or greater of students eligibility for free lunch.

> **There are approximately 10,000 schools in California, of which 2151 could immediately benefit from school-based health services due to the high concentration of poverty among their students** (defined as 75% or more eligible for free lunches).

At the California School-Based Health Alliance, we believe that comprehensive SBHCs are the optimal model for meeting the health needs of students, but when an SBHC is not feasible, schools can benefit from other school-based health programs to ensure that health needs are not a barrier to learning.

Key Issues and Opportunites in School-Based Health in California

Fostering Partnerships with Schools to Improve Academic Outcomes

One of the ongoing challenges in developing strong SBHCs is the difficulty of forging and maintaining strong partnerships between SBHCs and the schools where they are located. When the partnership is at its best, there is frequent two-way communication to coordinate services for individual students and align policies (e.g., when students can leave class or how the SBHC releases these students after an appointment to ensure that they go back to class). Teachers and administrators see the SBHC as a resource that contributes to the academic success of students by improving attendance, addressing behavioral issues, fostering a safe school climate, and minimizing health obstacles to learning.

However, a strong partnership is not easy to implement. Many SBHCs are run by community health centers that see themselves strictly as health care providers. Although we have made a great deal of progress in promoting school partnership as a key element of an SBHC, there are still some SBHCs that operate under a more traditional medical model. Even SBHCs that do understand the value of working closely with the school can be constrained by the lack of available staff to interface with the school and by the high rates of turnover among teachers and administrators. Most SBHCs are in low-income schools

where turnover is high and where, with each new principal, the process of forging a relationship must start again.

As a result of these challenges, even in areas of the state where SBHCs are well-established, continual effort is needed to foster strong partnerships between SBHCs and schools. Most SBHCs have room to strengthen this partnership and increase their impact on educational outcomes which, in the long run, will be critical to expansion of SBHCs.

Leveraging Greater Investment from School Districts

As SBHCs forge closer partnerships with schools and are able to better demonstrate their impact on academic outcomes, school districts will be more likely to invest in SBHC services. Although arrangements vary, typically, the district provides the facilities for an SBHC and covers the cost of utilities and/or custodial. School districts would also be the logical source of funding for services that go beyond basic health care and most directly impact student learning. These services might include participation in special education programs, interventions for chronically-absent students, school nursing, and health career programs. Previous experience with the state's Healthy Start program showed that for every dollar invested by the educational system, $3 to $16 could be leveraged in services from health care and other providers.[10]

This is an opportune moment to strengthen partnership and investment from schools. For the next several years (and possibly longer), districts with high concentrations of low-income students will receive significant increases in funding under the new Local Control Funding Formula. They will also have more discretion over how to best use their funds to boost student achievement. In addition, districts will be accountable for various outcomes including chronic absenteeism and school climate, two areas where SBHCs can have an impact. All of these changes give schools with the highest-need students more incentive and resources to consider investments in student health, some of which we are already seeing come to fruition. Changes in school financing and accountability have also put greater power in the hands of school districts, as opposed to the state government, to make decisions about how to use education dollars. Community voice has greater power than ever before to influence educational spending.

Increasing Funding from the Health Care Sector

While some health plans reimburse SBHCs for billable medical visits, there is tremendous room to increase the contribution of resources from health plans to enable more schools to open SBHCs. There are two key challenges to accessing this funding.

- SBHCs are not always a child's primary care provider. Today, most children in California are enrolled in a managed care plan. They pick a "primary care provider" (PCP) who is paid for their care. SBHCs, which open their doors to any student at the school, are not typically reimbursed when they serve students for whom they are not the PCP.

- SBHCs provide services that are not covered by insurance. The services provided in schools are not the same as the typical office visit. Many SBHCs provide a wide range of additional services including: health education, case management, outreach for health insurance, obesity prevention, coordination with parents and teachers, and referral troubleshooting. These services can be very time intensive and have not typically been covered by insurance.

Health care reform has created a more promising environment for school-based health. There is new impetus to find ways to get low-cost medical care to kids and to prevent future costly diseases. Hospitals

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[10] Bookmeyer, J., & Niebuhr, D. (2011, May). *California Healthy Start: Seed funding to build partnerships for student success.*

also have new requirements for investing in their communities. Every year, hundreds of children miss out on check-ups, dental care, immunizations, asthma medications, nutritional counseling, and many other services that they need to stay healthy. Health plans and medical providers are paying greater attention to the social determinants of health such as poverty, education, neighborhoods, or housing. SBHCs are the type of innovative approach to health care that addresses these social determinants of health, and health plans and hospitals are increasingly interested in these approaches.

