CALIFORNIA
SCHOOL-BASED
HEALTH ALLIANCE

Putting Health Care Where Kids Are

FROM VISION TO REALITY:

How to Build a School Health Center from the Ground Up

by the California School-Based Health Alliance

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Preface

The California School-Based Health Alliance (formerly CSHC) is pleased to share this manual with California communities interested in starting school health centers. We hope that this manual will grow initial sparks of interest into full-fledged school health centers, regardless of whether it's a school nurse, community clinic, school administrator, or mental health provider who spearheads the process. Since there are other comprehensive resources related to school health center start-up, such as the national School-Based Health Alliance's web-based *Blueprint*, we have focused on guidance specifically related to California. We have also highlighted issues or steps that have challenged some local communities, such as licensing a health center, developing an appropriate evaluation plan, and fostering cross-agency collaboration.

We consider this manual a "living document" and look forward to sharing updates with you, as well as new tools to support your school health center development and operations. Please note that the California School-Based Health Alliance staff is also available to answer questions, provide guidance, and in some cases, directly support your local start-up efforts. Please contact our offices or visit our website for more information on our technical assistance resources and services.

We would like to acknowledge the contribution of a number of individuals and institutions. The New Mexico Alliance for School-Based Health Care and the New Mexico Office of School Health generously offered their resource, *Opening a School-Based Health Center: A How-To Guide for New Mexico SBHC Coordinators*, as the foundation for this manual. Several state and local experts, staff, and consultants contributed greatly to this manual over the past couple of years:

- California School-Based Health Alliance Staff
- Heather Balas, Consultant to New Mexico Assembly
- Tamar Kurlaender, Consultant
- Sharon Kosch, Consultant
- Tracy Macdonald Mendez, Consultant
- Leyla Avila, Clinical Operations Analyst, California Primary Care Association
- The California Department of Health Care Services
- The California Department of Public Health

Thank you to the following funders for their generous support of this project: The McKesson Foundation, The San Francisco Foundation, and The California Endowment.

We look forward to working with you as school health centers continue to grow and thrive to serve children, youth and families in California!

Thank you,

Samantha Blackburn
Project Director
California School-Based Health Alliance


HEALTHY
Oranges

CHAPTER 01 Overview

FACTS ABOUT SCHOOL HEALTH CENTERS IN CALIFORNIA

There are currently about 1,700 school health centers in 45 states and the District of Columbia. The term school health center includes both school-based health centers (SBHCs), which are located directly on school campuses, and school-linked health centers, which are located off campus but closely linked to one or more schools. Mobile vans that serve one or more schools can also be considered school health centers.

School health centers emerged in the U.S. during the late 1960s and have since experienced a rapid and significant rise. They originated in connection with the advent of Medicaid in 1965, which among other things highlighted the need for better health care for low-income children. The year 2006 marked the 20th anniversary of California's first school health center in San Francisco; 2007 was the 20th anniversary of centers in Los Angeles and San Jose.

Today, California has over 226 school-based health centers and is poised to add many more. School-based health centers can be found throughout the state from Del Norte to San Diego Counties in urban, suburban, and rural settings, with the largest concentrations in Los Angeles and the San Francisco Bay Area.

The majority of communities served by California's school health centers are low-income areas where a large proportion of children do not have comprehensive health insurance coverage. School health centers serve many low-income and immigrant students – those that are least likely to have access to adequate health care and also more likely to experience difficulty in school.

BENEFITS OF SCHOOL HEALTH CENTERS

There is nothing more basic to a child's ability to succeed in school and in life than good health. Yet many children and youth in California do not get the health care they need, even when they do have health insurance. This inability to access care results in many children and youth coming to school every day suffering from conditions that seriously impact their ability to learn and succeed. School health centers help improve the lives of California's children because they place a breadth of essential services in exactly the right environment – our schools. School health centers benefit children, youth and families because they:

> Many of the benefits of school health centers have been documented through research. Please see fact sheets on www.schoolhealthcenters.org or www.sbh4all.org for more detail, and citations.

- **Create access.** School health centers offer services in a safe, familiar location and charge little or nothing for their services. They put health care where young people are for the majority of their days. Students who have access to school health centers are often less intimidated about seeking services.
- **Are cost-effective.** School health centers provide preventive and primary care services that can help reduce the need for more costly interventions down the line. Students who use SBHCs decrease their use of emergency rooms and hospitals while increasing their use of primary care, reproductive health, mental health counseling and substance use services.
- **Provide high quality care.** At school health centers, services are delivered by providers who can follow up effectively and who tend to have a broad understanding of the environment in which students are living. Primary care can be integrated with behavioral health, education, and prevention programs to a greater extent than it can be in medical office settings.

- **Reach the state's most vulnerable children.** School health centers tend to be located in schools with greater proportions of low-income students, English Language Learners, and students of color. Youth in these groups are less likely to have access to health and mental health services, and exhibit higher rates of violent injury, obesity, diabetes, asthma, teen pregnancy and sexually-transmitted infections. Without such services, these childhood risk factors are more likely to be translated into higher rates of heart disease, cancer and other chronic illnesses in adulthood. School health centers contribute to the reduction of the state's most persistent health disparities.
- **Support student learning.** School health centers support schools struggling to meet academic performance goals. The vast majority of centers in California are located in schools with Academic Performance Index rankings of 5 or less; over one third are in schools with an API ranking of 1. School health centers can influence academic achievement by improving mental health, diet, injuries, physical illness, self-esteem/resiliency, risky sexual behavior and health care utilization. Research also shows a positive impact of school health centers on graduation rates, absences, grade promotion, withdrawal/dropout rates, disciplinary problems, failing grades and tardiness.
- **Support families.** School health centers play an important role in helping families manage the physical and mental health care needs of their children. In addition to keeping parents in the workplace, school health centers strengthen the connection between school and the family so that they can work together more effectively to meet a child's educational needs. Parental consent is required for students to enroll for center services, with growing numbers of parents taking advantage of the opportunity to easily access health services for their children. Some school health centers, particularly those located in elementary schools, offer services to the entire family. Others offer parent support, resources, and/or education programs.

MODELS OF SCHOOL HEALTH CENTERS

School health centers encompass a variety of models – from large secondary school clinics that house full-time medical staff to smaller part-time clinics (often based in elementary schools) that may have a single staff person and rely heavily on referrals to linked providers.

School health centers may be **school-based** (housed on-site) or **school-linked** (housed off-site and linked to other providers). School-based health centers may be located within the main school building, often within one or more renovated classrooms, or in its own building on school grounds. To be considered a school-linked health center, a site must have a formal relationship with one or more schools (see Appendix A for an example of such a relationship). Some school-linked health centers are located within walking distance of the school; in other cases, transportation between the school and the health center is arranged. In some cases school health centers are housed in **mobile vans** that serve multiple school sites. Finally, a new and evolving model involves the provision of services at a school site through **telehealth** where the providers are actually off site but "see" the student through video-conferencing technology.

Although many variations exist, a school health center will typically include nurse practitioners, nurses and mental health care providers as well as part-time physicians and medical students in training. Lab facilities for routine tests are often on site and some centers also offer dental care.

Many different types of organizations run school health centers in California. The most common are:

- School districts
- Community Health Centers, including Federally Qualified Health Centers (FQHCs)
- Hospitals
- City or County public health departments
- Other community-based organizations
- Private physician groups
- Collaborations that include the above organizations

HOW SCHOOL HEALTH CENTERS ARE FINANCED

School health centers are typically funded using a combination of third-party billing revenues, public and/or private grants, and in-kind support from local organizations. In general:

- Important sources of third-party reimbursement are the Child Health and Disability Program (CHDP), Medi-Cal, Family PACT and Healthy Families (the State Children's Health Insurance Program).
- Schools contribute financially or through in-kind support of space, utilities, and custodial services.
- Community agencies contribute some of the services provided in a school health center.
- School health centers obtain grant funding from state, local and private sources. The type of comprehensive care available at many school health centers would not be possible without enhanced funding from these sources.

Much more information about funding for school health centers can be found in Chapter 6.

TYPES OF SERVICES

California's school health centers offer a wide range of services. The vast majority (86%) of clinics provide primary medical care, 47% provide mental health services, 40% provide reproductive health services and 18% provide dental care. Below are some common services within each category.

MEDICAL

- Primary care for injuries and illness
- Annual comprehensive physicals
- Sports physicals
- Reproductive health services such as family planning, contraception, gynecological exams, Pap testing, testing and treatment for sexually-transmitted infections, pregnancy testing and counseling[1]
- TB testing
- Hearing and vision screening
- Management of diabetes, asthma and other chronic conditions
- Immunizations and laboratory tests
- Over-the-counter medications and prescriptions
- Referrals and coordination of outside services such as x-rays, dental work, and other services not available at the school health centers

MENTAL HEALTH

- Alcohol and substance abuse counseling
- Mental health awareness and outreach, including suicide prevention
- Screening for depression
- Individual, group, and family therapy
- Crisis intervention
- Consultation with students, family members and teachers regarding student difficulties
- Clinical and behavioral case management

[1] This service varies by community, with some health centers offering these services on-site, others referring students to outside providers, and some and some not offering any type of reproductive care.

ORAL HEALTH

- Oral health screenings
- Fluoride varnish
- Sealants
- Dental cleanings
- Oral health education
- Referrals to local dental treatment and specialty services off-site
- Basic restorative services

HEALTH EDUCATION

- Health promotion and risk reduction programs, including educational efforts that encourage healthy lifestyles
- Nutrition education and physical activity promotion
- HIV/AIDS and sexually transmitted infection prevention education
- Pregnancy prevention
- Youth development activities such as peer health education and youth advisory boards
- Parent education programs

COORDINATED SCHOOL HEALTH

The Centers for Disease Control and Prevention has defined what it calls a "Coordinated School Health Program" consisting of eight interactive components:

Health Education – a curriculum designed to motivate and assist students to maintain and improve their health, prevent disease and reduce health-related risk behaviors

Physical Education – a curriculum that promotes optimum physical, mental, emotional and social development through activities that can be pursued lifelong

Health Services – services provided for students to appraise, protect and promote health

Nutrition Services – access to a variety of nutritious and appealing meals that accommodate the health and nutrition needs of all students and serve as a living laboratory for nutrition and health education

Counseling and Psychological Services – services provided to improve students' mental, emotional and social health

Healthy School Environment – access to healthy physical and aesthetic surroundings and a psychosocial climate and culture that are positive and promote well-being

Health Promotion for Staff – opportunities for school staff to improve their health status and encouragement to pursue a healthy lifestyle

Family/Community Involvement – active solicitation of parents and community resources and services to provide an integrated school, parent and community approach for enhancing the health and well-being of students

School health centers are uniquely positioned to play an important role in all eight coordinated school health components. These components should be taken into consideration when planning, assessing or evaluating potential services and their impact on a school community.

CHAPTER 02

Community Planning

PLANNING AND RELATIONSHIP BUILDING

All school health centers should provide services that respond to the needs of students, families and the community. The first step in starting a school health center is to bring together interested parties in your community. This action is essential for planning and assessing community interest and resources. The planning stage helps you identify community concerns about the health center before they become a crisis. It allows you to draw on expertise from other individuals and groups so you do not have to re-evaluate key components (such as floor plans or health center services) after they are established. It will also allow you to involve important community decision makers who can help tell your story and become your "champions."

A well thought-out and effective community planning process can make the difference between a successful school health center and one that closes its doors due to lack of community support or funding. This process should reflect the diverse racial, ethnic, religious, class and cultural composition of the community and acknowledge community priorities. Community planning activities include:

- Involving a wide range of school and community members;
- Conducting a needs assessment;
- Selecting your sponsoring agency and other participating providers (see Chapter 5 for more information on sponsoring agencies); and
- Identifying and recruiting community champions.

WHO SHOULD BE INVOLVED

SCHOOL ADMINISTRATORS - If the health center will be located on school property, school administrators will be important decision-makers. In this case, the health center will effectively be a guest in the school, and its coordinator should communicate on a regular basis with the school administration, especially the principal. School administrators can also be instrumental in helping identify funding for the health center and will need to support and promote the center to students, families and staff. They also tend to provide a great deal of in-kind support for items such as physical plant, phone and fax, utilities, and custodial services.

SCHOOL BOARD - If the school health center will be based on school property, you will need the approval of the school board. School boards typically pass a resolution in support of a school health center in order for the health center to open, and they may need to approve any changes to health center services. The school board will also need to approve any financial support from the school district and any major policies that impact the center (e.g., distribution of contraception, whether students from other schools can enter the campus).

SCHOOL STAFF - Many school staff – including teachers, school counselors and coaches – can benefit a great deal from school health services, and will be critical to the success of your site. Involve school staff during the planning process – everyone from secretaries to librarians to school psychologists – as they can be a great resource for determining what types of services students need most. They will also be influential in encouraging students to use the health center. Collaborate with school nurses, teachers, counselors and administrators to identify ways the health center can support them in their work. They should also understand early on the role of the health center and its limitations. Explaining policies, such as confidentiality and the limits to information-sharing, can prevent future frustration and misunderstandings (see Chapter 7, Operations).

COMMUNITY LEADERS - Community leaders are an important group that should also be considered during your planning phase. They can assist you with fundraising efforts, building community support, telling your story, and serve as an introduction to other key decision makers. These leaders should include business owners, civic clubs, local elected and appointed officials as well as state and federal legislators, media, religious leaders, or other influential people in your community. Look for leaders of community organizations whose missions are compatible with yours and who represent the diversity within your community. Also, look for leaders, both staff and volunteer, of other youth serving organizations.

PARENTS/CAREGIVERS AND FAMILIES[2] - By engaging parents in the earliest planning efforts, the center can design services that work for families, ensure that parents will bring their children (or encourage their teens) to use the center, and develop strong advocates. Any objections or concerns parents may have about the health center are best addressed during the planning stage, and any problems or potential conflicts can be resolved together before impacting the future operation of the center. Finally, it is important to remember that many of the health decisions affecting youth occur within families. By involving parents, your health center may be able to have an important impact on healthy choices that are made at home.

HEALTH CARE PROFESSIONALS - It is important to communicate to health care professionals that it is not the intent of the school health center to take business away from local providers; in fact, referrals from the center can help increase their patient base. Involving health care professionals at the start of your planning efforts will help to build a good foundation for future communication and coordination with primary care and specialty providers.

RIVERBANK HIGH SCHOOL

Riverbank High School Health Center began its parent engagement from its earliest days as a school health center start up. Parents were heavily included in the planning process through methods such as focus groups, providing input on health issues as well as center logistics such as hours and services. From early interactions and beyond, parents were recognized as experts in the health of their children. As a result, parents acted as vocal advocates for the presence of a health center when it came to soliciting support from other key stakeholders in education and politics.

YOUTH - For middle and high school sites, youth are critical to the planning process because they will be the primary stakeholders! Involving youth in the planning process is essential to understanding the services they value, their priorities, concerns, etc. Youth who are involved in the planning process will also help generate a "buzz" regarding the health center so that there is interest from their peers once the center is established. Look for youth who volunteer at other wellness organizations, are members of youth groups actively engaged in wellness work, and/or belong to youth commissions within your community. Identify youth who represent the population you will be serving (some of these youth may not be involved in other groups). See Chapter 3: Youth Engagement, for effective strategies to involve youth in needs assessment and planning efforts.

PUBLIC HEALTH OFFICIALS - Public health departments can be great partners in helping you determine the types of services your health center should provide and potential partners in providing this care. In some cases, public health departments are willing to provide health care practitioners to work at the health center, thus offsetting the costs of providing the services. The school health center can work with the local health department on public health measures such as immunizations, STD testing, enrollment in health insurance, or influenza surveillance.

COMMUNITY-BASED SERVICE PROVIDERS - In most communities there is a range of non-profit organizations that provide accessible, affordable health, mental health and social services to low-income families. They are described in more detail in Chapter 3: Health Center Structure. Of particular interest will be those that provide medical and behavioral health services to the population in question.

OTHER COMMUNITY GROUPS - Groups such as the American Lung Association, Boys and Girls Clubs and others may be involved in health education, promotion, prevention or treatment within your community. They know the community and can help advocate and refer to your services. They can also help identify youth and other community leaders who are supportive of a school health center. There are also community groups that work on social or environmental issues,

[2] In general, the term parent in this manual is used to include parents, guardians, custodial grandparents, and other adult family members.

or that are organized around the issues of specific populations (e.g., Latino families, disability groups) that may have an interest in the school health center. These groups can offer valuable perspectives for the community planning process.

CONDUCTING A NEEDS ASSESSMENT

A "needs assessment" is a process for gathering information to determine: 1) existing services and resources in the community, 2) gaps in services, needs and priorities of the community, and 3) best methods for addressing those needs. Needs assessments can include a number of tools, including surveys, focus groups, interviews with community leaders, community meetings or other strategies you develop to gather relevant information. It is also important that your needs assessment gather information about the ways culture and history in your community influence views about health care and education. Common questions that needs assessments help answer are listed below.

WHAT YOU CAN LEARN FROM A NEEDS ASSESSMENT[3]

- What are the biggest health problems and/or concerns for students and the community?
- How are these concerns different for different segments of students or community members, for example, based on gender, race, class, and ethnicity?
- In what ways do race and culture influence views about health and education in the community?
- What community and school health resources already exist?
- Which health facilities, programs and services are used most, by whom, and why?
- What are the barriers to care for students and families?
- How are services coordinated?
- Are different segments of the community satisfied with the current set of services?
- Given the needs and existing services, what are the gaps?
- How have previously implemented programs worked? For which segments of the community did they work well or not work well and why?
- Would the school health center model be best suited to meet student and community needs? Should other models be considered?
- What will it take to make the school health center effective in serving all of the different segments of the student body and community you hope to reach?
- What resources are available for a school health center and what additional resources do you need?
- Who are the key persons and agencies that need to be involved in program planning and implementation?

STRATEGIES FOR ANSWERING NEEDS ASSESSMENT QUESTIONS

There are many ways to answer the questions listed above. You will most likely need to use a few different strategies in order to answer all your questions. The strategies for collecting data for a needs assessment are the same as those you use for evaluation but with a different focus. These include collecting your own data through surveys, focus groups, public forums, or key informant interviews, as well as compiling data from existing sources such as statewide surveys, public health records, or school data. Chapter 9 provides a description of each of these different types of data.

While a simple needs assessment can be conducted by anyone, we recommend seeking professional advice and assistance if your budget permits. We can help you plan your needs assessment and find consultants to assist you.

[3] Adapted from Claire D. Brindis, D. W. *A Guidebook for Evaluating School-Based Health Centers*.

ESTABLISHING AN ADVISORY COUNCIL

Some school health centers are required by their funding sources to establish an advisory council. In fact, an advisory council is a recommended practice for all school health centers.

Advisory councils are generally comprised of 10-15 members representing various fields including, for example:

- Students/youth
- School district officials and/or school board members
- Medical providers, school nurses, mental health providers and/or dentists
- School administrators and teachers
- Local health department officials
- Community leaders
- Parents/family members
- Media
- Business leaders
- Religious leaders
- Local judicial officials such as parole officers or judges

The membership of your advisory council should relate to your health center's services; for example, if dental services are offered, it would be wise to include a dentist on the advisory council. Advisory councils should also reflect the gender, ethnic, class and other types of diversity present in your community.

Advisory councils can play different roles; some are actively involved in advising health center staff on programs, policies and procedures, while others play a strictly advocacy role and have no say in operations. In either case, these bodies rarely have true authority, since most school health centers are run by agencies with their own governing boards, and advisory councils do not displace these boards (although it might be advisable to have at least one member of the advisory council join the larger Board in order to ensure representation in the agency's decision-making).

Nonetheless, all advisory councils can play a major role in helping school districts develop effective school health programs and in advocating for their development, continuation and funding. Depending on their roles, advisory councils may be asked to review and endorse budgets, scope of services, hours of operation, health center policies, client satisfaction surveys, pay scales, staffing plans, community partnerships and advocacy efforts.

An advisory council will be most successful if desired competencies and expectations for participation are established early in the recruitment process. These should be based on the skills you need to support your center and the relationship you anticipate between your staff and the advisory council. It is suggested that each person serve a minimum two-year commitment with renewable option to encourage continuity and enhance committee functions. Terms might be staggered so that rotation occurs for only half the committee each year.

DIVERSITY ON THE ADVISORY COUNCIL

Most people will agree that diversity is important on an advisory council and that it is often difficult to accomplish. Some members will be professionals who are attending as part of their job (e.g., staff from community organizations or the public health department). These professionals are likely to be familiar with health and education issues and may lapse into jargon and acronyms. Generally they will want to meet during the day, although some professionals, such as physicians and teachers, do not have a lot of flexibility in their schedules. On the other hand, parents and community members who are participating as volunteers may work during the day and only be available evenings and weekends. Youth involvement in the planning process is also essential, especially for health centers serving students in middle and high schools. (Much more information on youth engagement strategies can be found in Chapter 3.) Having a truly diverse council that

represents the community may also mean including people who do not speak English, have little background in health issues, or are not comfortable in the school environment.

A diverse council means it is more challenging to establish shared understandings, find a schedule that works for everyone, ensure that everyone has background information, and make people comfortable. Addressing these challenges requires additional time, commitment, flexibility and "cultural humility" to be truly inclusive of multiple stakeholders and viewpoints. If you are committed to diversity on your advisory council, consider groups that might not readily volunteer for such a council (including one or two people who might be assumed to be less than fully supportive). For those from groups that have historically been underrepresented, it can be helpful to have two members from a given group. Talk to people from these groups and see if scheduling, child care, transportation, translation or something else altogether might make it easier and more satisfying for them to participate. There is no single right or wrong way to approach these challenges, but a commitment to a diverse advisory council is likely to pay off in the long-term success of the health center.

LONG-TERM COMMUNITY INVOLVEMENT

Conducting your needs assessment, establishing your advisory council, and perhaps starting a youth advisory committee are all ways to get the community involved in your school health center. As mentioned previously, these activities are important to ensuring adequate support for a new health center. However, *maintaining* that community involvement long-term is essential to your school health center's ongoing success. Ideas for maintaining community involvement follow:

- Host an open house at the beginning of each school year so that students, parents, and community leaders are familiar with the school health center.
- Make sure your advisory council continues to meet regularly and represents different viewpoints and backgrounds.
- Create a health newsletter that lets students and parents know what is happening in the school health center. (Consider collaborating with the journalism class to produce the publication once a quarter; the class then becomes another recruitment source for your advisory council.)
- Plan a luncheon twice a year with members of the health community.
- Train a cadre of youth to conduct outreach to youth-serving organizations in the community.
- Ask adult and youth advisory council members to help you organize booths or information tables at local community festivals, cultural holidays, or other events parents, students, and potential supporters are likely to attend.
- Partner with community leaders and other organizations on community activities and events to maintain visibility and position the school health center as a recognized resource for meeting the needs of young people in your community.

WORKSHEET: YOUR COMMUNITY PLANNING PROCESS

1. What are the major things you want to accomplish with your community planning process? (i.e., widespread support from local non-profits, endorsement by respected medical leaders in your area, support from the PTA or other parent groups)

2. Who are the key types of people who should be involved in your community planning process? What does each one bring to the effort? How will you ensure a diversity of perspectives?

3. What types of needs assessment tools (i.e., surveys, data collection, focus groups) will you use to gather initial information about your community? Which might you conduct later? Set timelines.

   What to do now:

   By when:

   What to do later:

   By when:

4. What types of people do you need to recruit for your advisory council? Is this list different than the list in Question 2? (You want a wide range of people reflecting diversity in gender, race, class, and professional expertise.)

5. How will you go about recruiting adults? How will your strategies differ for adults participating in professional roles (e.g., teachers, community agency staff) and adults participating as parents, family or community members? How will your strategies differ for people from different cultural backgrounds?

Recruitment strategies:

6. How will you recruit youth for your advisory council? What organizations exist in your community that could help you support your youth members? How will you bridge cultural differences between the youth and adults?

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7. Once you have achieved good community participation in your school health center – through your advisory council and other ways – how will you maintain that enthusiasm and interest? How will your strategies differ for different groups of community members? How will you solicit input from participants as to their perspectives on the work and their participation?

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CHAPTER 03

Youth Engagement

This chapter primarily applies to secondary (middle and high) school programs. Although children can be an important voice in elementary school health center planning, the tactics would be significantly different than those suggested here.

WHY YOUTH ENGAGEMENT IS IMPORTANT

As the primary clients of school health centers, youth should be engaged in the needs assessment, planning and implementation of school health services. Youth engagement can help ensure that the services provided are those of greatest need to youth, are developmentally and culturally appropriate, and are accessible to youth. Other advantages of youth engagement and positive youth development are described in more detail below.

The Search Institute has created a list of 40 developmental assets that help prevent young people from engaging in high-risk activities and help them become caring, responsible adults (see www.search-institute.org/system/files/40AssetsList.pdf).

According to the Search Institute[4] :

- Youth involvement is expanding beyond community service to emphasize democratic citizenship that embraces both individual rights and responsibilities and group work for the common good.
- Adults in multiple settings and at varying levels have a primary role in creating opportunities for youth and supporting them in building their competencies as they simultaneously work for change.
- Youth participation in partnerships with adults can take varying forms and is shaped by the mission of the organization or initiative. Youth and adults can work collaboratively in a true partnership, or the initiative can be driven by one party or with support and input from the other.

HOW YOUTH BENEFIT FROM BEING ENGAGED

In order for youth involvement to be successful for both the center and the youth, it should engage them in meaningful decision-making. This type of involvement is called youth engagement and can occur at the clinic level, at state or local government levels, or even nationally.

In addition to youth engagement being valuable to the school health center, it can be powerful for the youth involved. Young people involved in decision-making grow developmentally and academically. Research shows that youth engagement builds skills such as leadership and public speaking; increases self-esteem; enhances identity development; and improves academic achievement. Youth develop skills that help them become healthy, confident, well-rounded community leaders. They become "experts," able to influence both their peers and adults and influence positive change. Finally, youth who are involved in their school health center often develop positive, nurturing connections with caring adults – relationships that are invaluable to their development and help deepen their connection to school and work.

YOUTH STRENGTHEN SCHOOL HEALTH CENTERS BY:

- Advising on clinic policies, such as when the center is open, what types of services to offer, and whether those services are offered in culturally appropriate ways
- Developing or assisting with marketing efforts that reach youth
- Helping design health education programs on nutrition, active lifestyles, substance abuse, etc.
- Evaluating services and practices
- Advocating for the health center with policymakers and administrators

[4] Search Institute. (2005). *The Power of Youth and Adult Partnerships and Change Pathways for Youth Work.* W.K. Kellogg Foundation.

STRATEGIES FOR YOUTH ENGAGEMENT

There are generally three mechanisms for youth to become engaged with school health center development: youth-led research, youth involvement in service delivery, and youth advocacy. First, youth-led research may drive components of the initial needs assessment and/or ongoing evaluation efforts. Youth researchers may analyze findings and help determine what and how services should be provided by the school health center. Second, youth may develop and/or deliver services such as peer health education or mentoring. Third, youth may act as policy advocates for school health services locally or statewide. Youth advisory committees may engage in any or all of these three activities, in addition to their general advisory role. More details on each strategy, and California-based examples of each, are detailed below.

WHICH YOUTH TO ENGAGE?

Before launching youth engagement efforts, consider how you will recruit youth to participate. Often, adults will select youth who are already involved in school leadership activities. While these youth may have helpful experiences to contribute, they may not reflect the diversity of the student body.

In fact, **all** youth have strengths and the capacity to engage in school health center efforts, assuming appropriate support from adults. Prior to launching youth engagement activities, adults working on the school health center planning process should assess their own readiness to facilitate youth engagement. See www.nc4h.org/professionals/cpe/prkc.html for a comprehensive self-assessment tool to identify adults' areas of strength and need for professional development to support youth engagement. Issues to consider include what kinds of youth engagement activities are most appropriate for the school community, whether the adults involved have experience facilitating youth-led activities, and what kinds of training, support and resources adults and youth will need to ensure their success. Because well-meaning adults may unconsciously engage in behaviors that unwittingly disempower youth, they may need education and support to help them be effective in working with youth.

