



School-Based Health Care and the District of Columbia Safety Net

Medical Homes DC Report
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The **21st Century School Fund** (www.21csf.org) is a nonprofit organization dedicated to building the public will and capacity to modernize public school facilities so they support quality education and community revitalization.

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I. EXECUTIVE SUMMARY

This report provides the results of research into the variety of health care services currently offered in the public schools in the District of Columbia, with a particular focus on school-based health centers. Also provided are the results of research into the practice of utilizing school-based health centers nationally in the U.S. The report is prepared by the 21st Century School Fund in support of the current Medical Homes DC project led by the DC Primary Care Association (DCPCA).

Medical Homes DC is a project to expand, improve or build primary care clinical space in the District, and to ensure that the clinic providers in those spaces have the skills, organizational infrastructure, and equipment to provide high quality care. A *medical home* is a place where there is a primary care provider who knows a patient's health history; where a patient will be seen regardless of his or her ability to pay; and where the patient *routinely* seeks non-emergency medical care. The project is in the first year, with funding from the U.S. Department of Health and Human Services (HHS); the D.C. Department of Health (DOH); and Consumer Health, Meyer, Kaiser, and Marpat Foundations. The role of 21CSF in the first year was to be the D.C. public and public charter school facilities and health care services expert; to be the link between the Medical Homes DC team, school facilities and health care staff, and other organizations working to improve school facilities and health care; and to look for opportunities to place new clinics in school sites.

Overall, the research found that there are a wide variety of health care services and programs offered throughout the D.C. public school system, including the School Health Program which offers basic nursing care at least part-time at every school, to fairly comprehensive school-based health centers at a few schools. Additionally, there are a number of other health and mental-health services offered at selected schools that are administered by a variety of entities and funded by a variety of sources. There are clearly a number of health-related initiatives and activities taking place in District public schools, but they operate largely in isolation from one another and do not coordinate their efforts. There does not appear to be an overarching system or chain of accountability overseeing all of the health-related services in District of Columbia public schools.

The purpose of this research is to explore possible collaborations between school-based health services and primary care clinics in order to strengthen the primary care safety net for low-income District residents. Indeed, the school nurse program and existing school-based health centers already serve many low-income children and, in some cases, their families. Medical Homes is interested in working with DCPS, charter schools, and other parties in order to support the provision of high-quality school-based health services and create stronger linkages with the rest of the primary care safety net. For instance, DCPS is in the midst of a Capital Improvement Program to modernize or replace its school buildings, which offers an opportunity to place more health centers in schools, and in spaces specifically designed for such clinics. Additionally, school nurses

could benefit from more systematic information on primary care clinics and their services for referral purposes.

Based on our review of the D.C. public school health services, we make the following recommendations for how these schools and its partners can strengthen school-based health services and create a stronger relationship with the rest of the primary care safety net:

1. Improve the facilities, equipment, and supplies available to school nurses. Children’s National Medical Center runs the School Health Program, which provides nurses on at least a part-time basis to all public schools (traditional and charter), and the Center has reported that inadequate facilities, equipment, and supplies often limit nurses’ ability to deliver services.
2. Create more information-sharing and communication between the various health-care entities operating in the public schools. For instance, information technology could allow school nurses and school-based health clinics to share patient medical records.
3. Create a chain of accountability for the performance and direction of all health services provided in DCPS. There should be one person or office within DCPS or DOH who is responsible for overall school-based health care. This is absolutely essential to assure accountability for the delivery and performance of health services.
4. Actively look for opportunities and partners to open more school-based health clinics. As is documented elsewhere in the Medical Homes DC project, District children need greater access to high-quality primary care services. The school setting offers a valuable and appropriate site to deliver care and can be an important element in improving children’s health outcomes. School-based health centers support the learning environment – they reduce lost school time due to illness or leaving the school for appointments – and help keep kids healthy. DCPS can take advantage of its ongoing facilities modernization program to design spaces for school-based health centers in new or renovated schools.
5. Institute operating standards and guidelines for school-based health centers in the District. A number of states have created guidelines that set standards in a number of areas, including staffing, facilities, and scope of services. Enacting such standards in the District will assure uniform quality across centers.
6. School-based health centers should consider billing patients (when there is insurance) in order to enhance their financial sustainability.
7. Collaborate with the Medical Homes DC project on how school-based health services and the rest of the primary care safety net can work together. Medical Homes DC is particularly interested in expanding the number of school-based health centers.

II. BACKGROUND

A. District of Columbia Public Schools

There are 167 schools and learning centers in operation within the system, with a 2003-2004 school year total audited enrollment of 64,248 students. Enrollment has steadily declined over the past decade and continues to do so. There is a very diverse student population with more than 138 different nationalities, approximately 12% belonging to a language minority group, and another roughly 8% classified as Limited English Proficient or Non English Proficient. The demographic breakdown in 2003-2004 was as follows: African Americans, 84.4%; Hispanics, 9.4%; Whites, 4.6%; Asian Americans, 1.6%; and Other, 0.5%. Also, 60.8% of DCPS students received free or reduced price meal support during the 2003-2004 school year.

