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

Navigating the Promise of School-Based Health Centers

A Guide for Health Care Leaders

Introduction

The purpose of this document is to help leaders in the health care field who operate or are considering operating school-based health centers (SBHCs) make decisions wisely and with complete information. The California School-Based Health Alliance (CSHA) is a strong proponent of SBHCs: a unique, strategic and indispensable model for increasing health and education equity, especially in underserved schools and communities. We also know that there are very real challenges when more traditional health care agencies (i.e. hospitals, community clinics) operate SBHCs. This document will help to differentiate SBHCs from these other practices and models and equip practitioners, staff, agency leaders and other stakeholders with a deeper understanding on the SBHC model of care.

Thanks to those who requested and suggested this document – Kalila Banks of Clinica Sierra Vista and CSHA Board member Jessica Saint-Paul, among others. Thanks also to our generous funder, the California Health Care Foundation, and to reviewers Kalila Banks, Saun-Toy Trotter, and Sang Leng Trieu. The primary author and architect was Tracy Mendez, SBHC champion and forever friend of CSHA.

CSHA wants to support the development of thriving SBHCs in the right conditions. This is a resource to understand and deliver integrated health care through the innovative and collaborative school-based health model. Please reach out to us if we can support you in your journey.

> ***"Now is the time to invest in what we know works. School-based health centers, especially those that focus on both physical and mental health, are a proven path to better health outcomes for students, and we know that translates into better education outcomes."***
>
> *Tony Thurmond, State Superintendent for Public Instruction*

What Are School-Based Health Centers?

SBHCs are student-focused health centers or clinics that are located on or near a school campus, are organized through school, community, and health provider relationships, and provide age-appropriate, clinical health care services onsite by qualified health professionals. SBHCs provide primary medical care, behavioral health services, or dental care services onsite or through mobile health or telehealth. They can be considered part of the primary care safety net, like a neighborhood pediatrician or an outpatient Children's Hospital clinic.

In California, about half of SBHCs are operated by community health centers such as federally qualified health centers (FQHCs); about one fourth are directly operated by school districts; and the remainder by a combination of local hospitals, public health departments, and other entities such as community-based mental health organizations and medical groups. Often, SBHCs are run by a combination of organizations such as these – see the text box below for an example.

Since the 1970s, SBHCs have grown throughout California and the United States. The original SBHCs were often focused on teen pregnancy prevention as well as creating access to primary care for uninsured and low-income children in underserved, mostly urban, regions of the state and country. Newer health centers are more likely to include dental services and a wider array of behavioral health care ranging from social emotional wellness promotion to individual and family psychotherapy and support groups. With the COVID pandemic and heightened awareness of structural racism in the U.S., public sentiment and the policy environment have become more supportive of public health and mental health services and supports for children and youth.

The James Morehouse Project (JMP) at El Cerrito High School (ECHS) was started by a teacher in 1998. Today the JMP is a beautiful and comprehensive SBHC that is an anchor of school culture and climate at ECHS. The director is a school district employee; medical services are provided by Contra Costa Health Services; all other JMP staff are employed by the community mental health agency Bay Area Community Resources. Other community-based partners come onsite to lead groups or partner with JMP staff and interns on youth development projects. The partners work together closely to ensure center services feel seamless to youth.

Today there are over 300 SBHCs spanning most California counties and all age groups, with many more in the planning and development phases. SBHCs are heralded because they allow students to stay in school and schools to focus on education while helping young people learn how to advocate for their own health needs and navigate the health care system in a way that is safe and accessible.

Why Operate School-Based Health Centers?

There are many reasons a lead agency such as an FQHC, other health care provider, or school district might consider opening and operating a SBHC. These range from mission-focused values to smart business practice. We outline a few key ones below.