It is also important to define how youth will be engaged, and for how long. Many youth will be more likely to complete activities or projects that are short-term rather than year-long. Clearly outline the expectations and agreements for both youth and adults involved in your effort. In order to sustain youth interest, build into the project both intrinsic and extrinsic rewards (e.g., incentives). While financial incentives may be appreciated by youth, many will become involved for other reasons, such as completing community service requirements, forming new relationships, learning new skills, contributing to the school community, or garnering social recognition for leadership or peer mentoring. See Appendix B for a youth development flowchart to better understand the process for engaging youth in your school health center and for some ideas on the skills that adults and youth need to effectively lead these activities.

Be sure to secure parent/guardian consent for school-based youth engagement activities or clubs. Consider including in the consent form a release to use photos of youth leaders for promotional or reporting materials. If youth activities involve trips off-site, you will also need to have students secure written parent/guardian permission using your local school district "field trip" forms.

YOUTH-LED RESEARCH[5]

Before youth representatives (or any advocates) can be real participants in decision-making, they must do some research. For example, before suggesting that the school health center promote certain services, youth should canvass other students to see what they think are the most urgent health care needs. When young people can't explain the rationale for their recommendations, they run the risk of being disregarded or considered "puppets" of their adult advisors. However, when youth can independently describe survey results/recommendations, their credibility increases.

In this section we address three approaches to youth-led research: surveys, focus groups, and community interviews.

YOUTH SURVEYS – Working with youth to develop a survey is a great way for adults and youth to work together. This partnership works best if the adults involved have some experience developing and analyzing surveys so that they can

[5] Information in this section adapted from materials developed by the California Center for Civic Participation, www.californiacenter.org.

provide guidance on how to structure the questions in order to gather the information that the youth think is important. Generally youth surveys are not highly scientific in terms of the sample of youth surveyed. Often the youth simply survey their peers. It is a convenience sample, not a random sample. One alternative is to ask the school if the surveys can be distributed in class. If permission can be negotiated with the school and the youth can survey a class that all students take (often English), this can be a good way to get a more representative sample. Survey results can be analyzed using Excel or pen and paper tallies. Again, it is best to find an adult familiar with survey analysis to assist in the process.

YOUTH-LED FOCUS GROUPS – Focus groups are another way to gather information. Youth-led focus groups are small meetings led by youth moderators (with or without adults present) where people discuss a topic or topics. Focus groups are forums for discussion and conversation. They offer the opportunity to learn not only **what** people think about a certain issue, but also **why** they think that way. With a relatively small amount of training and practice, youth can moderate focus groups, giving them the power to collect feedback on a policy or a project idea without having to do a full survey. (For more information on focus groups, see Chapter 9.)

YOUTH INTERVIEWS OF COMMUNITY LEADERS – A final way for youth to do research is to identify key leaders in their school, city or community. The leaders can be elected officials, local citizens, principals, or directors of community organizations. Youth representatives, with or without adults, can organize these meetings and conduct structured or informal "interviews" with the leaders. Often even the most inaccessible public official will respond very positively to being approached by a teen regarding local issues.

> At the Balboa Teen Health Clinic in San Francisco, the Youth Advisory Board (YAB) was created with the goal of educating other youth on their minor consent rights. The YAB conducted a needs assessment in seven high schools assessing students' knowledge regarding minor consent rights and their opinions on school health. The YAB then presented their findings to the school district's Board of Education, urging them to pass a resolution incorporating minor consent education into San Francisco's high school health education curriculum. As a result of this process more youth became aware of the clinic and were referred by their peers for services. The youth presence made the clinic friendlier to youth and reinforced the perspective that youth were partners in the clinic with real responsibility, respect and the power to make change.

YOUTH-LED SERVICES

Another way to involve youth in the school health center is to develop peer-led programs such as peer health education and/or mentoring. These programs train students in one or more areas such as nutrition, substance abuse, or teen pregnancy. The health center oversees this training, provides the space and arranges the venues for youth to work with other students. It is important to note that adequate staff time must be devoted to these programs in order for them to succeed; usually, a minimum of one half-time staff person for each program, even if it only meets two hours each week. Find examples of a youth-led project below and in the pages that follow.

> The **My Choice Project** at the Manual Arts High School Health Center in Los Angeles is a peer education project with a focus on pregnancy prevention. The program delivers information through clinic health education counseling, classroom presentations, lunchtime discussion groups, campus-wide events, community outreach and after school activities. It makes more students are aware of the clinic services and helps them access those services. Students become the voice of the clinic outreaching to the entire campus. In addition, the program builds knowledge and skills and provides leadership opportunities for youth.

YOUTH ADVOCACY

Youth can also become key advocates for developing or sustaining their school health centers by engaging in local or state advocacy for school health services and programs. In many cases, youth can be more effective than adults in attracting and sustaining the attention of policymakers.

Youth-led **direct advocacy** occurs when people attempt to affect policy themselves, such as holding a face-to-face meeting with a policymaker, calling their legislator, or speaking at a hearing. They may also develop issue papers for

presentation at meetings of legislators or for newspaper or Internet articles for the public. Students in California participated in direct advocacy for the passage of legislation promoting school health centers. In Oakland Unified School District, young people helped overturn that district's previous ban on dispensing contraception.

Youth-led **grassroots advocacy** occurs when people organize others to take action. Youth can be very effective at leading petition drives or letter-writing campaigns, canvassing, distributing flyers, or organizing rallies. At the Manual Arts High School Health Center in Los Angeles, students on the Youth Health Action Board advocate for change in their school environment to promote healthy eating and fitness. A small group of students have met with cafeteria staff to promote changes in menu offerings. Using their newfound leadership skills, these students are changing their community. They are also showing their peers that youth can be a positive force recognized by adult decision makers.

YOUTH-LED MARKETING AND MEDIA CAMPAIGNS – Youth can be the most effective way to market your health center. They can also become the spokespersons for specific health initiatives. Let your youth help develop and implement a marketing plan for all types of media. If possible, draw support from your local newspaper or TV station, teachers, graphic designers, webmasters and others to guide the development of professional skills in this area.

At the **El Cerrito Community Project** at El Cerrito High School, a variety of youth development programs engage high school students across a range of youth-led projects including public health research, the arts, a youth leadership team and peer conflict mediation. These programs offer young people a chance to respond to community violence and other issues in ways that build meaning, enrich their lives and increase their connectedness to both school and the wider community.

When the project's youth leadership team talked about the prevalence of "cliques" among African American girls and the tremendous conflict that is embedded in this social infrastructure, a decision was made to convert the school's Conflict Mediation program into a group for African American girls to examine the role of conflict in their lives. Students made connections between the violence in their own lives and the causes of that violence in the world around them.

YOUTH ADVISORY COMMITTEES

In addition to, or in lieu of, involving youth in your advisory council (see Chapter 2), you may consider establishing a separate youth advisory body. Such a group often consists of 6-10 youth who meet regularly and make recommendations to health center staff. Youth advisory committees are a great way to build youth leadership skills, get youth feedback, and help prepare youth to become future members of your wider advisory council. Two or three youth from the youth advisory committee can become representatives to the advisory council, serving as the liaisons between the youth and adult councils.

The success of a youth advisory committee depends greatly on the degree of support and mentoring provided by the school health center. Some school health centers do not have the staff, funding or experience to support a youth advisory committee initially. In this circumstance, it is better to wait until the school health center has more resources than to launch a youth advisory committee prematurely without adequate staffing or support.

Promoting Health Awareness to Teens (PHAT) is the youth advisory board to the Logan Health Center in Union City. It meets once a week and serves as a forum for youth to give input into health center policies and functions. The group gives direct feedback to clinic staff. They develop "health tips" that air on the school video announcements. They also host workshops and health fairs. This group has represented the clinic and the school at community events that promote leadership, community involvement and civic participation. PHAT has been involved in the Month of Respect Multiracial Unity and Respect Fair. The program develops leadership skills and gives youth visibility and voice in the school and community.

SUSTAINING YOUTH ENGAGEMENT

Maintaining youth engagement is essential to your clinic's success. In general, youth participate because they:

- Have fun and feel good about doing the work!
- Make friends with other youth, as they form new, supportive social networks
- Recognize social injustices or problems in their community
- Seek to promote youth voices, ideas and opinions to influence decision-making
- Want to emulate an important person in their life
- Are provided with short- and long-term incentives that are meaningful
- Were encouraged, supported, or saw parents or other significant adults model the importance of involvement[6].

Promoting Health Awareness to Teens (PHAT) is the youth advisory board to the Logan Health Center in Union City. It meets once a week and serves as a forum for youth to give input into health center policies and functions. The group gives direct feedback to clinic staff. They develop "health tips" that air on the school video announcements. They also host workshops and health fairs. This group has represented the clinic and the school at community events that promote leadership, community involvement and civic participation. PHAT has been involved in the Month of Respect Multiracial Unity and Respect Fair. The program develops leadership skills and gives youth visibility and voice in the school and community.

In order to sustain youth engagement, school health centers need to ensure the adults working with youth view them as assets. They need to provide guidance, mentoring, role models and learning/professional development opportunities. And they need to build on creative youth-adult relationships or opportunities that support bringing youth and adults together as partners. Most importantly, however, the youth engagement program needs to be fun, and facilitate team-building between youth participants.

[6] Adapted from the Search Institute. (2005). *The Power of Youth and Adult Partnerships and Change Pathways for Youth Work*. W.K. Kellogg Foundation

WORKSHEET: DEVELOPING A YOUTH INVOLVEMENT PLAN

1. Drawing on the information in this chapter, as well as your own experiences, record at least three reasons that youth engagement should be a priority for your school health center:

   Reason #1: _____

   _____

   Reason #2: _____

   _____

   Reason #3: _____

   _____

2. This chapter presents several meaningful ways to involve youth in your school health center. Which of these do you want to pursue?

   _____

   _____

   _____

3. Consider ways in which the organization(s) involved are willing to let youth make or shape decisions. Are there areas where youth might influence decision-making, and others where they could have a voice but not direct influence? Make notes here.

   _____

   _____

   _____

4. Who is going to staff your youth engagement work? (Make sure it is realistic for them to incorporate this into their workload or the effort is destined to flounder.) What training or support do they need to be effective in working with youth?

   _____

   _____

   _____

5. How are you going to promote a fun, social, and positive dynamic between the youth?

   _____

   _____

   _____

6. How will you sustain youth involvement? Talk to both youth and adults to determine an effective model for a youth/adult long-term partnership.

   _____

   _____

   _____

CHAPTER 04

Health Center Structure and Staffing

THE LEAD AGENCY

Your school health center will need one sponsoring or "lead agency" to assume overall responsibility for the center. Major roles of the lead agency include:

- Assuming legal responsibility for the health center
- Hiring, training and supervising core health center staff
- Orienting health staff about school policies
- Conducting outreach and education with school staff
- Ensuring regular communication between school and health center staff
- Establishing and facilitating advisory council
- Securing funding for the school health center
- Communicating with parents about the school health center
- Ensuring adherence with HIPAA and FERPA requirements (see Chapter 7)
- Collecting data for program evaluation purposes
- Developing reports for school administration and the school board as appropriate
- Providing liability coverage

It will be important to select and involve a lead agency well before the health center is due to open. Every community is different with unique assets and needs and must determine which type of sponsoring agency will work best for it.

In California, the most common types of lead agencies are federally-qualified community health centers, school districts, hospitals and public health departments. These and other possible lead agencies are described below:

COMMUNITY HEALTH CENTERS – Community health centers (CHCs) are public or private non-profit entities recognized by the U.S. Health Resources and Services Administration (HRSA) as community-based and patient-driven organizations that serve populations with limited access to health care. They are required to provide services to patients regardless of health insurance or ability to pay, and must meet other administrative, clinical and financial requirements as mandated and regulated by HRSA's Bureau of Primary Health Care (BPHC). CHCs are partially funded by HRSA under various grants, and include Migrant Health Centers, Healthcare for the Homeless Programs, Public Housing Primary Care Programs, FQHCs and FQHC Look-Alikes (see below), and Tribal Health Organizations. The law defining this program is Section 330 of the Public Health Service Act and therefore sometimes CHCs are described as "Section 330" organizations.

CHCs are an ideal sponsor for the school health center. Their personnel are accustomed to handling a wide range of health needs and they have systems in place for handling medical records, insurance billing, and government regulations. CHCs also relieve the school district from handling most of the day-to-day operations of the school health center. CHCs can often leverage a range of federal, state, and private funds to support health center operations in underserved areas.

- **Federally Qualified Health Centers** (FQHCs) are federally funded, non-profit organizations that provide primary care and other services to people in medically underserved areas. Their services must be available to all residents in their service areas, with fees adjusted upon patients' ability to pay. Because school health centers operate under similar principles, FQHCs make excellent sponsoring agencies. In addition, FQHCs are reimbursed at a much higher rate for eligible services provided to Medi-Cal recipients and managed Medi-Cal members. An

FQHC can provide much of the staffing and billing infrastructure a school health center needs.

- **Federally Qualified Health Center Look-Alikes** are health centers that have been identified by HRSA as meeting the definition of "health center" under Section 330 of the PHS Act, although they do not receive grant funding under Section 330. They offer many of the same advantages to school health centers as regular FQHCs described above.

PUBLIC HEALTH DEPARTMENTS – Public health departments can be excellent lead agencies as they often have a strong public health infrastructure and typically understand the community and its health needs. Public health departments may also be certified as FQHCs or FQHC look-alikes, which grants them the same benefits with respect to Medi-Cal billing, despite the fact that they are not governed by consumer boards.

SCHOOL DISTRICTS – Some school districts run their own school health centers and contract with outside practitioners for services as needed. In this model, the school district assumes all responsibility and liability for operating the health center. Although there may be advantages to a district sponsoring its own center(s), the following barriers have been experienced by some sites when sponsored by school districts:

- Schools may find it difficult to hire their own health staff, especially when the health center's needs are part-time and the district does not have similar positions with which to share responsibilities. In addition, school personnel may have difficulty selecting among qualified applicants given that they are not health care professionals themselves.
- Schools usually lack experience with medical billing, which is complex and requires special expertise.
- School administrators must focus on adhering to education laws and regulations and may prefer not to utilize scarce resources learning about medical and mental health regulations.
- There are costs to establishing new systems for medical operations, billing, data collection and liability insurance. Some CBOs may already have these systems in place, resulting in cost efficiencies.
- School administrators may end up fielding patient complaints, providing oversight for medical staff, and other responsibilities for which they would need additional training.

UNIVERSITIES AND HOSPITALS – University and local hospitals can also serve as sponsoring agencies. There are numerous examples of such partnerships in California, including Children's Hospital Los Angeles, University of California Los Angeles and Children's Hospital Oakland. Sometimes these programs are affiliated with training programs for medical residents or nurses.

PHYSICIANS OR PHYSICIAN GROUPS – A local physician's office as sponsor is most common in small communities where funding is limited or where few health agencies exist.

OTHER PARTNERS

In addition to the services provided by the lead agency, a school health center may collaborate with other organizations to provide services or offer programs. For example, a lead agency that is a medical provider might contract with a mental health organization to provide therapy and case management to students and their families, paying them for some of these services from grants they receive. The same agency might also form an agreement with a local community services organization whereby that agency provides after school yoga classes to students and workshops for parents. In this latter case, the community agency might bring its own grant funding to support their activities in partnership with the school health center. (More information about contracts and memoranda of understanding can be found in Chapter 7.)

Collaborative arrangements bring greater resources to the health center but also require effort, creativity and sometimes compromise to manage effectively. Conflicts can arise regarding space-sharing, information-sharing, funding, communication with school staff, and technical needs. Although each agency involved will bring its own policies and protocols, the lead agency should ensure shared understanding regarding overarching health center policies in areas such as safety and security, cultural sensitivity, and client confidentiality.

STAFFING

There is a wide range in the numbers and types of personnel that work in California's school health centers; most, however, fall into the following broad categories: administrative, medical, mental health, dental, health education and school nurses. The most common staff types within each of these categories are described below, with typical job responsibilities. Which personnel should be licensed, registered, and/or certified according to the regulations governing their field is also described. (Please see Appendix C for detailed job descriptions.)

ADMINISTRATIVE PERSONNEL

SCHOOL HEALTH CENTER COORDINATOR – The coordinator of a school health center – also known as a Manager, Director or Supervisor – may be seen as the "face" of the health center. This person almost always works for the lead agency. His or her responsibilities usually include:

- Defining and maintaining operational procedures (within parameters established by the lead agency)
- Preparing and overseeing annual budget
- Supervising and/or coordinating work of all staff hired or contracted to work in the health center
- Preparing grant proposals and other fundraising activities
- Conducting or organizing outreach and marketing efforts
- Maintaining a positive and functional working relationship with the school and community
- Managing the advisory council
- Ensuring that health center services are delivered in culturally appropriate ways
- Coordinating health promotion activities such as classroom education, school wide campaigns and health fairs or other events
- Coordinating program evaluation and quality assurance/ improvement activities.

Because of the importance of this function, it is ideal for the Coordinator to work full-time, even if the center is not officially open five days a week.

There is no specific set of qualifications required to be a Coordinator. Some centers require a Bachelor's or Master's degree in Public Health; some prefer that a licensed medical or mental health professional hold the title; and others feel that commitment, interpersonal communication skills, organization and common sense are most critical. It is not uncommon for the Coordinator to be hired well before the center opens and then gradually hire appropriate staff as opening day comes closer.

RECEPTIONIST – This is a truly critical role! The receptionist is the first person with whom most visitors interact, and for both school staff and students a friendly, professional and dedicated individual is needed. Typical roles include opening the health center, scheduling appointments, answering the phone, greeting visitors and patients, registering new patients, and collecting and entering data. In addition, many receptionists act as billers for their health centers, processing patient encounter information to generate insurance claims. Some receptionists are also medical assistants (see below).

MEDICAL PROVIDERS

The licensed primary care provider can be a physician (typically a pediatrician or family practitioner); nurse practitioner (usually pediatric or family NP); or physician assistant (PA). These providers can deliver a wide range of services to students that include basic and emergency first aid; comprehensive physical exams; diagnosis and treatment of acute illness and injury; prescription and over-the-counter medications; reproductive health care; health education; and management of chronic conditions.

MID-LEVEL PRACTITIONERS – Much of the primary care provided in school health centers is delivered by "mid-level practitioners" – a category that includes nurse practitioners, physician assistants and certified nurse midwives. Mid-level practitioners are required to be licensed and should have experience working with children and/or youth.

Nurse Practitioners must hold an unrestricted license from the California Board of Registered Nursing (BRN), and should also have permission to furnish medications (write prescriptions) with a furnishing license and number. Some NPs will also hold a specialty practice certificate from a nurse practitioner credentialing body.

Physician Assistants must be certified by the National Commission on Certification of Physician Assistants as a "PA-C" and hold an unrestricted California license by the Physician Assistant Committee of the Medical Board of California. PA-Cs require periodic physician review and sign-off on patient records, in addition to protocol oversight.

PHYSICIANS AND RESIDENTS – In some school health centers, licensed physicians and/or medical residents provide primary care services. All physicians should hold an unrestricted California physician and surgeon license issued by the Medical Board of California or the Osteopathic Medical Board of California. Although not required, it is advisable to hire physicians who are Board-certified or Board-eligible in pediatrics, family practice or internal medicine.

Residents should be enrolled in a residency program approved by the Accreditation Council for Graduate Medical Education and be supervised by the teaching hospital's attending physician.

SCHOOL NURSES – School nurses are critical leaders in school health, and their role is often more familiar to students, families and schools than that of the school health center. School nurses are typically employed by the school district, but they should function in partnership with school health center staff. School nurses may perform the following services:

- Conduct immunization programs
- Assess and evaluate the health and developmental status of students (includes providing mandated health screenings for vision, hearing, etc.)
- Design and implement health maintenance plans for students with special health care needs
- Refer students and parents or guardians to other resources
- Make recommendations regarding the student's individualized education program (IEP)
- Provide training and serve as a medical resource for teachers and administrators
- Develop and/or implement a health education curriculum
- Counsel and assist students and parents in health-related and school adjustment services

Not all school nurses will provide all these services on a regular basis. In California, the ratio of school nurse-to-students is one of the highest in the country (about 1:4,500), and most school nurses serve multiple schools or even an entire district!

A school that has both a school nurse and health center will find that through collaboration both are able to do their work more effectively. For example, Roosevelt Middle School in Oakland employs a full-time school nurse, who assesses the needs of dozens of young teens who drop in to the health center each day. The nurse practitioner is able to focus her time on scheduled appointments and medically complex needs. This role definition allows the health center to generate more third party reimbursement and uses each practitioner at her highest level of skill. School health centers without a school nurse may find that much of their medical provider time goes to treating routine complaints such as headaches, stomachaches, minor scrapes and menstrual cramps.

It is important to recognize that ***school health centers do not replace school nurses***. Instead, they complement services already being provided by placing additional resources in or near schools. If your school community is fortunate enough to have a school nurse, we recommend you build a strong partnership with him or her during the planning process. This partnership should focus on assessing care needs, facilitating access to care, increasing compliance with treatment plans, providing case management and monitoring student outcomes. Both the national School-Based Health Alliance and the National Association of School Nurses support this collaborative relationship. See www.sbh4all.org for their joint position statement.

School nurses must have a baccalaureate or higher degree from a regionally-accredited college or university and a registered nurse license through the State of California Board of Registered Nurses (BRN) in order to apply for a Preliminary School Nurse Services Credential. This non-renewable five year credential allows nurses to work in a school setting while they are completing school nurse credentialing requirements. Within five years of starting work as a school nurse, registered nurses must complete school nurse credentialing coursework and required clinical experience through an accredited university's school nurse credentialing program. With successful program completion and two years experience working as a school nurse, she or he may then apply for a School Nurse Services Credential through the California Commission on Teacher Credentialing.

Other nurses working in school health centers as employees of the medical services provider, rather than the school district, must also have a registered nurse license from the BRN. In some cases licensed vocational nurses (LVNs) will provide more limited, assistive medical services such as giving vaccinations and administering first aid.

MEDICAL ASSISTANTS – Medical assistants (MAs) take patient vital signs, medical histories, give immunizations, draw labs, administer hearing and vision screenings, and provide first aid to patients with minor injuries. They follow up on no-shows, maintain medical supply inventories, record health information, and enter patient data. The MA may also help with program eligibility and enrollment.

In California, MAs are not required to be licensed, certified or registered, although most MAs complete an accredited Medical Assisting program which takes between 4-24 months plus technical on-the-job training. Voluntary certification is offered by the American Association of Medical Assistants and the California Medical Assistants Association; however, less than 5% of medical assistants in the state opt for either certification. Nonetheless, a school health center and/or supervising provider's malpractice insurance carrier may require that the medical assistant be certified. The Medical Board of California interprets and oversees MA regulations.

MENTAL HEALTH PROVIDERS

Mental health providers in school health centers help students who are experiencing stress, depression, substance abuse, family trouble, and difficulty with school or other mental health problems. They provide crisis intervention, psychological assessments, individual and family therapy, support groups, case management, truancy reduction and dropout prevention. Some mental health providers provide linkages to outside services such as housing, food, and employment assistance. In a few school health centers, psychiatrists prescribe and monitor the use of psychotropic medications.

Unlike medical providers, most mental health providers are not required to be licensed to work in school health centers. In order to practice without on-site clinical supervision, however, most need to be **registered** by the appropriate body (see below). Registration requires completing the appropriate degree program at an accredited school, meeting specified training requirements, including hours of supervised clinical practice, and filing with the relevant Board.

The most common categories of mental health providers working in California school health centers are:

CATAGORY	DEGREE	REGISTERED BY:	LICENSE OR CREDENTIAL	NOTES
Counselor	MA in Counseling (2 years full-time study)	California Board of Behavioral Sciences	MFT (Marriage and Family Therapist)	Some Counselors specialize in areas such as Drama or Art Therapy.
School Psychologist	MA in Counseling or School Psychology (2 years full-time study)	California Commission on Teacher Credentialing	Pupil Personnel Services (PPS) Credential	
Social Worker	MSW (Master's in Social Work) (2 years full-time study)	California Board of Behavioral Sciences	LCSW (Licensed Clinical Social Worker)	Not all social workers are clinical social workers.

CATAGORY	DEGREE	REGISTERED BY:	LICENSE OR CREDENTIAL	NOTES
Psychologist	PhD (~ 4 years graduate study + research component)	California Board of Psychology	Licensed Clinical Psychologist	Not all psychologists are clinical psychologists.
Psychiatric Nurse Practitioner	MSN (Master's of Science in Nursing)	California Board of Registered Nurses	NP (Nurse Practitioner)	A focus of this field is psychotropic medication management, although Psych NPs are also trained to provide counseling/ therapy and case management.

All unlicensed mental health providers need to be clinically supervised by an appropriately licensed clinician. Details of this supervision will vary, but it can typically be provided by someone located offsite. In addition, some programs utilize mental health interns or practicum students still enrolled in their graduate degree programs. Interns should be enrolled in a structured program that includes specified hours of individual and group supervision, case conferencing, and other quality assurance mechanisms.

Finally, some school health centers may hire unlicensed, non-registered mental health providers such as case managers and peer counselors who do not hold professional degrees in counseling or another field. These staff may provide direct services to youth and families as long as the individual's job description is consistent with their skills and training and does not exceed their scope of practice. In addition, clinical supervision should be provided by a licensed practitioner with experience with the population and age group being served.

DENTAL CARE PROVIDERS

In California, many of the oral health services provided in school health centers can be delivered by dental hygienists without a dentist present. Dental hygienists can provide dental education in the clinic or the classroom, clean and polish teeth, apply fluoride and sealants and take dental X-rays. Dentists provide restorative services such as extractions and fillings, and diagnose dental problems.

HEALTH EDUCATORS

Health educators of various kinds provide student, family, school and community education and outreach. In some cases, school health centers train peer health educators, also known as "promotoras," from the student body or the parent community to provide peer education on topics of importance. Nutritionists may also provide health education in the areas of healthy eating and exercise. Health education providers are not required to be licensed or registered, although they should be well trained and supervised by appropriate personnel. Only credentialed teachers and school nurses with a Special Teaching Authorization in Health may provide classroom-based health education without a credentialed teacher also present.

OTHER STAFF

Other staff that sometimes work in school health centers include youth development workers, mentors, advocates, tutors, or job and career counselors. There is virtually no end to the services from which young people and their families can benefit. School health centers in relatively remote or rural areas might want to consider utilizing "telehealth" service providers for primary, specialty or behavioral health care services. (Telehealth can be used for direct patient care or for provider-to-provider consultation.)

SAMPLE STAFFING OPTIONS

Some possible staffing configurations for three health center scenarios are shown below, although each school health center's staffing will vary.

	SMALL START-UP ELEMENTARY SCHOOL CLINIC	PHASE 2 HIGH SCHOOL-BASED HEALTH CENTER	LARGE URBAN SCHOOL-LINKED HEALTH CENTER
COORDINATOR	30 hours/week	40 hours/week	40 hours/week
OTHER ADMINISTRATION	Receptionist 20 hrs/wk	Receptionist 40 hrs/wk	Receptionist 40 hrs/wk Billing Clerk 20 hrs/wk
MEDICAL PROVIDER(S)	NP 8 hrs/wk	School Nurse 30 hrs/wk PA 25 hrs/wk MA 25 hrs/wk Physician as needed	NP 40 hrs/wk Physician 20 hrs/wk Residents 12 hrs/wk MA 40 hrs/wk
MENTAL HEALTH PROVIDER(S)	Psychologist 8 hrs/wk	Social Worker 30 hrs/wk Therapist 20 hrs/wk	Social Worker 40 hrs/wk MH Interns 24 hrs/wk Substance Abuse Counselor 6 hrs/wk Psychiatrist 4 hrs/mo
OTHER	Parent Coordinator 10 hrs/wk, and/or Parent promotora program 5 hrs/wk	Health Educator 35 hrs/wk After School Mentors 16 hrs/wk	Dentist 12 hrs/mo Health Educator 40 hrs/wk Nutritionist 10 hrs/wk

WORKSHEET: DETERMINING HEALTH CENTER STRUCTURE AND STAFFING

1. What lead agency makes the most sense for your school health center?

2. If not already involved, how might you approach one or more of those agencies?

3. If you selected the school district as your sponsoring agency, how will you overcome the challenges of using this model?