Strengthening State Support

Unlike some other states, California has no dedicated funding stream for SBHCs—every school that wants to start an SBHC has to put together a creative patchwork of grants, insurance payments, subsidies, in-kind contributions, and donations. This process can take many years. In addition, California ranks near the bottom of the nation in terms of funding for school nurses and other support personnel. An optimal financing model for school-based health will include support from the health care and education sectors (as described above), as well as direct support from the government. California is one of the few states with a large number of SBHCs that has no state program to support them.

However, SBHCs have never been in a stronger position, as their numbers continue to grow, creating new champions among school leaders, community members, students, and policymakers. A decade ago, we could not have imagined successfully passing legislation for SBHCs in California and at the federal level.

In 2006, AB 2560 (Ridley-Thomas) created a "Public School Health Center Support Program" to collect data, facilitate the development of SBHCs, and address the programmatic, clinical, finance, and policy needs of California's SBHCs. In 2008, SB 564 (Ridley-Thomas) created a grant program for SBHCs administered by the Public School Health Center Support Program. This bill amended the Health and Safety Code (Section 124174) to create a basic definition of an SBHC (referred to here as "school health center"):

> "School health center" means a center or program, located at or near a local educational agency that provides age-appropriate health care services at the program site or through referrals. A school health center may conduct routine physical, mental health, and oral health assessments, and provide referrals for any services not offered onsite. A school health center may serve two or more nonadjacent schools or local educational agencies.

Although neither AB 2560 nor SB 564 was funded, they created greater awareness of SBHCs. At the federal level, SBHCs were defined in the Child Health Insurance Plan Reauthorization Act passed in 2009, and the Affordable Care Act of 2010 included $200 million in one-time funding for capital and facilities in SBHCs. California secured $30 million of these funds which helped open 48 new SBHCs.

In 2016, Governor Brown signed a state budget that included two positions in the California Department of Public Health as part of a $600,000 augmentation for SBHCs. This is the first time that the state has allocated any funding specifically to SBHCs and it is an important opportunity to build greater support within the state government.

Meeting the Need for Behavioral Health Care

Across schools in California there is widespread demand for increased behavioral health services (i.e., mental health and substance use). In the eyes of many school administrators, behavioral issues are the most pressing need that SBHCs can address. Approximately 62% of SBHCs in California offer mental health services, and many more schools without comprehensive SBHCs have various types of mental health programs for special education and general education students. Yet, even schools that have mental health services have more demand than they can meet. In addition, many SBHCs find themselves unable to offer substance use counseling and treatment for the many students using illicit substances, particularly marijuana.

More broadly, there is greater societal awareness of mental health issues, both as a risk factor for violent behavior and as a consequence of exposure to traumatic events. The Affordable Care Act included important new requirements around parity—providing the same level of coverage for mental health services as for physical health services. In California, new guidelines were issued that made health plans responsible for "mild to moderate" mental health conditions under their Medi-Cal contracts. Several plans have come under fire for their inability to adequately provide these services for their members. Together, these factors reinforce the importance of strengthening behavioral health services in schools and they offer potential opportunities for financing them.

Accomplishments from the 2014-2016 Strategic Plan

Priority 1: Engage more school districts in expanding a variety of school health services, especially mental health services.
Overall, we were very pleased with our focused effort to engage more school districts. As we suspected, mental health was a topic of great interest, and the convenings and webinars we offered on this topic resulted in many new districts becoming connected with our organization. We chose this priority because we had observed that much of the growth in SBHCs was happening within districts that already had one or more SBHCs, and this growth was likely to continue organically. Thus, to reach more children, we saw a need to introduce SBHCs and CSHA to new districts. With 473 districts, only 90 of which have SBHCs, in our database, we now have a robust audience that can benefit from further training and assistance in expanding school-based health services.