DCPS is politically independent but fiscally dependent, meaning there is a majority-elected governing board that independently runs the school system but the system does not have its own revenue stream and instead receives most of its operating and typically all capital funds from the city through the City Council. DCPS annually receives some operating funds from the federal government, such as for teacher aides and free/reduced lunch programs, and occasionally receives federal funding earmarks for capital projects. For the city appropriation, the Council cannot instruct the school system *how* to spend the money given to it. The local operating funds are provided by law on a per-pupil basis (i.e., Uniform Per Pupil Funding Formula), supported by local taxes, while the local capital funds come out of a city general fund for capital expenditures, supported by general obligation bonds.

DCPS is governed by a nine member Board of Education that establishes the annual budgets, sets policies, and provides system oversight. This governing body is a mixture of 5 elected members, including a President, and 4 members appointed by the Mayor. A Superintendent (hired by the Board of Education) along with central administration staff runs the daily operations of the school system. A central administration Office of Student Services manages school health services and Office of Facilities Management directs facility operations for the system.

An initiative of note within DCPS is Transformation Schools. According to the DCPS website, this is “an initiative that aims to rapidly and effectively transform fourteen identified DC Public Schools into high-performing, child-centered, family- and community-focused learning centers with the full collaboration of everyone and anyone interested in ensuring success of the children of the District of Columbia.” A list of the participating schools is provided in Table 1. Expanded school-based health care is part of the initiative, and Georgetown University Children's Medical Center, Health Right, Inc., DC Chartered Health Plan Inc., AmeriGroup Corp., and Capital Community Health Plan are all partnering with DCPS to support students and families to that end.

Table 1: DCPS Transformation Schools	
Level	Schools
Elementary	H.D. Cooke Davis LaSalle Noyes Simon Stanton Turner Walker Jones Wilkinson
Middle	Choice Academy – Taft Evans Kramer
Junior High	R.H. Terrell
Senior High	Choice Academy – Douglas

DCPS is also over 4 years into the implementation of a long range educational Facilities Master Plan to fully modernize or replace its school buildings, including health service spaces. Design guidelines for the improved health spaces include separate areas dedicated to each of the following needs: treatment; cots; waiting/reception; office; storage; and toilets. The DCPS Facilities Master Plan, originally adopted in 2000 and then updated in 2003, targets approximately 10 schools a year for full modernization or replacement over 15 years, with each group of 10 in a designated tier (starting with a Tier 0). One of the many issues to be addressed by the Plan other than aging facilities is declining system enrollment and increasing excess space that is already a significant amount.

The implementation plan for the Facilities Master Plan is described in a 6-year DCPS Capital Improvement Program, which is updated annually based upon funding constraints and facility priorities. Approximately \$1 billion has already been authorized by the city for 26 schools in this program, with 7 new buildings opened to date, and the remaining 19 in the design, feasibility, or construction phase. However, a current capital funding shortfall in the District is forcing a major reassessment of the school system’s Capital Improvement Program as well as other agency’s capital improvements programs, with a significant slowdown and reordering of the schools highly likely.

B. District of Columbia Public Charter Schools

In addition to the traditional public schools in the District, there are currently 47 public charter schools. Charter schools are independently-operated public schools that were authorized by the U.S. Congress in the District of Columbia School Reform Act of 1995, and are not part of the D.C. government. The "charter" that establishes a school is a contract that states the school's mission, program, goals, students served, assessment methods, and means of measuring success. Each school has a unique focus, curriculum,

and set of teaching methods. Two boards in D.C. grant charters and oversee the schools: the D.C. Board of Education and a D.C. Public Charter School Board.

Public charter schools are open to all District residents, regardless of their neighborhood, socioeconomic status, academic achievement, or ethnicity. There are no admission tests or tuition fees. The total audited enrollment of all District charter schools in the 2003-2004 school year was 13,743 students. The demographic breakdown is as follows: African Americans, 92%; Hispanics, 7%; Whites, 1%; Asian Americans, 0.2%; and Other, 0.1%.

Similar to DCPS, charter schools receive public operating funds from the city based on the number of students they enroll, and they also receive some federal funding. A major difference between the charter schools and DCPS schools, however, is that charters also have a facilities allowance in addition to the per-pupil funding formula. This is because charter schools do not obtain funding from the city's capital budget since they are not associated with any D.C. government agency. The facilities add-on provides an amount based roughly on DCPS's per-pupil capital spending, which for the 2004-2005 school year is \$2380 per student. Charter schools also receive some federal funding for their capital needs, such as from City Build, which is a new initiative that will provide \$1M grants to some District charter schools to become neighborhood centers that would incorporate new spaces such as health clinics.

C. School-Based Health Care

1. Health Services and Programs

According to the George Washington University Center for Health & Health Care in Schools, school-based health care generally falls into two categories: health programs and health services. Health programs range from those that help students adopt healthy habits to those that foster a physically and emotionally healthy school environment. Programs can address environmental issues, nutrition needs, physical activity, and pregnancy, violence, tobacco, and drug use prevention. Health services include screenings and referrals to community resources; services to support students with special needs; and primary and preventive physical and mental health care.