4. Based on the results of your needs assessment and staffing chart, what types of staff will you hire and for how much time?

ex: Nurse Practitioner/Physician Assistant	*12 hours/week*
Social Worker	*25 hours/week*

5. What types of hiring procedures must you put in place (e.g., job announcements, eligibility criteria, interview teams, benefit plans, salary ranges)?

6. What are your diversity goals for the make-up of your staff?

7. Will you need to hire contractors? If so, for which services?

CHAPTER 05

School Health Center Funding

HOW SCHOOL HEALTH CENTERS ARE FUNDED

Unfortunately, there is no single source of financing for school health centers in California. Most school health centers are funded using a combination of third-party billing revenues, support from local organizations, and grants from foundations or public entities. The various sources for third party reimbursement, services covered and billing mechanisms are outlined in detail in our *Third-Party Billing: A Manual for California's School Health Centers. A related resource, The California School Health Center Financial Sustainability Tool*, offers multiple Excel spreadsheets with formulas into which school health center administrators can enter data to develop an operational budget. Both of these resources may be acquired by visiting us online at www.schoolhealthcenters.org. This chapter is focused on developing a fundraising plan, and how to seek public and private grant and other funding support.

CULTIVATING FUNDERS

In order to raise the funds for your school health center, it's important to cast your net broadly – to foundations, government sources, and even local civic organizations. To be successful at fundraising, you must make a compelling case. You also need to cultivate potential funding sources, especially those in your own community. The following are some suggestions for cultivating funding support.

- Invite potential funders to health center events such as an open house.
- Put key potential funders on your mailing list. Always send an introductory letter and ask if they want to continue to receive your information.
- Save brochures from your programs to include in mailings.
- Save brochures, programs and annual reports from related organizations or programs. You can get funding ideas from reviewing their lists of funders.
- Research potential funders. You may be surprised what you can discover on the Internet. Be sure you know if there are geographic or program restrictions on the funding that would eliminate you from consideration. (We send members frequent grant opportunities.)

FUNDING SOURCES

This section includes information and links to various funding sources.

FEDERAL GOVERNMENT

Some federal grants are available only to local educational agencies (LEAs) such as school districts or county offices of education, while others are available to community-based organizations as well. Federal grants tend to have stringent reporting requirements; be sure to understand these requirements and build those activities and costs into your proposal.

Federal formula grants are based on an identified need that certain communities may qualify for based on specified demographics or health statistics. **Federal project grants** are more open and tend to be highly competitive. **RFPs (request for proposals)** are requests to fulfill a government program. RFPs are often very specific in the type of services required to qualify.

Some sources for federal grants include:

- **Health Resources and Services Administration (HRSA)**: A variety of grant programs in areas that include Healthcare Systems, HIV/AIDS, Maternal & Child Health, Primary Health Care/Health Centers, and Rural Health. www.hrsa.gov/grants/default.htm
- **Substance Abuse & Mental Health Services Administration (SAMHSA):** Grants often have a research requirement or focus. www.samhsa.gov/grants/2009/fy2009.aspx
- **U.S. Department of Education (USDE) - Safe Schools-Healthy Students Initiative:** Grants support LEAs in creating safe and drug-free schools and promoting healthy childhood development. Coordination with CBOs is required. Strategies must include violence prevention activities; substance use prevention; mental health services; and other student supports. www.ed.gov/programs/dvpsafeschools/index.html
- **USDE - Grants for the Integration of Schools and Mental Health Systems:** Provides grants to LEAs for the purpose of increasing student access to quality mental health care by linking schools and mental health systems. Funded program must enhance or improve prevention, diagnosis, and treatment services to students, including crisis intervention services, and provide training for school personnel. www.ed.gov/programs/mentalhealth/index.html
- **Office of Juvenile Justice and Delinquency Prevention (OJJDP):** Provides funding to states, localities and private organizations through formula and block grants and discretionary grants. www.ojjdp.ncjrs.gov/funding/FundingList.asp

STATE GOVERNMENT

While California does not currently offer state funding specifically for school health centers, there are state grants available for medical services, mental health, prevention education, outreach, youth development and other support services that can be used to support a school health center. Some state grants, especially those from the Department of Education, require an LEA applicant. Other grants are available to local public health departments, community-based organizations, or Community Health Centers. To maximize funding opportunities, school health centers will want to work in partnership with the local school district and other public and private entities.

Some specific grant opportunities from the **California Department of Education** (www.cde.ca.gov/fg/) include:

- **The School Community Violence Prevention Program:** Provides grants of up to $500,000 for a five-year period for school districts or county offices of education to address school safety and violence prevention. Approximately 10 percent of funds are awarded to rural school districts. www.cde.ca.gov/fg/fo/profile.asp?id=841
- **Healthy Start:** Designed to encourage the integration, coordination, and collaboration of services at the local level. One type of grant combines planning and operational funds over a 7-year period. The second is the traditional 5-year operational grant. The grant is used to achieve identified results for schools and children and can coordinate services and activities such as health care, dental care, mental health counseling, child welfare and employment services, crime prevention, child care, youth development, supplemental food and nutrition education, English language or citizenship classes, and peer-to-peer strategies. www.cde.ca.gov/ls/pf/hs/facts.asp
- **21st Century Community Learning Centers grants:** While specifically designed for after school academic support as funded through "No Child Left Behind" legislation, these grants may also support after school enrichment, such as health education or youth development programming. www.cde.ca.gov/ls/ba/cp/
- **California School Age Families Education (Cal-SAFE):** A comprehensive, integrated, school-based program for expectant and parenting students and their children. www.cde.ca.gov/fg/fo/profile.asp?id=1056

Grants available through the California Department of Public Health (www.cdph.ca.gov/) include:

- **Network for a Healthy California:** Formerly known as the California Nutrition Network, this program funds local

nutrition services and education programs, as well as special statewide projects such as Project LEAN and the 5 a Day Campaign. www.dhs.ca.gov/ps/cdic/cpns/network/

- **Office of Family Planning Teen Pregnancy Prevention grants:** These grants include Community Challenge Grants, Male Involvement Program, and Information & Education (I & E) grants. Their focus is on reducing unintended pregnancy among adolescents through primary prevention and community-driven activities. There are some collaboration and match requirements. www.etr.org/ofp/programs/index.htm. (Note: I & E and Male Involvement grants were cut in 2008.)

LOCAL GOVERNMENT

Counties often have local funds available through their share of state and federal dollars; they can also direct locally raised funds to programs for which school health centers may be eligible. Examples include:

- **Mental Health Services Act (MHSA):** The MHSA was funded by Proposition 63, which creates a large amount of dedicated funding for improved mental health services throughout the state. The Act's Prevention and Early Intervention (PEI) program focuses interventions and programs on individuals across the life span prior to the onset of a serious emotional or behavioral disorder or mental illness. County Departments of Mental Health or Behavioral Health Services are charged with spending this money appropriately to meet state-identified goals in line with locally-determined priorities. Eligibility is determined county by county, but a significant portion of PEI funding can be dedicated to school-based services for children and teens.
- **Community Development Block Grants (CDBG):** The objective of the CDBG program is the development of viable urban communities by providing a suitable living environment and expanding economic opportunities for those with low and moderate incomes. Administered by the California Department of Housing and Community Development, CDBG grants have been used to support school health center facilities construction, service delivery and youth development programs.
- **Tobacco Master Settlement Agreement:** These were allocated to counties as the result of litigation against major tobacco companies. Some of these funds may be allocated by counties for health and wellness services.
- **Other local revenues:** Other sources of funding may include bond measures or local tax revenues, often allocated for specific purposes by local governance.

> The Alameda County Board of Supervisors allocated a significant amount of funding from Tobacco Master Settlement Funds (TMSF) and Measure A, a local sales tax passed by residents. Together TMSF and Measure A provide most adolescent SBHCs in the County with base funding of $100,000 annually. Funding from these sources also supports technical assistance, planning and coordination of services.

FOUNDATIONS

Private or corporate foundations also fund health and mental health services for children and youth; others support education or youth development activities broadly defined.

National foundations with past support for school health services include:

- **W.K. Kellogg Foundation:** www.wkkf.org
- **The New York Life Foundation:** www.newyorklife.com/foundation
- **Prudential Foundation:** www.prudential.com/community
- **The Commonwealth Fund:** www.cmwf.org
- **Robert Wood Johnson Foundation:** www.rwjf.org
- **The Annie E. Casey Foundation:** www.aecf.org
- **The Atlantic Philanthropies:** www.atlanticphilanthropies.org

California Funders with past support for school health services include:

- **Kaiser Permanente:** http://info.kp.org/communitybenefit/
- **The California Endowment:** www.calendow.org
- **The California Wellness Foundation:** www.tcwf.org

LOCAL FUNDERS

- There are over 65 local community funds in California. Search community fund locator at Council on Foundations (www.cof.org)
- There are also numerous smaller foundations , including corporate and family foundations, that focus their giving on a specific geographic region. The Foundation Center database (see below) can help you find potential funders in your area.

FUNDING LINKS

Other Web-based resources include the following:

- Foundation Center: www.foundationcenter.org
- Foundations Online Directory: www.foundations.org
- School Grants: www.schoolgrants.org
- Center for Health and Health Care in Schools: www.healthinschools.org/News%20Room/Grant%20Alerts.aspx
- Federal grants: www.grants.gov/
- GrantStation: www.grantstation.com
- Grantwriters.com: www.grantwriters.com

TYPES OF GRANTS

There are different types of grants. Three general types that you might consider seeking include:

- **Planning grants** to cover expenses during a planning and research phase of a new program (such as launching or expanding a school health center)
- **Program or operating grants** for a particular service or set of services (such as a drug prevention program to be run from your school health center)
- **Research grants** with which you study a problem or evaluate a program (such as whether students using your school health center know more about nutrition than their peers who do not use the health center)

In the best of cases, you might combine three grant types to support one well-funded program. For example, if you wanted to launch an obesity prevention program at your health center, you might seek a 6-month planning grant to prepare your curriculum, followed by 3-year program grant to staff and implement the program, and a research grant to track the program's effectiveness.

DEVELOPING A FUNDRAISING PLAN

Planning is fundamental to fundraising. Any plan should include, at a minimum:

- Names of potential funders and the amount you might seek. Do your homework! Funders report that one of the primary reasons applicants are denied is that their proposal is not within the scope of what the funder funds.
- Strategy for how these funders should be approached. We highly recommend setting up an in person meeting prior to submitting a proposal. Invite the potential funder to your site, discuss your work and ask whether they see this as a fit with their priorities. Funders want to make good grants and will give you advice about what would be the best request.

- Priority order and dates when proposals are due
- Person(s) responsible
- Ideas for future proposals
- Cultivation ideas for future funders

A short-term fundraising plan is designed to meet your health center's immediate needs. These are funders who can be approached quickly for programs that are operational or near-operational. A long-term fundraising plan should focus on funders that need more lead time either because of their grantmaking procedures or your ability to generate the proposal. This plan should also help you look ahead at the program you want to initiate over a period of time. A comprehensive fundraising management plan should look ahead for 3-5 years and manage all elements of fundraising including cultivation (i.e., meeting, greeting and familiarizing funders with your work). This may be an evolving document and should be linked with your health center's or lead agency's strategic plan.

WRITING A GOOD GRANT PROPOSAL[7]

Different funders have different procedures for requesting grant support. Foundations often request a short Letter of Interest (LOI) that explains your basic request, after which they may (or may not) invite a full proposal. Government agencies typically issue a Request for Proposals (RFP) and often use a strict protocol for answering questions prior to receiving your proposal. Any proposal, especially one for government funding, should follow written guidelines closely. The sections below reflect a common order that proposals follow:

COVER LETTER – The cover letter should include your organization's name, the funder's name, the program name, and contact information. It will set the tone for your proposal so pay careful attention to it. The letter should be succinct and captivating. Highlight your strengths and accomplishments but don't exaggerate or make sweeping statements that you cannot back up.

EXECUTIVE SUMMARY/ABSTRACT – Produce this section after you have completed the proposal. It should stand alone and summarize the entire proposal. Include, as appropriate, your school health center's mission, a program summary, a brief description of why the program is important, and how much money you are requesting. The Executive Summary should be straightforward but should also convey a passion for your request.

STATEMENT OF NEED – Most proposals open with some kind of problem statement. Ideally you want to capture the problem in a way that sets the stage for the reader to see how your program superbly addresses that very issue. Include information such as:

- Demographics and relevant health statistics (e.g., number of schools, number of health care providers, socioeconomic indicators, community health statistics, immunization rates, teen birth rates, etc.) Present information related to your proposal.
- Information about your school health center (e.g., what percentage of your school population is enrolled in the school health center; the age, size, and condition of your facility; what services you provide; client demographics such as age, gender and race; family involvement in the health center; use of volunteers; and the number of clients and visits provided each year)
- Information about your school(s) (e.g., dropout rates, suspension numbers, retention rates, percent of students who receive free and reduced price lunches, etc.)
- "The hook"—what is the problem? For example: "Less than half of the students attending Blank Middle School have access to mental health services, and last year over 60% identified pervasive feelings of helplessness and depression."
- NOTE: Tailor the statement of need to the needs that your project will actually address. For example, if you are requesting funding for an immunization program, do not present needs related to mental health. This is a very

[7] Portions of this section drawn from materials developed by Howard Spiegelman, New Mexico Assembly on School-Based Health Care

common pitfall in proposal writing. Avoiding this pitfall means you will need to rewrite the statement of need for each proposal, not just recycle one from a previous proposal.

PROGRAM GOALS – Goals are general statements of what you want to accomplish (vs. objectives, which are more specific and measurable). Goals are broad in scope, focused on long-term attainment, and are not usually easily measurable. Some examples:

- Goal #1: Create a healthier environment at Anytown High School by establishing a new school health center where students can access health care in a safe, convenient place.
- Goal #2: Generate community support for the school health center among local businesses, religious groups, civic organizations, parents, and students.
- Goal #3: Increase the availability of health information resources for students including materials on nutrition, physical activity, substance abuse, teen pregnancy, and STDs.

OBJECTIVES – Objectives are desired outcomes of your program. Unlike goals, objectives should be specific and measurable. The acronym "SMART" can be used as a reminder in crafting objectives.

S = Specific; **M** = Measurable; **A** = Achievable; **R** = Realistic; and **T** = Time-bound

Typically, each program goal will be supported by about three objectives. The objectives below support Goal #1 above:

- Objective 1A: By October 2005, convert two Anytown High School classrooms into a single health center comprised of a waiting room, two exam rooms, a common room for meetings and group therapy, and two staff offices.
- Objective 1B: By December 2005, hire a part-time nurse practitioner and a part-time therapist.
- Objective 1C: Beginning in January 2006, provide physical and mental health services two days per week to an average of 30 students per month.

Objectives may be "process"-oriented (i.e., indicating how many students will be served), or they may be outcomes-driven (e.g., outlining the expected impact on health status.) It is much easier to predict and measure process objectives, but outcome objectives are more powerful in conveying what will change as a result of the funder's investment.

ACTIVITIES – The grant activities section outlines what you will do if funded and how you will do it. It is typically the longest section in the proposal, but most funders review hundreds of proposals a year, so aim for simplicity and clarity. This section may be in narrative or table form. It should indicate "what," the activities planned to meet the stated objectives; "when," the projected timeline; and "by whom," key personnel and their role(s) in these activities. Another common pitfall in grant proposals is not providing a clear picture of the activities you will undertake. The funder should be able to envision exactly what you will do based on what you write. Avoid jargon and use simple, short sentences.

EVALUATION PLAN – Include a plan to measure your goals and objectives. Some funders may require or suggest an outside evaluation which will typically cost money. (See Chapter 9, Data and Evaluation, for more information.)

BUDGET(S) – Many grants request two budgets: a request budget, indicating how you will spend this particular funder's money, and program budget, showing the cost of the whole program. Often funders do not want to support the full cost of a program. Depending on how you define your program, it could be all revenues and expenses for the health center or for a specific program within the center. The budgets should be clear and follow the funder's guidelines. Typical categories include:

- Personnel—salaries and benefits
- Consultants and contract services
- Space costs—office rent, utilities, maintenance
- Equipment
- Medical and office supplies

- Miscellaneous—printing, postage, travel, etc.
- Indirect costs or overhead – typically a fixed percentage of the budget charged by the lead agency to cover general costs such as liability insurance, accounting and legal services, etc. Many funders place a limit on indirect costs at 15%.

In addition to the numbers, some funders will also request a line item justification with details on the requested items. Your budget should be clearly linked to your activities and objectives. Go back and read through your activities and for each activity ask yourself if you have budgeted for the staff or expenses to undertake that activity. If the funder requests a sustainability plan, be sure to include interest from other funders, information about your fund development plan, and your ability to generate third-party reimbursement.

Sample grant proposals are available in the School-Based Health Alliance's Blueprint – see "exit:"

- *Planning and Evaluation*
- *Resources*
- *Funding and Resources*

We have a strong track record in grant funding and reviews proposals for members and on a fee-for-service basis.

APPENDICES/ATTACHMENTS – Your proposal may contain additional materials supporting your request, including letters of support, press clippings, resumes for key staff, or related materials. **Only include information that is directly relevant to your request.** Examples might include:

- List of Board and/or Advisory Committee members with community/business affiliations
- Audited financial statements (for lead agency)
- Current operating budget
- Job descriptions and/or resumes/biographical sketches of key staff
- Letters of support or endorsement from local partners, legislators, etc.
- Testimonials from students and/or parents
- Selected file of articles/reprints about your organization and its mission
- IRS letter showing tax exemption (most foundations will only make grants to 501(c)3 organizations)
- List of major donors with or without amounts

OTHER – Overall, try to write in an active voice using varied devices to hold the reader's attention: lists, numbered items, **boldface** and *italic* type. Use headings and subheadings to differentiate between sections. Make sure you keep it simple and are clear about what you are going to do. Ask someone not familiar with your work to read the proposal and explain back to you what they think you are saying.

Send your proposal flat. Folded packets of paper are difficult to copy for review purposes. ***And deliver your proposal on time!*** It is a good idea to call the agency when applying for a federal grant and ask the preferred method of delivery. Mail screening to federal agencies may cause delays.

WHAT IF YOU DON'T GET FUNDED? If your proposal is not funded, always try to find out why. You can learn a lot about how to strengthen your next proposal by interviewing a funder who just declined your grant. If you were turned down by a foundation, ask if you can revise and resubmit. Do not be discouraged, since the majority of proposals nationwide are declined.

OTHER SOURCES OF SUPPORT[8]

While the majority of your funds will likely come from government or foundation grants, be sure to explore non-traditional sources as well. This section explores two examples – local service organizations and school health center sponsors.

[8] Portions of this section were adapted from material developed by the national School-Based Health Alliance

LOCAL SERVICE ORGANIZATIONS – Service organizations can be a great source of money and volunteers. Often their members perform community service as a requirement of membership. When approaching service organizations, a good long-term goal is to sustain an annual commitment to funding and/or in-kind support. To solicit support from local service organizations:

1. Develop a list of service organizations in your community (e.g., Lions Club, Rotary Club, Elks Club, Women's Club, Chamber of Commerce, or local chapters of national organizations like La Raza, the NAACP, the U.S Hispanic Chamber of Commerce, the American Association of University Woman or the AARP).
2. Determine each group's service interests, the types of special projects it supports, and the types of members it attracts.
3. Consider joining one or more of these organizations as appropriate. Encourage members of your advisory council to join civic groups as well.
4. Write the president or chair of the organization a letter that spells out your request, and ask if you can give a presentation to the group. Be clear and avoid the use of jargon or acronyms.
5. Follow up your letter with a phone call.
6. If you get the opportunity to give a presentation, consider bringing a youth representative.

Once an organization donates money or time to your school health center, make sure they will want to donate again:

- Stay in touch! Periodically send photos and updates about your work and the ongoing value of the organization's donation.
- Send a thank you letter, and possibly include a personal note from one of your youth leaders.
- Acknowledge the organization's support in your newsletters, mailings, website, or other outreach materials.

SPONSORSHIPS – Many organizations are successful in recruiting sponsors for special events and activities; the same approach can be used for longer-term sponsors also. Sponsors can be from the local community or even national corporations. Look for organizations that support your mission or have a good record of community involvement. Don't forget the companies with which you do business – for example, pharmaceutical companies and office supply vendors. When you approach a potential sponsor, be clear about:

- The exact nature of your request. For example, you are asking for food for an event that will be held on _____ and attended by _____ people.
- Range of options for giving. For example, we are seeking sponsors at three different levels of giving, $500, $1,000, $2,000 or we are seeking monetary sponsors or donations of supplies.
- What you will do for them in return, e.g., include the company logo in your promotional materials or on your Website, or pass out their promotional materials at your event.

WORKSHEET: DETERMINING YOUR FUNDRAISING STRATEGY

This worksheet will help you plan and implement a funding strategy for your school health center. To best estimate staffing and other health center costs (including those below), use The California School Health Center Financial Sustainability Tool, available through our website. The worksheets below may be used to summarize your actual or projected costs.

1. Using estimated personnel costs, the Financial Sustainability Tool, and any projected expenses you already know, develop an estimated annual budget for your health center.

PERSONNEL	Estimated Annual Salary
School Health Center Coordinator	$
Medical Practitioner(s)	$
Mental Health Practitioner(s)	$
Clerk	$
Other	$
Fringe Benefits @ ___ %	$
Total Personnel Cost	**$**
NON-PERSONNEL	**Estimated Annual Amount**
Medical expenses	$
Office supplies	$
Other	$
$	
Indirect Costs @ ____ %	$
Total Non-Personnel	**$**
GRAND TOTAL	**$**

2. List any funding sources that are already committed to support your school health center.

COMMITTED FUNDING SOURCE	Amount of Grant or Donation
In-kind support from your school	$
Local contributions	$
In-kind or financial support from local health department	$
Other state or federal grants	$
Foundation grants	$
Third party billing reimbursement	$
Other	$
Other	$
Other	$
Other	$
Total Funds Already Committed	$
Your Estimated Annual Costs (from above)	$
Subtract the Difference This is how much money you need to raise.	$

3. Fill out the following table to develop a plan. Some samples are provided here:

Potential Funding Source	Amount (Range)	Likelihood of Success	Timeframe to Funding	How To Approach
Local Rotary Club	*$500-$1,500*	*75%*	*3 months*	*Draft a letter. Ask the Advisory Council Chair, who is a Rotarian, to deliver the letter to the club.*
Federal SAMHSA grant for mental health services	*$20,000-$60,000*	*35%*	*6 months*	*Research grant online and subscribe to receive RFP when it comes out. Read it thoroughly and put together a community partnership to develop the proposal. Develop a process that includes peer review.*
The California Wellness Foundation	*$50,000*	*50%*	*9-12 months*	*Request meeting with program officer. Write a letter of intent, per the foundation's guidelines, and co-sign it with the school principal. Follow up with the foundation 2 weeks later by phone.*

4. Using the information in your "How to Approach" column, develop a long-term action list for yourself and your colleagues. Remember to call on your professional colleagues, other community organizations, and Advisory Council members to help.

Action Steps	Responsible

CHAPTER

06 Licensing and Regulations

School health centers must meet various legal and regulatory requirements involving the facility used to deliver primary care clinical services, the certification of laboratory services provided in the clinic, and eligibility for reimbursable services under various insurance programs. This chapter provides an overview of these requirements.

PRIMARY CARE LICENSING

Most primary care clinics operating in California must be licensed by the Cailfornia Department of Public Health (CDPH). They must follow guidelines established by CDPH's Licensing and Certification Program (L&C) and the U.S. Centers for Medicare and Medicaid Services (see "Medi-Cal Certification" below).

There are, however, several types of clinics that are exempt from state licensure requirements; the most relevant example is school health centers run by a school district (see text box at right). Other examples include Tribal Clinics, HMOs, and community mental health centers.

> Primary care clinics qualify for exemption from clinic licensure under state Health and Safety Code if they are directly conducted, maintained or operated by a school district. In fact, because the state's licensing authority does not apply to exempt entities, such a clinic **can not** be licensed even if it wants to be. This may prevent such clinics from full participation in the Medi-Cal program, which may in turn limit some reimbursement opportunities. For example, district-run clinics can bill under LEA Medi-Cal, CHDP and Family PACT, but not Fee-For-Service or Minor Consent Medi-Cal. (For more information, refer to our member resource *Third Party Billing: A Manual for California's School Health Centers*.)

TYPES OF CLINICS

School health centers can operate under their own primary care clinic license, as a satellite or affiliate clinic of an existing medical facility, or as a mobile van.

FULLY LICENSED CENTER – If the school health center's lead agency or medical provider is not already a licensed PCC, the site must apply for licensure through Licensing & Certification (see "How to Apply", below). A school health center applying for PCC licensure must apply as a Community Clinic, Free Clinic, Mobile Clinic or Rural Health Clinic. This process typically takes more than 90 business days and often the preparation takes well over a year. When a school health center has its own primary care clinic license there is no limit to the number of hours the school health center may provide health care services. However, this arrangement is not very common.

SATELLITE OR INTERMITTENT CLINIC SITE – A school health center operated by a licensed primary care clinic (PCC) is exempt from licensing requirements if it is operated on separate premises from the licensed PCC and is open no more than 20 hours a week. This is known as a satellite or intermittent clinic.

Federally Qualified Health Centers (FQHCs) and other medical providers frequently operate school health centers as the satellites of a licensed "parent" PCC. The parent PCC provides all staffing, protocols, equipment, supplies and billing services for the satellite center. These sites do not require separate licensure; however, they must meet all other legal requirements and administrative regulations pertaining to fire and life safety.

AFFILIATE CLINIC – Affiliate clinics are additional sites of existing PCCs that have no restrictions on the number of hours they can operate. A school health center can operate as an affiliate clinic if the parent clinic has held a valid, unrevoked, and unsuspended license for at least five years prior with no history of repeated or uncorrected violations of law or regulation that pose immediate jeopardy to patients and no pending actions to suspend or revoke a license. The process for receiving an affiliate license is significantly shorter; the law requires L&C to act on affiliate applications within 30 business days.

MOBILE HEALTH CARE UNIT (VAN) – According to the Mobile Health Care Services Act, a "mobile service unit" can be approved as a service of a licensed clinic (similar to an affiliate clinic) or it may be separately licensed as a primary care clinic. More information about the requirements related to mobile health care units can be found at http://ceres.ca.gov/planning/pzd/1998/misc_16.html.

HOW TO APPLY

Applications for clinic licensure are processed by the Central Application Unit (CAU) of Licensing & Certification (L&C). L&C is responsible for ensuring health care facilities comply with state laws and regulations. In addition, L&C cooperates with the Centers for Medicare & Medicaid Services (CMS) to ensure that facilities accepting Medicare and Medi-Cal payments meet federal requirements.

For **intermittent or satellite sites**, the state recommends the following steps:

- Send a letter of notification to the local District L&C office within 10 days of opening the site. The letter should provide the parent clinic license number and address, the new satellite address, and a brief description of the services to be provided.
- Keep a fire and safety clearance, as well as other necessary administrative regulations and requirements, on file.

Once the District L&C office receives these documents, they reserve the right to conduct an on-site licensing survey (site visit) at any time.

When applying for a **new or affiliate clinic license**, certain forms and fees should be submitted to the CAU prior to opening the clinic. In general the following forms must be completed:

- **HS 200 – Application for Facility License** – must include various items indicating proof of compliance with California Building Codes; a copy of non-profit tax status from the IRS; organizational chart; and documentation of property ownership (e.g., lease or MOU with school)
- **HS 215A – Applicant Information** – includes information about facility administrator, Board members, and facility information
- **HS 309 – Administrative Organization** – includes information regarding governance, by-laws and articles of incorporation
- **HS 602 – Transfer Agreement (with a local hospital)**
- **HS 609 – Bed or Service Request** – check "Clinic Only"
- **STD 850 – Fire Safety Inspection Request (not required for mobile clinics)**
- **DHS 1051 – Civil Rights Compliance Review** – should be submitted directly to the Office of Civil Rights

More information about licensing, including all application forms and instructions, can be found at (www.cdph.ca.gov/pubsforms/forms/Pages/HealthFacilities-Clinics.aspx.