Outcome Target	Accomplishment
1.1. **650** school districts will receive our information (i.e., have an active contact who is opted in to our listserv).	This target turned out to be harder than expected but we now have **473** school districts receiving our information—up from 336 at the beginning of the two year strategic plan.
1.2. **250** schools districts or county offices of education will use CSHA's tools or trainings to strengthen their health or mental health programs.	We exceeded this target with **303** school districts using one or more of our resources during the two years.
1.3. **80,000** children and youth will have better access to mental health services at school as a result of CSHA's efforts to help schools establish more comprehensive mental health programs.	We estimate that **54,600** students attend schools that made changes or expansion to their mental health services as a result of our assistance. However, this figure does not capture the new students who will enroll in years to come and benefit from these services.

Priority 2: Increase the number of SBHCs that are well-integrated with the school to maximize their impact on student health and learning.
During the last two years, we experienced rapid growth in funded projects that allowed us to re-grant money to SBHCs. As a result, we exceeded our goal of improving practices at 30 SBHCs (indicator 2.2) and actually reached 47. We see this as a trend that will likely continue now that we have developed our capacity to fundraise for these projects. We had envisioned using our "principles and indicators checklist" (indicator 2.1) as important tools to drive program improvements in SBHCs. And while this tool was well-received by some SBHCs, especially those in the early stages of operation, in the absence of project funding, this tool would not be sufficient to dramatically change practice.

Outcome Target	Accomplishment
2.1. Sixty of the state's SBHCs will seek to maximize their impact on children's health by using the CSHA's school-based health principles and indicators checklist to identify areas for quality improvement.	During the strategic plan period, **63** SBHCs around the state completed the checklist to assess their practices and identify areas for improvement.
2.2. Thirty of the state's SBHCs will become more connected to their host schools to increase access to care, deliver stronger prevention programs, and/or provide greater individualized support to high-need students.	CSHA projects are helping **47** SBHCs meet this indicator. (Sites involved in multiple projects are only counted once.) • California Asthma Learning Collaborative - **6** SBHCs improved asthma care through schoolwide screenings and evidence-based care for students with asthma. • Tobacco Peer Education- **5** SBHCs engaged students as tobacco prevention educators. • Oakland Trauma Project - **5** high school SBHCs implemented schoolwide screenings, improved referrals, and coordinated services. • West Contra Costa - **9** SBHCs participate in the WCCUSD SBHC Coalition to share information and best practices for supporting the highest-need students. • Hallways to Health - **5** SBHCs provide prevention programs and forged new partnerships with school administration to gather schoolwide health data and coordinate schoolwide primary prevention and system-level strategies with their school sites. • Youth Health Worker - **6** SBHCs in West Contra Costa engaged youth in outreach, peer education, and exploration of health careers. • Fit and Healthy - **4** SBHCs screened over 1,800 students. The SBHCs identified 80 students in need of support and provided obesity support groups. • Central Valley SBHC Early Childhood - **9** SBHCs mapped early childhood resources, and identified gaps and opportunities to better link families to resources. • Technical assistance to Salud Para La Gente increased access to care for students at **6** SBHCs.

Priority 3: Advocate for health care financing for the key elements of the school-based health model that are not currently reimbursed.

We set a challenging task for ourselves in seeking to catalyze three partnerships between health plans and SBHCs to pilot coordination or reimbursement for non-clinical SBHC services. Many SBHCs need a lot of support to work with health plans, in part because they are stretched too thin to initiate new relationships or data collection. Health plans, while interested in new approaches to prevention, are more interested in innovations for high-cost patients, such as seniors with chronic illnesses, than for children. When plans do come to the table, they want basic data about what services SBHCs are providing to plan members, which SBHCs often cannot provide. Thu,s we need to simultaneously build the capacity of the field to collect data and interest health plans in what SBHCs have to offer.

FINAL

The past two years were the first time we challenged ourselves to meet a goal regarding health plan and SBHC partnerships. We are very pleased with our progress and believe that this will continue to be a productive, albeit incremental, focus for our efforts in the future.