Research and experience demonstrate that SBHCs have a positive impact on health and education outcomes and equity. They increase attendance, and in a recent study of SBHCs in Los Angeles Unified School District, this pattern is most pronounced among students who use mental health services at their SBHC. SBHCs can also increase students' connectedness to caring adults and their school, which is a protective factor against multiple health and education risks. Utilizing SBHCs reduces high-risk behaviors, especially among marginalized populations such as LGBTQ+ youth and young men of color.

One young woman referred to her SBHC as "the beating heart" of her high school. It was the first place she and many students received any mental health services, and also helped support a positive school culture and climate.

SBHCs increase the use of cost-effective preventive care such as immunizations, family planning, well-child visits, and behavioral health care. Children and youth covered by Medi-Cal – especially those over age 5 – receive less than half of the preventive services recommended by pediatricians, and therefore important opportunities for identifying trauma, developmental delays, and a range of chronic health conditions are missed. Adolescents, and especially low-income adolescents of color, are not always well served by the existing health care system but benefit from many health care touchpoints given the rapid physical, socio-emotional, behavioral, and developmental changes that occur during this time period. By providing care in a familiar, trusted location, like a school-based health center, young people receive more screening, prevention, and earlier intervention for concerns that, if left untreated, may have lasting consequences. In fact, most care in SBHCs is focused on prevention and wellness, which involves ample time for screening, counseling, and anticipatory guidance. This is especially important given recent increases in the incidence of COVID-19, depression, anxiety, suicide, overdose, obesity, and sexually-transmitted infections. SBHCs also decrease utilization of emergency room services for students with asthma and other chronic conditions.[1]

Related to the above, **SBHCs can help health care agencies improve clinical quality scores** in areas like well-child visits, immunizations, chlamydia screening, depression screening and follow-up, and asthma control. This can help with pay-per-performance and value-based care, accreditation, primary care health home status, and reporting for HEDIS, UDS, and other measures.

SBHCs increase health equity. Access to culturally competent, high-quality, first-contact primary care through SBHCs is an effective, research-based strategy to reduce health inequities and improve health outcomes for LGBTQ+ youth, low-income youth, and youth of color. SBHCs assure equal opportunities for all children to access needed health care services.

SBHCs focus on health care services for children and youth with Medi-Cal coverage. SBHCs leverage the fact that fewer children than adults are uninsured and almost half are covered by Medi-Cal. Youth in California have access to the program regardless of documentation status and with higher family-income thresholds than adults.

More generally, **SBHCs help increase a lead agency's base of patients/clients.** They provide outreach to a wide cross-section of the community and a way to generate a steady flow of young people and families that need medical, dental and behavioral health care without a costly or complex marketing campaign. As community health centers have struggled to retain patient numbers in the face of widespread gentrification in many California cities, SBHCs can also serve broader communities in need.

[1] 5. Key JD, Washington EC, Hulsey TC, Reduced emergency department utilization associated with SBHC enrollment, J Adol Health 2002; 30:273- 278; 9. Santelli J, Kouzis A, et al. SBHCs and adolescent use of primary care and hospital care. J Adol Health 1996; 19: 267-275.

Satisfied SBHC patients can become promoters of lead agencies for their friends and families well past graduation.

SBHCs offer lead agencies deeper connections to the communities they serve and positive visibility with a range of stakeholders. They are a health care model built on authentically listening to and engaging with the target population. The impact of this model has gained attention of funders at the federal level, as evidenced by several recent rounds of grants from the Health Resources and Services Administration (HRSA) focused exclusively on SBHCs.

SBHCs allow health care providers to more easily collaborate with the other important players that impact child health and development. In traditional health settings it is difficult for a pediatrician to participate in a special education meeting, or for a psychologist to have easy access to a student's teachers. Most primary care providers can't easily coordinate with school nurses around daily medications or blood sugar levels. SBHCs promote this integration and support much smoother coordination of care, ultimately improving health and education outcomes.

SBHCs support workforce development. Many health care providers and other staff welcome the opportunity to work in this novel setting delivering relationship-based "upstream" preventive care to young people. This can help with workforce recruitment and retention at a time when this has never been more challenging. In addition, SBHCs mentor young people to enter health careers, helping build a diverse health care pipeline that better reflects California demographics and promotes graduation/career pathways.