There are many federal, state, and local initiatives and requirements affecting the provision of school-based health care programs and services. At the federal level, the Medicaid program has been supportive of school-centered health care, and has specific requirements associated with implementing health services/programs and seeking Medicaid funding. Typically, schools which provide health services provide a number of Medicaid-covered services, and this is true for the public schools in Washington, DC. These services include early assessment of children's health care needs through periodic examinations under Medicaid's Early and Periodic Screening, Diagnostic and Treatment

benefit, or those associated with a child's Individualized Education Plan or Individualized Family Service Plan, under the Individuals with Disabilities Education Act (IDEA).¹

IDEA defines the responsibilities of school districts to provide services that ensure children with certain specified disabilities receive free, appropriate education. Under the law, school districts must prepare child-specific Individualized Education Plans that outline all special education and related services needed, and the schools must provide these services. Such services most commonly include speech therapy, physical and occupational therapy, and counseling. The most costly related service is transportation, with the cost of transporting a special education student in Washington, DC averaging \$18,000 per student for the 2004-2005 school year.

Aside from IDEA, other federal legislation defining health services for disabled children who attend school and are enrolled in special education programs include Section 504 of the Rehabilitation Act of 1973, and the American with Disabilities Act (ADA). The former is a civil rights law protecting the rights of individuals with disabilities to participate in programs that receive federal financial assistance. The U.S. Department of Education has issued regulations implementing Section 504, including a requirement that schools provide a written plan identifying services essential for a student to access the educational program. The latter extended the protections of the Civil Rights Act to persons with disabilities. Under ADA, public programs must enable individuals with disabilities to have equal access and opportunity for equal enjoyment of facilities and programs.

The federal government also supports school-based behavioral health care through an initiative called Safe Schools/Healthy Students, a program run by the HHS Substance Abuse and Mental Health Services Administration. Started in FY1999, Safe Schools/Healthy Students is a grant program designed to develop real-world knowledge about what works best to reduce school violence. During the first two years of the program, grants of \$1M to \$3M were awarded to 77 local school districts (including DCPS) that had formal partnerships with local mental health and law enforcement agencies. School districts use the funds to help communities design and implement comprehensive educational, mental health, social service, law enforcement, and juvenile justice services for youth.

At the local level, Washington, D.C. Public Law 7-45 requires that a school nurses program be available to all students enrolled in DCPS and the public charter schools, and that the program provides twenty (20) hours of clinical services each week at each of the schools. The law defines a minimum level of health services and responsibilities for school nurses, which are described in section III of this report under School Health Program.

¹ *Medicaid and School Health: A Technical Assistance Guide*, U.S. Department of Health and Human Services, August 1997.

2.School-Based Health Centers

School-based health centers are the most comprehensive form of physical and mental health service delivery in schools. Typically, clinical services are the responsibility of a qualified health provider (hospital, health center, health department, group medical practice, etc.), and a multidisciplinary team of nurse practitioners, clinical social workers, physicians, and other health professionals care for the students. Also typically, the center works cooperatively with school nurses, coaches, counselors, classroom teachers, and school principals and their staff to assure that the health center is an integral part of the life of the school.

School-based health centers emerged in the U.S. during the late 1960's, and have experienced a rapid and significant rise in number since then. They apparently originated in connection with the advent of Medicaid in 1965, which among other things, highlighted the need for better health care for low-income children. In the late 1960's and early 1970's, the first school-based health centers in the country were established in Cambridge, Massachusetts; Dallas, Texas; and St. Paul, Minnesota and were staffed by nurse practitioners, part-time physicians, and mental health professionals. According to the Center for Health & Health Care in Schools, there were at most 50 school-based health centers across the country in 1985; roughly 600 in 1994; and 1,498 by 2002.

Since the 1970's, the HHS Bureau of Primary Health Care has supported and promoted the concept of school-based health centers through its Federally-Qualified Health Centers program. Federally-Qualified Health Centers are nonprofit community health centers that provide health care to the medically underserved and uninsured with certain requirements, such as serving a federally-designated health professional shortage area, medically underserved area, or medically underserved population. To be a federally-qualified school-based health center, a center must also operate year-round for at least 30 hours per week, with signed agreements between the host school, local school district, and others. Federally-Qualified Health Centers are supported by federal grants, Medicaid, Medicare, private insurance payments, and state/local contributions.

In 1994, the Bureau of Primary Health Care started a Healthy Schools, Healthy Communities program to promote and establish comprehensive school-based health centers for services and programs such as: counseling, mental health, dental, and nutrition. The Bureau of Primary Health Care has also provided funding for the development and operation of 512 school-based health centers (130 of these are funded through the Healthy Students, Healthy Communities program), and provided policy leadership, technical assistance, training, models, and operating standards and guidelines for those centers that it supports. In addition to the federal government, several states have also provided funding and logistical supports to school-based health centers. See section IV of this report for more information on these federal and state funding and logistical supports.

In Washington, D.C., the Board of Education has issued policy, but not actual standards, governing the operation of school-based health centers in DCPS schools, titled

*Utilization of Public Health Services in School-based Adolescent Health Centers.*² The Board of Education policy applies only to school-based health centers operated by DOH. The policy lists specific limitations for center operations, some of which include:

- Services shall not include the dispensing of prescription drugs and contraceptive devices;
- Services shall be provided only during hours between 8:00AM and 5:00 PM unless otherwise stipulated in an interagency agreement between DCPS and DOH;
- Services shall be provided only to students currently enrolled in the school in which the center is located, except that such services may be provided to students previously enrolled within that school during the school year, upon approval of the school principal, or to prospective students as part of an enrollment process.
- Services shall be provided free of charge or at nominal cost to students and their parents, unless otherwise stipulated in an interagency agreement between DCPS and DOH. Nothing in this section should be read to relieve an insurer, Medicaid, or any similar third party from an otherwise valid obligation to pay for these health services.