Outcome Target	Accomplishment
3.1. There will be greater capacity in the school-based health field to be active participants in delivery system reform and innovation.	We attempted to build the capacity of the field by sharing information about delivery system reform efforts. We provided regular updates to 221 SBHC leaders, many of whom expressed appreciation for them. We also provided webinars on delivery system changes, revamped our website with resources, and offered workshops on delivery system issues at our annual conferences in San Diego and Sacramento. While we increased the information available to the field through these efforts, we learned that getting the field to actively participate in innovation requires the kind of one-on-one, intensive engagement that we undertook to achieve target 3.2.
3.2. In at least three locations in the state, there will be robust pilot projects to implement or fund a school-based health model as a health care delivery or social impact innovation.	We ended our two-year strategic plan with five projects that, while not necessarily as robust as we might have hoped, represent clear progress toward the challenging goal we set to achieve. 1. Kern Family Health Systems (health plan) and Bakersfield and Delano Unified School Districts have jointly implemented an obesity prevention program. The school districts are sharing data on participants, BMI, and services with the health plan on a monthly basis. We are working with the health plan to develop an MOU that will outline reimbursement for services provided at two SBHCs that will be open this fall. 2. Alameda Alliance (health plan) is working with an SBHC in the Bay Area to obtain information on the number of members that receive health education on nutrition and physical activity. 3. Central California Alliance for Health (health plan) has agreed to meet with an SBHC in its area to review data on the number of plan members that the SBHC is reaching with obesity prevention services. We hope this conversation will reduce any duplication of services and identify options for reimbursement. 4. We are working with Fresno Unified School District, five hospitals, Fresno County Department of Mental Health and Department of Public Health to expand SBHCs. A subcommittee is preparing an Accountable Community for Health proposal with SBHCs as a key component. 5. Kaiser Permanente has opened a discussion with us on how SBHCs serve Kaiser members to explore opportunities for reimbursement of SBHCs (which is happening in Oregon).
3.3. Policymakers, health care payers, and advocates will work towards financing the elements of the school-based health model (expanded access, prevention, individualized support, and	We were successful in engaging health care payers in exploring financing options for school-based services through the work described under 3.2. We also obtained a significant level of support from state legislators and the Governor with the inclusion of $600,000 in the 2017 budget to fund two positions for two years in the Calfornia Department of Public Health. We plan to work closely with the Department to maximize the impact of these positions on financing for SBHCs. Finally, we catalyzed conversations among stakeholders about the way in which changes to the "free care rule" in Medicaid could be used to expand funding for school-based health care. These stakeholders included several school districts and county offices of

integration with the school) that go beyond a traditional health care visit.	education, the California School Nurses Organization, and the California Department of Health Care Services.
	Our advocacy day in Sacramento in May 2016 engaged 150 members of our field in reaching out to 75 legislative offices and 6 administrative departments to educate them about the need for school-based health. In June 2016, we continued this advocacy with 20 visits to legislative offices in Washington, D.C. as part of the national School-Based Health Alliance's advocacy day.

FINAL

Needs	Core Strategies	2016-2018 Priorities	Improvements in School-Based Health	Impact on Children/Youth

Needs

1. Many children and youth have **unmet health and mental health needs**, which directly affect learning and success in and out of school.

2. There are **insufficient health and mental health services offered in schools**—where kids are— to meet the level of need.

3. Decision makers have **limited understanding** of the need for and importance of school-based health services.

4. There is **lack of sustainable financing mechanisms** for the essential elements of school-based health and mental health services.

5. School-based health and mental health providers **need more capacity and proven care delivery models** to succeed in the reformed health care system.

6. Many school-based health providers **need stronger linkages to host schools** to maximize health and educational outcomes.

Core Strategies

Communications and Outreach
Goal: Raise awareness and build support for school-based health.
Activities: Electronic communications, presentations and exhibits, written materials, targeted outreach.

Programs and Training
Goal: Improve the quality of school-based health practice.
Activities: Conference, re-granting, learning collaboratives, trainings, webinars, toolkits.

Policy
Goal: Improve the funding and policy environment for school-based health.
Activities: Educating policymakers, advancing legislation and administrative policy, shaping the conversation about SBHCs in health and education reform.

2016-2018 Priorities

Strengthen grassroots advocacy for school-based health.

Integrate SBHCs into schools and strengthen impact on educational outcomes.

Improve financing of school-based health.

Improve school mental health services.