If all the forms are complete and other conditions met (e.g., if the Parent Clinic submits evidence of compliance with the minimum construction standards of adequacy and safety), CDPH must approve an affiliate clinic license without conducting an on-site inspection.

Mobile clinics will additionally need to provide information about vehicle registration and some other items (follow previous link for mobile clinic licensing requirements).

ADDITIONAL REQUIREMENTS

For most types of primary care licenses, the following conditions must be met:

- Clear signage with clinic hours visibly posted
- Valid Certificate of Occupancy

- The health center must have a name that will be utilized for all licensing, insurance and billing purposes
- The facility must be cleared by the fire department (see Chapter 8)

FQHCS ONLY – School health centers that will operate in conjunction with Federally Qualified Health Centers should take the following additional steps:

- File a scope of project change with the Health Resources and Services Administration (HRSA). For FQHCs covered by the Federal Tort Claims Act (FTCA), doing so will ensure that malpractice and liability coverage includes the school health center. Others should contact their insurance brokers to be sure the new site is covered.
- Prepare a cost report.
- Provide a Transfer Agreement with a local hospital.

MEDI-CAL CERTIFICATION

Primary Care Clinics that want to bill Medi-Cal must be certified. The following documents should be prepared and sent to the Central Application Unit (CAU), which will then forward this information to the Medi-Cal Provider Enrollment Branch for issuance of a Medi-Cal provider number. Forms can be downloaded at http://www.cdph.ca.gov/pubsforms/forms/Documents/LC-AllFormsPage.pdf:

- **HS 269** – Application for Medi-Cal Certification as a Clinic Provider (http://www.cdph.ca.gov/pubsforms/forms/CtrldForms/hs269.pdf)
- **HS 328** – Notice-Effective Date of Provider Agreement
- **DHCS 9098** (8/08) – Medi-Cal Provider Agreement

Satellite clinics are not required to have a separate Medi-Cal provider number; however, the state recommends that the parent clinic notify the Medi-Cal Provider Enrollment Branch when opening a satellite site using Form HS 269.

OSHA

School health centers should comply with the U.S. Department of Labor Occupational Safety and Health Administration (OSHA) rules, and staff should receive yearly training on OHSA rules and requirements. This typically includes, at a minimum, having plans for blood borne pathogen exposure, and making arrangements for infectious and biohazardous waste management. Staff should practice universal precautions at all times. For further information on OHSA see www.osha.gov.

LABORATORY REQUIREMENTS

The Clinical Laboratory Improvement Amendments of 1988 (CLIA) requires all entities that perform even one laboratory test to meet certain federal requirements and register with the CLIA program. To apply for CLIA certification, you must fill out the CLIA Application for Certification, Form CMS-116, from The Centers for Medicare and Medicaid Services (CMS), and mail it to the California Department of Public Health. The CLIA application collects information about a laboratory's operation which is necessary to determine the type of certificate to be issued and relevant fees. All CLIA certificates are effective for two years. An overview of this process, and information on the different types of CLIA certificates, is provided in the document How to Obtain a CLIA Certificate (www.cms.hhs.gov/CLIA/downloads/HowObtainCLIACertificate.pdf).

INSURANCE PROGRAM CERTIFICATION

CHILD HEALTH AND DISABILITY PROGRAM

The Child Health and Disability Prevention (CHDP) Program is a partial insurance program that reimburses providers for providing periodic health assessments and other preventive health care services to low-income children and youth[9].

[9] Since 2003, CHDP has operated in close connection with Medi-Cal, with the intent of helping California enroll more eligible children in the Medi-Cal and Healthy Families programs. The resulting effort, known as "CHDP Gateway," is a hybrid of CHDP, Medi-Cal and Healthy Families

Preventive care services include comprehensive physical exams and mandated screenings such as dental, vision, hearing and specified laboratory tests. The CHDP program also provides care coordination to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services.

CHDP services can be provided by private physicians, nurse practitioners, local health departments, community clinics and school districts. Clinics can participate in the CHDP program as a "comprehensive care" or "health assessment only" provider. Comprehensive care providers deliver not only health assessment services but also serve as the primary care home for the patient, inclusive of all treatment, follow-up and medical case management.

In order to become a CHDP provider and be reimbursed for services provided under this program, the agency providing medical services must complete the CHDP Health Assessment Provider Application. Medical providers may apply to become a CHDP provider simultaneously with the primary care clinic licensing application. For more instructions on how to apply: www.dhcs.ca.gov/services/chdp/Pages/BecomingaCHDPProvider.aspx.

Once an application is received, the local CHDP program (usually operated by the County or other local health department) performs an on-site review of an applicant's or provider's site to assure that a minimum standard is maintained in the delivery of quality care. The review includes a facility review and medical record review.

FACILITY REVIEW – All CHDP provider service sites must receive an initial on-site review; these sites may also have subsequent periodic inspections. A facility review is conducted to assess site access and safety, including the presence of appropriate emergency medical equipment and supplies; personnel qualifications, licensure and/or certification; site management; and compliance with CLIA. Specific components of the facility review tool are defined as "critical elements" which must be in full compliance before the facility can be considered for approval. Critical elements include the following:

- Appropriate equipment and staff training for airway, breathing and circulatory management
- Emergency medication on-site for anaphylactic reactions to immunizations
- Current professional licenses for site and all medical providers
- Participation in the Vaccines For Children program
- Compliance with the Pharmaceutical Services Survey Criteria
- Compliance with the Preventive Services Survey Criteria

MEDICAL RECORD REVIEW – The medical record review is performed to ensure that CHDP clients receive appropriate levels of care. Reviewers check for the following:

- **Format:** A well-organized system that permits confidential client care and quality review.
- **Documentation:** Well-documented medical records that facilitate communication and coordination, and promote the efficiency and effectiveness of treatment.
- **Coordination and Continuity of Care:** The medical record includes the client's past and current health status, medical treatment and future health care plans in an effort to ensure seamless continuity of care for the child.

More information on the CHDP application and review process can be found in the CHDP Provider Manual at http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/chdp/manual/

FAMILY PACT

Family PACT (Planning, Access, Care, and Treatment) is a state-run program designed to ensure access to reproductive health care services for uninsured and under-insured California residents. Services covered include reproductive health education, gynecological and male health exams, birth control methods, pregnancy testing, and testing and treatment for sexually-transmitted infections. Services can be provided by both licensed medical staff as well as unlicensed health educators.

School health centers can be reimbursed for providing these services to eligible clients by enrolling as a Family PACT provider. In order to become a Family PACT provider, the agency must be licensed as a primary care clinic and Medi-Cal provider in good standing; attend a provider orientation session; and submit completed Application and Enrollment Agreement forms. Certain services must be in place, as well as referral resources; and assurances of client confidentiality. For more details and to access these forms online visit www.familypact.org/en/Providers/provider-enrollment.aspx or call the Provider Resource Line 1-877-FAMPACT.

TITLE X

In 1970, Title X of the Public Health Service Act established the "Population Research and Voluntary Family Planning Programs." Title X is a federal grant program designed to provide comprehensive family planning services, including contraceptive supplies and information, to low-income individuals.

The Title X Family Planning program is administered by the U.S. Office of Family Planning (OFP). Title X grantees include community health centers, public health departments, tribal organizations, hospitals, and university health centers. In addition to contraceptive services and counseling, Title X clinics provide preventive health services such as breast and pelvic examinations; breast and cervical cancer screening; STI and HIV testing; and pregnancy testing and counseling.

Although the funding that programs receive from Title X does not begin to cover all the costs incurred in providing this care, it can help to subsidize the revenue received from Family PACT. In addition, the California Family Health Council (CFHC) – the organization that distributes Title X funds in California – also provides agencies with a variety of technical assistance and training, and raises money from private foundations and research grants which it passes on to delegates. In recent years, CFHC has operated a number of grant programs focused on adolescents and school health centers directly. In return, participation in Title X requires that health centers follow certain federal guidelines and collect specified data on clients, their birth control methods, and services provided.

To learn more about how to become a Title X agency, consult the OPA grants page at http://www.hhs.gov/opa/grants/index.html. Requests for proposals are released periodically.

VACCINES FOR CHILDREN PROGRAM

The Vaccines for Children (VFC) Program, established by an act of Congress in 1993, helps families by providing free vaccines to doctors who serve eligible children 0 through 18 years of age. In California, the VFC Program is administered by CDPH, Immunization Branch. Through this program, the state contracts with vaccine manufacturers to buy vaccines at reduced rates. Enrolled VFC providers then order vaccines for eligible children through the VFC Program and receive routine vaccines at no cost. To be eligible, children must be 18 years of age or younger and eligible for Medi-Cal or CHDP, uninsured, or American Indian or Alaskan Native. Children enrolled in the Healthy Families program are not VFC-eligible. Children who have health insurance that does not cover immunizations may receive VFC vaccines, but only at FQHCs or rural health clinics.

Any California-licensed physician or health care organization serving VFC-eligible children can become a VFC provider. Once certified, VFC providers must record patients' eligibility status and comply with CDC's Standards for Pediatric Immunization Practices (www.cdc.gov/mmwr/preview/mmwrhtml/00020935.htm). Providers are visited periodically by a VFC Field Representative who conducts a Quality Assurance Review.

MENTAL HEALTH PROGRAMS

The California Department of Mental Health administers a number of behavioral health programs for children and youth. It is beyond the scope of this manual to fully outline all the mental health programs in California. In terms of mental health *insurance program certification*, the most important is the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. This is a billable program for children and youth under 21 years old who qualify for full-scope Medi-Cal and need therapeutic behavioral health services. EPSDT providers may be employed by a county, a community mental health agency, or a school district. EPSDT is managed by county mental health/behavioral health departments. To become an EPSDT provider, you must establish a contract with your local county behavioral health department; please contact them for details.


LA
NY

CHAPTER 07 Operations

SCHOOL HEALTH CENTER GUIDELINES

We have developed guidelines for school health centers in California (see Appendix D). These guidelines have not yet been adopted as *certification standards* by any certifying agency but are a helpful tool in guiding health centers toward practices and operations that support high-quality services. In these guidelines, school health centers are defined as school-based, school-linked, or mobile school health programs that offer at least one of the following types of clinical care: medical, behavioral health, and/or dental care. Both a minimum and a recommended scope of services are outlined for each type of clinical services provided. There are also minimum guidelines for all types of school health centers, some of which are summarized below. Some of the guidelines, such a those related to staff certification, licensing, and facilities, are fully developed in other chapters in this manual.

ADMINISTRATION – The school health center should have a lead agency with overall responsibility for administration, operations and oversight. There is an identified staff person responsible for the health center's overall management, quality of care, and coordination with school personnel.

FACILITY/PHYSICAL SITE – All school health centers must be housed in a facility, whether stationary or mobile, that is easily identifiable by students, families, and school staff. The facility must include at least one confidential treatment space appropriate to the services provided, as well as an additional area for patient and family reception, enrollment, and triage. See Chapter 8 for more detail on facilities components and planning.

ACCESSIBILITY – School health centers are intended to increase access to care, especially among traditionally underserved populations, and in geographic areas where there is limited access to care. In particular, our position is that school health centers should serve all students in the school regardless of insurance status or ability to pay. The center may also serve siblings, parents or other community members and may develop its own policies regarding fees and accessibility of services for these populations. Other mechanisms to increase the accessibility of services include maintaining hours of operation that meet the needs of students and families, facilitating transportation to the health center, establishing comprehensive non-discrimination policies, and providing language/translation services as needed.

HEALTH INSURANCE OUTREACH AND ENROLLMENT – All school health centers should take steps to ascertain student insurance coverage, health plan, and primary care provider (if applicable) with the goal of obtaining this information for all students seen at the health center. The health center should facilitate student enrollment in health insurance programs such as Medi-Cal, Healthy Families or other local coverage options.

THIRD PARTY BILLING – It is important that school health centers maximize revenue from available sources. The health center should bill CHDP, Medi-Cal, Healthy Families, health plans and/or other third party payers as appropriate based on the lead agency, community and services provided. For more detail on billing sources for medical services, case management, and outreach, please see our related member resource, *Third Party Billing: A Manual for California's School Health Centers*.

QUALITY IMPROVEMENT – School health centers should adhere to relevant standards of care adopted by national professional organizations such as the American Academy of Pediatrics, Society for Adolescent Medicine, American Dental Association, etc. Quality improvement efforts should be tied to evaluation, such as gathering feedback from both clients and school stakeholders through annual needs/resource assessments and age-appropriate client satisfaction surveys as well as satisfaction surveys with parents and school staff. Focus groups or a "comments box" can also be used for this purpose. Please see Chapter 9 for more detail.

CONTRACTS AND MEMORANDA OF UNDERSTANDING

There should be a written, formalized relationship between the school or school district and health providers. Each school health center will develop contracts, Memoranda of Understanding (MOUs), or Letters of Agreement (LOAs). These legal documents lay out relationships and responsibilities associated with the school health center. These agreements may describe the relationship between the school district and the provider(s), or between the district and the lead agency for the health center, which should then have its own written agreement with other service providers. The contract or agreement should be active (not expired); the term/length of the agreement may be decided by both parties involved; the agreement may define a process for reviewing what is working/not working during the "life" of the agreement. (See Appendix A for examples.)

The essential elements of an agreement include:

- Formal naming of parties to the agreement
- Duration
- Purpose
- Scope
- Each party's responsibilities
- Fiscal accountability including compensation and billing
- Confidentiality issues
- Reporting accountabilities
- Liability statements
- Failure to perform procedures
- How to amend, extend, renew or terminate the agreement

Agreements with different agencies may include many more elements, including agreement on specific aspects of school health center operation.

COMMUNICATION AND COLLABORATION

COMMUNICATION WITH SCHOOL STAFF

There should be a process for referring students/families to the health center that is understood and approved by school staff and administrators. The referral process should *facilitate* access to care as opposed to relying on the student/family to initiate contact with the health center. Mechanisms for facilitating access could include: walking the student/family to the health center, assisting with scheduling an appointment, initiating contact from the health center by calling students out of class or calling families at home (while protecting student confidentiality).

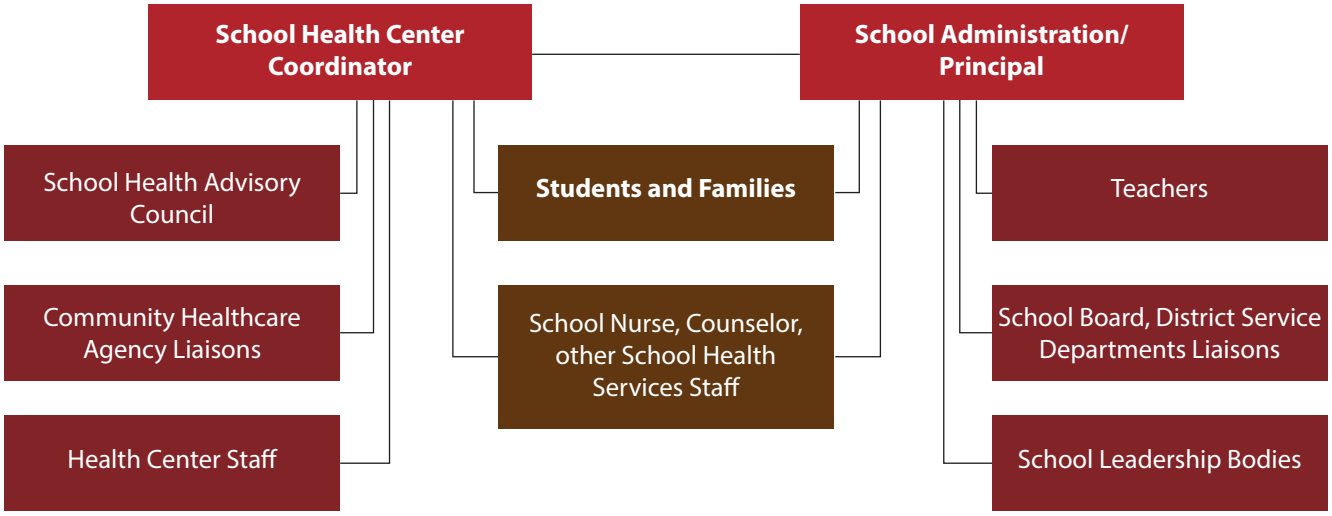
School health centers should develop policies/protocols to coordinate care, ensure continuity of care, and facilitate case management in partnership with the school and other service providers. School personnel include credentialed school nurses, health assistants, administrators, teachers, counselors, and support personnel. One process for this coordination may be through the school's Student Success Team. In particular, there must be coordination between the health center and the school nurse or health assistant (if applicable) including delineation of roles and responsibilities (especially for state-mandated health services in the absence of a school nurse). There should also be protocols defining permissions related to sharing of medical information (e.g., immunization records, serious medical conditions) and procedures for service coordination, reviewing how the partnership is going, and making needed adjustments.

School health centers must provide services in keeping with district policies and related administrative regulations, which outline how a policy should be implemented. For instance, a district's governing board may expand or limit the range of services that may be provided by school health centers, such as reproductive health services, or condom

availability, for adolescents. District health policies may also dictate how schools handle certain conditions, like head lice, outlining whether students may attend school if they have head lice eggs, or "nits," in their hair. There are also site-based procedural issues that should be identified and adhered to, such as how/when students may be called out of class for a clinic appointment. Some policies and procedures may be advocated for or appealed by a school health center or clinical staff. It is best to work with an "internal" district ally in these efforts, as they will understand the procedures by which new policies may be introduced, or existing policies may be changed.

All school districts must now have a "Local School Wellness Policy." The development and implementation of this policy is an excellent opportunity for the school health center to bring health expertise to bear on district policies and perform a useful service for the district which may be struggling to implement the policy. One model that has been used successfully by some districts to create a comprehensive Wellness Policy is CDC's Coordinated School Health Model (described in Chapter 1).

It is vital that school health center staff communicate regularly with school staff. A sample model of this communication is provided below:



COMMUNICATION WITH OUTSIDE PROVIDERS

The school health center must develop procedures for communicating with the primary care providers (PCPs) of the clients for whom the school health center is not serving as the PCP. These procedures are necessary to promote continuity of care, facilitate provider collaboration, assure appropriate utilization of health resources, and ensure appropriate protection of confidentiality. When a student's PCP and/or health plan are identified, the PCP and/or health plan should be notified every time the patient/ member receives a prescription for a new medication or adjustment of existing medication. It is also strongly recommended, though at the clinician's discretion, to also notify the PCP when the patient/ member receives:

- A well-child/adolescent examination
- Immunizations
- Diagnosis of an acute condition that requires follow-up
- Recurring episodes related to a chronic condition

CULTURAL COMPETENCE

The United States health care system is caring for an increasingly diverse nation. Since the year 2000, California has become a "minority-majority" state, and 65% of school-aged children are people of color. It is therefore essential to consider the impact of cultural issues on students, their families, and providers. The reality is that U.S. health care

providers offer services along a spectrum of cultural competency, from recognizing to understanding, to appreciating the significance of diversity. Culture impacts people's views about general health care, reproductive health care, and consent issues. According to one definition:

> *"A culturally sensitive health care system is one that is not only accessible, but also respects the beliefs, attitudes, and cultural lifestyles of its patients. It is a system that is flexible – one that acknowledges that health and illness are in large part molded by variables such as ethnic values, cultural orientation, religious beliefs, and linguistic considerations. It is a system that acknowledges that in addition to the physiological aspects of disease, the culturally constructed meaning of illness is a valid concern of clinical care. And finally, it is a system that is sensitive to intra-group variations in beliefs and behaviors, and avoids labeling and stereotyping." According to the Kaiser Family Foundation, it is also important to take into account other population groups such as those defined by social class, religious affiliation, and sexual orientation may also have unique perspectives that should be incorporated into the definition.*[10]

Cultural and linguistic competence is a set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals that enables effective work in cross-cultural situations. "Culture" refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious or social groups. "Competence" implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors and needs presented by consumers and their communities.[11]

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

1. Promote and support the attitudes, behaviors, knowledge, and skills necessary for staff to work respectfully and effectively with patients and each other in a culturally diverse work environment.
2. Have a comprehensive management strategy to address culturally and linguistically appropriate services, including strategic goals, plans, policies, procedures, and designated staff responsible for implementation.
3. Involve the advisory council in designing culturally competent service delivery.
4. Develop and implement a strategy to recruit, retain and promote qualified, diverse and culturally competent administrative, clinical, and support staff that are trained and qualified to address the needs of the racial and ethnic communities being served.
5. Require and arrange for ongoing education and training for administrative, clinical, and support staff in culturally and linguistically competent service delivery.
6. Provide limited English proficiency clients with access to bilingual staff or interpretation services.
7. Translate and make available signage, other visuals such as posters, and print materials (e.g., brochures, flyers, magazines) in commonly used languages.
8. Ensure that the clients' primary spoken language and self-identified race/ethnicity are included in the medical record.

CONFIDENTIALITY AND CONSENT

Every school health center must be familiar with laws and professional ethics regarding consent for various types of treatment and sharing of health information. A summary of those that pertain to most school health centers is provided below. A detailed guide to Understanding Minor Consent and Confidentiality in California: A Provider Toolkit is available from the Adolescent Health Working Group at: www.californiateenhealth.org/download/teen_confidentiality_doc.pdf

[10] *This Land Was Made for You and Me: Cultural Competence in School-Based Health Centers*, published by the Center for Health and Health Care in Schools, http://www.healthinschools.org/sh/cult2.asp.

[11] Office of Women and Minority Health at the Bureau of Primary Health Care, HRSA.

CONSENT FOR TREATMENT

State and federal law prescribe whether a minor's parent or guardian must consent to the minor receiving specific services or whether the minor can consent him or herself.

PRIMARY MEDICAL AND DENTAL CARE – In general, the parent or guardian must consent to a minor receiving primary medical or dental services. In an emergency, however, a medical or dental provider may treat a minor who has a condition or injury which is considered an emergency, but whose parent or guardian is unavailable to give consent. In this case the provider should document their effort and the circumstances carefully.

REPRODUCTIVE HEALTH CARE – Minors of any age can consent to family planning and contraceptive services with the exception of sterilization. Minors age 12 and over can consent to their own diagnosis and treatment of sexually-transmitted infections, including HIV. Minor consent law extends to health education provided in a clinic setting but may NOT extend to classroom health education. If a school health center wants to provide family life or sexual health information within the school curriculum, it should consult with its school district's Board of Education.

PREGNANCY-RELATED CARE – Minors may consent to any pregnancy-related care including pregnancy testing, prenatal care, and abortion. Being pregnant does not by itself, however, emancipate a minor (see below). In other words, a non-emancipated pregnant teen still needs parental consent for primary care, dental or mental health treatment (unless other exceptions have been met).

MENTAL HEALTH – In general minors cannot consent to their own outpatient mental health treatment; however, those age 12 and over can consent to limited mental health services if both of the following are true:

- The minor, in the opinion of the mental health professional, is mature enough to participate intelligently in services; AND
- The minor would present a danger of serious physical or mental harm to self or to others without the mental health treatment or counseling OR is the alleged victim of incest or child abuse.

The parent or guardian must consent to the prescription of psychotropic medications.

SUBSTANCE ABUSE TREATMENT – A minor who is 12 or older may consent to medical care and counseling relating to the diagnosis and treatment of a drug or alcohol related problem. However there are many subtleties imbedded within the various laws and ethics governing substance abuse treatment; health centers planning to provide substance abuse treatment should become familiar with the details.

EMANCIPATED MINORS – In California, emancipated minors may consent to medical, dental or psychiatric care without parental consent. Minors are considered emancipated if they are currently or have been married or are participating in the armed services. The court may additionally declare a minor emancipated if it finds that the minor:

- is at least 14 years old;
- willingly lives separate and apart from parent or guardian with the consent or acquiescence of the parent or guardian;
- is managing his or her own financial affairs;
- does not derive his or her income from criminal activity; AND
- emancipation would not be contrary to his or her best interests.

In addition, a minor may consent to his/her own medical or dental care if he or she:

- is at least 15 years old;
- is living separate and apart from the minor's parents or guardian, with or without the consent of a parent or guardian and regardless of the duration of the separate residence; AND
- is managing his/her own financial affairs, regardless of income source.

CONFIDENTIALITY

How providers share information about health care services provided to patients is governed by federal and California law, as well as professional ethics. As a general rule, whoever has the right to consent to a given health care service is also the only individual who can view the records related to that care and is also the only one authorized to control the disclosure of that information. So, for example, a parent can access his child's primary care medical and dental records, and permit disclosure of these records to outside parties; however, he may not view or release records related to birth control or pregnancy testing without his minor daughter's explicit consent.

State law does provide for certain exceptions to these confidentiality rules in the following circumstances:

- if the provider knows or reasonably suspects that a minor is the victim of child abuse or neglect
- if the patient expresses or indicates a threat of serious harm to self or other(s)
- if the minor is engaged in sexual activity with a minor which is coerced or exploitative
- If a minor under age 16 is involved in sexual activity with an adult age 21 or over
- if a minor under age 14 is involved in sexual activity with a minor age 14 or over
- it the patient tests positive for certain infectious or communicable diseases such as syphilis, Chlamydia, gonorrhea or HIV[12]

In general, mental health providers must involve a parent or guardian in the treatment of minors unless, in the opinion of the treating professional, it would be inappropriate and this is *documented in the minor's record*. It should also be noted that health care providers may refuse to provide parents or guardians access to a minor's medical records when they determine that this access would have a detrimental effect on the minor or the provider's professional relationship with the minor.

School health centers should make the rights of clients very explicit during the registration process and early clinic visits. We are working with the National Center for Youth Law to develop a set of sample consent forms for school health centers. These will be available through our website, and as a supplement to this toolkit. (A sample school health center information and consent package is available in Appendix E.)

HIPAA – In 1996, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA) to address the problem of health insurance confidentiality in the era of electronic information. Federal HIPAA regulations generally restate California law regarding confidentiality and information-sharing. HIPAA permits health care providers to share health information, without written release, to other health care providers, health plans or contractors for purposes of diagnosis, treatment or payment. In other cases, authorization must be obtained from parents or minors using a HIPAA-compliant release of information form. Overall, the minimum amount of information needed should be disclosed.

HIPAA regulations are detailed and carry both financial as well as criminal penalties for non-compliance. Most school health centers are subject to HIPAA regulations and should train staff to follow procedures established by the sponsoring agency. For more information on HIPAA, see www.hhs.gov/ocr/hipaa.

FERPA – The Family Educational Rights and Privacy Act (FERPA) was passed in 1974. FERPA requires that schools receiving federal funding must hold the information in a student's education records confidential, making it available only to parents or students over the age of 18 years or to those within the school who have a "need to know" in order to provide adequate education. FERPA is administered and enforced by the U.S. Department of Education's Office for Civil Rights. School districts have been operating under FERPA for many years and all school districts should have standards in place to comply with the requirements of this law.

Generally schools must have written permission from the parent or eligible student in order to release any information from the student's record. This includes health information documented by school personnel such as nurses, psychologists and physical therapists. Schools, on the other hand, are specifically exempted from HIPAA, creating ambiguities for school health centers run by school districts. For more information on FERPA, see www.ed.gov/offices/OM/fpco.

[12] Until recently, California maintained only general data on the prevalence and incidence of HIV in the state. Since 2006, however, a names-based reporting system has been established, and this information must be reported. Anonymous HIV testing is still an option for some providers.

CHAPTER 08

School Health Center Facilities

School health centers can be constructed in a variety of spaces, ranging from converted classrooms to adjunct portables to stand-alone school-based or school-linked buildings. Some schools have provided shop buildings or locker rooms that are no longer in use; large spaces such as these can provide an ideal environment for innovative designs. As discussed earlier, some school health services are delivered from a mobile van. There are site infrastructure requirements for mobile vans, such as finding/creating an appropriate pad or parking place for the van, and establishing the requisite electricity, water, and sewage disposal facilities. For specific requirements for mobile van facilities, please refer to ceres.ca.gov/planning/pzd/1998/misc_16.html

The health center should be thoughtfully planned and designed to support the services it will provide. Various stakeholders – including students, parents, school nurses, school administrators and health center personnel – should participate in the design process. Building contractors and architects should ensure that the health center design follows the functional specifications and adheres to relevant building codes and regulations. Funding for facilities development must be secured well in advance of construction. This chapter includes information about various funding sources available for school health center construction and capital improvement.