² D.C. Municipal Regulations, Title 5 (Education), Chapter 24

III. PUBLIC SCHOOL HEALTH CARE IN WASHINGTON, DC

A. School-Based Health Centers

There are currently only three public schools in the District that house school-based health centers, all of them within DCPS. These three schools are Eastern Senior High School in Ward 6, Woodson Senior High School in Ward 7, and Brightwood Elementary School in Ward 4. Health centers are connected to Marie Reed Elementary School in Ward 1 and Walker Jones Elementary School in Ward 6, but aren't considered school-based health centers for the purposes of this report since they aren't housed within the schools. Planning is underway for a fourth DCPS school-based health center at H.D. Cooke Elementary School in Ward 1, and a charter school health center at Community Academy Public Charter Elementary School in Ward 4. A description of the three operating school-based health centers follows.

1. Eastern Senior High School

The school is located at 1700 East Capitol St, NE. The total audited enrollment for the 2003-2004 school year was 968 students, and approximately 890 of the students were currently enrolled in the health center. The school is currently not yet scheduled for a planned facility modernization, according to the current DCPS Capital Improvement Program.

The health center is an independently-licensed Federally-Qualified Health Center that opened in May of 2001, and is operated by Unity Health Care, Inc., a Washington, DC 501(c)(3) nonprofit organization with a network of primary health care and social service providers around the city. Unity Health Care is a member of the DC Healthcare Alliance. The center is located in the basement of the school, and is collocated with the school nurse. According to the health center manager, there is a good working relationship with the school nurse; however, there is no sharing of patient records between them.

The health center is open from Monday to Friday, 8:00 AM to 4:30 PM, and includes the following staffing: pediatrician, 0.5 FTE; nurse practitioner, 1.0 FTE; psychiatrist, 0.1 FTE; clinical social worker, 1.0 FTE; and medical assistants, 2.0 FTE. The annual operating budget is approximately \$200,000. The center size is roughly 1,400 sq. ft., and includes 3 exam rooms (see Figure 1), a waiting room, and storage. The patient load is predominantly students enrolled with the center, and an occasional teacher.

The services and programs offered in the center include the following:

- Pediatrics
- Medical case management
- Preventive screening and testing
- Preventive health education

- Routine lab tests
- Social service case management
- Urgent care
- Dental care

Figure 1: Eastern Senior High School School-Based Health Center Exam Room



Funding sources include a federal Healthy Schools, Healthy Communities grant, and patient billing. Over the past year, the patient health coverage has included the following: Uninsured, 19%; Medicaid, 4%; Medicaid Managed Care Organization, 40%; and private insurance, 37%.

2.H.D. Woodson Senior High School

The school is located at 5500 Eads St, NE. The total audited enrollment for the 2003-2004 school year was 661 students, and approximately 510 of them were enrolled in the health center. The school building is scheduled to be replaced by FY07 according to the current DCPS CIP, and is currently being redesigned. The plan is to build a new school next to the existing one, while the current one is still occupied, and then demolish the existing school to make room for fields, parking, and other exterior amenities.

The health center facilities were built into the existing (1977) building. The DOH Maternal and Child Health Administration has been the program operator since 1996. The center is located in the basement of the school, and is not collocated with the school nurse, although they will be collocated in the new building. According to health center staff, there is a very good working relationship with the nurse even though they are located at opposite sides of the building. The nurse must provide a referral for any student wishing to visit the health center, and there is collaboration on immunizations and health education.

The health center is open from Monday to Friday, 8:30 AM to 4:30 PM, and includes the following staffing: nurse practitioner, 1.0 FTE; registered nurse, 1.0 FTE;

front desk registration, 1.0 FTE; and social service representative, 1.0 FTE. The center size is approximately 1,500 sq. ft., and includes 2 exam rooms (see Figure 2), a lab (see Figure 3), waiting room, office, conference room, and storage. The health center serves only students currently enrolled at the school. The annual operating budget was not determined.

Figure 2: H.D. Woodson School-Based Health Center Exam Room



The services and programs offered in the center include the following:

- Pediatrics
- Preventive screening and testing
- HIV/AIDS screening, testing, primary care
- Preventive health education
- Routine lab tests
- Urgent care
- Community special events (e.g., health fair)

The only funding source is the DOH Maternal and Child Health Administration. There is no patient billing.

Figure 3: H.D. Woodson School-Based Health Center Laboratory



3. Brightwood Elementary School

The school is located at 1300 Nicholson St, NW. The total audited enrollment for the 2003-2004 school year was 503 students, and approximately 130 of them were enrolled in the health center. The school building will be fully renovated and expanded under the current DCPS Capital Improvement Program, and is scheduled to be opened in fall 2006.

