

SCHOOL HEALTH CENTER GUIDELINES

We have developed guidelines for school-based health centers in California (see Appendix E). 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-based 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-based health centers, some of which are summarized below. Some of the guidelines, such as those related to staff certification, licensing, and facilities, are fully developed in other chapters in this manual.

ADMINISTRATION – The school-based 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-based health centers must be housed in a facility, whether stationary or mobile, that is easily identifiable by students, families, and school staff. Best practice for a SBHC is to include at least one clinical space and a reception area. See Chapter 8 for more detail on facilities components and planning.

ACCESSIBILITY – School-based 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-based 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-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.

THIRD PARTY BILLING – It is important that school-based health centers maximize revenue from available sources. The health center should bill CHDP, Medi-Cal, private 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 see Chapter 5.

QUALITY IMPROVEMENT – School-based 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-based 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-based 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. The Lead agency should then have its own written agreement with other service providers who may also provide services at the SBHC. 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 F 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-based 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-based 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-based 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-based 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 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-based 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, by which 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-based 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 Whole School, Whole Community, Whole Child model (described in Chapter 1).

It is vital that school-based health center staff communicate regularly with school staff.

SCHOOL INTEGRATION

Integrating SBHC services into the school is key to both clinical and financial success. Some best practices in integration include:

- Participate in Coordination of Services Team (COST) or other equivalent meetings/process; use this process to determine the best provider and service fit for students based on clinical need, insurance, language and other considerations. For more information see: Alameda County Coordination of Services Team Toolkit at http://achealthyschools.org/wp-content/uploads/2020/05/149_01_COST_Guide_email.pdf
- SBHC clinicians cross-train school staff in health topics such as Adolescent Development, Youth Mental Health First Aid, Sleep, Sexual Health, Trauma Informed Practices, Depression and Anxiety Awareness and Skills, Crisis Intervention and Response, Self-Care for Staff, ACEs, Toxic Stress and Resilience, How to Support Student Resilience, etc.
- SBHC staff attend school staff meetings and professional development, as well as Back-to-School nights and other family-centered events.
- Include SBHC outreach in school registration events and include parent consent forms for clinic services in school registration packets to ensure high access and participation rates.
- Support school culture and climate (MTSS Tier 1) and help to shift the school to a more trauma-informed approach. For more information see: Schoolwide Interventions at <https://www.schoolhealthcenters.org/resources/sbhc-operations/trauma-informed-sbhcs/school-interventions/>
- Support school staff wellness through mindfulness practices, yoga, or other movement opportunities, healthy food options in meetings, and resources to support staff health and resilience. For more information see: Staff Wellness Toolkit at <https://www.schoolhealthcenters.org/resources/sbhc-operations/trauma-informed-sbhcs/staff-wellness/>
- Support schoolwide clinical crisis response for significant events impacting the school community. For more information see: School Mental Health Crisis Leadership at https://cars-rp.org/_MHTTC/docs/SMH-Crisis-Leadership-Lessons-Guide.pdf

An excellent overall resource for SBHC-School Integration Assessment from The Los Angeles Trust for Children's Health can be found in Appendix G.

COMMUNICATION WITH OUTSIDE PROVIDERS

The school-based health center must 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. 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

SBHCs PROMOTING EQUITY

Racism and other systems of oppression negatively impact all students' ability to learn and be healthy. SBHCs are uniquely situated to address and reduce health disparities in schools, and work to increase access, equity, and opportunity for all students. The majority of students in California are Black, Indigenous and People of Color. Young people of color, as well as those who are LGBTQ+, people with disabilities, low-income or from other marginalized communities, face increasing health disparities that impact their health, mental health, education and life prospects. Some ways SBHCs can reduce the impact of racism and other systems of oppression on students include the following:

- Address implicit bias in staff and providers. Because implicit bias is largely subconscious, it takes repeated exposures to education, introspection, and re-programming to achieve lasting change.
- Center the voice of BIPOC youth - those affected by inequities in health and education know their own experience, needs, and communities. Their voices are essential in guiding effective strategy and realizing change and progress. SBHCs can listen authentically to the young people they serve and others in the school through a variety of intentional strategies. See Chapter 3.
- Partner with school staff to work towards a school climate that promotes equity and inclusion. Help create a safe and trauma-informed environment in both the SBHC and wider school culture.
More here: <https://www.schoolhealthcenters.org/resources/sbhc-operations/trauma-informed-sbhcs/>
- Acknowledge the historical racism in health care and the medical industry and educate SBHC staff and providers about race and racism. There are many good resources on this topic that acknowledge not only past assaults but the effects of ongoing racial bias and structural racism. Some examples can be found here: <https://www.schoolhealthcenters.org/resources/student-impact/anti-racism-resources/>
- 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.
- Partner with external organizations and programs to complement the strengths of the SBHC. For example, SBHCs may have a difficult time hiring medical practitioners of color but they can collaborate with other groups in their community that are BIPOC-centered and advocate for BIPOC youth.
- Take a broad social perspective that does not pathologize individuals but recognizes the impact of individual, family, and cultural strengths, as well as community-level traumas such as structural racism, inequality, and poverty. See best practices here: <https://www.acesaware.org/wp-content/uploads/2022/01/ETR-ACEs-Aware-SBHC-Practice-Paper.pdf>.
- Incorporate non-traditional therapeutic approaches such as peer providers and affinity groups.