The current policy environment is very supportive of the development, expansion and improvement of SBHCs. A variety of current state initiatives recognize the importance of child and adolescent trauma, behavioral health care, collaboration between health and social services, and community school partnerships. Although California continues to be one of the few large states that does not *directly* fund SBHCs, the broader conditions in the Golden State are generally favorable. For example, most low-income children and youth now qualify for Medi-Cal; Family PACT covers family planning services for most adolescents; and multiple state initiatives support adolescent and school mental health services.

For much more information on SBHCs and their benefits, see schoolhealthcenters.org.

How the Model Is Unique

This section addresses some of the many ways SBHCs differ from other pediatric and teen health care settings:

SBHCs are smaller than typical community-based health centers. Most SBHCs are physically small (1-3 exam rooms) and have less than one full-time medical practitioner working in them. (This ranges from 0.2 FTE to 2.0 or more medical providers.)

The service mix varies. For example, in a typical community health center, there might be one behavioral health clinician for every four medical providers, whereas SBHCs might have more behavioral health than primary care FTE. In general, school communities find that it is beneficial to maximize behavioral health services availability, and maintain at least a 1:1 ratio of behavioral health to medical provider time. While the medical needs of a population of 1,000+ adolescents can usually be addressed by a 1.0 FTE nurse practitioner or physician assistant[2], behavioral health needs are much more time-intensive. It is also recommended to have a high ratio of health education staff given the many opportunities for health promotion, counseling, teaching, and motivational interviewing.

SBHCs address many social determinants of health and education. Going back to their origins, SBHCs have always supported young people in ways that were holistic, not strictly clinical, acknowledging the ways that factors like hunger, school failure, and dating violence impacted student health and well-being. SBHCs operate peer health education programs, conduct classroom education, and connect students to employment services and youth development programs in their communities that support social connection. Some SBHCs host school supply giveaways and food distribution, many operate peer mentorship or peer health education programs, others host medical legal partnerships, and still others offer groups for new immigrants, young men of color, and/or girls' empowerment. Because of both proximity and collaboration with school, students often walk into their school-based health centers seeking support they might be reluctant to request from a community-based medical center or mental health program. SBHC staff accept this challenge and go “outside the clinic walls” to support adolescent autonomy, health, and well-being. SBHCs also help promote developmental assets (positive supports and strengths that young people need to succeed) such as a caring school environment, positive adult relationships, and demonstrating that the community values youth.[3]

Staffing needs vary. Because SBHCs are small, their staff care teams are often less specialized than those working in larger health centers. For example, larger community-based clinics may employ medical records personnel, referrals staff, a call center, and/or billers, not to mention dedicated nurse case managers that support a number of primary care providers. SBHCs are more likely to have a few

[2] Another difference is that SBHCs usually employ fewer physicians than other outpatient clinic sites, and more advanced practice providers (APPs) like nurse practitioners and physician assistants. A common ratio is 4:1 or 5:1 APP to MD time, and in some cases physicians are only engaged in a consultative/supervisory capacity. This staffing pattern is cost effective, especially since reimbursement is generally high for these two categories, and acknowledges that the *medical* complexity of patient care in SBHCs is often low but the need for medical practitioner, behavioral health and health education *time* is high.

[3] The Developmental Assets Framework - Search Institute (search-institute.org)

staff who play multiple roles – e.g., a medical assistant that also handles referrals and medical records, and a receptionist/clerk who does billing and insurance enrollment.

There are more collaborative relationships to navigate. At a minimum, SBHC operators – assuming they are not run by the school district itself – will need to work in close collaboration with the host school and school district. Schools often have many other service providers on campus, so those entities are also important partners – this includes after-school programs, Family Resource Centers, and other mental health providers working with special populations. (See more on coordinating services below.)