DESIGNING THE SCHOOL HEALTH CENTER[13]

The following are some suggested steps to take in the process of designing your school health center facility.

1. **Goals and Planned Usage:** First identify the school health center programs and services that will be provided at the center (see Chapter 2, Community Planning).
2. **Operational Schedule:** Identify the anticipated hours of operation on a daily, weekly, monthly and annual basis. A preliminary calendar should be developed which identifies all programs and services that will be operated and when.
3. **Clients**: Identify the numbers and ages of the individuals that you project will utilize the center. Consideration should be given to caseloads and anticipated occupancy at any given time. This would include a comprehensive list of staffing, including full-time, part-time, and on-call staff.
4. **Relationship to School Nursing Services:** The relationship between the school health center and other school district health services should be clearly identified and integrated to the extent possible. School nursing services may be delivered from within the school health center or from a linked area nearby.
5. **Accessibility:** The specific needs and requirements for access to and from the center depend upon: (a) the relationship between the school health center and the school's other health programs; (b) the schedule of planned operations; and (c) the coordination of programs and services between participating agencies. There should be direct access from the interior of the school building to the school health center for students to receive services during school hours; some programs will require an external entrance to serve the public during school hours and when school is not in session. The center must be fully accessible to individuals with disabilities. If possible, there should be access for medical emergency vehicles.
6. **Function and Flow:** Imagine how the various functions and services will interact in order to determine how spaces should be clustered or arranged for the smooth and efficient flow of personnel, clients and materials. (See Appendix I for sample floor plans.)
7. **Parking:** Identify the number of parking spaces that should be provided or considered for staff and patients. Disabled parking and accessibility must be provided.

[9] Much of this section is adapted from *Guidelines for Maryland School-Based Health Centers*, The Center for Health and Health Care in Schools.

8. **Security:** The school health center should be planned for a high level of security. Particular attention should be given to areas where medical records, medical supplies and equipment will be located. Access to the center should be limited to health center staff and a security system installed if possible.

KEY ELEMENTS OF SCHOOL HEALTH CENTERS

Although designs and needs will vary, there are some considerations which are universal. All school health centers should guarantee privacy, confidentiality, and a sense of well being.[14] They should be inviting to students, other clients and the public and operate within an appropriate physical plant. The facility must have current fire and building safety certificates and comply with laws and regulations governing health facilities, particularly the Americans with Disabilities Act (ADA) and state laboratory requirements. (See Chapter 6 for more information on facilities licensing.) More details on each of these areas are provided below.

Privacy: The facility's physical layout should meet students' need for privacy. The waiting area should not be visible from an external hallway; the examination/counseling room/s should be secluded from the rest of the health center by walls or partitions; and there should be at least one phone line in a private room. Privacy should be fostered, both acoustically and physically: for example, if walls are not soundproof, white noise machines should be used.

Confidentiality: Patient health records must be confidential, so all school health centers should have locking filing cabinets and storage spaces for medical records and medications. Charts, files, schedules and equipment should be kept out of patients' reach. If the health center serves both adolescents and a wider age group, provide separate spaces or specific hours of service for teen clients so that they do not fear encountering parents or neighbors in the center. Having confidence in the confidentiality of services is one of the most important factors related to teen usage of a school health center.

Sense of well-being: School health centers should offer a relaxing and soothing atmosphere to foster student and family comfort, safety, and calm. Soft colors promote quiet and concentration, and natural light from windows relieves strain and anxiety. Minimizing noise can lower blood pressure and lessen frustration. Especially in large urban schools, this "safe space" can offer a real respite from the challenges of daily school life, particularly for students with physical and emotional difficulties.

Spatial requirements: The spatial requirements for each school health center will depend on the programs and services to be provided. The spaces identified below are a partial listing of programs or services, and the range of square footage that might be required. In some situations, multiple exam or counseling rooms will be required; in others, it may be possible to create shared functional spaces, such as a charting area with laboratory, or a cot room combined with office supply storage. In considering space requirements, consider both functions and regulatory requirements. The figures below offer estimated net square footage for each type of space required.

Program/Service/Function	Estimated Square Footage
Waiting/reception area	75 – 200
Office(s)/charting area – each	60 – 120
Sick/resting area (for student cots)	100 – 200
Examination/counseling room(s) - each	80 – 100
Bathroom	50 – 120
Laboratory	80 – 150
Record storage	50 – 75
General storage	50 – 100
Conference/meeting space/break room	120 – 200
Custodial closet	15 – 30

[14] Adapted from *School Health Centers*, National Clearinghouse for Educational Facilities.

Climate control and ventilation: School health centers are often at the mercy of larger (and sometimes antiquated) systems for heating, cooling and ventilation. If possible, a separate mechanical system should be considered, particularly if it the health center will operate during non-school hours. Health center management should have access to these controls to ensure a comfortable and sanitary environment for patients. Special attention should be given to exam room(s), lavatories, and the laboratory.

Plumbing: A sink with hot and cold water should be provided in each examination room, each lavatory and in the lab room/area. Ideally, the water controls should be hands-free to reduce contamination.

Electrical/electronic requirements: Electrical outlets should be provided in all spaces as required by code, which local facilities staff or contractors will outline for you. The electrical circuit for refrigerators and freezers should remain active at all times, even when school is not in session, or valuable vaccines may be lost (see Chapter 6 for VFC requirements.) Locations should be identified for telephones, computer terminals, modems and/or local area networks. When possible, the school's central phone, intercom, and/or public address system should be connected to the school health center.

Lighting: Natural lighting should supplement artificial lighting in the school health center. Lighting in each space should be controlled by the occupant of the space. Special attention should be given to lighting in the space that will be used for vision testing.

Sanitary requirements: Surface finishes for floors, walls, windows, window coverings and counter tops should be designed for easy cleaning and sanitizing. Provisions should be made for custodial services and the containment and removal of biohazardous waste .

Display: Identify any requirements for bulletin boards, tack strips, display cases, display racks for educational materials, and chalkboards as required and appropriate.

Furniture and equipment: The movable furniture and equipment required for each space should be identified. This includes desks, tables, chairs, bookcases, cots, storage cabinets, file cabinets, computers and printers, telephones, photocopier, wall clocks, refrigerator, freezer, exam table(s), and other medical/dental equipment.

ADA requirements: The construction and alteration of most public and non-profit buildings must comply with Title III of the Americans with Disabilities Act (ADA) – the ADA Standards for Accessible Design (www.ada.gov/adastd94.pdf). In health care and educational settings, the standards establish specific dimensions for hallway, doorway, and room clearance, to name a few. Local district facilities departments as well as contractors will be able to describe and apply ADA requirements appropriately.

Fire clearance: Fire clearances are required by the Health and Safety Code prior to initial licensing or before any changes to a licensed facility can be approved by the State. State-licensed health care facilities require a fire safety inspection to be conducted by the local fire authority (either City fire department or County Fire Marshall for unincorporated areas). Prior to your application for state licensure you may request that the fire department conduct a pre-inspection to help you identify any possible changes needed. A fire clearance application, site and floor plans, and applicable fees, are required. The facility may also need local Zoning, Building or Fire Code permits. The Fire Marshal's Office cannot issue a fire clearance until all agencies' requirements have been met. Contact your local fire department to learn more.

FINANCING FOR SCHOOL HEALTH CENTER FACILITIES

Most new school health centers require funding to construct or renovate their facility. In order to determine the capital costs required, follow the steps above to identify the overall square footage involved, including wall thickness, circulation space and any connecting corridors. A budget should then be developed that realistically reflects the estimated cost for new construction, renovations, and/or additions. In addition, the school health center facilities development plan should be included in the school district facilities master plan.

> **In 2006, Oakland voters passed Measure B, the most significant construction program in the history of the Oakland Unified School District. The $435 million bond was restricted to a list of specific projects, including the construction or renovation of 10 school health centers.**

School health centers in California have primarily relied on state and local funding to support construction of their facilities. Specific funding available for school health center facilities includes:

STATE SCHOOL FACILITIES GRANTS

The California Department of Education (CDE) allows school facilities grants, including modernization grants and new construction grants, to be used for constructing school health centers within existing school facilities.

Modernization grants must be used to modernize or update outdated and unsafe facilities. Grants are based on the number of students served by the district/school to be modernized, and require a 40% local match. Because most districts use their entire modernization grant to update classroom and core support facilities, little modernization funding has been used to support school health center construction.

New construction grants can be used if a school health center is being designed and built simultaneously with the new construction of a school. In this case, the district would develop a facilities master plan, identify potential site(s) for the new school facility inclusive of the school health center, and then the CDE would evaluate and approve the proposal. School districts are required to match 50% of the state grant for new construction.

Finally, the CDE has defined a **Joint-Use Program** under the School Facility Program. This program allows a school district to utilize funds from a joint-use partner to build projects such as libraries, child care facilities or gymnasiums. Over $100 million has been made available for these projects, and although the state has generally not recognized school health centers as a valid use of this funding. Proposed legislation may change this, so planning groups should contact the state to determine if their project might be eligible for joint-use funding: http://www.cde.ca.gov/ls/fa/sf/jtuse.asp

LOCAL BONDS

Some school districts such Los Angeles Unified School District are using funds from local bond measures to finance their local "joint-use" projects, including school health center construction. Due to inadequate state facilities funding, many school districts secure funding for school facilities repair and construction by issuing local general obligation bonds. These bonds can be authorized with the approval of either 66.67 or 55 percent of the voters in the district. The bonds are repaid with local property tax revenue. School districts can also impose developer fees levied on new residential, commercial and industrial developments. Developer fees vary significantly by community, depending on the amount of local development. In fast-growing areas, the fees could make notable contributions to school health center construction. Finally, school districts may form special districts to sell bonds for school construction projects, known as **"Mello-Roos" bonds**. These bonds require two-thirds voter approval, and are paid off by property owners located within the special district.

CALIFORNIA HEALTH FACILITIES FINANCING AUTHORITY (CHFFA)

Medical service providers can sometimes secure facilities funding from CHFFA. CHFFA provides public and non-profit health care providers with loans, grants, and tax-exempt bonds. CHFFA also provides loans to small and rural health facilities through the HELP II Financing Program and offers two grant programs, the Children's Hospital Program and the Community Clinic Grant Program. CHFFA financing may be used for the following project-related costs:

- Construction
- Remodeling and renovation
- Land acquisition (as part of the proposed project)
- Acquisition of existing health facilities
- Purchase or lease of equipment
- Refinancing or refunding of prior debt
- Working capital for start-up facilities
- Costs of bond issuance, feasibility studies and reimbursement of prior expenses

For more information on grant and loan cycles, go to: http://treasurer.ca.gov/chffa/

COMMUNITY DEVELOPMENT BLOCK GRANTS (CDBG)

CDBG grants are administered by the California Department of Housing and Community Development, and may also support school health center facilities construction. The primary federal objective of the CDBG program is the development of viable urban communities by providing decent housing and a suitable living environment and by expanding economic opportunities, principally for persons of low and moderate income. Each year the program makes funds available to eligible jurisdictions through several allocations; school health centers may be constructed or renovated with General CDBG grants. Grant-funded activities must be directed toward the planning of a project which, if brought to completion, would be a CDBG-eligible activity in which at least 51 percent of the beneficiaries would be low or moderate income households.

Each year the program makes funds available to eligible jurisdictions such as cities and city districts. Notices of Funding Availability are published for each allocation as the funds become available. More information is available at www.hcd.ca.gov/fa/cdbg/about.html.

OTHER SOURCES OF FUNDING

Some foundations will support construction or equipment costs. School sites or districts with a higher tax base may have general facility funds to allocate to school health center construction. If a federally qualified health center is going to be the medical provider, it may have access to funding sources for facilities. The federal stimulus package passed in February 2009 includes $1.5 billion for construction of clinic facilities. Creatively leveraging a variety of state, local and private funding sources is likely to be the most effective strategy for garnering adequate funds.

FACILITIES CONSTRUCTION PROCESS

This process will differ for school-based and school-linked health centers. Once the facilities design plan for a school-based site has been established, it may be required or advisable to update the school board. A presentation can include an overview of the needs assessment process and results, facilities design plans, and a rationale for how the new health center correlates with district and community goals.

If the health center will be on school grounds, preliminary architectural designs should be submitted to the Division of State Architecture (DSA) for review and approval (see www.dsa.dgs.ca.gov/PlanRev/default.htm).[16] The DSA requires some fees for Project Plan Submittal, and may also charge additional fees for later changes to the plans. Depending on the size of the project, DSA approval may take three months.

If approved, the DSA will issue a building permit and construction can begin. A core work group should be formed to guide and troubleshoot facilities construction. Members of this group may vary depending on whether the facility is school-based or –linked, who owns the land, and also who is the lead agency for the health center.

When health centers are constructed on school district property, special attention must be paid to developing clear work plans and timelines with the district facilities personnel and the local school board. District facilities departments are often understaffed and under funded, and many school districts will "contract out" construction projects other than basic maintenance and repair to outside building contractors. The school board should set clear expectations for the oversight and monitoring of construction projects.

Once construction is complete, the DSA schedules an inspection. If the facility is approved by the Inspector of Record, the DSA issues a certificate of occupancy. At the same time, the local fire department needs to inspect the property for fire safety.

[16] The DSA reviews plans for public school construction and certain other state funded building projects to ensure that plans, specifications and construction comply with California's building codes.

CHAPTER 09

Evaluation and Data Collection

This chapter provides an overview of evaluation for school health center services, with an emphasis on what you should consider in the early stages of planning and start-up. It is not a comprehensive guide to evaluation. Additional resources for evaluation are listed at the end of the chapter.

WHY EVALUATION IS IMPORTANT

Evaluation is important for several reasons. Although initially you may be able to secure resources and support for your school health center just because people believe it is a good idea, eventually funders, policymakers, and the school community will want some evidence that the clinic is a good use of scarce resources. This "evidence" can take many forms, and this chapter provides some ideas on how you can collect it. Second, once your school health center is up and running, you will want to know how you are doing. Are patients happy with your services? How could you improve them? How could you attract new patients? Evaluation can help you answer those questions. Finally, evaluation can be important simply because it is required by many funders. It is often easier and more effective to establish an overall evaluation plan than to try to create something for each new grant you receive.

WHY START EARLY?

Amidst the challenges of starting and funding a new school health center, it is easy to think that evaluation can wait until after you are actually up and running. While it is true that you cannot actually *complete* an evaluation until after you have something to evaluate, you should try to **start** as early as possible.

Why? Because there are important data that you can collect BEFORE the health center opens in order to document the CHANGE that the health center made. Think ahead five years. If you want to show that the school health center has reduced the number of children sent home due to illness or injury, you need to ask the school to keep a record of these numbers before the health center opens. The same is true for disciplinary referrals, school days lost to illness, immunizations, teacher satisfaction, and a variety of other measures. The more data you can collect before the health center opens, the more you have to compare to data you collect later.

FIRST STEPS

Evaluations come in many forms, ranging from those run by a team of external evaluators or researchers who collect and analyze data over a period of several years to simple data collection efforts by school health center staff. The scope of your evaluation will depend on the resources you have available, the questions you want to answer, the demands of your funders, and competing priorities.

If at all possible, we recommend consulting with a professional evaluator to assist you in developing an evaluation plan, even if you do not yet have the resources to hire an evaluator to collect and analyze your data. Most organizations involved in starting a school health center engage some type of consultant to assist with needs assessment and planning. In choosing such a consultant, you may want to seek one that also has evaluation experience and set aside several days of his/her time to work with you on an evaluation plan that is realistic for you. We assist members in finding and selecting evaluators. Please contact us if you would like help.

WHO IS YOUR AUDIENCE AND WHAT DO THEY CARE ABOUT?

Different audiences might have different questions and needs for information about the operation and impact of your school health center. While one evaluation might not address everyone's needs, it is worth considering many perspectives when planning your evaluation.

THE SCHOOL AND DISTRICT – Regardless of how they are funded or run, school health centers rely on collaboration and resources from their partner schools. Because resources are always scarce, the school will eventually want to know that the health center is a good value. Some outcomes that are likely to be important from the school's perspective include:

- Improved academic performance
- Increased attendance
- Lower dropout rates
- Improved student behavior
- Increased teacher satisfaction and reduced turnover
- Increased parent participation in school activities
- Increased parent and student satisfaction
- Improved school climate

CLINIC USERS – Clinic users (patients) will "vote with their feet." If they value the services the health centers provides, they will come; if they do not, they will seek care elsewhere. In this respect, potential clinic users are your most important audience. Patients may not be as interested in the graphs and tables you produce from your evaluation as they are in the changes you make in your services as a result of your evaluation. As you design an evaluation, consider assessing clients' (and potential clients') perspectives on:

- Ease of accessing clinic services
- Types of services provided
- Hours of operation
- Wait time for an appointment
- Friendliness of clinic staff
- Environment of clinic
- Confidentiality
- Stigma (or lack thereof) among peers

FAMILY/CAREGIVERS AND COMMUNITY MEMBERS – Although family and community members may not all use the health center, their support can be critical to its long-term sustainability. If community members believe that the school health center is making the school or neighborhood safer, helping families, or making the school more successful, they will be more likely to object if clinic funds are threatened. In planning your evaluation, consider the issues that are important to the community at large.

ELECTED OFFICIALS – Legislators, school board members and other elected officials want to use public resources wisely and keep their constituents happy. Many of the outcomes of interest to this group will be the same as those for the school and district. However elected officials will also be interested in health outcomes such as:

- Number of children served, especially uninsured
- Number of uninsured children enrolled in health insurance
- Number of immunizations or physicals given
- Prevention or youth development programs
- The popularity of the school health centers among parents and voters

- Support for the school health center among businesses, community leaders and other groups

HEALTH CENTER ADMINISTRATORS – Those involved in planning and managing the school health center may be the ones who make the best use of evaluation data. You will rely on this information to raise funds, demonstrate to local officials that the health center is valuable, make staffing and budgetary projections, improve the quality of your services and verify client satisfaction. School health center managers find that good data makes their own jobs easier and more effective.

TYPES OF EVALUATION

There are different types of evaluation; the approach you take will depend on the questions you want to answer. Two common types are process evaluation, and outcome evaluation. A process evaluation can assess strengths and weaknesses of the school health center, versus an outcome evaluation, which might track the health impacts of your program on clients. Following is a brief overview of these two types of evaluations to help you understand what type of questions each can answer.

PROCESS EVALUATION

Process evaluation looks at program implementation. Did you deliver the services you intended? Did you serve your target population? Did you serve as many students as you had expected? If not, why not? Successful implementation of a new program is not always on a straight road, you may take some unexpected turns along the way. The data you collect through process evaluation can help you make decisions as you fine tune your program.

This type of evaluation also focuses on the operations and dynamics of a program in an attempt to understand its strengths and weaknesses. It can capture changes in the system. Process evaluation helps answer questions like:

- What is happening at my school health center and why?
- Are school health center users representative of the school population? If not, which students are not accessing school health center services?
- What services are utilized the most? The least?
- How does the staff feel our program is going?
- Are the mental health and primary care providers in the school health center collaborating?
- In what ways is the collaboration between the school and the school health center improving services and in what ways is it hindering services?

Process evaluation often includes monitoring clients' and other stakeholders' experiences with the program. Client satisfaction surveys determine if your school health center is really meeting the needs of your target population. Satisfaction surveys answer questions like:

- Are clients and/or their families satisfied with the type of services offered?
- Are they comfortable with the staff?
- How do clients and/or their families think services could be improved?
- What additional programs or services would they like?
- How well is the school health center accepted by the school community?

Satisfaction surveys can take many forms including written surveys, focus groups, public forums and interviews with stakeholders. You can conduct needs assessments and client satisfaction surveys yourself, hire an evaluator to help, and/or engage your youth to help. For example, some clinics have measured the teen friendliness of their services by training a group of young people to anonymously visit the clinic as consumers and then systematically rate their experience with the services.[17] (See sample satisfaction survey in Appendix F.)

[17] *Measuring Teen Friendliness: A System for Young People to Assess Family Planning Service Facilities*, Philliber Research Associates and Cornerstone Consulting, 2000.

OUTCOME EVALUATION

Unlike process evaluation, which focuses on the program, outcome evaluation looks at the impact on clients, the school or the community. It measures change in your clients' knowledge, attitudes, behavior or condition as a result of your program services. It could measure changes in the school, such as family involvement, or in the community, such as crime rates. Outcome evaluation can examine changes in the short-term and in the long-term. It helps answer questions like:[18]

- Did the absenteeism rate go down after the health center opened? Or, how does the rate compare with that of a similar school without a school health center?
- Was there a reduction in suspensions or explusions after mental health services were started?
- Are students with access to a school health center more likely to have their vaccinations up-to-date than students without access to a school health center?
- Are there fewer 911 calls made from the school since the health center opened?
- Did students who participated in a health education program change increase their knowledge or change their behaviors after the program?
- Are teachers more likely to make referrals to your school health center now than when it first opened?
- Do teachers feel more supported and satisfied with their jobs?
- Are there more parents participating in school activities since the health center opened?

FINDING A COMPARISON

Outcome evaluation requires that you have some sort of comparison to make your case. There are two common types of comparisons you can make:

- Change over time, for example, absences before the health center was started and after a full year of operation.
- Differences between groups, for example, absences at a school with a health center and a similar school without a health center

The best, most scientifically valid, evaluations combine these two types of comparisons and track, for example, two demographically similar schools over time, one that implements a health center and the other that does not. Another example would be two similar groups of students, with one group receiving a health education program that the other does not. It is very difficult for a school health center on a low budget to conduct this type of study. Most likely you will have to make do with a less scientific approach, using your best judgment about what evidence is persuasive. We can advise on evaluation design issues and help you find an evaluator for your site.

CREATING A LOGIC MODEL AND EVALUATION PLAN

Having a clear road map for delivering your services and reaching your intended outcomes is necessary before you start planning your evaluation and data collection. This road map is often referred to as a logic model, which links your program activities (services) to the outcomes (both short- and long-term) you hope to achieve. There are many different formats for logic models but they all essentially have the same components:

Process Objectives		Outcome Objectives	
What services will you deliver?	Who is your target population?	What change will occur in the short-term?	What is the expected long-term change?

A logic model should follow a logical sequence from start to conclusion. It must make sense that if you deliver a set of services to the appropriately targeted population that you would then see the short-term change that you could reasonably expect would lead to the long-term change. Once you have a clearly stated logic model that identifies your program strategies, target population, and outcomes, the next step is for a professional evaluator to help you to develop an evaluation plan that is realistic for your school health center.

[18] Some questions drawn from A Guidebook for Evaluating School-Based Health Centers (1999) by Claire D. Brindis, David W. Kaplan and Stephanie L. Phibbs.

DEVELOPING AN EVALUATION PLAN

The most important thing to remember as you develop your evaluation plan is that you need to create a plan that is realistic for your school health center. You don't have to measure everything! In fact, without a sufficient budget and staff capacity you are likely to get overwhelmed if you try to document everything. Instead, it is best to check in with your stakeholders and prioritize what matters most to them. What is going to be the most compelling evidence for them that you are being effective? What are you required to track for your funders? What data are already being gathered (e.g., service delivery) that can tell your story? How can you collect other evidence in a way that is the least burdensome but the most likely to capture your outcomes?

As mentioned earlier, it would be worth the investment to hire a professional evaluator to help you develop your logic model and your evaluation plan. The evaluation plan ties directly to your logic model. It spells out how you plan to measure your process and outcomes. The plan identifies the source of the data, the frequency of data collection and who will be responsible for gathering the data. The professional evaluator can assess your capacity for gathering and analyzing data and will help you develop a plan that is realistic for your school health center.

Creating a realistic evaluation plan will increase the chances that you will be able to successfully implement it and have the evidence that you need in order to show your health center's accomplishments. Once you have decided on your evaluation plan, you must be committed to collecting data consistently. Incomplete data will not accurately tell your story and is best not to use at all.

WAYS TO COLLECT YOUR OWN DATA

Process evaluation and outcome evaluation both need data sources. You can collect your own data or use data sources. Most likely you will do some combination of the two. The following is a brief description of several common ways that you can collect your own data. It is not necessary to use all of these sources, however, your evaluation will be strengthened if you use a variety of sources.

SURVEYS – Surveys or questionnaires can be used for both types of evaluation. You can either use a standardized survey (one that has been created and tested by others) or you can create your own. It makes the most sense to create or adapt your own client satisfaction survey, as that way you can customize it to your unique program. However, it's best to use a standardized survey for capturing outcomes. Resources for creating your own surveys and finding existing standardized surveys that are commonly used in school health centers can be found at the end of this chapter.

Surveys can be anonymous, which is the preferred way to administer a satisfaction survey, or they can have the clients' names and/or "unique identifier" if you want to be sure that the same students took the pre-test as took the post-test. Matching pre- and post-tests is essential if you want a scientifically rigorous evaluation. A "unique identifier" is used to preserve confidentiality and can be the clients' school identification number or can be constructed using letters of the clients' names and birthdates.

Depending on the content of the survey, if you are using names or unique identifiers, you might need to get **active parental consent** for the students to take these surveys according to California Education Code section 51513.[19] If your survey is given anonymously but contains sensitive content as described in California Education Code section 51513, then **passive parental consent** can be obtained.[20]

[19] California Education Code section 51513. No test, questionnaire, survey, or examination containing any questions about the pupil's personal beliefs or practices in sex, family life, morality, and religion, or any questions about the pupil's parents' or guardians' beliefs and practices in sex, family life, morality, and religion, shall be administered to any pupil in kindergarten or grades 1 to 12, inclusive, unless the parent or guardian of the pupil is notified in writing that this test, questionnaire, survey, or examination is to be administered and the parent or guardian of the pupil gives written permission for the pupil to take this test, questionnaire, survey, or examination.

[20] California Education Code section 51938(b). Anonymous, voluntary, and confidential research and evaluation tools to measure pupils' health behaviors and risks, including tests, questionnaires, and surveys containing age-appropriate questions about the pupil's attitudes concerning or practices relating to sex may be administered to any pupil in grades 7 to 12, inclusive, if the parent or guardian is notified in writing that this test, questionnaire, or survey is to be administered and the pupil's parent or guardian is given the opportunity to review the test, questionnaire, or survey and to request in writing that his or her child not participate.

Surveys can be administered in many settings. They can be mailed (for example, a satisfaction survey can be mailed to parents of students served by your school health center), administered by telephone, on the Internet (using technology such as Survey Monkey), or taken in person (for example, in the health center or in a classroom).

> **If you do gather data with names or identifiers, it is *essential* that you keep the data confidential and protected. Data with names or identifiers should be kept in a locked file cabinet or on a computer that is password protected. Reports of the data should be in the aggregate and never identify individual student results.**

Remember to match your method for collecting survey data to the group(s) you are trying to survey. For example, a survey collected in the clinic waiting room will miss students/families who do not use the clinic. That may be fine if your goal is to learn about the satisfaction of students who have received services. But if you want to know about what additional services to offer, you would also want to reach students who are not currently using the health center. A classroom-based survey will be more effective at reaching all students.

Surveys can gather both qualitative and quantitative data. Qualitative data is typically gathered through "open-ended" questions such as, *"What do you like best about our school health center?"* Open-ended questions don't constrain the answer and can be a rich source of information and feedback. The downside to this type of question is that it is more labor intensive to sort through the responses of many surveys. Also, many people won't take the time to give a response on an open-ended question because it takes longer. This will be particularly true for students or family members who are not comfortable with writing.

"Closed-ended" questions are multiple choice and produce data that are easy to quantify (e.g., the number of people who checked "always," "sometimes," or "never"). The advantage of this type of question is that it is easier to analyze quickly when the surveys are returned. The downside is that clients are limited to the choices. This can be partially solved by always having an "other" open-ended category or a place following a multiple choice or scale question for clients to elaborate. (See Appendix G for sample surveys.)

