Santa Clara County Office of Education

Guide to School Health Partnerships

CSHA & SCCOE

CALIFORNIA SCHOOL-BASED HEALTH ALLIANCE

Putting Health Care Where Kids Are

NOVEMBER 2024

INTRODUCTION

Across California, school-aged children and youth are suffering from health and mental health conditions that impact their learning and well-being. Many of these conditions are preventable and treatable, and the prevalence and severity of the conditions worsened during and following the COVID pandemic. Well-child health visits and immunizations fell sharply, and there have been dramatic increases in already rising rates of depression, anxiety, and suicidality. In low-income, rural, and communities of color, these difficulties are often magnified by limited access to health care that is appropriate for age, culture and language.

California public schools face an astonishing myriad of responsibilities based on state, federal and local laws and regulations, some of which include the health and mental health of students. Schools can be an ideal place to deliver a broad range of health and mental health services because they are accessible and trusted by so many children and families. These services can go well beyond the traditional nursing and school counselor services to include things like dental screenings and sealants, trauma-informed support groups, and physical exams. **But schools do not need to, and usually cannot, provide all these important health care services alone.** Almost all schools have local partners they can lean on: community health centers, medical groups, local hospitals, dentists, mental health agencies, and countless others. It is often squarely within the scope and mission of these organizations to provide this needed care. And in fact, California has a long history of innovative approaches to school-community health partnerships just like this.

This guide attempts to illuminate some of these creative and longstanding partnerships, as well as some new ones that are experimental and promising. It is intended to provide California schools, school districts, and offices of education – from superintendents to principals, nurses and concerned teachers – an understanding of the ways in which health care services for children and youth are structured so that they can consider partnerships to enhance student health and well-being. Although far from exhaustive, we hope this guide will offer some practical strategies for local educational agencies (LEAs) to expand their school health offerings in order to best serve their students while preserving limited education dollars.

This guide was created by the California School-Based Health Alliance (CSHA) through the generous support of the Santa Clara Office of Education (SCCOE), with funding from the California Department of Education and Health Care Services. Thanks to our partners the California Children's Trust and West Ed for their contributions and review of this document.

HEALTH SERVICES AS AN INTEGRAL COMPONENT OF YOUR COMMUNITY SCHOOL

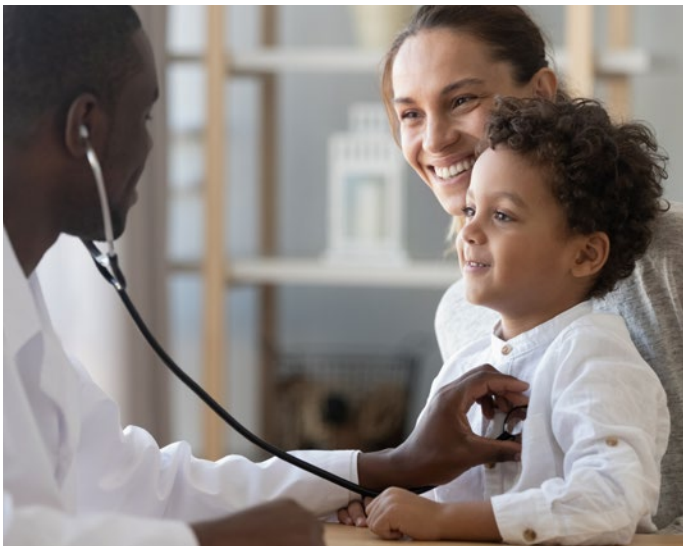
A community school is a school that utilizes a "whole child" approach to education. They integrate a focus on academics with health, social services, community development and community engagement. A robust community school will include the following four pillars:

- Integrated student supports,
- Family and community engagement,
- Collaborative leadership and practices for educators and administrators, and
- Extended learning time and opportunities.

The school-based health center and wellness center (SBHC/WC) model is a strong complementary asset to the goals and vision for community schools in the state. SBHC/WCs are a way for community schools to bring reliable, affordable, quality health care services to students and their families in an accessible and coordinated way.

- SBHC/WCs address the five outlined student needs in the Community Schools Framework
- SBHC/WCs create a site in a community school where school and community resources can be organized together and co-located
- SBHC/WCs allow for the community school to provide wrap-around services and care to students to help close the achievement gap and break down physical and mental health barriers to learning
- Having support for basic needs allows students to participate fully in their education

Tapping into the potential health partnerships in your community can be a uniquely effective way to strengthen your Community School, and meet the needs of students and families.