The school's health center opened in September of 2003, and is operated by Mary's Center for Maternal and Child Care, a Washington, DC 501(c)(3) nonprofit organization that offers comprehensive, family-centered services, including prenatal, pediatric, and social services. The health center is located on the second floor of the building in a converted classroom, and is collocated with the school nurse. According to the health center manager, there is not a very strong working relationship with the school nurse; however, there is some collaboration on immunization records and treatment.

The health center is open from Monday to Friday, 8:30 AM to 4:30 PM, and staffing includes only one full-time nurse practitioner. The annual operating budget is approximately \$95,000. The center size is approximately 300 sq. ft., and is only one room shared with the school nurse (see Figure 4). The center will have improved space

in the modernized school building, including 2 exam rooms, a waiting area, and office. The health center serves only students currently enrolled at the school.

The services and programs offered in the center include the following:

- Pediatrics
- Preventive screening and testing
- Preventive health education
- Social service case management
- Routine lab tests
- Urgent care

Figure 4: Brightwood School-Based Health Center



The only funding source is a grant from Fight for Children. There is no patient billing, but this is being planned and is under development. Over the past year, the patient health coverage has included roughly the following: Uninsured, 10%; Medicaid, 10%; Medicaid Managed Care Organization, 60%; and DC Healthcare Alliance, 20%.

B. Other School Health Care Programs

1. School Health Program

This program provides health care services through nurses to all D.C. public school students (traditional and charter). It is funded through the DC Healthcare Alliance, which is a public-private partnership between DOH and five private sector partners that was established in July 2001 with a goal of providing eligible underinsured D.C. residents open access to quality health care. Children's National Medical Center, one of the Alliance private sector partners, has been contracted by DOH to run the School Health Program since the 2001-2002 school year. Prior to then, the program was run by the DC Health and Hospitals Public Benefit Corporation.

Children's National Medical Center, as the School Health Program contractor, provides health care services to D.C. public school students in accordance with D.C. Public Law 7-45. These services include immunization status review; basic health screenings (e.g., vision and hearing) and comprehensive education and prevention programs for smoking, nutrition, pregnancy, HIV/AIDS, substance abuse and mental illness. Nurses are also responsible for implementing effective referrals into the larger health care system when a health need is identified; and for facilitating or coordinating services with community-based providers, hospitals, and managed care organizations for those students that are enrolled in Medicaid and receive care through a Medicaid HMO. Also per the contract, Children's National Medical Center must track, trend, and report utilization data for the School Health Program, and provide reports containing that data to DOH on a quarterly basis. The reports must include data on encounters (including the most prevalent complaints), referral types (e.g., dental, vision, etc.), and immunization completions and compliance status.

In addition to the Alliance-funded 20 hours of nursing at each school, many schools pay for an additional 20 hours out of their local school budget. Phone calls to every D.C. public school (although some couldn't be reached) this past spring revealed that at least 52 DCPS (including all high schools) and 9 charter schools had a full-time nurse at that time.

According to the School Health Program 2001-2002 Annual Report submitted by Children's National Medical Center (a 2002-2003 report was requested by the author but wasn't received), there are a number of facilities, equipment, and supplies problems that limit the full delivery of service to students. For one, it was reported that one-third of nurse suites had inadequate running water ("adequate" defined as having hot and cold). For another, it was reported that more than half of nurse suites had inadequate screens, beds or cots, and pillows. For a third, it was reported that 60% of nurse suites did not have a separate refrigerator for medications. And lastly, it was reported that only 15 schools at the time had computers and internet connectivity in the health suites.

2.DCPS Health Plus Initiative

This is an initiative established by the DCPS Office of Student Services to provide student health services beyond those of the School Health Program in some of the DCPS schools. The overall goal of the initiative is to connect students who are enrolled in Medicaid with a medical home, and to provide uninsured students access to preventive and primary healthcare services. To implement the initiative, Memoranda of Understanding (MOU) were established with the following Medicaid Managed Care Organizations: Health Right Inc., DC Chartered Health Plan Inc., and AmeriGroup Corp. There is also an MOU with Georgetown University’s Children’s Medical Center. Under the terms of the MOUs, each organization is able to provide free student health services on DCPS grounds, and all students must have parental consent to receive services from the organizations.

Table 2 provides a summary of the participating schools, program types, operating organizations, and funding sources for the augmented health services available through the Health Plus Initiative. This information was obtained from DCPS, although detailed information on the specific services provided at each school was available only in the case of the three school-based health centers (directly from staff at these centers). Numerous requests to both DCPS and the operating organizations for information on services offered through the programs at the schools proved unfruitful, and for reasons that are unclear. The DCPS School Health Officer did report, however, that similar to the School Health Program, this initiative and health services/programs in DCPS in general suffer from facilities, equipment, and supplies problems as well.