FOCUS GROUPS OR PUBLIC FORUMS – Focus groups or public forums are another way to gather data. A focus group is a small gathering of 6-10 people during which a moderator asks questions about a particular topic. It can be a good way to gather feedback relatively quickly and can be an excellent pre-cursor to a survey because it can help develop and refine survey questions and topics. It is also a good way to collect qualitative information about more complex issues such as cultural values and concerns. Be careful, however, about generalizing from a focus group. Six to ten people, especially if they are volunteers who have a particular interest in health, may not represent the entire group.

Focus groups are most successful when there is an objective moderator, so if your budget permits, it may be worthwhile to hire a consultant who specializes in planning and facilitating focus groups. If not, begin by brainstorming a set of open-ended questions on the topic for which you want feedback. Then recruit participants to your focus group. Be sure to reach out to students and families who do not usually volunteer to participate or you may end up with very skewed results. Offering food or a small incentive such as a gift card is very helpful in recruiting.

Groups generally work best when all the participants are similar (e.g., all youth, all teachers, all parents). Consider conducting separate focus groups for different language groups so that the groups can be conducted in a language that is most comfortable for participants. Once the group is assembled and some simple ground rules reviewed, ask the questions and allow everyone attending the opportunity to speak. Be sure to assign someone to take notes or record the meeting.

A public forum is a larger venue for getting feedback from stakeholders of your school health center. A public forum is not typically constrained in terms of the number of people who can attend and participate. Usually in a public forum a presentation about the topic would precede an open dialogue or opportunity for feedback from the attendees. You could conduct a public forum with the school community (administrators, teachers and staff), parents, students or the broader community. Consider having a public forum off-site to reach a wider audience and to get diverse views. For instance, ask local churches if they would be willing to host a forum. Resources on how to design and run a focus group and/or public forum can be found at the end of the chapter. (See a sample focus group report in Appendix H.)

KEY INFORMANT INTERVIEWS – Conducting individual interviews can be a useful strategy for collecting data and is sometimes easier than focus groups or surveys. Key informants can be any stakeholders in the school, community or even in other arenas, such as health plans or government. Interviews are useful when you don't think your informants will attend a focus group or fill out a survey. This might be because they are busy, don't speak English, are not familiar with surveys, or would not be comfortable in a focus group. Key informant interviews work well when the questions are structured so that there is some similarity between the interviews. Often interviews combine both open-ended and closed-ended questions and are usually between 30-60 minutes.

CLINIC RECORD DATA

School health centers need to keep records on the services that they provide to their clients. Providers usually need services data for billing purposes. This is potentially a rich data source for process evaluation. As you are planning your school health center, you should review the information that will be collected on the clients as well as how services will be tracked. It may be possible for you to augment the information that is to be collected.

The School-Based Health Alliance recommends the following set of data elements be tracked by SBHCs:

Client Information

- Date of birth
- Gender
- Race-ethnicity
- Language spoken at home
- Insurance status at visit
- Identification of primary care provider
- School status (enrolled in this school, another school, or not enrolled)
- Client is faculty/school personnel
- Client is family of student user
- Client is other person from community
- Risk factors (not ICD-9 or CPT codes)

Service Delivery Information

- Provider type
- CPT codes
- ICD-9 codes
- Referrals (internal and external)
- Communication with parent
- Student disposition (sent back to class, home, ER, other)
- Communication occurred between school health center and primary care provider

Setting up a clinic data system is a fairly technical process. It is possible to keep data on paper or in an Excel file, but much more useful to use a management information system or practice management software. If the school health center's medical provider is a community clinic or county health department, they will likely have a system in place at other sites that can be used in the school health center. If such a system is not available, you will need outside consultation to select and implement a data system.

UTILIZING EXISTING DATA SOURCES

Collecting your own data allows you to collect data on your specific school, students, families or community members. However, you may also be able to use existing data that is already collected by the school, county, or other entity. Several of these data sources are described here.

STUDENT SURVEY DATA

Many schools elect to administer a standardized risk assessment survey to their whole school population or to select grades. These surveys typically are administered on a regular (annual or bi-annual) basis. The most widely used survey in California is the California Healthy Kids Survey (CHKS) which covers a variety of topics. The core module is used by most school districts for students in grades 5-12.

California Health Kids Survey (CHKS) Modules	
Core Module covers:	**Supplemental Modules cover:**
• Drug use • Violence • Crime • Physical health • Mental health	• Resilience • Alcohol and drugs, violence and suicide • Tobacco • Physical health • Sexual behavior • Indicators for after school programs • Customizable module

Student survey data can be used for a needs assessment and for an outcome evaluation if you think you will have an impact on the entire school population. For instance, a targeted smoking prevention and cessation program may result in your high school population smoking less over time. However, be careful to match the data you collect to the nature of your program. If your health center provides immunizations to 50 families, do not expect to see a change in physical fitness levels or alcohol use across the entire school. This sounds obvious, but it is easy to fall into the trap of measuring things that you have no hope of changing (see section below on logic models).

COMMUNITY OR COUNTY-LEVEL DATA

The California Department of Health Care Services, California Department of Public Health, and local health departments collect and make available a wide variety of public health indicator data. The state departments as well as larger counties make these data available via searchable databases.

It is important to track down health and education data for your area to determine your school's health care needs. It will also prove helpful later when you start writing grant proposals. The following table provides some useful online resources.

DATA SOURCE	WHAT IT CONTAINS	URL
Annie E. Casey Foundation	KIDS COUNT identifies and tracks state and county-level trends in child well being	www.aecf.org/MajorInitiatives/KIDSCOUNT.aspx
California Center for Public Health Advocacy	Data on child weight, fitness and diabetes	www.publichealthadvocacy.org/research.html
California Department of Education	Data and statistics on enrollment, dropouts, English learners, performance rankings, and student fitness.	www.cde.ca.gov/ds
California Department of Finance	Demographic data, Census data and population projections	www.dof.ca.gov/research
California Department of Health Services	List of city/county health organizations; information for state health policy program; epidemiology statistics, vital statistics	www.dhs.ca.gov/statistics
California Department of Maternal, Child and Adolescent Health	Reports, research, publications, evaluations and funding opportunities	www.mch.dhs.ca.gov
California Health Interview Survey	Access to data from adolescent health telephone survey	www.chis.ucla.edu
California Healthy Kids Survey	Results of school administered survey since 1999	www.wested.org/pub/docs/chks_bsearch.html
County and Statewide Archive of Tobacco Statistics (C-STATS)	Data sources on tobacco usage	www.cstats.info
Ed Source	Links to various sources of district, county and state data on education in California	www.edsource.org/

DATA SOURCE	WHAT IT CONTAINS	URL
Family Health Outcomes Project	County level data and health profiles	www.ucsf.edu/fhop
Guttmacher Institute	Information and statistics on teen pregnancy and abortion	www.guttmacher.org/statecenter/california.html
Henry J. Kaiser Family Foundation	State health facts with a special section for children's health; demographic information; health status indicators; and health insurance coverage statistics for CA and US	www.statehealthfacts.org
National Adolescent Health Information Center	Data, monographs and fact sheets on a range of adolescent health issues	http://nahic.ucsf.edu/
Office of the Attorney General, Criminal Justice Statistics Center	Juvenile justice profiles and arrest statistics by county and statewide	www.ag.ca.gov/cjsc
Rand California	California and U.S. statistics, including child abuse, Food Stamps, hospital utilization and other health and socioeconomic indicators	www.ca.rand.org
California Attorney General's SafeState	Data from the California Student Survey on drug and alcohol abuse; data on child abuse	www.safestate.org/index.cfm?navID=2
SRC Free Demographics	Data from the 1980, 1990, 2000 census	www.freedemographics.com
US Census Bureau Quick Facts	State and county demographic data compared to U.S. data in easy read format	http://quickfacts.census.gov/qfd/

These county or local level public health data can be very helpful if you don't have the funding or capacity to conduct your own data collection. However, caution should be used for using community or county-level indicators as a measurement of your school health center's outcomes. County-level and community indicators are difficult to change and are affected by many factors.

TOOLS FOR ANALYSIS

Compiling your data would be the next step after collection. This may be when you want to call in some help! Below we suggest some tools for simple data analysis. For anything more complicated, you need someone with expertise in data analysis.

Hand count with calculator – If you have a small number of survey forms and only want to do descriptive analysis, it is relatively simple to use a tally sheet to hand count the frequencies for each question and calculate the percentages using your calculator.

Summaries of open-ended responses – If you have done a lot of focus groups, key informant interviews or surveys with open-ended questions, you will be faced with the task of summarizing these responses. There are many techniques for doing this including tallying up common responses, pulling out quotations to illustrate a point, and summarizing interesting comments. It is useful to note when many respondents gave a similar response, but do not discount a response just because it was only made by one person. The point of open-ended questions is to uncover new perspectives; they do not have to be shared by everyone.

Spreadsheet or database – Once you have a large number of forms and want to do simple statistical analysis such as calculating means (averages), you would be better served entering your data into a spreadsheet or a database. If you are receiving a download of data from another system (like ARIES Student Information System) it is best to have it saved in a spreadsheet format. Excel is a spreadsheet application that is commonly used. A database application that is commonly used is Access. The benefit to Access is that you can design a data entry sheet that mirrors your survey forms. Both are part of Microsoft Office.

USING EVALUATION FINDINGS

Now you have arrived at the last but probably most important step. You have collected and analyzed your data, and now need to understand what the results mean, how to use them, and how to communicate the results to your stakeholders.

UNDERSTANDING AND USING YOUR RESULTS

The first step in understanding and using your results is to go back to your logic model and compare what you had planned to do with what you actually accomplished. If you had intended to deliver four series of educational workshops and only delivered two, give some thought to what happened. Or, you may have intended to serve 200 students and only reached 100.

You shouldn't be too hard on yourself when your results don't match your expectations. Programs rarely unfold exactly as they are planned. However, you should use it as an opportunity to stop and reflect. What caused the mismatch between expectations and results? Was it something that you can control, such as a staff person who struggles with time management? Or something you might change in the future, such as changing the time of a new fitness class so as it does not conflict with another popular after school activity.

When results don't match expectations you might want to follow-up by having a meeting with staff to discuss the results. You might even want to hold a focus group with the students or conduct a new needs assessment. Most of all, understand that your results are just that *your* results and you don't have to share every finding with a broader audience. That said, you shouldn't make an effort to hide negative results, instead use them as an opportunity to make changes and improve your program.

When results do meet or exceed your expectations then it is time to use those results to their maximum. For example, if your results show that 85% of your student clients are "very satisfied" with their visits to the school health center, or if you find that students who completed your asthma management workshops now have improved school attendance, you should definitely use this information. Sharing positive results is important for staff morale. The results can unify the school health center staff with the school staff, by providing evidence of how the school health center helps students. You can also use your results when seeking additional funding and support for your program.

COMMUNICATING YOUR RESULTS

Different stakeholders in your school health center are most likely interested in different levels of detail of your evaluation results. The facilitator who runs educational workshops would be far more interested in the full results of their program than the school administrator would be, who might want just a brief summary of impact. For that reason, it is best to make customized reports for your various stakeholders. However, reports do not have to be long and complicated. A one- or two-page report that summarizes the results of a survey or the impact of a program is often enough and is more likely to be read by stakeholders.

Regardless of the audience, it is important to communicate your results in plain and simple language. Describing results in brief, bulleted statements is more powerful than long narratives. Displaying results graphically such as in bar graphs or pie charts makes the results easy to understand. Examples on how to clearly communicate evaluation results can be found in the resources at the end of this chapter.

You might also consider making a PowerPoint presentation for sharing results at meetings or other public forums where evaluation findings and their implications can be discussed. Meetings or public forums provide your stakeholders an opportunity to discuss the findings, both positive and negative, and give input for program improvements from their perspective.

Don't overlook the opportunity to highlight your program in the press. This can be a powerful tool for garnering more support for your services. You might want to write a press release to invite the public to an event at the center. You could engage some of the youth who are actively involved in your program to make poster boards that highlight your results with pictures and graphs.

In addition to sharing results locally, you should consider sharing your results to a larger audience. Usually opportunities exist to share program highlights at state conferences. We also share program highlights in our eNews. School health centers learn a lot from each other and you can help us advance the field. You might be called upon by us to share your results to the legislature in an effort to keep this model in the forefront.

EVALUATION RESOURCES	
A Guidebook for Evaluating School-Based Health Centers (1999) by Claire D. Brindis, David W. Kaplan and Stephanie L. Phibbs. This comprehensive evaluation manual, available to School-Based Health Alliance members, is designed to walk you through the school health center evaluation process, using detailed descriptions, and case studies of previous research, as well as worksheets and step-by-step instructions in school health center evaluation.	School-Based Health Alliance members may download the manual at: www.sbh4all.org
W.K. Kellogg Foundation Evaluation Handbook (2004). This comprehensive evaluation guide was developed for grantees of the W.K. Kellogg Foundation but is available to all.	You may download it for free at: www.wkkf.org/pubs/tools/evaluation/pub770.pdf
We Did it Ourselves: An Evaluation Guidebook (2000) by SRI, International. This comprehensive guide is one part of a three-part tool kit developed for the Sierra Health Foundation's Community Partnership for Healthy Children Initiative.	You may download it for free at: http://www.sierrahealth.org/assets/files/other_pubs/WDIO-Evaluation-Guide-Book.pdf Or, you may order *We Did It Ourselves* publications by e-mailing a request to info@sierrahealth.org.
A Field Guide to Outcome-Based Program Evaluation (1994) *How to Manage and Analyze Data for Outcome Based Evaluation* (2000) *Outcomes for Success* (2000) All three helpful documents are available from Organizational Research Services, which is the parent company of the Evaluation Forum.	The documents can be downloaded from: http://www.organizationalresearch.com/publications_and_resources.htm#htmaadfobe

APPENDICES


USE KIND WORDS
NO FIGHTING
{BE NICE} play hard
EAT HEALTHY
LOVE FREELY
respect your parents
{READ MORE} RELAX
SHARE
BE GRATEFUL
BE HAPPY

APPENDIX A Sample Memorandum of Understanding

I. INTENT

This Memorandum of Understanding (MOU) is hereby entered into by and between the Alameda Unified School District, a California public school district (hereafter "the District") and Xanthos, Inc., a California non-profit corporation whose principal office is located at 2325 Clement Avenue, Alameda, CA 94501 (hereafter "Xanthos"). The MOU sets forth the terms and conditions by which Xanthos will provide medical, mental health, health education and other support services to the students of Encinal, Alameda, Island and BASE schools at the Alameda High School and Encinal High School site based health centers.

II. AREAS OF AUTHORITY

Alameda Unified School District. The District has responsibility to provide and maintain site.

Xanthos, Inc. Xanthos shall:

(a) act as Employer of Record for all on-site, Tri-High School-Based Health Center staff at each school site;

(b) provide fiscal services, including processing payroll, tax payments, workers' compensation for said employees;

(c) make benefits available to its employees, including health and dental;

(d) provide all necessary financial accounting and reporting services for said employees;

(e) obtain an annual independent audit as part of Xanthos' overall audit process;

(f) obtain and/provide and maintain all necessary equipment and services in connection with contracting, purchasing, computer and MIS needs;

(g) provide all necessary development services (including grant writing and solicitation of individual giving);

(h) provide all budget services necessary to each site-based Health Center;

(i) prepare and provide all necessary and/or legally required reports to funders;

(j) provide overall management and leadership of site-based staff; and

(k) assure and supervise the day-to day operations of each site-based program.

III. TERM

The term of this MOU shall be July 1, 2002 to June 30, 2003. This MOU may be extended by the mutual written agreement of both parties.

IV. INDEMNIFICATION

Xanthos agrees to indemnify, to defend at its sole expense, to save and hold harmless AUSD, its officers, agents and employees from any and all liability in addition to any and all losses, claims, actions, lawsuits, damages, judgments of any kind whatsoever arising out of negligent acts, omissions, or intentional misconduct of Xanthos or Xanthos, employees, agents, subcontractors or volunteers in performance of services rendered pursuant to this agreement.

AUSD agrees to indemnify, to defend at its sole expense, to save and hold harmless, Xanthos, its officers, agents, and employees from any and all liability in addition to any and all losses, claims, actions, lawsuits, damages, judgments of any kind whatsoever arising out of negligent acts, omissions or intentional misconduct of AUSD or AUSD employees, agents, subcontractors or volunteers in performance of services rendered pursuant to this agreement.

V. INSURANCE

Xanthos shall maintain in force, at all times during the term of this agreement commercial liability and automobile liability attached hereto and made a part of this Agreement. Xanthos shall provide Worker's Compensation insurance at Xanthos' own cost and expense, and neither Xanthos, nor its carrier shall be entitled to recover from AUSD any costs, settlements, or expenses of Worker's Compensation claims arising out of this Agreement.

VI. RESPONSIBILITIES OF LEAD AGENCY, XANTHOS, INC.

In its capacity as the lead agency for the Tri-High school-based health centers, Xanthos shall provide the following services under the MOU:

1. Mental Health Services

   Mental Health Clinicians provide individual and group counseling, crisis intervention, and substance abuse counseling for students. Consultations, information, and referrals in reference to students are provided to school staff and faculty. An onsite Mental Health Clinician will provide counseling services a minimum of five days a week at Encinal and Alameda High, two mornings a week at Island High, and one morning a week at BASE High school. Services will only be rendered during the hours of operation of the school-based health center site.

2. Health Education Services

   A part-time Health Educator provides classroom presentations, workshops, and individual health education on a variety of health topics to students at Alameda, Encinal, Island and BASE high schools.

3. Medical Services

   Xanthos subcontracts with Native American Health Center to provide medical services at the two school-based clinics (AHS and EHS). In accordance with the subcontract between Xanthos and Native American Health Center (hereafter "NAHC"), NAHC shall provide the following services:

   Provide a minimum of three clinics (a clinic is defined as a 4-5 hour period of time per week throughout the school year, except during those weeks when the District has closed the school for a holiday or a staff/teacher development/ planning day.) Services to be provided include: Physical exams, sports physicals, family planning, hearing and vision screening, management of chronic illnesses, screening and treatment of sexually transmitted diseases, immunizations, treatment of minor illnesses and injuries, and well baby exams. Services will only be rendered during the hours of operation of the school-based health center sites (Mon. – Fri., 8:00 – 4:00).

VII. RESPONSIBILITIES OF THE ALAMEDA UNIFIED SCHOOL DISTRICT

In its capacity as local grantee, the AUSD agrees to fulfill the following responsibilities:

1. **Space**: AUSD will allocate sufficient space to the Tri-High School Health Services to satisfy the Bureau of Primary Care space regulations for school-based health centers, maintain confidentiality of clients who obtain health services through private exam rooms and counseling offices, and secure confidentiality of patient records through a locked safe/space.

2. **Facilities**. AUSD will maintain the school-based health centers in a manner acceptable to Xanthos and the designated Program Director. Prior to the beginning of each school year, the Program Director will conduct a walk-through inspection of the facility to determine its readiness for school based health center operations. The walk-through will include inspection of: facility cleanliness, safety and accessibility; paint; safety; furniture; and AUSD equipment. The Clinic Supervisor will identify any problems in writing, and AUSD will attempt to remedy these problems within a reasonable period of time not to exceed 2 weeks.

3. **Equipment**. All equipment provided by AUSD will be maintained by the district directly or through maintenance agreements with outside vendors. This includes but is not limited to:

   - Door locks, keys, other equipment related to access to schools and clinics
   - Telephones
   - T1 Lines
   - Plumbing
   - Climate control (heat/air conditioning)
   - Electrical/wiring

4. **Telecommunications**. AUSD will provide and fund a minimum of seven (7) independent telephone lines for the exclusive use of the Encinal High school-based health center site and six (6) independent telephone lines for the exclusive use of the Alameda High school-based health center site. If the school is unable to meet this need (for confidential telephone, facsimile and Internet access), AUSD will permit the Xanthos MIS department to install additional telephone lines for the school-based health center. Any computers, whether provided by AUSD or Xanthos, will be networked and Internet-ready during regularly scheduled school operations.

5. **Communication**. AUSD will identify one (1) liaison at the school district level and one (1) liaison at the school site.

6. **Contracts/Accountability**. The following grid will be filled out by the school and/or school district within the first 4 weeks of the school year beginning. This list will be updated as appropriate to maintain easy access to key functions and personnel.

AREA	Responsible (Name/Title)	Phone
Security		
Plumbing		
Climate control (heat/air conditioning)		
Electrical/wiring		
Maintenance/		
AUSD equipment		
Incident reports		
Keys/access to school and clinic		
Custodial		
Student contact information		
Registration		
Student discipline (e.g., suspensions and expulsions)		
Guidance counselors		
School psychologist(s)		
Telephones		

7. **Health Clerk**. School-based health center staff will work collaboratively with the Health Clerk to provide immunizations to students, identified by the Health Clerk, who need immunizations to enroll in school.

8. **Access to Information**. School-based health center staff will be given easy access to student information (such as class schedules) needed for its functioning. Specifically, staff will be able to access the school's most current student emergency and contact information through emergency cards and/or the school's SASI system.

9. **Access to AUSD Staff**. AUSD representatives will respond to requests from Tri-High School Health Services in a manner consistent to the AUSD process of response to school staff.

10. **Keys**. AUSD will provide at least eight (8) sets of keys to SBHC personnel, each of which set will include access to the school, the SBHC and any other relevant areas (e.g., gates, locked areas within school/health center) to allow access after hours and during school breaks.

11. **Custodial**. AUSD will maintain the cleanliness of the SBHC in accordance with OSHA standards for medical facilities. On a daily or as-needed basis determined by SBHC staff, AUSD will refill soap dispensers, paper towels and toilet paper. More comprehensive cleaning will occur on at least a biweekly basis or as needed to ensure these standards are met. In the event that the district/school is unable to fulfill this obligation, AUSD will cover costs borne by Tri-High School Health Services to purchase outside custodial services. AUSD will then provide the cleaning crew contractors with necessary tools (e.g., keys, alarm codes) to access the SBHC after school hours.

12. **Safety**. AUSD will ensure that each school-based health center meets state safety and fire codes.

13. **Policies and Procedures**. AUSD and school staff will inform SBHC staff, verbally or in writing of appropriate procedures in the following situations upon request:

    a. Student sick or injured; no medical personnel onsite; parent/guardian not reachable.

    b. Emergency procedures, including fire, earthquake, violence or threat of violence on campus.

Tri-High will be informed within a reasonable amount of time of a request to modify facility (e.g., erect wall, remove furniture).

14. **Storage**. Adequate storage will be provided for office and medical supplies, biohazardous waste disposal, and student medical records. This space will be locked and inaccessible to school staff to ensure safety and protect patient confidentiality.

15. **Student Access**. School liaison will ensure that students who have been given an approved pass are allowed to leave class or other school activities to use the school-based health center.

16. **Confidentiality**. AUSD will respect the client's right to confidentiality in accordance with the Board of Behavioral Science and the American Psychological Association ethics.

VIII. BILLING AND COLLECTIONS

1. Xanthos and its subcontractor will attempt to bill and collect for services provided through appropriate third party

payers (i.e. Medi-Cal, Family PACT, CHDP, etc.) All revenues generated by school-based health center staff will be retained by Xanthos to cover costs incurred by the school-based health center.

2. Under the direction of the Program Director, the Administrative Assistants and Medi-Cal eligibility workers will be responsible for helping student patients apply for and enroll in appropriate health insurance coverage. All services will be provided to students free of charge

IX. RELATIONSHIPS BETWEEN AUSD AND XANTHOS

Fundraising. AUSD and Xanthos are committed to sustaining the onsite school-based clinics at Alameda and Encinal High and mental health services/health education at all of Alameda's public high schools. As in past, if funds in the AUSD budget become available for allocation, AUSD may provide funding to supplement Tri-High's services. AUSD and Xanthos agree to coordinate and inform each other of any fundraising and grant writing efforts on behalf of the health center or associated programs.

Communication. AUSD and Xanthos will promote and maintain a strong and positive collaboration through open and clear verbal and written communication.

The Tri-High Program Director and other school-based health center staff will have access to students, faculty and staff for SBHC outreach activities. Alameda, Encinal, and Island High Schools will include Tri-High's parent consent forms with new student registration mailing and other mailings as appropriate. Meetings between the Tri-High Program Director and AUSD will include the two-way identification of problem areas and a commitment to shared problem solving and accountability.

The undersigned agree to the terms and conditions of this agreement:

_____ _____

AUSD Superintendent Xanthos, Inc. Executive Director

Memorandum of Agreement
Between
The ANY Public Health Commission and
ANY Public Schools regarding
The ANY School Health Center

This Memorandum of Agreement is designed to formalize the continuing relationship between the _____ through the ANY Public Schools, and the ANY Public Health Commission, regarding the operation of a school health center.

The parties agree to collaborate on the implementation and operation of the School Based Health Center ("SBHC") at _____.

PS and PHC agree that the SBHC will occupy space rent-free at _____ in the Health Suite Room _____, where space has been renovated for the SBHC. This space will be used to provide comprehensive school-based health services to the _____ students who are enrolled in the SBHC.

Terms of Agreement

1. Public School and _____ agree to provide the following at no cost to the Public Health Commission:
    - Space at _____ in Health Suite Room _____ as renovated and presently defined as shared reception area, one examination room, shared bathroom, shared clean and dirty areas, office, and storage. In addition, when possible and at the discretion of the Headmaster, the _____ will provide space for additional counselors and/or health educators as arranged with the _____ Headmaster.
    - All utilities.
    - Security services: i.e. services of school safety officers as needed.
    - Routine maintenance and repairs (e.g. light bulbs, windows, ceiling tiles, towels, toilet paper).
    - Rubbish removal (Non-hazardous waste).
    - Telephone line
    - Two telephone extensions.
    - Custodial services
    - Annual alpha list of students and their class schedules, updated as necessary.
    - Immunization information on students enrolled in the SBHC at
2. PHC will provide the following at no cost to PS or _____:
    - Comprehensive school-based health center services as defined in the consent form and in compliance with PS policies.
    - Health care equipment and supplies for use in the SBHC.
    - Proper maintenance and disposal of hazardous waste.
    - One direct phone line.
    - Computer equipment and maintenance of same.
    - Appropriate staffing for the SBHC (with training and licensing as warranted)
    - Medical supervision of staff.
    - All billing responsibilities.
    - Medical malpractice insurance for all appropriate staff.
3. PHC agrees to allow the PS to list the names of the SBHC and the PHC in catalogs, brochures and correspondence as the entities operating the ANY School Based Health Center, subject to the prior approval by PHC for such use.
4. PS agrees to allow PHC to list the name of the _____ in catalogs, brochures and correspondence as the host and collaborating agency for the SBHC, subject to prior approval by PS for such use.
5. PHC agrees that it has complete responsibility over the operation of the SBHC at .
6. PHC agrees to serve patients under age eighteen (18) with parental consent or, alternatively, with self-consent in accordance with Massachusetts Emancipated Minor laws. Patients eighteen (18) and over may sign their own consent forms.
7. PHC agrees that it will, to the extent permitted by law, protect the confidentiality of any and all information received from students who seek services at the school-based health center unless disclosure is necessary for the health and safety of the student and/or other persons.
8. The SBHC and PS staff will work cooperatively.