SCHOOL HEALTH PARTNERS IN YOUR COMMUNITY

Every community in California is likely to have some local organization(s) delivering health and mental health services for children, youth and families. Although every community is unique, there are some general organizational types that are most common and relevant for school health.

The health care providers that deliver most health care for lower-income Californians with Medi-Cal[1] or limited/no health insurance are collectively referred to as the health care "safety net." These organizations often specialize in providing care for populations that face practical, cultural, and/or language barriers to accessing affordable, high-quality health care services. Health care staff often reflect the population served minimizing cultural and language barriers. Safety net providers are generally not-for-profit or public entities that often have access to specific health-related grants and funding streams that can support school-based, school-linked and other "place-based" services for specific populations.

The tables on the next two pages depict some of the most common health care provider types in California with core features that may be helpful for schools to understand, with a focus on the health care safety net.

[1] Medi-Cal is California's Medicaid health care program. It pays for a variety of medical services for children and adults with limited income and resources. Medi-Cal is supported by federal and state taxes.

Organization Type	About this Type of Organization	Overarching Mission	Typical Services	Target Population(s)	Majority of Funding	Considerations for Schools
Community Health Centers (includes Federally Qualified Health Centers, Rural Health Centers, Tribal & Urban Indian Health Centers, FQHC Look-Alikes, and Free Clinics)	These are private and public non-profit health centers with community-based boards of directors	Provide primary care and related services to low-income, underserved populations	• Primary care • Behavioral health services for those with mild-to-moderate mental health and substance use concerns • Dental • Lab/Pharmacy • Enabling services such as transportation, translation and outreach • Health education, individual and group	Low- income people of all ages living in medically underserved areas, especially those covered by Medi-Cal or who have no health insurance	Reimbursement from Medi-Cal and Medi-Cal managed care plans (most receive enhanced Medi-Cal rates to recognize their increased costs and importance to the health care safety net) Some receive grants from the US Health Resources and Services Administration (HRSA), state, local health departments and foundations	Most school-based health centers in CA are operated by CHCs so this is a highly aligned model Very mission-related Model requires a high volume of clinical visits that can be hard to achieve in a school setting Because schools are not their typical settings, this model and the coordination required may be challenging Will need to consider how to support students with commercial health insurance such as Kaiser
Local Health Departments	These are government departments that operate in all 52 California counties and 3 cities (Berkeley, Long Beach and Pasadena) They are the backbone of California's public health system	Preventing, preparing for and responding to communicable disease outbreaks and public health emergencies	Varies widely - role is often focused on planning, funding, guidance and regulations Some LHDs provide or coordinate vaccinations, HIV services, STI services, Black Infant Health, home visits, and other important services Some operate their own primary care clinics similar to Community Health Centers (see above)	All residents of the local region with a focus on those who experience health disparities	State allocations based on population size Federal, state and other grants	Well aligned because of population health focus Sometimes less nimble because of government processes

Organization Type	About this Type of Organization	Overarching Mission	Typical Services	Target Population(s)	Majority of Funding	Considerations for Schools
Community Mental Health Agencies	Mostly private, community-based providers of a variety of mental health and substance use related services	Provide mental health services to the broader community (particularly to people with moderate to severe mental health diagnoses)	• Individual therapy • Psychiatry • Wraparound services such as transportation, groups and care coordination • Crisis services	Focus is often on low-income people who meet specialty mental health services medical necessity criteria	Contracts with local Mental Health Plans for Medi-Cal services for children, youth and adults	These organizations are already partnered with many Local Education Agencies (LEAs) on school campuses to deliver Educationally Related Mental Health Services (ERMHS) for students in Special Education, foster care and other circumstances In general, can only serve students with specified needs, care plans and levels of needs subject to treatment authorization and case review
Local Hospitals	These are typically large public or private institutions focused on emergency and inpatient care	Non-profit hospitals (the majority in California) may have a responsibility to provide "community benefits" that address community needs and priorities through disease prevention and improvement of health status, especially for vulnerable populations	• Emergency department • Inpatient stays • Cancer care • Surgery • Labor and delivery • Outpatient specialty care • Some also operate primary care clinics	All individuals in a local region who need services	Medicare, commercial insurance and Medi-Cal reimbursement	Prevention and early intervention may not be their focus Many are affiliated with teaching and training programs Non-profit hospitals are required to invest in Community Benefits programs Can be quite costly due to high indirect cost rates

SCHOOL HEALTH PARTNERS IN YOUR COMMUNITY

There are other organizations that may become involved in delivering school health services such as private dentists, physician groups, local health plans or medical societies, but these are far less common. LEAs should explore the resources in their communities!