Improvements in School-Based Health

MORE school-based health
- # of SBHCs in California
- # SBHCs in high school, middle school, elementary school
- # emerging SBHCs
- # of school districts with SBHCs
- # of federally qualified health centers running SBHCs

GREAT school-based health
- # of SBHCs offering medical, mental health, health education, reproductive, preventive dental, dental treatment, youth engagement.
- % of SBHCs serving at least 75% of the school population.
- # of SBHCs working with school to impact academic outcomes.
- # of SBHCs implementing schoolwide prevention and public health approaches.
- Number of SBHCs and school mental health programs meeting national quality standards.

Impact on Children/Youth

Increased Access to Health Care and Healthy Environments

Reduced Disparities in Children's Health and Mental Health

Greater Educational Equity and Academic Success

Organizational Development
Goal: Ensure that CSHA has funding, staff, and organizational capacity to effectively pursue its mission.
Activities: Fundraising, information and communications technology, staff recruitment and leadership development, board recruitment and development, finance and operations.
2016-2018 Priorities
- Improve internal communication
- Improve effectiveness of Salesforce, including integrated mailer and conference registration
- Increase revenue for the core work of the organization, such as policy and start-up assistance
- Improve effectiveness of external communications in influencing intended audiences

12

Core Strategies

Programs and Training

Goal: Increase and improve the quality of school-based health practice.

Activities:

- Provide support to communities working to launch new SBHCs.
- Develop tools, resources, webinars, and trainings.
- Seek funding for programs to promote SBHC best practices.
- Host annual conference.
- Highlight best practices and growth in the field through CSHA communications and awards.

Core Metrics

A. # of schools/SBHCs that improve their programs or services by working with a CSHA learning collaborative or funded project.
B. # of students reached with improved programs or services.
C. # of school districts and # of SBHCs/community partners whose capacity has been built in school-based health by attending a CSHA conference, webinar, workgroup, or local coalition.

Policy

Goal: Create a more favorable environment for school-based health.

Activities:

- Educate policymakers and advance legislation and administrative policy.
- Shape the conversation about SBHCs in health and education reform through policy papers, coalitions, meetings, etc.
- Engage a broad range of stakeholders in advocacy for school-based health including school-based health providers, parents and youth, grassroots organizations, school personnel, and advocacy organizations in the fields of health care, education, and children's issues.
- Train youth to be effective spokespersons and advocates for school-based health.

Core Metrics

D. Favorable policy changes.
E. # of meetings with policymakers in targeted sectors.
F. # of policy communications from CSHA.

Communications and Outreach

Goal: Raise awareness and build support for school-based health.

Activities:

- Send electronic communications (listserv, website, social media).
- Conduct presentations and exhibits at venues with targeted audiences.
- Produce and disseminate written materials (factsheets, brochures, cards, etc.).
- Conduct media outreach.
- Collaborate with partners to reach new audiences.

Core Metrics

G. # of people receiving CSHA e-communications.
H. # of Twitter followers.
I. # of Facebook fans.
J. Average website visits per month.
K. Click through rates on e-blasts.

Strategic Priorities 2016-2018

Priority 1: Strengthen grassroots advocacy for school-based health.

Over the past six years, our outreach efforts have focused primarily on school districts and federally qualified health centers (the two building blocks of SBHC expansion). These efforts drew many more health and education professionals to our organization. These stakeholders are working to expand school-based health in their communities, and we continue to support them. At this juncture, we believe that expanding our outreach efforts to community members, grassroots organizations, and youth is essential to growing the movement. Community members have greater influence than at any time in recent history on how funding is allocated in their schools. They must know about SBHCs and school mental health programs as an option for their communities so that they can advocate for these services, if they feel that these would be beneficial for their children and youth.

Targets

1.1. Representatives from 20 grassroots or youth advocacy organizations will learn about SBHCs from CSHA's staff, youth board, board, or other ambassadors and 10 will join our listserv.
1.2. Twenty-five schools/SBHCs will more actively engage youth as grassroots advocates.
1.3. Four case studies of grassroots or youth advocates successfully advocating for school-based health will be disseminated by CSHA, and at least one will be picked up by a regional or statewide news outlet.