9. Either the PHC or PS may terminate this Agreement for any reason or without reason upon at least ninety (90) days written notice to the other party. However, if an academic semester has commenced or is within sixty (60) days of commencing, such notice of termination shall not be effective until completion of said semester. Either party may also terminate this Agreement at any time if the other party defaults in any of its material obligations hereunder, but only is such default shall have continued for a period of ten (10) days after the receipt of a written notice thereof from the other party. Further, PHC may terminate its obligations immediately and without liability, in the absence, withdrawal or termination of availability of funds from the Grantor or other external Funding Source, if any, or authorization from the Funding Source to expend grant moneys for the purposes described in this Agreement. Nothing in this paragraph shall be construed to limit or alter PHC's responsibility to transition PS students to continuing and appropriate health services, upon termination of the PHC's obligations under this Agreement.
10. This Agreement constitutes the entire understanding and Agreement between BPHC and BPS with regard to all matters herein. This Agreement supersedes in the entirety any and all previous agreements, whether written or oral, between the parties.
11. This Agreement may be amended only in writing signed by all the parties hereto.
12. All notices and other communications required or desired to be given shall be given personally, or sent by telefax, registered or certified mail, postage prepaid, return receipt requested to the persons at the addresses set forth below. Notices will be deemed received (a) on the date delivered, if delivered personally; (b) when sent by telefax (if confirmation notice is sent by registered or certified mail on the same day; or (c) three (3) business days after posting, if sent by registered or certified mail:

Public Health Commission:_____.	Public Schools:
School Health Programs	Superintendent of Schools
Public Health Commission	Public Schools
Street Address	Street Address
City, State, Zip	City, State, Zip

The parties shall rely upon the addresses set forth above unless notified in writing of a change.

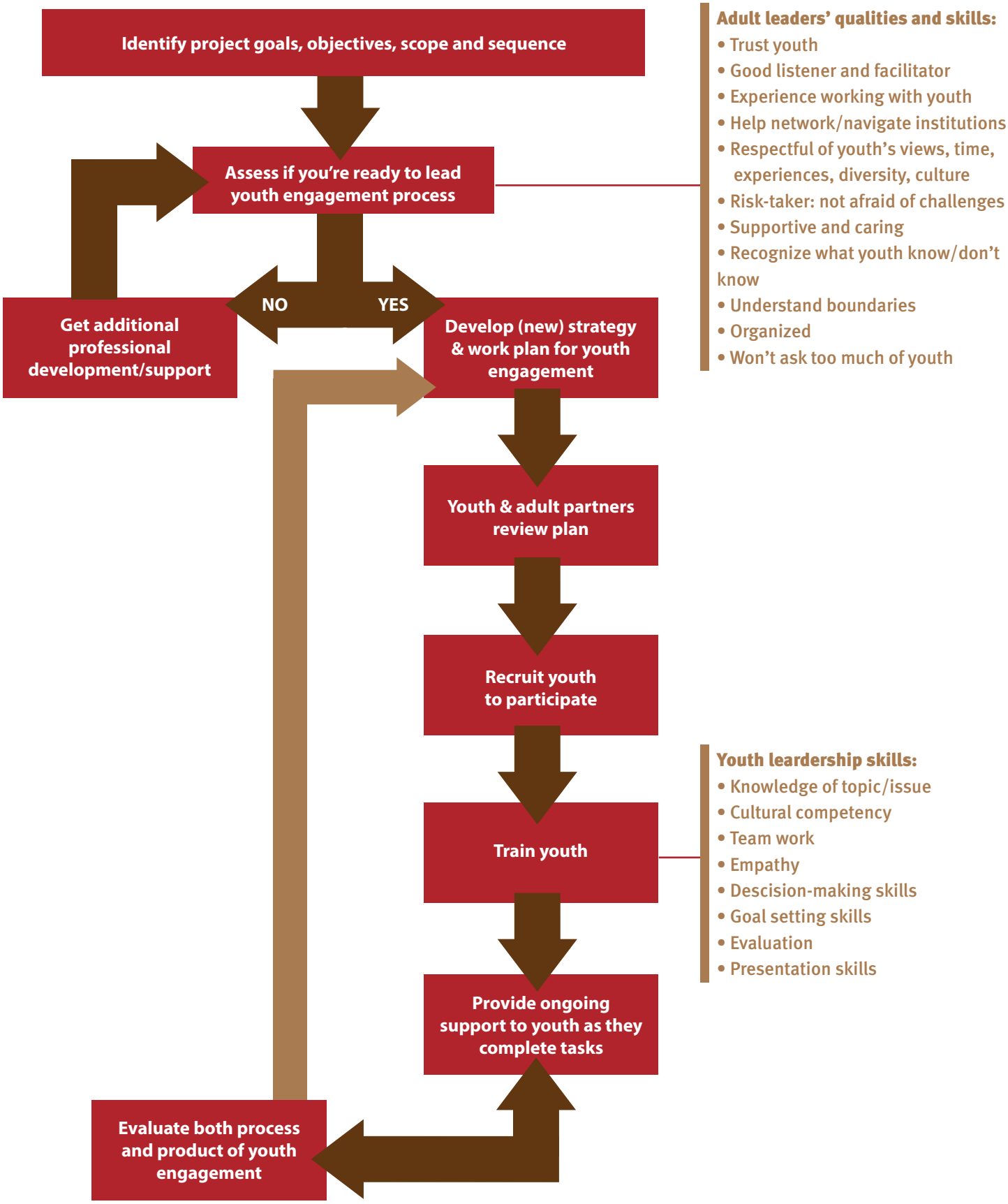
13. This Agreement shall be governed by the laws of the Commonwealth of Massachusetts.
14. Nothing herein shall create or be deemed to create any relationship of agency, joint venture or partnership between PHC and PS. Neither party shall have the power to bind or obligate the other in any manner except as expressly provided in this Agreement.
15. The parties' attention is called to General Laws c.268A (the Conflict of Interest Law). No party shall act in collusion with any other party, person or entity to circumvent such law.
16. Neither party shall be liable to the other or be deemed to be in breach of the Agreement for any failure or delay in rendering performance arising out of causes beyond its reasonable control and without its fault or negligence. Such causes may include, but are not limited to, acts of God or the public enemy, fires, floods, epidemics, quarantine restrictions, strikes, freight embargoes or unusually severe weather.
17. If any provision of this Agreement is declared or found to be illegal, unenforceable, or void, then both parties shall be relieved of all obligations under that provision. The remainder of the Agreement shall be enforced to the fullest extent permissible by law.
18. Any waiver, expressed or implied, by either party of any rights, terms or conditions of the Agreement shall not operate to waive such rights, terms or conditions or any other rights, terms, or conditions beyond the specific instance of waiver.

The Parties hereby cause this instrument to be executed by their duly authorized officers.

_____	_____
Executive Director, Public Health Commission	Date
_____	_____
Superintendent of Public Schools	Date
_____	_____
Headmaster	Date

APPENDIX

B Youth Engagement Process




1150
Community Care
Jefferson

APPENDIX C Job Descriptions

POSITION TITLE: DIRECTOR OF SCHOOL-BASED HEALTH SERVICES

REPORTS TO: Executive Director

FUNCTION: Coordinate all services for school based health center(s). Provide leadership for staff; act as liaison with the campus; assist in design and funding of health services for adolescents.

RESPONSIBILITIES:

1. Manage comprehensive school-based health program development including maintenance and recruitment of collaborative partners.
2. Serve as liaison to campus administrator and work cooperatively with the campus staff and Stockton Unified School District.
3. Develop and participate in Healthy Start Programs at various schools. Provide assistance to the development of Franklin and Chavez High School Health Centers.
4. Provide center management at Edison Health Center; supervise clinical staff and program at Stagg Healthy Start Center. Supervise and evaluate staff; schedule staff as needed for various services. Plan and coordinate staff training and meetings.
5. Develop parent/campus/student support for CHDP and primary care; expand campus enrollment in MediCal and Healthy Families managed care.
6. Assist with funding development and ensure that objectives of funding agencies are met and/or that plans are generated to meet program objectives.
7. Develop budgets based on program funding in consultation with Fiscal Director.
8. Ensure compliance with clinic licensing laws and contract agreements. Maintain all medical records, quality assurance data, policies, procedures and protocols in a professional manner in cooperation with the Director of Clinical Services.
9. Report accurate data on a timely basis as required by billing and administrative departments. Collect regular statistics on center activities and other relevant data and submit them to appropriate persons and/or work with the evaluation team.
10. Participate as a member of the Management Team for the agency.
11. Represent Delta Health Care in the community at various meetings and events.
12. Participate in meetings, training, or workshops as required.
13. Provide case management and counseling services to students as necessary.
14. Assume other duties as requested.

QUALIFICATIONS:

- ☐ Advanced degree in Public Health, Social Work, Counseling, or Nursing preferred.
- ☐ Minimum two years of management experience in health care setting and/or school-based services.
- ☐ Knowledge of grant development/writing.
- ☐ Experience working with adolescents.
- ☐ Ability to relate to people from diverse backgrounds.
- ☐ Energetic, organized and proficient in time management.
- ☐ Ability to work under pressure.
- ☐ Bilingual helpful.
- ☐ Valid California drivers' licence, DMV printout, and proof of automobile insurance.
- ☐ Able to pass physical examination requirements.

POSITION TITLE: CASE MANAGER I

REPORTS TO: Director of School Based Programs

FUNCTION: With supervision from Director of School Based Programs, the Case Manager is responsible for the development, implementation and evaluation of case management activities. Provides limited lab testing and related counseling to students. Facilitates better mental and physical health in Health Center clients through appropriate and timely referrals, follow-up, and assistance.

RESPONSIBILITIES:

1. Conduct case management intake interviews with individuals and develop treatment plan.
2. Monitor client needs and service provision and conduct follow-up as necessary.
3. Follow-up on all referrals received by administrators, teachers, and other staff.
4. Provide pregnancy testing, counseling, and referral to students seeking this service.
5. Provide case management to pregnant students and students participating in family planning services.
6. In coordination with medical staff, provide HIV testing/counseling and Gonorrhea and Chlamydia testing (urine only) at Edison and Stagg sites.
7. Assist Health Educator in the development of health education materials, and in providing special workshops and programs.
8. When necessary and appropriate, work with family members in obtaining services.
9. Conduct group and individual sessions on various physical and mental health issues.
10. Provide client advocacy activities including coordination of in-house and referral services for medical care, emotional and practical support, public assistance, community services and mental health services.
11. Prepare reports on case management activities, track statistics, and monitor outcomes.
12. Maintain thorough client documentation, including obtainment of consent forms and follow proper procedures for charts and fee slips.
13. Attend all staff meetings and training as required.
14. Perform other duties as required.

QUALIFICATIONS:

- ☐ BS/BA degree in psychology, sociology, social work, or related field. At least three years of work experience in a related field MAY be considered in lieu of the degree requirement.
- ☐ At least one year experience in individual and/or group counseling and case management programs such as school-based health centers, mental health facilities, or other social services settings.
- ☐ Knowledge of and ability to communicate information on sensitive issues including sexuality, pregnancy, and mental health.
- ☐ One year experience working with Office of Family Planning and other state-sponsored programs such as Teen Smart, Family PACT, Medi-Cal, and Healthy Families.
- ☐ HIV testing and counseling certificates desired.
- ☐ Strong written and verbal communication skills.
- ☐ Bilingual preferred.
- ☐ Valid California driver's license, DMV printout, and proof of automobile insurance.
- ☐ Able to pass physical exam.

POSITION TITLE: CASE MANAGEMENT ASSISTANT

REPORTS TO: Director of School Based Programs

FUNCTION: Assists families with completion of *Medi-Cal* and *Healthy Families* enrollment forms.

RESPONSIBILITIES:

1. Assist case manager assigned to Stagg High School with student and family activities.
2. Provide application assistance to families desiring enrollment in Healthy Families and/or Medi-Cal insurance programs.
3. Assist school-based medical staff with managed care outreach and enrollment.
4. Maintain daily records and documentation of activities.
5. Conduct outreach to the community to promote school-based health programs.
6. Attend community meetings or public events, representing the agency as required.
7. Attend all required staff meetings and training.
8. Perform other duties as required.

QUALIFICATIONS:

- ☐ High school graduate.
- ☐ Fluent in English and language of population served, with demonstrated communication skills.
- ☐ Experience in completion of Healthy Families and Medi-Cal Applications. Certified Application Assistor (CAA) Certificate desired.
- ☐ Knowledge of community services and resources.
- ☐ Valid California driver's license; DMV print-out; working vehicle; evidence of automobile insurance.
- ☐ Able to pass physical examination.

POSITION TITLE: TRI-HIGH PROGRAM ASSISTANT

REPORTS TO:

FUNCTION:

RESPONSIBILITIES:

1. Provide clerical, administrative, and computer support to the Program Director and Health Center staff
2. Answer all incoming calls
3. Oversee and help organize office procedures for the Center
4. Manage front office and waiting area
5. Greet clients and members of the community
6. Provide information and referral services
7. Schedule appointments for Health Center staff
8. Organize, schedule and provide clerical support to the medical clinic
9. Responsible for lab work pick-up/drop-off twice a week
10. Accurate and timely documentation of services and other related paperwork
11. Maintain an inventory of supplies and order as needed
12. Organize and file all Health Center related forms and materials
13. Create and develop forms and protocols for Health Center operations
14. Create and develop educational and publicity materials for Health Center services such as flyers, announcements, brochure inserts etc.
15. Data entry for all Health Center services, maintain Health Center client data base system and maintain the Alameda County client data system
16. Learn and maintain new software programs for the Center when needed
17. Attend and participate in staff meetings and trainings as designated by the Program Director
18. Other duties as assigned by Program Director

QUALIFICATIONS:

- ☐ Previous administrative, computer, and clerical experience
- ☐ Excellent organizational skills and attention to detail
- ☐ Ability to relate to youth, school district personnel, and staff
- ☐ Flexibility and ability to handle multi-tasking responsibilities
- ☐ Excellent communication and interpersonal skills
- ☐ Energy, enthusiasm, resourcefulness, and the ability and desire to initiate projects
- ☐ Ability to work independently and as part of a multi-disciplinary team;
- ☐ Multi-cultural sensitivity

POSITION TITLE: PRIMARY CARE PROVIDER

REPORTS TO: Medical Director of the ACC

FUNCTION: To provide primary care services to enrollees at the ACC in compliance with the Supervisory Agreement of Gates County Family Practice. The PCP will operate at the ACC in hours opposite to the RN for approximately 4 hrs per day when the ACC is open.

RESPONSIBILITIES:

1. On-site primary and emergency care of the ACC enrollees
2. Development and implementation of health and prevention programs
3. Prescribing medications in accordance with license and DEA regulations
4. Appropriate documentation and maintenance of health records
5. Compliance with CLIA and OSHA requirements
6. Compliance with ACC standards as regarding Health Checks
7. Assuring ACC facility is maintained and appropriately stocked for service provision
8. Corresponding with parents/guardians as to the care of the child
9. Monthly contributions to public service announcements from the ACC
10. Supervision of the "Future Health Professionals of America" club at Gates County High School

QUALIFICATIONS:

- ☐ Graduation from an accredited PA or NP program.
- ☐ Current Licensure in the state of North Carolina
- ☐ Current DEA certification or willingness to obtain such certification
- ☐ Current certification by appropriate credentialing body (NCCPA)
- ☐ Understanding of the unique functions of a School-Based Health Center.

POSITION TITLE: REGISTERED NURSE

REPORTS TO: Direct ACC supervision of this role will rest with the PCP. Ultimate supervision and assurance of all qualifications and certifications is the responsibility the Nursing Supervisor of Hertford-Gates District Health Department

FUNCTION: To provide nursing services to enrollees at the ACC in compliance with the NC State Personnel Description "Public Health Nurse II." The RN will operate at the ACC in hours opposite to the primary care provider for approximately 4 hrs per day when the ACC is open.

RESPONSIBILITIES:

1. On-site primary and emergency care of the ACC enrollees within the scope of practice of an RN and in compliance with agreed upon nursing protocols.
2. Development and implementation of health and prevention programs
3. Coordination and performance of Health Check physical exams
4. Appropriate documentation and maintenance of health records
5. Compliance with CLIA and OSHA requirements
6. Coordination of the ACC immunization program
7. Assuring ACC facility is maintained and appropriately stocked for service provision
8. Corresponding with parents/guardians as to the care of the child
9. Monthly contributions to public service announcements from the ACC

POSITION TITLE: NUTRITIONIST

REPORTS TO: Direct ACC supervision of this role will rest with the PCP. Ultimate supervision and assurance of all qualifications and certifications is the responsibility the Health Director of Hertford-Gates District Health Department.

FUNCTION: To provide nutrition services to enrollees at the ACC in compliance with the NC State Personnel Description "Nutritionist III." The nutritionist will operate at the ACC for approximately 7.5 hrs per week and be available for extended service to parents and faculties on a prn basis.

RESPONSIBILITIES:

1. Provision of medical nutrition therapy to students.
2. Maintenance of appropriate nutrition data in patient record
3. Collaboration with all other ACC services in the provision of care
4. Provision of nutrition education using age appropriate language, written materials and audio and visual resources.
5. Maintenance and ordering of needed nutrition materials with the approval of the ACC Program Director.
6. Planning and supervision of nutrition programs during National Nutrition Month
7. Monthly contributions to public service announcements from the ACC

POSITION TITLE: HEALTH EDUCATOR

REPORTS TO: Direct ACC supervision of this role will rest with the PCP. Ultimate supervision and assurance of all qualifications and certifications is the responsibility the Health Director of Hertford-Gates District Health Department..

FUNCTION: To provide health education services to enrollees at the ACC in compliance with the NC State Personnel Description "Health Educator." The health educator will operate at the ACC for approximately 7.5 hrs per week and be available for extended service to parents and faculties on an as needed basis.

RESPONSIBILITIES:

1. Developing and implementing a wellness program for students
2. Providing health education and health promotion to ACC enrollees
3. Provide group Health Education for parents and faculties
4. Maintenance of appropriate health education data in patient record
5. Collaboration with all other ACC services in the provision of care
6. Participate in grant writing
7. Share responsibility with the PCP in sponsoring the "Future Health Professionals of America" club at Gates County High School
8. Maintenance and ordering of needed health education and other promotional materials with the approval of the ACC Program Director.
9. Monthly contributions to public service announcements from the ACC

POSITION TITLE: MENTAL HEALTH WORKER/LCSW

REPORTS TO:

FUNCTION: This is a half-time hourly position that provides mental health services for adolescents at the Adolescent care Center, ACC. The position will provide basic mental health screening and support services on-site at the ACC.

RESPONSIBILITIES:

1. Addictions counseling (for alcohol, drugs, co-dependent relationships)
2. Anger management
3. Anticipatory Guidance
4. Behavior modification/ Self esteem enhancement
5. Case management
6. Community resource planning (linking patients to financial help in community)
7. Counseling for grief and loss
8. Counseling for victims of abuse and neglect
9. Crisis intervention
10. Eating disorders counseling
11. Emotional support and encouragement
12. Parenting skills
13. Problem solving/guidance for life's decisions
14. Psychosocial assessments/screenings (mental health screenings for depression)
15. Psychotherapy
16. Stress management

QUALIFICATIONS:

- ☐ Masters Degree in social work from an accredited university approved by the Council on Social Work.
- ☐ Provider must have either a North Carolina clinical license in social work (LCSW) or a provisional North Carolina clinical license in social work (LCSW-P) and access to a supervisor who has a North Carolina clinical license in social work.

APPENDIX D Guidelines for School-Based Health Centers

DEFINITION

A school-based health center is a facility that delivers one or more of the following clinical service components on a school campus or in an easily accessible alternate location including a mobile health van stationed on or near a school campus. School-based health centers in California may provide one or more of the following clinical service areas:

- Medical services
- Behavioral health services
- Oral health services

School-based health centers may be open as full-time or part-time sites.

- Full-time sites should be open during all normal school hours with at least one staff person present. (Clinical services are not necessarily available during all of these hours.)
- Part-time sites are open limited hours as dictated by need or resources.

PURPOSE OF SCHOOL-BASED HEALTH CENTERS

Research has shown that school-based health centers provide an effective means for students to access comprehensive health care, mental health services, health education, prevention services, oral health and social services. Parents/guardians find that school-based health centers are an accessible and reliable source of care for their children that ensure their child's health needs are being met and that keep the child in school.

There is a strong relationship between academic achievement and a child's physical, emotional and mental health.

School-based health centers in California are designed to serve the following purposes:

- increase access to medical, dental and behavioral health services
- support schools in improving academic outcomes
- contribute to public health goals related to disease prevention and control.

California's school-based health centers are located in high-risk communities, communities that are medically underserved, and/or in areas with few health care professionals.

GENERAL GUIDELINES IN ALL THREE CLINICAL SERVICE CATEGORIES

Administration

1. Every school-based health center should have a *lead agency* that has overall responsibility for school-based health center administration, operations and oversight. The lead agency is usually the fiscal agent for the health center and employs the center director/manager. The lead agency may or may not be the clinical services provider.
2. There should be an identified staff person responsible for the school-based health center's overall management, quality of care, and coordination with school personnel.

Facilities

3. All school-based health centers, regardless of the service components offered, should be housed in a facility, whether stationary or mobile, that is easily identifiable by students, families, and school staff. The facility should include at least one confidential treatment space appropriate to services provided, as well as an additional area for patient and family reception, enrollment, and triage.

Staff

4. All staff should have appropriate health credentials to practice, including active certification or current licensure, as appropriate to their position. Additionally, all staff shall maintain their licensure through appropriate professional standards.

Confidentiality and Privacy Protection

5. *School-based health centers should ensure confidentiality in the sharing of medical information under state and federal laws including HIPAA, FERPA, and Minor Consent as defined by California law. The health center should annually inform (in writing) enrolled students and their parents/guardians of their rights and responsibilities regarding:*
    a. confidentiality
    b. privacy
    c. safety and security
    d. informed consent
    e. release of information
    f. financial responsibility
    g. minor consent laws and sensitive services in California

School Integration

6. School-based health center services are developed based on local assessment of needs and resources.
7. Parents, students (at the high school level), school staff and community members are engaged in the development, oversight, and/or provision of school-based health center services.
8. School-based health centers provide services in keeping with district policies.
9. There should be a written, formalized relationship between the school or school district and health providers. This may be a written contract, memorandum of understanding, or statement of agreement between the school district and all outside service providers that comprise the health center describing the relationship between the district and the provider(s), or between the school district and the lead agency for the health center, which should then have its own written agreement with other providers. The contract or agreement should be active (not expired); the term/length of the agreement should be decided by both parties involved; the agreement may define a process for reviewing what is working/not working during the "life" of the agreement.
10. School-based health centers should either convene or participate in a school-wide health/wellness collaborative. This collaborative should include members from all providers (district, school-based health center, and community) of health or wellness services to the school community. They may use a model such as the CDC's *coordinated school health program* to drive the integration of comprehensive school-based health programs. If the school does not have such a collaborative, the school-based health center is responsible for forming and convening it at least twice a year. Distributed/shared leadership models are recommended.
11. School-based health centers develop policies/protocols to coordinate care, ensure continuity of care, and facilitate case management in partnership with the school and other service providers. School personnel include credentialed school nurses, health assistants, administrators, teachers, counselors, and support personnel. One process for this coordination may be through the school's Student Success Team.

12. There should be a process for referring students/families to the health center that is understood and approved by school staff and administrators. The referral process should facilitate access to care as opposed to relying on the student/family to initiate contact with the health center. Mechanisms for facilitating access could include: walking the student/family to the health center, assisting with scheduling an appointment, initiating contact from the health center by calling students out of class or calling families at home (while protecting student confidentiality).
13. There should be coordination between the health center and the school nurse or health assistant (if applicable) including delineation of roles and responsibilities (especially for state-mandated health services in the absence of a school nurse), protocols defining permissions related to sharing of medical information (e.g. immunization records, serious medical conditions), procedures for service coordination, and reviewing how it is going and adjustments needed.

Prevention Programs

14. The school-based health center should have a role in school-wide health education and outreach, school-based public health programs, youth development programs, or family support programs. Activities may include: classroom presentations, table/presentation at school functions, lunch time activities, posters or displays on campus, presentations to school staff, participation in wellness policy councils or other health committees, and nutrition and fitness promotion programs. Full-time centers should participate in/offer at least two school health-promoting activities/year. Part-time centers should participate in/offer at least one school health-promoting activity/year.
15. Unlicensed staff that provides health education, youth development, and/or family support services should be trained in basic health promotion, public health, and/or community engagement principles. A CHES (certified health education specialist) is preferred, though not required.

Health Insurance Outreach and Enrollment

16. All school-based health centers should take steps to ascertain student insurance coverage, health plan, and primary care provider (if applicable) with the goal of obtaining this information for all students seen at the health center. The health center should facilitate student enrollment in health insurance programs such as Medi-Cal, Healthy Families or other local coverage options.

Billing Capacity

17. The health center shall bill CHDP, Medi-Cal, Healthy Families, health plans and/or other third party payers as appropriate based on the lead agency, community and services provided.

Access to Care

18. *Fees*. The center serves all students in the school regardless of insurance status or ability to pay. No student can be denied services because of inability to pay. The center may also serve siblings, parents or other community members and may develop its own policies regarding fees and accessibility of services for these populations.
19. *Hours*. The health center shall be open during hours accessible to its target population, and provisions should be in place for the same services to be delivered during times when the center is not open. These provisions shall be posted, given to and/or explained to clients including at a minimum an answering service/machine message. The health center shall have a written plan for after-hours and weekend care, which shall be posted, given to, and/or explained to clients.
20. *Transportation*. If the health center is not on school grounds, there is a mechanism to facilitate transportation from the school to the health center, or to ensure a safe pedestrian corridor to/from the health center, if necessary. This mechanism will be publicized appropriately with clients and families.
21. *Non-discrimination*. Students shall not be denied access to services based on race, color, national origin, religion, immigration status, sexual orientation, gender identity, disability, handicap or gender.
22. *Language*. Reasonable accommodation shall be made to provide language/translation services to non-English speaking and deaf students.

Quality Improvement

23. Adherence to relevant standards of care adopted by national professional organizations – American Academy of Pediatrics, Society for Adolescent Medicine, American Dental Association, etc.
24. Gathering of feedback from both clients and school stakeholders through *annual* needs/resource assessments and age-appropriate client satisfaction surveys as well as satisfaction surveys with parents and school staff. Focus groups or a "comments box" can also be used for this purpose.
25. Process for reviewing patient/school feedback and adjusting practice as needed.

Advisory Committee

26. School-based health centers should maintain a local advisory committee that meets at least two times per year. The committee membership should include at least two representatives from the school staff, parents, and students (if middle or high school). The committee should also include two health care providers outside the school-based health center (e.g., community-based primary care providers, hospitals, community clinics), public agencies (e.g., local health department, county office of education, probation, county mental health department), and local community-based organizations. The function of the committee is to:
    a. Provide input on school or community issues related to student health.
    b. Make recommendations for the type of services that the school-based health center should start, continue, expand or discontinue.
    c. Make recommendations for policies and procedures at the school-based health center.
    d. Develop an annual summary of school-based health center work and recommendations that will be made public (e.g. to school board, school leadership team)

** The advisory committee is not meant to usurp the authority of an existing FQHC advisory board and may function as a subcommittee or workgroup of a larger advisory board.*

Data Collection

27. Certain data variables shall be collected at each encounter or visit including:
    a. Unique patient identifier (not name)
    b. Date of birth
    c. Gender
    d. Ethnicity/Race
    e. Insurance status
    f. Date of visit
    g. Location of visit (site identification)
    h. Provider type
    i. CPT visit code(s) (for MediCal providers only)
    j. Diagnostic code(s) (ICD-9 or 10)
    k. Selected risk factor status
    l. For managed care counties: Visit time units

GUIDELINES FOR SCHOOL MEDICAL SERVICES

Minimum Services

28. Well child or adolescent exams, consisting of a comprehensive health history, complete physical assessment, screening procedures, and age-appropriate anticipatory guidance
29. Episodic acute care including diagnosis and treatment of illness and injury
30. Immunizations
31. Basic laboratory tests including urinalysis and hemoglobin
32. Follow-up and coordination of care for identified illnesses or conditions
33. Assessment and education related to nutrition, fitness, and oral health (may be provided by nonclinical, unlicensed staff)
34. Chronic disease management:
    a. Assist primary care providers and school nurses in the day-to-day management of student chronic illness.
    b. Respond to emergency exacerbations of chronic illness with nebulized treatments for severe asthma, glucagon injections for severe hypoglycemia, and epipen administration for anaphylactic reactions.
35. If serving an adolescent population, and approved by local school board:
    a. Conduct psychosocial/risk assessment
    b. Offer pregnancy tests and counseling as appropriate
    c. Offer tests and treatment for sexually transmitted infections as clinically indicated
36. Referrals for specialty care or other needed services not provided onsite

Recommended Services

37. Comprehensive health education/promotion outside of the clinical setting
38. Nutrition services, such as nutrition counseling, healthy habits support, family education, healthy cooking/shopping classes
39. Developmentally appropriate, culturally competent reproductive health care, including:
    a. Contraceptive counseling and dispense or prescribe contraceptives and emergency contraception
    b. Diagnosis and treatment for sexually transmitted infections (as above) plus HIV testing and counseling
    c. Gynecological examinations and cancer screening *if indicated*
    d. Treatment or referral for prenatal and postpartum care

Licensing

40. School-based health centers with a community health center or hospital serving as the medical services provider must be licensed by the California Department of Public Health as an independent clinic, affiliate clinic, satellite clinic, or mobile van of the community health center or hospital. District-run school-based health centers are waived from this licensing requirement by the state.
41. School medical service provider agencies, whether a community health center, hospital, or school district, must be certified as CHDP and/or Medi-Cal providers.
42. Stationary, school-based health center facilities must pass school fire and safety clearance.
43. The school-based health center is in compliance with OSHA rules regarding occupational exposure to blood borne pathogens.
44. The school-based health center is in compliance with the Clinical Laboratory Improvement Amendments of 1988 (CLIA) regulations for the type of laboratory tests being performed on site.