Ultimately, the best partners are ones that want to come to the table, are dedicated to children's health, and are willing to explore creative partnerships with long-term commitment. This will vary markedly by community and the unique players are more important than the generalized considerations above.

How to Find Them

To locate these services in your community, you can:

- Use this **link** to find community health centers based on zip code
- Use this **link** to locate your local public health department (search by city or county)
- Use this **link** to locate the Mental Health Plan in your city/county and then find contracted service providers

IDENTIFYING NEEDS

The type of healthcare partner(s) a school or district needs depends on the kinds of services it is seeking for its students. Ideally, LEAs will conduct a needs assessment to identify the unmet health concerns for students and families, existing community and school health resources, their utilization, barriers to care, and other gaps. It can also help highlight models of care in place for similar groups in similar communities.

Conducting a needs assessment can involve using a number of tools, including surveys, focus groups, key informant interviews, community meetings or other strategies to gather relevant information. Schools and their partners can compile data from existing sources such as student/school/community surveys, public health records, and local school/health indicators. data. The California Departments of Health Care Services, Public Health and Education, as well as local health departments, collect and make available a wide variety of data and some make these data available via searchable databases. Local public health departments and school districts may also have access to regional and local data about student health outcomes and gaps in services. School level data may be available for information on health insurance, vaccination records, chronic health conditions, and vision and hearing screenings. In addition, CSHA has created a resource called the **Student Health Index** (SHI) which combines data on health, socioeconomic, and school demographics and outcomes in an interactive mapping tool that spans all large K-12 public schools in the state of California. The Index and Dashboard can be a helpful resource as a part of, or in conjunction with, your needs assessment.

More information on data sources and needs assessments can be found in Chapter 2 of **CSHA's Vision to Reality toolkit** and **STAC's resources on conducting Needs and Assets**.

MODELS FOR PARTNERSHIP

LEAs and schools can approach school health partnerships in a number of ways. At one extreme, an LEA can operate all health services independently, accessing no partners and delivering all the school health services its students need through its own funding and personnel. This is relatively unusual, but it does allow the LEA the most control over the services and related student information. The advantage of this arrangement is that the school district does not need to coordinate with outside entities, avoiding some of the tricky issues that arise with inter-agency and especially inter-sector collaboration. It retains full control and can share information easily across providers, with all documentation of student strengths, needs and services within the educational record. On the other hand, this model has major disadvantages: it does not leverage the unique strengths and assets of local partners that may be well suited to providing student health services and have funding and resources to cover some or all of the costs. Schools can wisely take advantage of these partners, as shown in next sections, to extend the services available to students in support of their health, well-being, and educational success.

At the other extreme end of the continuum is an LEA that has decided to contract or turn over all school health services to an outside health agency or agencies. This LEA may reduce its operational burden and financial obligation, take advantage of health partners, and also lose some measure of direct control. This can occur if a school district is under state oversight or other distress, and must focus exclusively on education. Other times it is because a strong public health department offers an entire package at low or no cost to the district. Of course, even in these cases, health partners should collaborate closely with schools, as described in the next section of this guide.

In reality, most schools and school districts operate between these two polar extremes, offering school health programs with select partners and maintaining some involvement and programmatic oversight. For example, most LEAs engage outside providers for at least some of the Educationally Related Mental Health Services.[2] Partner-delivered services might be provided all year or on a seasonal schedule at key times – e.g., physical exams before the school year starts, scoliosis screenings, or crisis interventions following major school incidents.

Most school-based health centers (SBHC/WCs) in California are run by an outside entity such as community health center or local hospital, and many operate with a high degree of autonomy from the host campus. SBHC/WCs operated by outside entities follow their own regulatory requirements, policies, and, as we discuss below, can only share limited information with school personnel. This model can be uncomfortable to schools and school districts accustomed to

[2] Educationally Related Mental Health Services (ERMHS) describe a range of support services provided to and/or on behalf of a student with an Individualized Education Program (IEP). If deemed necessary following a targeted assessment, the purpose of these services is to allow a student with mental health needs to access and benefit from his or her education. ERMHS are intended to specifically support skills required for the student to access the educational environment.

exercising near total control over their campus environments. However, the wealth of resources and services an SBHC/WC can bring to students, families and the school is typically well worth the cost of collaboration. (For more information on SBHC/WCs, see www.schoolhealthcenters.org).