Projected Activities

- Develop a presentation and/or materials on SBHCs and school mental health for community members.
- Provide information about SBHCs and school mental health to grassroots and youth groups (e.g., present or exhibit at local events, increase social media contacts, increase the number of local policy organizations in our database.)
- Engage CSHA's youth board as ambassadors to grassroots and youth advocacy organizations.
- Use social media to raise awareness of SBHCs among grassroots or youth advocacy organizations.
- Support more SBHCs, schools, or community groups in engaging youth as advocates by providing trainings, tools, and grants.
- Amplify the voices of youth or grassroots advocates for school-based health through CSHA's communications channels and outreach to other news and media outlets.

Priority 2: Better integrate SBHCs into schools and strengthen their impact on educational outcomes.

A primary challenge noted by our local affiliates and many in our field is integrating SBHCs and other school health providers into the school setting. This integration is essential if SBHCs are to fulfill their potential as a unique model for delivering health and mental health services. We have chosen to make this issue a priority for the next two years because it remains the most difficult challenge in SBHC practice. Improvements in integration between the SBHC and school, and commensurate impact on academic outcomes, will be an important driver of future demand for SBHCs from districts that do not currently have them.

Targets

2.1. Each year 15 SBHC/school district partnerships will implement new practices to examine the impact of health services on academic outcomes (e.g., attendance, graduation, reading by third grade, school connectedness, disciplinary actions).

2.2. Each year 40 SBHCs/schools will build capacity to improve integration of SBHCs and schools and/or strengthen the impact of SBHCs on educational outcomes through CSHA's trainings, webinars, conferences, or resources.
2.3. Four stories of SBHCs' impact on academic outcomes will be shared by CSHA, at least one of which will be picked up by a regional or statewide news outlet.
2.4. The number of school districts receiving CSHA's communications will increase by 10% each year.

Projected Activities
- Seek funding for projects (e.g., early childhood development, chronic absence, high school graduation) to help SBHCs improve practices related to integration into the school setting and increasing impact on academic outcomes.
- Incorporate assessment of academic outcomes into CSHA projects with SBHCs.
- Identify effective practices for health services to improve academic outcomes from existing research, new research, ongoing projects, and dialogue with SBHC and school leaders.
- Work with local affiliates and the national School-Based Health Alliance to improve data collection that addresses educational outcomes.
- Promote effective practices using CSHA's principles, checklist and other tools, communications, and trainings.
- Document successes through the development of stories or case studies and disseminate them as broadly as possible.
- Identify venues or channels for outreach to school district personnel and use them to target communications about school-based health.
- Conduct research into school district health personnel to develop lists of contacts for targeted outreach.

Priority 3: Improve financing for school-based health services through health plans, hospitals, Medicaid, and public health.

Financing continues to be the primary impediment to growth in school-based health, and the health care sector has significant potential as a source of funding. As a result, we are continuing the work we started in our previous strategic plan to develop partnerships and models that will lead to increased funding of school-based health through the health care sector. The past two years have put us in a better position to approach health plans and hospitals because we have strengthened SBHC practices through our many funded programs. Lastly, we are including public health as a target in this strategic plan because the new state SBHC program staff provides us with a tremendous opportunity to make inroads into the Department of Public Health.

Targets
3.1. Three new pilot projects will be launched between SBHCs/schools and hospitals/health plans that involve data exchange, reimbursement, or coordination of services
3.2. Convenings of local health care payers and providers with SBHCs in six counties will be held to explore strategies for financing school-based health and mental health services.
3.3. CSHA will double the number of hospitals in its database.
3.4. Each year, 10 school districts will build capacity to expand health services using expanded LEA Medicaid billing as a result of CSHA tools and trainings.
3.5. CSHA will have strong collaboration with the new state SBHC program and the school Medi-Cal program through monthly meetings and joint fundraising, policy, training or data collection efforts.
3.6. California will continue to have a state SBHC program office after June 2018.

Projected Activities
- Continue outreach to health plans and hospitals to engage them in discussion with SBHCs in their regions.
- Continue to work with SBHCs to collect information needed to engage with health payers.
- Facilitate meetings between health care payers and SBHCs.
- Work with Department of Health Care Services, California Department of Education, and California Department of Public Health on improving the LEA Medicaid billing program and implementing changes to the free care rule.
- Educate school districts about Medicaid reimbursement options (e.g., hearings, webinars, factsheets).
- Work with CDPH to maximize the impact and sustainability of the two positions in the SBHC program.

Priority 4: Improve school mental health services.