During the COVID pandemic, one SBHC had staff going to students' homes to help with Wi-Fi hot spots for students and families. This gave them critical access to their online education and also telehealth appointments with SBHC clinicians and others.

In part because of the relationships described above, **SBHCs typically require a higher ratio of management to provider FTE than other centers.** SBHCs lack the assembly line efficiencies or economies of scale, are intrinsically complex, and benefit from an administrator who is very skilled at nurturing trusted relationships for the school and parent community.

Parents and guardians are often not present for their children's care. The beauty of the model is that caregivers can authorize consent at the beginning of a school year or enrollment and then children can independently access the care for which consent was provided. This means less transportation burdens and interference with work for families and caregivers. This facilitates easy access but can also complicate some aspects of the care. For example, children and youth often cannot give a thorough medical history; discussions about vaccines, specialty referrals and other decisions or follow-up take coordination with parents/caregivers through collateral visits by phone, video and sometimes in person.

Lack of a clearly defined model. Unlike some other provider types (such as FQHCs, free clinics, and/or tribal clinics), there are no statutes in California governing SBHCs. SBHCs therefore follow various licensing and regulatory rules depending on their lead agency and other factors such as how many hours per week they operate. Unlike other states, SBHCs are not required to submit any consistent data that is centered on the model or the needs of children and youth. Site visits to ensure quality are not consistently performed and therefore there is abundant variation and diversity across sites.[4] In addition, related concepts like "school wellness center" (see text box at right) can introduce more complexity and

The term "wellness center" has become popular in recent years but is used inconsistently across California. Most often it is used to refer to a center run by an LEA (local educational agency) with a primary focus on behavioral health and no onsite physical health services.

[4] Some variation between SBHCs is appropriate in order to allow services to address local context and needs, drawing on community strengths and assets.

variation, and sometimes centers that appear to be SBHCs are opened with non-SBHC names. It is difficult in this context to promote clarity and understanding about SBHCs in California.

It's hard to control an SBHC's payer mix. The SBHC model works best with an open door policy that allows **all** students to access services. This is in contrast to other settings that are often focused on patients with a particular health insurance/payer – e.g., a closed system like Kaiser Permanente or clinics that have members assigned by Medi-Cal managed care plans. While this approach is a deliberate way to encourage children and teens to utilize the primary and preventive care services, it can mean there are many services provided without a payer source – e.g., when a student with Kaiser coverage chooses to use their SBHC for a comprehensive sports physical. (One promising future development will be the state's development of a Statewide School-linked Fee Schedule for all payers, due to be implemented by 2024.)

Limited hours of operation. For budgetary reasons and because client volume is limited by the school size, some SBHCs operate for as little as one day each week. Many are closed during school breaks and summers, making arrangements for continuity of care via their lead agency or other community partners.

Less predictable operating schedules. School environments are quite different from health care settings. SBHC operations are interrupted by events like assemblies, fire drills, exams and state testing, school lockdowns[5], pep rallies, field trips, and professional development days. These disruptions are common and can disable the SBHC for hours or days at a time. With a small number of providers, an entire clinic shift can be impacted by the nurse practitioner responding to a medical emergency on the football field or in the classroom, or the social worker coordinating a 5150 psychiatric hold and consult.

At La Clínica de La Raza, a large FQHC based in Oakland that operates 8 SBHCs, productivity standards are approached differently than in other primary care clinics. Providers working at La Clínica's non-SBHC sites are given 20% follow-up time to complete charting, coordination of care, quality improvement, and other patient care related duties. SBHC providers are expected to include their follow-up time in their regular shift s but see fewer patients in each scheduled hour. This pace, and the frequency of no-shows and unexpected interruptions, amounts to a similar overall number of patients per FTE per year as FQHC national standards: 2,100 for non-physician practitioners (NP, PA and CNM) and 4,200 for physicians.

[5] A school lockdown is issued when there is a threat to students and school staff. Schools protect students by responding cautiously to violence in the community and other potential threats to school safety.