Staff

45. The school-based health center shall be staffed during all hours of clinic operation by a certified nurse practitioner (FNP, PNP, or SNP), licensed physician, or a licensed physician assistant working under the supervision of a physician. The nurse practitioner must be a licensed RN, and certified or eligible for certification in California. The physician and physician assistant must be licensed to practice in California.

46. Some licensed professional staff may work remotely via a telehealth system, so long as appropriate support staff is on-site to facilitate the telehealth assessment or treatment.

Coordination with Primary Care Providers

47. The school-based health center should develop procedures for communicating with the primary care providers (PCPs) of the clients for whom the school-based health center is not serving as the PCP. These procedures are necessary to promote continuity of care, facilitate provider collaboration, assure appropriate utilization of health resources, and ensure appropriate protection of confidentiality.
48. When a student's PCP and/or health plan are identified, the PCP and/or health plan *should* be notified every time the patient/member receives *a prescription for a new medication or adjustment of existing medication.*
49. It is also strongly recommended, though at the clinician's discretion, to also notify the PCP when the patient/member receives:
    a. a well-child/adolescent examination
    b. immunizations
    c. diagnosis of an acute condition that requires follow-up
    d. recurring episodes related to a chronic condition.

GUIDELINES FOR SCHOOL BEHAVIORAL SERVICES

Minimum Services

50. Age-appropriate, culturally competent screening and assessment to facilitate early identification of substance abuse, domestic/dating violence, and mental health disorders
51. Client education on mental health and substance abuse prevention/awareness
52. Individual, family and/or group therapy/counseling provided by an appropriate staff person (see Staff section below)
53. Crisis intervention/counseling
54. Case management/client advocacy
55. Referrals to a continuum of mental health services, including for medications, emergency psychiatric care, community support programs, substance abuse services, and inpatient and outpatient mental health programs

Recommended Services

56. Collateral contact such as consultation with school administrators, parents, teachers and students
57. Home visits
58. Alcohol, drug, and tobacco abuse education or cessation/treatment
59. Family support services and referrals, such as counseling or parenting education
60. Follow-up procedures for referrals
61. School faculty education, such as in-service training, on mental health conditions' signs and symptoms
62. School-wide mental health promotion, such as stress management or suicide prevention
63. Violence prevention, education and intervention

Staff

64. School behavioral health services should be provided by:
    - a *licensed* mental health professional,
    - a *registered* (though not yet licensed) mental health professional, or
    - an unlicensed mental health intern or trainee under clinical supervision by a licensed mental health professional. Clinical supervision must be provided as defined by the Board of Behavioral Science Examiners.

    While registered mental health professionals may receive clinical supervision from an off-site licensed supervisor, interns and trainees should have on-site supervision of their services. These may include psychologists, social workers, psychiatrists, psychiatric/mental health nurses, and licensed professional counselors.
65. Non-clinical services such as discussion groups, classroom education on mental health or substance abuse, non-clinical collateral contacts, or assistance with referral and follow-up may be provided by unlicensed, unregistered support staff who have received professional development in health education, youth development, or non-clinical support services.
66. Some licensed professional staff may work remotely via a telehealth system, so long as appropriate support staff is on-site to facilitate the telehealth assessment or treatment.

GUIDELINES FOR SCHOOL ORAL HEALTH SERVICES

Minimum Services

67. Oral health screenings
68. Fluoride varnish
69. Sealants
70. Dental cleanings
71. Oral health education
72. Referrals to local dental treatment and specialty services off-site

Recommended Services

73. Basic restorative services
74. Follow-up procedures for referrals

Staff

75. Services may be provided by a licensed dentist and/or hygienist, depending on level of service.
76. Some licensed professional staff may work remotely via a telehealth system, so long as appropriate support staff is on-site to facilitate the telehealth assessment or treatment.

APPENDIX E

Sample Consent Package

PROGRAM DESCRIPTION

Chappell Hayes Health Center at McClymonds High School

A School-based Satellite Center of CHILDREN'S HOSPITAL AND RESEARCH CENTER AT OAKLAND

The Chappell Hayes Health Center at McClymonds High School provides a variety of services for adolescents, including the following:

Medical Services (i.e. comprehensive physical exams; management of acute and chronic illnesses; sport, college and employment physicals; vision and hearing services; reproductive health services; immunizations; first aid and triage; emergency medical response),

Counseling and Therapy (i.e. individual, family and group counseling; psychiatric assessment and medication management; crisis counseling; anger and stress management; depression and anxiety counseling; relationship counseling; drug and alcohol counseling; body image and eating disorders counseling; behavioral, narrative and solution focused therapy)

Youth Development* (i.e. Peer Health Education internships; FACES health careers internships; Youth Leadership Council; Youth Sounds Media Arts; YELL! Youth Research and Advocacy; Adventure Academy Wilderness Excursions) *Please note that these programs have separate admissions criteria and are not covered by the following conditions and Program Description.

Health Education (i.e. healthy life style counseling including nutrition and exercise; substance abuse and tobacco prevention services; HIV/STD prevention and counseling; conflict resolution services; family planning; peer health education; human sexuality support groups and counseling)

CONFIDENTIALITY:

Participation in any of the health centers' services involves the collection of personal information. As required by law and by our payors, we keep written progress and treatment records. Your written records will be handled as confidentially as possible within the law. Please note that most insurance companies and third party payors, including Alameda County Behavioral Health, do require that providers share information with them about our patients' assessment, diagnosis and treatment. All written materials and videotapes will be stored in locked files in the Health Center.

We often videotape our sessions for the purpose of providing better care, if you give consent. You will be asked to sign a separate consent form for any videotaping that might be done.

In our department we work as a team, consisting of medical doctors, nurses, interns, post-doctoral fellows, psychiatrists, marriage and family therapists, social workers and psychologists. Information about you, your family and your child may be shared with other members of the team, or other providers at Children's Hospital Oakland if we believe that such a consultation will assist in your child's treatment. All information is kept confidential by Children's Hospital staff. If you wish for us to communicate about your child's treatment with physicians, school personnel or other persons outside the hospital, we will ask you for a signed consent.

During supervision meetings, all clinicians review their work with clinical supervisors. The purpose of these meetings is to have an opportunity to review their treatment approach and ensure the quality of their work. Our clinical supervisors hold information shared in these meetings in confidence.

LIMITS OF CONFIDENTIALITY:

If previously unreported incidents of child abuse or imminent physical injury to self or others come out during the course of our work with the adolescent or family, they will need to be reported to Children's Protective Services and/or the police, as required by law. If this would ever be necessary, we will discuss this with you, if at all possible, prior to making the report.

According to California law there are three additional areas that are exceptions to confidentiality. They are:

- If you are seriously considering harming yourself, we are required to take whatever steps are necessary to keep you safe.
- If you state that you are seriously considering harming another person, we are required to notify that person and the police.
- We are required to report abuse of a person over 65 or a dependent adult.

POTENTIAL RISKS OF TREATMENT:

Psychotherapy is a process that requires time and commitment. Sometimes the process of exploring and resolving problems can cause emotional distress or increase the client's negative behaviors for a period of time. In some cases, treatment may be ineffective, or in rare cases can cause disruptions in your life. Consistent participation, family involvement, and adequate length of treatment are central to effective therapy.

Because of the personal nature of psychotherapy and mental health care, some of the questions that you may be asked in the course of treatment may make you feel uncomfortable and you are free to decline to answer questions, stop any discussions at any time, or decide to provide the requested information at some later date. However, we will be most effective if we can develop a trusting relationship in which information is freely shared.

There are also risks associated with the use of psychiatric medications. If your child is prescribed medication through our department, the psychiatrist will discuss with you the potential risks and benefits.

FREEDOM OF CHOICE:

PARTICIPATION IN ANY OF OUR SERVICES IS VOLUNTARY. You are free to decline to participate in our program, or to withdraw from it at any point. Your decision as to whether or not to participate will have no influence on your present or future status as a client at the Chappell Hayes Health Center or any other Children's Hospital Oakland programs.

You have the right to request and receive information at any time about fees and methods of payment, your therapist's qualifications and education, cancellation policies, the goals of therapy, your child's progress and type of treatment. If at any time you continue to have any questions or concerns about the quality of care you are receiving at the Heatlh Center, please feel free to contact Alex Briscoe, Health Center Director, at (510) 813-2525.

You have a right to refuse any services for yourself or for your family. If you prefer to receive services from other professionals or agencies in the community, we can assist you with referrals.

ATTENDANCE & CANCELLATION POLICY:

In most cases our counseling services require your weekly attendance for therapy sessions. If for some reason you are unable to meet during your schedule appointment with a clinician, please inform the staff member as early as possible. Other programs and internships may have specific attendance policies that will be explained at intake.

TREATMENT BY INTERNS, ASSOCIATE CLINICAL SOCIAL WORKERS AND POST-DOCTORAL FELLOWS:

Chappell Hayes Health Center is part of Children's Hospital Oakland, a teaching institution, and some of the therapy work in the department is provided by unlicensed individuals who are supervised by senior licensed staff while they complete their training. If your therapist is a trainee, they will conduct their practice under the direct supervision of a licensed therapist. The primary supervisor is responsible for the client's treatment. Please feel free to contact the Alex Briscoe, Health Center Director, at 813-2525 if you have any questions or concerns about your work with your therapist.

CHAPPELL HAYES HEALTH CENTER --- PROGRAM DESCRIPTION CHECKLIST

Child's Name _____

Child's Date of Birth _____/_____/_____ Child's Social Security Number _____

I have received a copy of the Patient Bill of Rights. _____
(initials)

I have received Patient CHRCO Notice of Privacy Practices. _____
(initials)

If not received, please explain: _____

Services to be provided by the Health Center have been described to me. _____
(initials)

I understand and agree to the confidentiality agreement outlined in the Program Description. _____
(initials)

I have been informed that acceptance of and participation in this program is voluntary and shall not be considered a prerequisite for accessing other community services. Further, I retain the right to access other reimbursable services and have the right to request a change of provider. While the program will attempt to provide every reasonable accommodation, it cannot guarantee that request for change in clinician or staff person will be granted.

_____
(initials)

I have received a copy of the Alameda County Behavioral Health Care Services Consumers Complaints Resolution/Grievance Information.

_____
(initials)

_____ _____
Date Parent or Guardian

_____ _____
Date Parent or Guardian

_____ _____
Date Witness


COTTON
TONGUE DEPRESSORS

APPENDIX F

Sample Customer Satisfaction Surveys

PARENT SATISFACTION SURVEY

Dear Parent/Guardian, Date _____

The _____ School Health Center is conducting an evaluation of our services to your son or daughter. We are interested in your opinions about our services.

Your participation in this survey is voluntary. All your answers will remain private and no one other than the administration of the health center will see your survey.

Thank you for your participation. We appreciate you sharing your thoughts about your child's health care.

If your child has been to the Wellness Center, please answer the following questions.

1. What services did your child receive at the Center? (Check all that applies)

- ☐ Illness (flu, cold, stomach ache or something more serious)
- ☐ Chronic health problem (asthma, depression, headaches)
- ☐ Vision or hearing exam
- ☐ Immunizations (vaccines)
- ☐ Dental exam
- ☐ Acne or skin problem
- ☐ Nutrition counseling
- ☐ Drug/alcohol prevention
- ☐ Counseling for substance abuse (tobacco, alcohol, drugs)
- ☐ Information for parents about your child or health care in general
- ☐ Yearly physical or sports physical
- ☐ Treatment of injury or accident
- ☐ Care for girls with menstrual problems
- ☐ Pregnancy test
- ☐ Services for pregnant teens
- ☐ Counseling for personal or emotional problems.
- ☐ 0ther, please tell us: _____

2. How much do you think your student was helped by the Center?

☐ A great deal ☐ Somewhat ☐ Very little ☐ Not at all ☐ Don't know

3. Did you feel that the staff was courteous to you? ☐ Yes ☐ No ☐ Don't know, I never met the staff

4. Did the staff at the Center explain your child's medicine or treatment clearly?

☐ Yes ☐ No ☐ My child did not receive medicine or treatment

5. Did the staff at the Center refer you to other services not provided by the Wellness Center?

☐ Yes ☐ No ☐ Don't know

6. How would you rate the following aspects of the Center?

	Excellent	Good	Fair	Poor	Don't know
Communication with parents	☐	☐	☐	☐	☐
Appearance of the clinic	☐	☐	☐	☐	☐
Convenience of the location	☐	☐	☐	☐	☐
Hours that it is open	☐	☐	☐	☐	☐
Quality of medical care received	☐	☐	☐	☐	☐

7. Do you agree or disagree with the following?

	Agree	No opinion	Disagree
a. The Center encourages students to be more responsible for their health.	☐	☐	☐
b. Students miss less school because of the Center.	☐	☐	☐
c. The care at the Center is confidential (private).	☐	☐	☐
d. The Center has saved you a trip to the doctor, the school or the hospital.	☐	☐	☐
e. The Center is a valuable service to the school community.	☐	☐	☐

8. Are there any services that you would like the Center to provide?

☐ Yes ☐ No ☐ Yes If yes, please describe: _____

THANK YOU

STUDENT SATISFACTION QUESTIONNAIRE (HIGH SCHOOL)

Grade level _____ ☐ Male ☐ Female

Date_____

Is this your first visit to the health center this year? ☐ Yes ☐ No

If no, how many times have you visited the health center? ☐ 0-1 ☐ 2-5 ☐ >5

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

During my visit…

1. The clinic staff was courteous and friendly to me. ☐ Yes ☐ No ☐ Don't Know

   Comments _____

2. The health care provider answered all of my questions. ☐ Yes ☐ No ☐ Don't Know

   Comments _____

3. My privacy was respected. ☐ Yes ☐ No ☐ Don't Know

   Comments _____

4. I waited too long to be seen by the health care provider. ☐ Yes ☐ No ☐ Don't Know

   Comments _____

5. Did you receive medication or a prescription? ☐ Yes ☐ No ☐ Don't Know

   If yes please answer #6.

6. The health care provider explained to me **why I needed** the medicine and **how to take it**, using words I understood. ☐ Yes ☐ No ☐ Don't Know

   Comments _____

7. Would you recommend the health center to your friends? ☐ Yes ☐ No ☐ Don't Know

   Comments _____

8. Could you have gone somewhere else in your community to receive the same type of service provided here at the school health center? ☐ Yes ☐ No ☐ Don't Know

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

   ☐ I like its location ☐ I don't have insurance ☐ I don't want people to know about my medical care

   ☐ Its free (no cost to me) ☐ I trust the staff ☐ Other _____

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

    _____

    _____

Thank you for completing the questionnaire.

STUDENT SATISFACTION QUESTIONNAIRE (MIDDLE SCHOOL)

Grade level _____ ☐ Male ☐ Female

Date_____

Is this your first visit to the health center this year? ☐ Yes ☐ No

If no, how many times have you visited the health center? ☐ 0-1 ☐ 2-5 ☐ >5

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

During my visit.....

1. I waited too long to be seen by the health care provider. ☐ Yes ☐ No ☐ Don't Know

   Comments _____

2. The health center staff was friendly to me. ☐ Yes ☐ No ☐ Don't Know

   Comments _____

3. The health care provider answered all of my questions. ☐ Yes ☐ No ☐ Don't Know

   Comments _____

4. My privacy was respected. ☐ Yes ☐ No ☐ Don't Know

   Comments _____

5. I received the services I wanted toay. ☐ Yes ☐ No ☐ Don't Know

   Comments _____

6. Would you recomment the health center to your friends? ☐ Yes ☐ No ☐ Don't Know

   Comments _____

7. Were you satisfied with the health center? ☐ Yes ☐ No ☐ Don't Know

   Comments _____

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

   _____

   _____

   _____

   _____

Thanks……You're Awesome!!

SAMPLE SCHOOL STAFF/TEACHER SURVEY

Date_____

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

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

1. Have you ever referred a student to the School Health Center ☐ Yes ☐ No ☐ Don't Know about services

   Comments _____

   _____

2. If yes, did you receive any feedback stating the student was seen? ☐ Yes ☐ No

   Comments _____

   _____

3. Do you know that providers are available to discuss issues regarding students with you? ☐ Yes ☐ No

   Comments _____

   _____

4. Would you like the school health center staff to do a presentation in your class next year? ☐ Yes ☐ No

   If yes, name of teacher _____ Extension _____

5. Do you know the difference between the School Nurse and the School Health Center? ☐ Yes ☐ No

   Comments _____

   _____

6. Do you have additional suggestions for us?

   _____

   _____

   _____

   _____

APPENDIX G Sample Surveys

SAMPLE TEACHER SURVEY

Dear Teacher and/or Staff Member,

Provide brief background on health center and purpose of survey.

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

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

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

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

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

Services _____

Hours _____

Prevention _____

Other _____

SAMPLE PARENT SURVEY

Dear Parent:

Adams County School District #50, The Children's Hospital, the Colorado University School of Nursing, and Adams Community Mental Health Center are thinking about opening a School Health Center. Children attending the Early Childhood Center (ECC) and their brothers and sisters (birth through grade 5) would be eligible to receive services at the School Health Center. Services might include immunizations, physical exams, care of minor illnesses (ear aches, sore throats, cuts and bruises) and related family support services. The cost of services would be based on a sliding-fee scale, and no one would be refused service because of inability to pay.

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

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

- ☐ Headaches
- ☐ Sore throat or strep throat
- ☐ Colds/fever
- ☐ Often being really tired
- ☐ Ear aches or infections
- ☐ Injuries or accidents
- ☐ Tooth aches or dental problems
- ☐ Stomach aches
- ☐ Skin problems or rashes
- ☐ Diarrhea or vomiting
- ☐ Problems with eating or weight
- ☐ Bedwetting

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

- ☐ Asthma
- ☐ Attention deficit or hyperactivity
- ☐ Diabetes
- ☐ Seizures
- ☐ Allergies
- ☐ Other _____

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

- ☐ Family doctor or clinic
- ☐ Emergency room
- ☐ Regular source of healthcare
- ☐ Other _____

4. Do you have a regular source of dental care for your child? ☐ Yes ☐ No

5. Do you have someone you could go to for counseling services for behavioral problems?
(e.g., unusual or extreme fears, depression, nervousness) ☐ Yes ☐ No

6. How do you currently pay for health services?

- ☐ Private insurance or belong to an HMO
- ☐ Medicaid or social security
- ☐ Armed Services medical plans
- ☐ No insurance and generally pay out-of-pocket
- ☐ Other _____

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

- ☐ Would definitely use the Center
- ☐ Would probably not use the Center
- ☐ Would probably use the Center
- ☐ Would definitely not use the Center

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

- ☐ Before school
- ☐ During school
- ☐ Evenings
- ☐ Saturdays
- ☐ Immediately after school

THANK YOU!

APPENDIX H

Sample Youth Focus Group Results

The following focus group results provide an example of another type of needs assessment or evaluation tool. It is also a useful example of youth-led research. *The following recommendations came from a series of youth-led focus groups conducted in seven California communities.*[1]

Forum Participants' Suggestions for School Health Centers

Youth Recommendation #1: Advertise School Clinic Services More Broadly

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

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

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

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

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

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

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

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

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

- Physical therapy for people to recover from injuries
- An athletic/ fitness trainer
- Counseling for family problems and psychological problems such as depression
- Health counseling to help students maintain good diets
- Sexual health services and education materials

[1] Study coordinated by California Center for Civic Participation and Youth Development

Youth Recommendation #4: Emphasize Confidentiality

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

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

Additional Findings:

Mental Health

Most students reported that school clinics that provide mental health services were very helpful but that students did not use these services as much as they should, in some cases because they were not aware of them. Others thought talking to a counselor carried a stigma that teens would want to avoid. Recommendations listed earlier in this document regarding teen-friendliness and confidentiality might eliminate barriers to teens seeing mental health services.

Health Coverage

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

APPENDIX

Sample Floor Plans

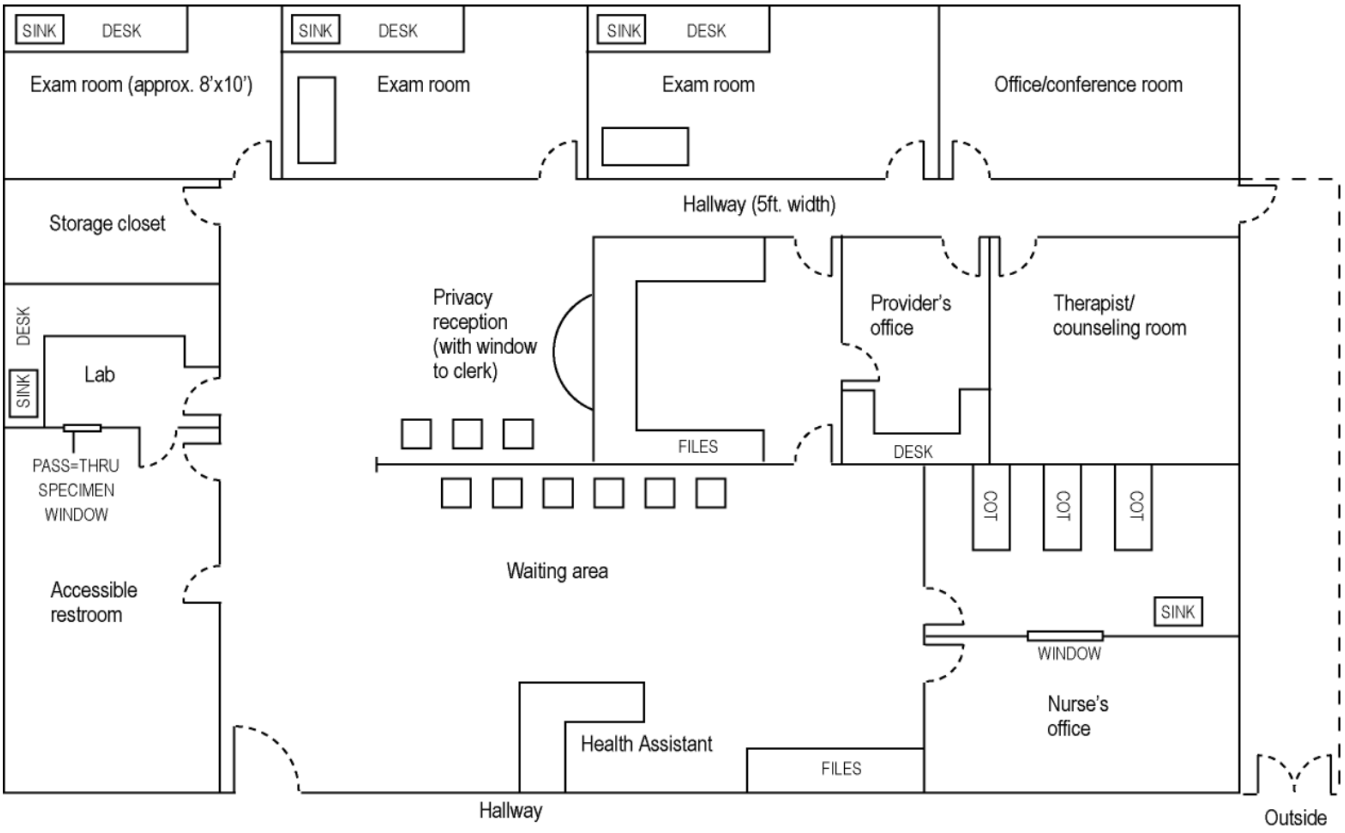
The floor plans that follow demonstrate different ways that schools may utilize existing space or create new space to house their school health centers.

SILVER CITY, NM SBHC FLOOR PLAN

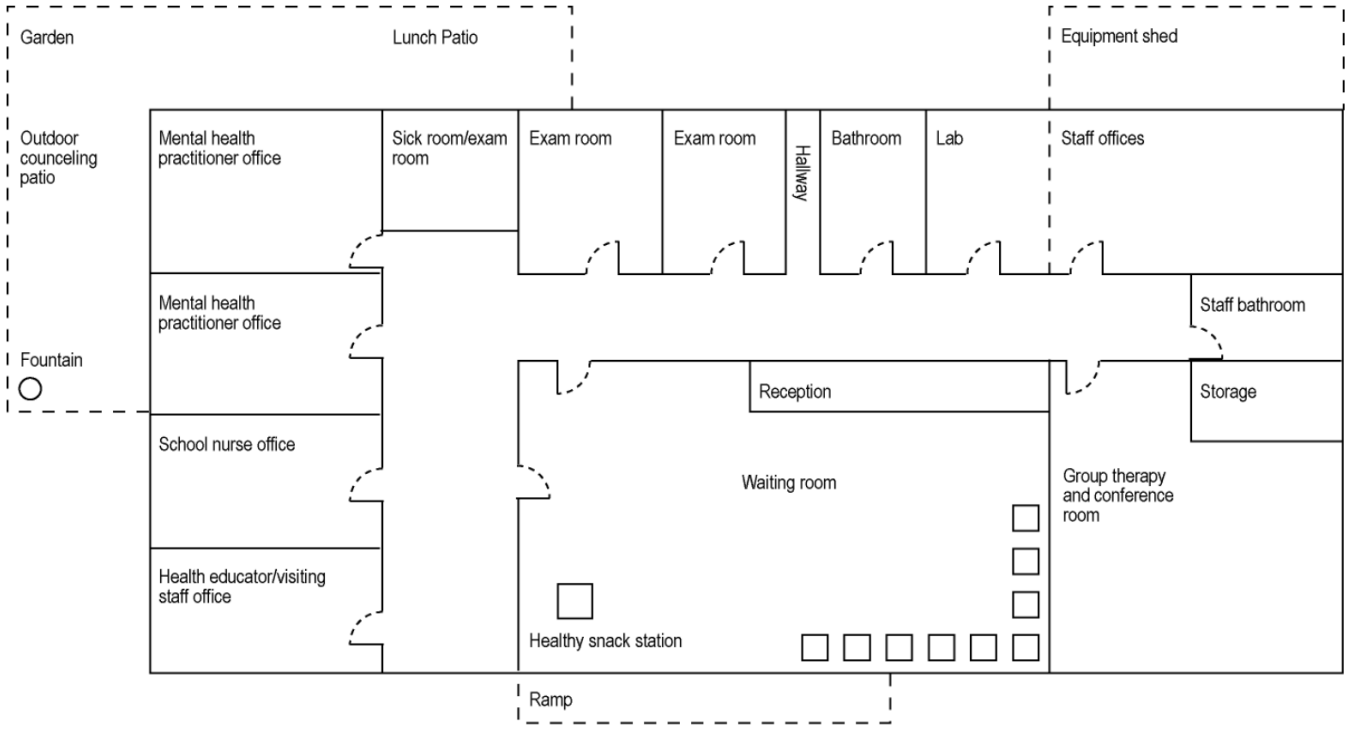
(SBHC converted from two large classrooms.)

BELEN HIGH SCHOOL SBHC FLOOR PLAN

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



HYPOTHETICAL FLOOR PLAN FOR A FREE-STANDING SBHC



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