Health Services Commonly Provided by California Schools	Health Services Commonly Provided by Onsite Partners
Nursing Speech therapy Academic counseling Hearing and vision screenings Focused therapy for specific populations	Dental screening Dental sealants Trauma screening and interventions Vaccines Sports Physicals Sexual and reproductive health services Health Education, individual and classroom Youth Leadership and Peer Health Education

The next section of this guide walks through some of the common challenges of school health partnerships and how they can be best structured for success.

KEY ELEMENTS FOR SUCCESSFUL PARTNERSHIPS

Assuming a school or district decides it wants to partner with outside agencies, it's never too late to improve the quality of those partnerships – even existing ones. And because partnerships inherently introduce complexity, below are some tips and recommendations to ensure these partnerships are effective for the students and staff involved.

Data and Information Sharing

Schools should be aware that the laws governing confidentiality and release of health information may be different for their health care partners than they are for the school district itself. In general, a school health program's records are subject to the Family Educational Rights and Privacy Act (**FERPA**) if the program is funded, administered and operated by or on behalf of a school or educational institution. However, health care provider records are subject to Health Insurance Portability and Accountability Act of 1996 (**HIPAA**) if the program is funded, administered and operated by or on behalf of a public or private health, social services, or other non-educational agency or individual. These federal laws regulate privacy and the exchange of specific types of information, and either HIPAA or FERPA may apply to control the release of the health records created when health services are provided on a school campus.

Schools should know a few things, including:

1. Although in a school setting, the parent/guardian typically has the ultimate authorization for education and school health services, there are some specific health care services that in California minors can consent to receiving without parent involvement. This includes services related to sexual health (pregnancy prevention, STI/HIV prevention and treatment), as well as some mental health and drug/alcohol related services. For services covered under the 'minor's consent' health care providers are *not permitted* to involve families without the minor's explicit permission and/or another legal reason. More information can be found here: www.schoolhealthcenters.org/consent

SCHOOL HEALTH PARTNERSHIPS IN PRACTICE: A COMMON SCENARIO

A health provider operating on a school campus provides a student with birth control pills. The student's parent discovers these in the student's backpack and learns they came from a school health center. Frustrated at having been left out of this decision, they approach the health center. The health center administrator politely explains state law and why they can not discuss these matters with the concerned parent. The parent then approaches a school administrator demanding information, recourse, and a change in policy. **Despite everyone's best intention, the health center staff cannot share information with either the parent or the school unless the student authorizes it.**

This is in fact a very typical scenario that schools should plan and prepare for. They can help contextualize and explain the law and the reasons for the laws to parents and guardians to prevent misunderstandings and disruptions.

2. In general, health care providers can not share protected health information with school personnel, even when services are provided on their campus, without signed authorization from the patient/client or their parent/guardian. (The same person who consents for the service is generally the person who needs to consent to releasing information about the care.) There are some exceptions to this rule, however, and case conferencing to support coordination of health care is allowable without an explicit release of information.

CRISIS MANAGEMENT WITH SCHOOL HEALTH PARTNERS

Health care providers on a school campus, as in any setting, are required to notify emergency personnel if a minor is expressing suicidal intent and has a viable plan that represents a danger to themself (Welfare and Institutions Code, Section 5150). Even if the provider engages emergency personnel on the school campus, they still can not divulge any details about this concern to the school administration. They can and should notify the school about the general activity, and will work with the student's family as appropriate, but they must protect the privacy of the student or risk legal action. Schools need to understand and respect these laws, finding a way to coordinate effectively to support the student in crisis without unnecessarily disrupting normal school operations.

Schools should assume that, like them, health care providers are acting in good faith, following the law, and protecting their clients and patients. School leaders should frame these issues for their staff to prevent hostility during tense moments and to establish clear expectations for all parties. It may be helpful to have a process in place for disagreements about what information can be shared and how to resolve these disagreements. Such circumstances are normal in this thorny territory, and all players should avoid making these issues personal, threatening the collaboration, or putting students and families in the middle/withholding helpful services.