Standard measures of provider productivity are likely to be lower than in other settings. Most outpatient health practices operate based on underlying principles of how many clients/patients can be seen throughout a clinical shift in order to balance operating revenue, access, and clinical quality. These standards should be based on reasonable expectations that allow good relationship-building, respect, and clinical quality, even if hurried clinicians sometimes feel otherwise. However, standards set for good outpatient practices do not always translate well to SBHCs because of: (1) a less predictable operating environment (see above); (2) constant turnover of patient population; (3) caregivers not present (see above); and (4) most care focused on prevention and wellness, which involves ample screening, counseling, anticipatory guidance, and conversation, with very few procedures or "expedited" visits. SBHC providers may need to spend relatively more of their total work time building trust and relationships, not just with student clients but also with families and school staff.
While no formal standards exist at a state or national level, CSHA suggests the following based on best practices collected from SBHCs over the years:

- medical providers can see about 2 patients per hour at most in an SBHC setting
- behavioral health clinicians can see an average of 4-6 clients per day
- dental providers/teams can see 15-18 patients per day

As a result of many of the factors described above – low productivity, frequent closures, more management time, and few economies of scale - **health insurance reimbursement alone is often insufficient to cover the full costs of providing high-quality SBHC care.** In addition, most SBHCs do not charge patients/families for non-reimbursable care. And in general, staff spend a higher proportion of their time in non-reimbursable activities such as group education, outreach, crisis management, etc.

Incomplete local control. SBHCs are "guests" on a school campus, which means lead agencies are subject to at least some of the school's policies and procedures. This means staff need to be respectful of school rules like hall passes, visitor policies, and being intentional about how and when to pull students from class. Many SBHCs wanted to keep their doors open during the early months of the COVID pandemic, but had to follow district closures.

Venice Family Clinic, which operates three SBHCs in the Los Angeles area, has found that doing facilities work such as implementing a data network for EHR access has been challenging. Lead agencies need to know who owns the equipment at the SBHC, where to go for repairs, and know that the timeline for making these kinds of changes might be very different than what they expect. This is often learned when planning and constructing a new SBHC where multiple players can slow the process significantly.

There can be controversies. In California, there are laws to support a young person accessing confidential and/or sensitive services, known as California Minor Consent and Confidentiality Laws. Even with this law, concerns may surface about

children and teens independently accessing health care services – especially ones like family planning, mental health, or even immunizations.

Schools and the education sector have different rules about information-sharing than health care providers. Schools are governed by a federal law called FERPA (Family Educational Rights and Privacy Act) that differs quite significantly from HIPAA (Health Insurance Portability and Accountability Act) and other health care laws. In California, minors are legally permitted to access a variety of health care services during the school day without parent/guardian consent; however, schools are responsible for what happens to students on the school campus[6] and are accustomed to knowing everything about what happens to students while there. Accustomed to operating with full information about students, administrators can become frustrated when they are not informed of things like mental health emergencies, child abuse reports, pregnancies, and/or students using substances on campus. These issues can be challenging in any setting serving adolescents but can be particularly thorny in SBHCs. The next section includes suggestions for how to increase clarity, partnership and collaboration to address these very challenges.

Recommendations & Lessons Learned

Although not exhaustive, this section offers a few suggestions for how SBHC staff and lead agencies can be most successful operating in this unique environment so that expectations are clear and aligned for all parties.

Budget realistically and appropriately. This includes setting realistic productivity standards that may differ from other sites operated by the lead agency; building in non-productive time for outreach, coordination, shorter school days, and more frequent service interruptions. In the absence of good historical data, consider reducing by at least 20-30% the service volume you would expect in a different setting. There also may be good reasons to evaluate an SBHC's budget and financials without allocating the lead agency's full indirect overhead. This can be especially true when the lead agency is a hospital or academic medical center with research, teaching, and training costs, as well as ancillary departments less frequently used by SBHCs (e.g., radiology, pharmacy, etc.).