In the 2014-2016 strategic plan, we made school mental health a priority. This was the first time that CSHA set specific goals for growth in an area of school health services that was not SBHCs. We are maintaining this focus in our current plan because we know that there is still a high level of unmet need and demand for services among both school personnel and students/families. Mental health proved to be an effective entry point for discussion of school-based health with new school districts, an interest that was likely reinforced by the inclusion of school climate and attendance in the new school accountability framework. This year, we plan to build on the work we launched under our previous strategic plan and take advantage of the forthcoming national standards for school mental health as a tool for driving high-quality practices.

Targets
4.1 Every year, 40 school districts/SBHCs will build capacity to implement high-quality school mental health services through CSHA's trainings, webinars, conferences, or resources.
4.2 Twenty school districts/SBHCs will make identifiable improvements in their mental health services.
4.3 Five schools will develop school mental health programs that meet national quality standards and be featured in CSHA's communications.

Projected Activities
- Conduct outreach to engage schools outside our existing network by attending regional convenings on school mental health and building relationships with county offices of education.
- Provide training, resources, and webinars to school administrators and mental health staff.
- Offer individualized technical assistance to schools or school districts seeking to improve their mental health services.
- Develop materials highlighting best practices and data from exemplary sites that meet national standards and seek opportunities to share these practices with more school districts through conferences or publications.

Organizational Development

Core Strategy

Goal: Ensure that CSHA has funding, staff, and organizational capacity to effectively pursue its mission.

Activities
- Implement aggressive development program including grants, membership, sponsorship, conference, individual donors, and cause marketing.
- Maintain strong information technology and communication infrastructure (web hosting, webinar services, telephones, SalesForce, server, etc.).

- Ensure that facilities and office equipment support productivity.
- Recruit qualified staff and invest in staff leadership development.
- Recruit and nurture high-performing board.
- Implement accurate and timely systems for accounting, contracting, accounts payable/receivable, financial monitoring and controls.
- Ensure all human resource policies and functions are compliant with labor laws and support staff productivity.

Core Metrics
L. Total annual revenue.
M. Unrestricted net assets.
N. Amount of reserve.
O. % board giving.

Organizational Development Priorities 2016-2018

1. Improve internal communication

As in most organizations, communication and coordination among staff at CSHA can be challenging. Although there have been no catastrophes, confusion over how certain procedures are handled and who has what responsibilities contribute to increased stress and lower job satisfaction among staff. Two factors have exacerbated this problem in recent years: the growth in the number of contracts that CSHA processes to distribute resources to other organizations and turnover in several key staff positions. As a result, we have decided that internal communication should be a priority for the next strategic plan cycle.

Targets
- Staff report feeling confident about individual roles and responsibilities.
- Staff report improvement in internal communications and clarification of roles and procedures (such as contracts and budget monitoring).

Projected Activities
- Update all staff job descriptions annually when performance reviews are conducted.
- Finalize, test, and refine improved process for contract/grant kick-off and budget monitoring.
- Maintain agenda for weekly all-staff calls to provide a prompt for staff to identify communications or process challenges.
- Continue regular project team meetings.
- Refine and document internal communications procedures.
- Continue regular staff meetings with formal agendas for all-staff updates.

2. Improve effectiveness of Salesforce including integrated mailer and conference registration

Salesforce has been a powerful tool for CSHA, despite the fact that we do not have in-house IT support. However, with the departure of our lead staff person for Salesforce, new staff coming onboard, and changes in Salesforce technology, we are at a point where we need to dedicate some attention to improving both our database, related technologies, and our use of these tools.

Targets
- All staff will regularly and accurately enter data into Salesforce.
- Salesforce reports will help monitor progress on strategic priorities and complete reports to funders.
- MailChimp will be used for CSHA e-communications and will be integrated with Salesforce.
- In 2018, conference registration will be integrated with Salesforce.