School Name	Program Type	Operating Organization	Funding Source(s)
Anacostia SHS	?	DOH	DOH
Ballou SHS	?	CNMC	DC Healthcare Alliance
Dunbar SHS	?	Georgetown Univ. Children’s Medical Center	Georgetown Univ. Children’s Medical Center/Medicaid
Eastern SHS	School-based health center	Unity Health Care, Inc.	Federal HSHC grant
Spingarn SHS	?	Georgetown Univ. Children’s Medical Center	Georgetown Univ. Children’s Medical Center/ Medicaid
Woodson SHS	School-based health center	DOH	DOH
Lincoln MS	?	Health Right Inc.	Medicaid
Brightwood ES	School-based health center	Mary’s Center	Private grant
Ferebee Hope ES	?	Health Right Inc.	Medicaid
Lasalle ES	?	Health Right Inc.	Medicaid
HD Cooke ES	?	Health Right Inc.	Medicaid

3. Safe Schools/Healthy Students Program

This is a federally-funded behavioral health care program, described in section II.C, which is locally-operated through a public-private partnership between DCPS and Triad Health Management. Since February 2002, Triad has been under contract with DCPS to provide behavioral health services for high risk students, and to provide training in classroom behavioral intervention strategies for DCPS teachers. The Triad-managed Safe Schools/Healthy Students program currently operates in 12 schools, which are listed in Table 3.

In this program, students are referred to Aggression Replacement Training groups based on their status as “at-risk” due to critical behavior patterns, including aggression, disciplinary infractions, truancy, juvenile justice involvement, and academic failure. The methodology for teaching the training groups utilizes mental health professionals to engage students in active and participatory teaching strategies (e.g., modeling, role-playing, and performance feedback) involving real life discussions of behavioral health challenges.

Level	Schools
Elementary	Brightwood Kenilworth LaSalle M.C. Terrell P.R. Harris Seaton Stanton Tubman Wilkinson
Middle	Kelly Miller
Junior High	Deal
Senior High	Bell

4.School Mental Health Program

This is a program funded and run by the D.C. Department of Mental Health (DMH) to provide school-based mental health services in partnership with DCPS and the public charter schools. The program is based on the federal Safe Schools/Healthy Students model, and represents one piece of a system of mental health care for D.C. children and youth focused on prevention and early intervention. It currently operates in 18 DCPS schools (primarily in Wards 5 and 7), including 5 Transformation schools, and 10 public charter schools. The participating schools are listed in Table 4. The majority of the DCPS schools comprise a cluster that feed into Spingarn Senior High School in Ward 5.

DCPS	DCPS Transformation	Public Charter
Spingarn SHS Browne JHS Eliot JHS Ron Brown MS Marshall MS/ES Young ES Fletcher-Johnson ES Matthew Emery ES Benning ES Webb ES River Terrace ES Miner ES Gibbs ES	Choice Academy/Douglas SHS R.H. Terrell JHS Davis ES Lasalle ES Turner ES	Cesar Chavez SHS Booker T. Washington SHS Friendship-Edison/Woodson SHS IDEA SHS Maya Angelou SHS SEED SHS/MS Options MS Children's Studio ES Meridian ES SAIL ES

DMH has fully funded the clinical positions for the program. Almost every school has a full-time equivalent position (Cesar Chavez has 0.75 FTE; SAIL has 0.4 FTE; and Booker T. Washington has 0.4 FTE) for a qualified mental health provider to offer an array of services on site. Clinical staff in each school is trained as social workers, psychologists, counselors, or mental health specialists (having at least masters in psychology or counseling). The clinician works in partnership with the principal, the school counselor, the school nurse, and any other school-hired or community-based providers that work within the school. He or she is an active member of the early intervention team (i.e., the teacher assistance team, child study team) where all referrals for interventions are made, appropriate services are delineated, and assignments are made using a multidisciplinary team approach.

Mental health providers offer assessment, treatment, prevention, consultation, training, and case management services to students and their families. Prevention activities include educational workshops, consultation, or training aimed at helping students, family members, or school staffs acquire new skills or information. Early intervention refers to services that are provided at the first occurrence (or early after onset) of an emotional, behavioral, or social problem with the aim to prevent further deterioration of functioning. Psychological or behavioral assessments are provided to determine the level, duration, or intensity of clinical services that an individual child may need. Treatment involves the use of interventions through various therapeutic modalities, including individual, family, and group counseling. Crisis services (interventions provided for emergent situations and needs) are also included. Finally, referrals and linkages to other community mental health programs and supports are made as necessary and clinically appropriate.

5. Special Education Programs

These programs are run by the DCPS Office of Special Education, and are designed to meet the requirements of IDEA, ADA, and Section 504 of the Rehabilitation Act of 1973 for students with disabilities. The programs have an overall goal of providing a continuum of services that offers students with disabilities the opportunity to actively participate in the learning environment of their neighborhood school. After a student is found eligible for special education services, an Individualized Education Plan team may determine what related services, if any, are necessary for the student to benefit from the education program. The team identifies the service(s); decides who will deliver the support; and determines the least restrictive environment in which the service(s) can be provided.

Special education related services include the following:

- Audiology - works with students, teachers, and families regarding hearing loss, monitors hearing aid function, assesses the classroom environment and individual auditory skills and makes recommendations for assistive listening devices.
- Counseling - services provided by qualified social workers, psychologists, guidance counselors, or other qualified personnel.
- Orientation and Mobility - provided to blind and visually impaired students to enable them to safely move within their school, home, and community.
- Physical and Occupational Therapy - observes and evaluates students to determine the impact of motor and sensory problems on the students' ability to benefit from special education; works with the student and other school staff to help the student move about the school, develop motor skills, and increase general strength and endurance needed in school; gives direct assistance to the student in improving the use of his or her hands, self-care abilities, appropriate sensory processing and eye-hand coordination.
- Psychological Services - interpret assessment results, consult with school staff in creating positive behavioral interventions.
- Speech and Language Services - identifies, assesses and diagnosis specific communication deficits; provides direct intervention in the habilitation of communication deficits and counsels teachers, students, and parents about communication deficits.
- Transportation - travel to and from school; provides specialized equipment, accommodation, and supports if they are required to transport a student with a disability.