Secure some base funding that is not reliant on third party reimbursement. Unfortunately, California does not yet have state grants for SBHCs, but other SBHCs have gained this contribution and commitment from a variety of sources that include: county allocations, Mental Health Services Act (MHSA) grants, private donors, foundation grants, fundraising events, and/or in-kind support from their lead agencies.

[6] *In loco parentis* implies strong central authority of educational institutions, stating that schools take the role of parents when the students are placed under their care.

Negotiate a clear MOU that specifies roles and responsibilities. CSHA recommends that all SBHCs have Memoranda of Understanding (MOUs) or other documentation with their school hosts and any other close partners (e.g., other agencies with which you will share space), and Business Associate Agreements (BAAs) as needed with agencies that will be sharing patient health information. The MOU should specify roles, responsibilities, data governance/data sharing expectations, and scope of services, as well as any financial agreements. If possible, lead agencies should protect their ability to provide all care within the normal scope of their agency and clinical licensure – for example, not allowing the school or district to impose restrictions on family planning, behavioral health or substance use counseling.

The Alameda County Health Care Services Agency provides base funding of $110,000 per year to 28 SBHCs. This funding is sourced through Tobacco Master Settlement Fund and local sales tax revenue.

Venice Family Clinic provides base funding to its SBHCs through private donations, fundraising and school district contributions.

Hire for success. Beyond any technical or licensure requirements, providers and other care team members should love children and youth, understand the unique SBHC model, and thrive when working flexibly in a small, low-resource environment under a range of circumstances. Staff continuity is important for building trust with the school community, so rotating staff through the SBHC is not recommended. Students need to feel comfortable with the front desk, medical assistant, providers, and others. Employers also need to be very explicit about schedules and other arrangements: e.g., if the SBHC is closed for the summer, what happens to employees? Are they guaranteed employment at another location? Are they expected to take paid time off? Are they 10- or 11-month employees and if so what happens to their health insurance coverage and other benefits? Finally, management staff need to be emotionally intelligent and skilled at negotiating effectively with school administrators, families, and other partners. Some of the most effective SBHCs in California are led by experienced, seasoned professionals that blend advocacy and assertiveness with lived experience and cultural humility; others are newer to the field and exhibit all these essential skills! All are comfortable going outside established protocols, deferring and consulting when needed, being self-reflective, managing through crisis and change, and never losing sight of their mission or why they are there.

Establish strong relationships with key players on the school campus. Ideally, SBHC staff will meet regularly with the school principal or other key administrators. If this is not possible, which is common, they should find ways to share general information about the health center and be a visible presence at most school events and integrated into school culture, including staff meetings, back-to-school night, family orientation, fairs, and PTSA meetings. Be sure to communicate SBHC closures outside of school

closures, and try to determine what is most valuable to the school about the SBHC, highlighting these services - whether back-to-school physicals, vaccines, crisis intervention, or periodic consultations for school staff. Keep communication as open and simple as possible, and submit reports at least a few times each year to let school stakeholders know how many students are using the services and other key metrics or stories. Staff should share what they can with school partners – e.g., let them know an emergency vehicle is coming, but not why or for whom. Any new SBHC planning should involve, at minimum, school nurse(s) from the site or district level, and ideally ongoing collaboration with nursing staff. Be aware and sensitive to the fact that some school staff may be less welcoming of the clinic presence, fearing they may lose their unique role or connection to students. It is always advisable to find influential allies such as vice principals, counselors, coaches, teachers, nurses, and/or Community Schools Managers. Also, remember that school staff turnover can be high and that introductions, overviews and tours are needed every school year, even if the SBHC has been on campus for decades!