Projected Activities
- Complete Salesforce upgrade and integeration with MailChimp through Exponent Partners.
- Build new enews/eblast templates in MailChimp.
- Configure reports for new strategic plan priorities.
- Produce a step-by-step user manual for all functions currently used in Salesforce. Field-test and revise that written manual so that it can be understood by people who do not have expertise in Salesforce.
- Train staff on the current platform/functions. Document this training so that it forms the boilerplate for ongoing new staff training.
- Assign 1-3 staff members as a committee to identify needs that are being under-met by Salesforce. These staff should take advantage of Salesforce training and listen in on the dialogue happening with the online non-profit user community.
- Review and debounce email addresses and note unsubscribed contacts in Salesforce after eblasts are sent.
- Build on system used by School-Based Health Alliance for 2017 convention to identify options for 2018 conference registration.
- Create timeline and test new systems for conference registration so that it can be implemented by December 2017.

3. *Increase revenue for the core work of the organization, such as policy and start-up assistance*

These functions are essential to the work of CSHA, but we have been losing funding in these areas. If we want to maintain the effectiveness of the organization, we need to ensure that fundraising supports this work.

Targets
- Budget will support 1.5 staff FTEs dedicated to policy without drawing from annual reserve.
- Budget will fund one staff person dedicated exclusively to supporting emerging sites start SBHCs.

Projected Activities
- Identify policy projects that are not direct advocacy (i.e., LCFF toolkit, school mental health funding toolkit) that could be supported by grants.
- Add a small policy component to more program grants and develop a clear role for policy staff. This could range from sharing program lessons with policymakers or cultivating local advocacy to sustain programs.
- Partner with other organizations for policy work.
- Focus non-grant fundraising on policy work.
- Increase membership dues to support additional start-up or policy work.

4. *Improve effectiveness of external communications in influencing intended audience*

We must continue to fine tune our messages about our organization's value and the benefits of school-based health to school districts, policymakers, health care thought leaders, and our core field of school-based health care practitioners. The education and health care fields are crowded, and our audiences require nuanced messages to be persuaded that our solutions are the right ones for their needs. Staff require training to become effective messengers so they can better speak to the value of our work and bring these new audiences into our network.

Targets
- Our stories and activites will be shared in at least one education and/or health sector trade publication per year.

- E-communications will be sent to segmented lists by audience type to allow for better message targeting.
- Staff will have talking points to clearly state the benefits of school-based health for the following: a) academics, b) health plans, and c) community safety and well-being.
- Staff will be confident in speaking about our work and school-based health care with educators and health care finance leaders.

Projected Activities
- Attend training on messaging for specific audiences (i.e., educators, health care reform leaders, grassroots activists).
- Survey audiences to determine usefulness of messages, how well we are addressing needs, and to inform future engagement strategies.
- Identify and follow best practices for segmenting lists.
- Better utilize analytics to gauge and reach audiences.
- Implement A-B message testing to identify more successful messages.
- Identify writers to edit our communications for specific audiences.

Improvements and Impact

CSHA's core strategies, organizational infrastructure, and strategic plan priorities are designed to work together to expand and improve school-based health in California and, ultimately, to support the health and academic success of children and youth.

Improvements in School-Based Health

Improvements in school-based health fall into two categories, in line with our national organization's priorities: "more" and "great" school-based health.

Indicators of More School-Based Health
- # of SBHCs in California.
- # of SBHCs in high school, middle school, elementary, other (linked, mobile, mixed grade).
- # of emerging SBHCs known to CSHA.
- # of school districts with SBHCs.
- # of federally qualified health centers running SBHCs.

Indicators of Great School-Based Health
- # of SBHCs offering the following types of care: medical, mental health, health education, reproductive, preventive dental, dental treatment, youth engagement.
- % of SBHCs engaging at least 50% of the school population.
- # of SBHCs working with school to impact academic outcomes.
- # of SBHCs implementing schoolwide prevention and public health approaches.
- # of SBHCs and school mental health programs meeting national quality standards.

Impact on children and youth

If CSHA's work to create more and great school-based health is successful, the impact should be felt in terms of children's access to both care and healthy environments, their health, and their academic outcomes. Although we do not have a way to directly measure the impact of school-based health across the entire state, we have identified the outcomes in each domain that we believe are most relevant to school-based health.

Access: CSHA seeks to advance health equity by enabling all children to live in healthy environments and have access to health, mental health, and oral health services.

Health: CSHA is working to reduce health disparities with a focus on health conditions that are most common among children/youth and most likely to impact educational success.

Education: CSHA's work will improve attendance, reduce suspensions, and improve school climate and ensure that no child's academic success is limited because they did not receive health, mental health, or oral health services.