- Conduct active outreach to groups that face the greatest health risks and barriers, tailoring this outreach whenever possible. Engage students from these groups so that the young people feel safe and comfortable utilizing services and know they have allies.
- Consider providing or supporting peer affinity groups that allow young people to connect with youth of similar identities and/or experiences. These can include newcomer groups, young men of color, and/or LGBTQ+ support groups using a mix of staff-led education and peer support.
- Focus on relationship building and not just the transactions of a specific service. Young people may want to connect to the receptionist for several weeks through conversation but not make an appointment. They also may need several visits with SBHC practitioners before disclosing personal histories or relevant health information.
- Provide limited English proficiency clients with access to bilingual staff or interpretation services. Translate and make available signage, posters, and print materials (e.g., brochures, flyers, magazines) in commonly used languages.
- Ensure that patients' primary language, self-identified race/ethnicity, and self-identified sexual orientation and gender identity are included in the medical record.
- Talk openly about race, racism, and other forms of oppression. Do not pretend that young people live in a color blind society.
- Promote, expect, and support training and ongoing education to ensure that staff have the awareness and skills necessary to work respectfully and effectively with patients, families, and each other in a culturally diverse environment. This includes understanding the role of intersectionality and the intersectional identities formed by race, ethnicity, class gender, religion, ability, and sexual orientation. Intersectionality is the concept that all oppression is linked and there is an interconnected nature to social categories that creates overlapping and interdependent systems of discrimination or disadvantage. Intersectionality is the acknowledgement that everyone has their own unique experiences of discrimination and oppression and we must consider everything and anything that can marginalize people.

A culturally sensitive health care system is one that is accessible and 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.

The above is only a partial list. SBHCs can and should make ongoing inquiries into the impact of race and other identities on their patients, staff, and services a part of their operational improvements.

CONFIDENTIALITY AND CONSENT

Every school-based 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-based 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:

<https://www.schoolhealthcenters.org/consent-confidentiality-provider-toolkit>

For a quick overview see:

<http://teenhealthlaw.org/wp-content/uploads/2019/08/2019CaMinorConsentConfChartFull.pdf>

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-based 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 – Recent changes in California law allows minors aged 12 and over to consent to their own mental health care counseling if a mental health professional deems them mature enough to participate intelligently in treatment. It is generally best practice to engage a minor’s parent or guardian whenever it is safe to do so. Sharing information with other health care providers, educators and others is complex and governed by different laws. These topics are beyond the scope of this guide but much more information about minor consent laws, confidentiality and information sharing can be found here: <https://www.schoolhealthcenters.org/resources/sbhc-operations/student-records-consent-and-confidentiality/>

SUBSTANCE USE 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 embedded within the various laws and ethics governing substance use treatment; health centers planning to provide substance use treatment should become familiar with the details. For more information see: <https://www.schoolhealthcenters.org/NCYL-SUD-Minor-Consent-FAQ>

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 their child's primary care medical and dental records, and permit disclosure of these records to outside parties; however, they may not view or release records related to birth control or pregnancy testing without their minor'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
- if the patient tests positive for certain infectious or communicable diseases such as syphilis, chlamydia, gonorrhea, or HIV

In general, mental health providers should 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-based health centers should make the rights of clients very explicit during the registration process and early clinic visits. A sample school-based health center information and consent package is available in Appendix H.

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-based 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 and <https://www.schoolhealthcenters.org/hipaa-basics/>.

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. For more information on FERPA, see www.ed.gov/offices/OM/fpco and <https://www.schoolhealthcenters.org/ferpa-basics/>.

HIPAA and/or FERPA – Understanding how HIPAA and FERPA interact and which law a provider falls under can be challenging. For example, schools are specifically exempted from HIPAA, creating ambiguities for school-based health centers run by school districts. For a video and flowchart to help clarify some of these challenges, see <https://schoolhealthcenters.org/hipaa-ferpa-key-points/>.

Release of Information – Generally schools and health centers must have written permission from the parent or eligible student in order to release any information from the student’s record. See Appendix I for sample release of information forms.

TELEHEALTH IN SCHOOL-BASED HEALTH CENTERS

With the COVID-19 pandemic, many schools and SBHCs transitioned to telehealth services as a strategy for meeting student health needs when school campuses were closed. Telehealth, defined as the use of telecommunication technologies to provide patient care by delivering clinical services remotely and from a separate location than the patient, can provide timelier and improved access to care by allowing patients to receive care from remote providers. It is also considered a cost-effective alternative to health care that is provided in-person, especially for rural and underserved areas.

Although it’s possible to operate an SBHC almost exclusively using telehealth technology, this model does not take full advantage of the trust and access created by more relational in-person care models, especially for new SBHCs. At the same time, all SBHCs should consider using telehealth to improve access to outside care providers and to extend care to students when either students or providers are unable to use the physical center. They can use a “hub and spoke” model to provide clinical telehealth services to schools or other locations that do not have them. SBHCs can function as both “hubs” and “spokes”, depending on the service. For more detailed information on telehealth in SBHCs, see: <http://www.schoolhealthcenters.org/telehealth>