Beyond this general collaboration, **the SBHC should be integrated within the web of on-campus service providers** and participate in Coordination of Service Team (COST) meetings or the equivalent. SBHC staff should be regular members of COST, there should be clear referral pathways and processes for students who might benefit from SBHC services, and service providers should share information based on clear parameters and agreements shaped by their professional laws and regulations. More information about the COST process can be found here: Coordination of Services Team**.**

One SBHC provided an annual School Staff Recognition Day with lunch and other goodies. Several provide TB tests for teachers on campus so they don't have to visit their providers, and one SBHC in East Oakland operates a wellness room focused on wellness and support for school staff as well as students. These touches can make a big difference!

Educate school personnel. SBHC leadership should be proactive in sharing the SBHC mission, services and other key facts with school leadership and families both to improve SBHC efficiency and to avoid unnecessary misunderstandings and controversies. They should also *listen* to those same stakeholders to understand their concerns. Some examples: (1) Ensure secondary school staff understand that minors 12 and over (and in some cases even younger) can consent to some of their own health care such as family planning and mental health services. Let stakeholders know that SBHCs follow the same minor consent and confidentiality rules applicable in any other health care settings such as a community pediatrician. Armed with this information they can help respond to caregivers with questions or concerns. This video offers some helpful examples of how schools and SBHCs can better work together within their mutual laws and regulations. (2) School staff should understand the scope of services, since some misinformed voices have spread rumors that SBHCs provide abortion services or gender reassignment surgery. (They do not.) (3) SBHC providers can be inundated with non-revenue generating tasks such as basic first aid or consultations with teachers. Although some of these activities are valuable, it may help to educate school and district personnel up front about providers' scope of

practice and the SBHC revenue model so they become your partners and use your team to the highest level. Collaborating with front office staff, school nurses, and administrators - as well as classroom teachers - can really make a difference for maximizing the skills of all those involved.

Conclusion & Resources

CSHA strongly encourages organizations that care about the health and well-being of children and youth to consider opening and operating SBHCs. They are a tremendous way to increase access to care that we know helps improve health, well-being, school success, and health equity. They support families and can help schools focus on education.

We also know the most successful SBHCs are ones where the leaders have their eyes wide open about these issues, set achievable goals, and support the onsite staff without expecting replicas of other ambulatory sites.

The following resources are available to support you and your teams as you plan, operate, evaluate and improve SBHCs. Please don't hesitate to reach out to CSHA at info@schoolhealthcenters.org – and sign up for our mailing list here to learn about our many webinars, trainings, and annual conference. We are here to help you build and sustain the best SBHC for your school community!

- **Vision to Reality Guide to Planning a SBHC:** www.schoolhealthcenters.org/vision-to-reality
- **Alameda County Coordination of Services Team Toolkit:** https://achealthyschools.org/wp-content/uploads/2020/05/149_01_COST_Guide_email.pdf
- **Consent & Confidentiality: A California Guide to Sharing Student Health & Education Information:** www.schoolhealthcenters.org/hipaaferpa
- **Sustaining & Growing Behavioral Health Services at SBHCs:** www.schoolhealthcenters.org/sustaining-behavioral-health
- **SBHCs Maximizing Third Party Reimbursement:** www.schoolhealthcenters.org/third-party-reimbursement
- **Braiding New Funding to Support California SBHCs:** www.schoolhealthcenters.org/funding/sbhcs
- **Student Confidentiality and Consent:** www.schoolhealthcenters.org/resources/sbhc-operations/student-records-consent-and-confidentiality/consent/
- **Student Health Index:** www.schoolhealthcenters.org/student-health-index/

About the California School-Based Health Alliance

The California School-Based Health Alliance (CSHA) is the statewide nonprofit organization helping to put more sustainable health care services in schools to improve the health and academic success of children and youth while reducing health and education disparities.

CSHA:

- **H**elps schools and communities start SBHCs
- **E**nsures high-quality SBHCs through education and training
- **A**dvocates for public policies to support SBHCs
- **R**aises the visibility of SBHCs so they are valued by the public
- **S**upports youth engagement and healthy youth development

Learn more about our work and find additional resources for school-based health on our website: https://www.schoolhealthcenters.org.

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