For much more detailed information on this complex and important subject, please see A California Guide for Sharing Student Health and Education Information.

Understanding Funding for School Health Services

Another difference between LEAs and health care providers is in the funding they can access for providing similar services to similar populations.

Generally, schools and LEAs can receive matching funding for specified health services such as speech therapy and medical transportation delivered to certain students through the LEA Medi-Cal Billing Option Program and Medi-Cal Administrative Activities program. These programs require that school districts demonstrate certain aspects of care delivery and compliance through a special claiming process. This process is not as cumbersome as the one followed by health care providers to receive reimbursement for health care services delivered through the traditional health insurance system. Here is a high level overview of how that system generally works:

- Most health insurance in California, including Medi-Cal, is provided through managed care organizations, also known as managed care plans or health plans.
- Managed care plans require that health providers such as doctors, clinics and hospitals establish contracts, and these contracts require that the individual clinicians employed go through a credentialing process in advance that can take several months.
- Before services are rendered, individuals need to be registered as patients or clients with appropriate informed Consent for Treatment, positive assent to a HIPAA Notice of Privacy Practices, and collecting demographic information/health history. For some services – e.g., dental cleaning, physical exam, immunizations, or care and prescriptions for asthma – informed consent must be provided by the parent or guardian of a non-emancipated minor. For others – such as sexual health services and some mental health treatment[3] – the minor can consent to their own care.
- Before each visit, providers validate that patients are active members in the correct plan and county. For some services, prior authorization from the health plan is required.
- After the visit, providers submit detailed claims with information such as diagnosis, procedures, and other information.
- Claims are denied if any information is wrong, erroneous, or a service is not covered/approved. This "revenue cycle" can take 60 days or more to complete.

Most of the information above is not collected by schools or typical school health personnel.

[3] Since 2011, minors as young as 12 years old may independently consent to outpatient mental health treatment without the approval of a parent or guardian if the mental health clinician believes the minor is mature enough to participate intelligently in the services. Although this topic is too complex for purposes of this guide, it should be noted that many minors benefit from having their families involved in their treatment, and this is permissible or encouraged in most cases.

And while schools generally offer health and other services that are "universal" – i.e., provided to all students regardless of health insurance or income, health care providers are often organized by types of insurance – e.g., the Kaiser delivery system is for those with Kaiser health insurance; and many providers and clinics are differentiated between patients that have Medi-Cal vs. private insurance coverage.

For all these reasons, it is important for schools to understand that when they partner with community health care providers, and if the health care provider is relying on outside reimbursement to cover its costs, this may limit the number or types of students they can serve. It is also a good practice for all personnel to work toward the top of their skills, scope and license rather than doing tasks that someone with less training could perform. For all these reasons, a nurse practitioner employed by a community health center working in a school should not spend their days delivering basic first aid to students. It would likely not be able to collect this information to support ongoing service provision, whereas a school nurse could generate sufficient documentation to draw down LEA Medi-Cal matching funds.

Each health care provider brings its own circumstances and often access to grants and funding. In California there are currently a number of initiatives aimed at helping provide more extensive health, behavioral health and social services to young people – e.g., the Children and Youth Behavioral Health Initiative (CYBHI), Student Behavioral Health Incentive Program (SBHIP), CalAIM, and the California Community Schools Partnership. In general, it's helpful to understand how your partners' funding works and ways in which it can be leveraged to support more students and families in need. You can download the document "How Local Education Agencies and Partners Can Braid New Funding to Support School-Based Health Centers" **here** which further outlines the many funding sources that can be braided and blended to support school health services.

Joint Fundraising

To extend the benefits of school health partnerships, schools might consider working with their health care provider partners to explore ways to co-generate funding for the school health services. Often funders such as government and foundations value inter-agency and cross-sector collaborations. And having multiple agency types expands eligibility for funding streams that either alone might not qualify for. As partners grow more familiar with one another, they will naturally keep one another in mind when funding initiatives and opportunities emerge. It is strategic to engage entities such as the School Board, City Council and/or County Board of Supervisors as part of initiatives and investments in children and youth.

Written Agreements Between Parties

In school-health partnerships, misunderstandings and even conflicts can arise regarding a variety of issues ranging from space and information sharing to funding, communication, facilities maintenance, and other technical needs.