Presently, students receive services in the following environments:

- Local School-Based Program: Serves students with mild to moderate disabilities in the neighborhood school.
- Citywide Program: Serves students with the same disability in general education facilities located in various parts of the city.
- Separate Day Program: Serves students with severe disabilities who require specialized intervention in restricted environments generally in a separate facility.

The local school-based program functions at all school levels (elementary, middle, junior and senior high) with a goal to serve students with learning disabilities, mild to moderate retardation, mild to moderate emotional disabilities, autism, speech-language impairments and students receiving itinerant services for hearing impairment, visual impairment, and physical disabilities. Students attend their neighborhood school and are assigned in age-appropriate heterogeneous classrooms. The program provides comprehensive special education instruction; related services (all are available, based on the individual requirements of each child's Individualized Education Plan); and diagnostic services to students with multiple needs and varied disabilities.

A citywide program exists for students with emotional disabilities. Its goal is to provide a highly structured learning environment and intensive behavioral programming for students experiencing significant emotional and/or behavioral difficulties. Separate day programs also exist for students with severe emotional disabilities. In these separate day programs, a full-time social worker and psychologist provide individual and group counseling to students and their families. The following centers are the separate day schools: M.C. Terrell, Moten, Hamilton, Taft, Browne, and M.M. Washington.

A citywide program exists for students with mild to moderate mental retardation. The main goal is to provide instruction in functional life skills and basic academics based on the modification and adaptation to the general education curriculum. A separate day program also exists at Mamie D. Lee ES for students with severe mental retardation.

A separate day program exists at Sharpe Health School for students with multiple disabilities. A full-time registered nurse and a licensed practical nurse supervise and attend to the daily medical needs of the students, aided by a medical doctor. In addition, dental services are provided by a dentist.

A citywide program exists for students diagnosed with Autism Spectrum Disorder. One of the program goals is to provide direct instruction and comprehensive services in the areas of communication, community survival skills, daily living skills, vocational and work habit skills. Another goal is to provide support to families with home management and understanding of their child's disability and unique needs.

A separate day program exists at Patricia R. Harris School for students with communication disorders. One of the goals is to improve student skills in understanding and use of oral language as a basis for the development of academic skills utilizing the general education curriculum in reading, math, and written language, and to support acquisition of knowledge in the content areas. Students have essentially normal vision, hearing, and motor ability, and typically demonstrate average cognitive ability and emotional development.

Lastly, a program exists for students with visual or hearing impairments. For visual impairment, one of the goals is to support the education of students according to their individual needs by providing materials and equipment, including Braille. For hearing impairment, one of the goals is to enable students to develop effective language and communication skills through intensive communication training, especially oral and auditory communication training.

6.Strong Families Program

This program, run by the DC Department of Human Services (DHS), Family Services Administration/Strong Families Division, began in October 2002 as part of the Mayor's "Child Safety Net Coordination System" to serve families with multiple, complex problems who are in crisis or at high risk for family dissolution. The program uses a family support case management model, and has an objective to create a unified system of care through formal partnerships among DHS, local health, human and social services agencies, and DCPS. Families with children who either attend or reside in communities surrounding a DCPS Transformation School are a part of the target population. The program conducts assessments and works in partnership with family members to identify needs and mutually plan for the provision of required services.

Table 4 provides a list of the participating schools and the current health care services coordinated by the Strong Families Program.

Table 4: Supplementary Health Services in Strong Families Program Schools			
School Name	Dental	Pre/Post natal Care	Prevention workshops
HD Cooke ES	Daily (5 hrs)		
Walker Jones ES	Daily (5 hrs)		
LaSalle ES	Daily (5 hrs)		
Noyes ES	Daily (5 hrs)		
Davis ES	Daily (5 hrs)		
Turner ES	Daily (5 hrs)		
Simon ES	Daily (5 hrs)		
Stanton ES	Daily (5 hrs)		
Wilkinson ES	Daily (5 hrs)		
Fletcher Johnson EC	Daily (5 hrs)	School-linked, as needed	
Evans MS		School-linked, as needed	HIV prevention (Tuesdays)
R.H. Terrell JHS		School-linked, as needed	HIV prevention (Wednesdays)
Eastern SHS		School-linked, as needed	HIV prevention (Wednesdays)
Anacostia SHS		School-linked, as needed	HIV prevention (Fridays)
H.D. Woodson SHS		School-linked, as needed	HIV prevention (Thursdays)
Ballou SHS		School-linked, as needed	

IV. SCHOOL-BASED HEALTH CENTER PRACTICES IN THE U.S.

A. School Types

School-based health centers have been housed in all different types (i.e., levels) of public schools across the country since their inception, but in recent years elementary schools have replaced senior high schools as having the largest portion. According to a Center for Health & Health Care in Schools 2002 state survey of school-based health center initiatives, 37% of school-based health centers that year were located in elementary schools; 36% in senior high schools; 18% in middle/junior high schools; 3% in K-12 schools; 1% in alternative schools; and 4% in a mix of other schools. See Figure 1. Since 1996, elementary schools have seen the largest growth in school-based health centers; growing from 286, or 32% of the total, to 557, or 37% of the total in 2002.

