

E Guidelines for School-Based Health Centers in California

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: <ol style="list-style-type: none">confidentialityprivacysafety and securityinformed consentrelease of informationfinancial responsibilityminor 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 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)

<p>34. Chronic disease management:</p> <ul style="list-style-type: none"> 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.
<p>35. If serving an adolescent population, and approved by local school board:</p> <ul style="list-style-type: none"> 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
<p>36. Referrals for specialty care or other needed services not provided onsite</p>
<p>Recommended Services</p>
<p>37. Comprehensive health education/promotion outside of the clinical setting</p>
<p>38. Nutrition services, such as nutrition counseling, healthy habits support, family education, healthy cooking/shopping classes</p>
<p>39. Developmentally appropriate, culturally competent reproductive health care, including:</p> <ul style="list-style-type: none"> 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
<p>Licensing</p>
<p>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.</p>
<p>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.</p>
<p>42. Stationary, school-based health center facilities must pass school fire and safety clearance.</p>
<p>43. The school-based health center is in compliance with OSHA rules regarding occupational exposure to blood borne pathogens.</p>
<p>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.</p>
<p>Staff</p>
<p>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.</p>

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: <ul style="list-style-type: none"> 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
<p>64. School behavioral health services should be provided by:</p> <ul style="list-style-type: none"> • 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. <p>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.</p>
<p>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.</p>
<p>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.</p>

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.