To minimize friction and promote positive working relationships, CSHA and SCCOE strongly recommend that LEAs put in place written, formalized agreements between the school or school district and any health providers, even if no funding is exchanged. Agreements can take the form of contracts, Memoranda of Understanding (MOUs), Letters of Agreement (LOAs), or any other appropriate legal document. These documents lay out relationships and responsibilities associated with the school health services. Some key elements of a written agreement include:

- Formal names of parties to the agreement
- Duration/term (can be determined by both parties involved; be sure to calendar times to review and update)
- Purpose/scope
- Each party's responsibilities
- Fiscal agreements if any
- How outreach and marketing to students, families and school staff will occur
- Other expected communication (see below)
- Information sharing, privacy and confidentiality issues
- Any expected reporting between parties
- Liability and indemnification arrangements
- Recourse for failure to follow agreement
- How to amend, extend, renew or terminate the agreement

Some examples of MOUs and other agreements can be found here:

- Sample Memorandum of Understanding
- Sample Letter of Agreement

School Integration and Ongoing Communication

School and district leaders can help promote positive school/health collaborations by facilitating clear expectations and level-setting early on, and ensuring shared understanding among all parties. For example, how will students be released from class to receive the health care services? How will teachers be notified about this excused absence? Although much of this early communications may be provided at an upper level of district administration, it is advised to consider assigning a clear liaison or point of contact for each health care provider partner closer to the point of service (e.g., a school vice-principal). And partners should also appoint a clear point of contact – depending on the service and the scope, this might need to be someone designated onsite (e.g., an SBHC/WC administrator), or for a more intermittent/part-time service it can be someone working at the home agency who confirms schedules, communicates with families, and is available for trouble-shooting. Ideally the school can help promote the health services to students and families, and help streamline service enrollment by making information and forms available in various settings including front office, back-to-school events and websites.

Ideally there should be periodic meetings or other communication with this liaison and the health partner even during times of stability. This will help ensure enough familiarity and trust is established to help during crisis, change and other challenges. As implied throughout this document, ongoing communication can help bridge the gap and support translation between the education and health care cultures that is normal and to be expected.

The frequency and specifics of this communication depends on the partnership and services involved, and also how new the partnership is. More communication is typically needed on the early/front end of establishing services or a new program. Any time there is new school leadership and/or health center management, it is essential to build the individual and organizational relationship and expectations. Unfortunately, once a program is well established, communication often fades away. This is a mistake. The authors recommend ongoing communication between school and health partners, even if brief, on some regular cadence.

Some other suggestions to ensure ongoing coordination and communication include inviting and encouraging health partners to participate in school professional development activities; presenting at staff meetings; hosting open houses, fairs and other events; engaging partners with PTSAs; and inviting partners to participate in Coordination of Services Team (COST) or other multidisciplinary case conferences designed to support students.

Assessing the Effectiveness of Partnerships

It is recommended that school leaders periodically re-visit their health partnerships to ensure they are still serving the school community well. This can take a number of forms, including a simple internal review with any aggregate data on program utilization and qualitative input from key stakeholders (school staff, students, families and the provider community). As always, concerns and constructive feedback should be used to make program adjustments and improvements whenever possible.

This kind of consideration could be practiced every 1-2 years, also allowing partners to re-evaluate changes in programs, policies, school demographics, each agency's strategic priorities, and any funding changes. Unlike the ongoing communication described in the previous paragraph, these conversations should involve those at the district or county level as well as those involved at the individual school site(s).

CONCLUSION

As champions of school health, we are optimistic that those of you reading this guide will use it to find ways that your school community can improve access to needed health care services for students in your school, district or county. Please use the additional resources listed below or reach out to our organizations if we can be supportive. Best wishes for a safe, healthy and connected school community!

ADDITIONAL RESOURCES

Santa Clara County Office of Education
Youth Health and Wellness website:
https://www.sccoe.org/yhw/Pages/default.aspx

CSHA Vision to Reality Toolkit:
www.schoolhealthcenters.org/vision-to-reality

CSHA School Integration Overview
www.schoolhealthcenters.org/integration

CONTACT

For more information or support, please visit:

Santa Clara County Office of Education
Youth Health and Wellness/School Health Systems & Billing

California School-Based Health Alliance

Guide to School Health Partnerships

CSHA & SCCOE

Santa Clara County Office of Education

1290 Ridder Park Drive, San Jose, CA 95131

www.sccoe.org