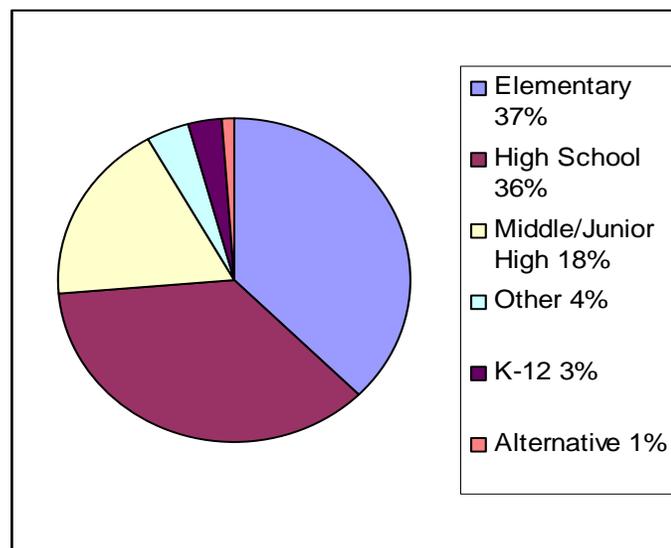


Figure 1. Types of Schools Housing School-Based Health Centers

B. Service Providers

Many different types of organizations sponsor (i.e., provide for the operation of) school-based health centers across the country. According to a 2001-02 school-based health center census conducted by the National Assembly on School-Based Health Care, the most frequent sponsors of school-based health centers include hospitals (32%), health departments (17%), federal community health centers (17%), school districts (14%), and nonprofit agencies (12%). The most frequent community partners (non-sponsors) providing staff and services include the school (60%), health department (41%), local hospital (29%), and mental health agency (26%). And, primary care providers – usually

a nurse practitioner of a medical doctor – work full time in 54% of the centers, and part-time (25 hours per week or less) in the remaining 46% of the centers.

C. Operating Standards & Guidelines

Standards have been developed and issued by several states that fund school-based health centers. The National Assembly on School-Based Health Care has put together a composite of example standards from eight of these states, grouped under the categories of: principle, mission, and goals; levels of service; staff requirements; facility requirements; governance; consent; scope of service; medical records and confidentiality; relationship with community; continuity of care; fiscal management; and quality assurance. A list of the composite of example state standards is provided in Appendix 1. In addition, the state of Maryland is in the process of developing standards for school-based health centers which cover many of these same areas.

D. Facility Size, Design, and Equipment

Information has been developed on the suggested size, design, and equipment for school-based health centers. The size recommendations depend upon the enrollment of the school and the health center. In a school with a health center enrollment of 700 or more, approximately 1,500 to 2,000 square feet is suggested.³ For the facility design, the Center for Health & Health Care in Schools has recommended the following spaces be included in a health center:

- two exam rooms (with sinks)
- one or two counseling rooms
- one laboratory
- one patient bathroom
- one waiting room
- one administrative room
- one storage room
- one file room

See Figure 2 for a suggested school-based health center facility floor plan.

The Center for Health & Health Care in Schools has also recommended the following clinical equipment for school-based health centers:

- exam tables (with retractable stirrups)
- stool
- gooseneck or halogen lamp
- wall mount blood pressure gauge or cuffs (adult/child)

³ Guernsey, B. et.al., *Comprehensive School-based Health Centers: Implementing the Model*, Adolescent Medicine: State of the Art Reviews – Vol. 7, No. 2, June 1996.

- wall mount otoscope-ophthalmoscope
- wall mount sharps container
- thermometer
- peak flow meter
- accucheck
- scoliometer
- tympanogram
- hemocue
- refrigerator/freezer
- scale
- microscope
- nebulizer
- eye chart and cover
- single container for crash cart supplies (i.e., out-of-clinic emergency)
- incubator

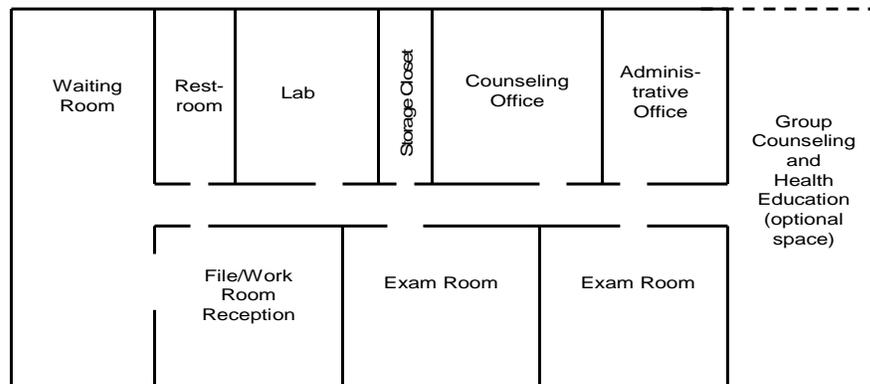


Figure 2. Suggested SBHC Facility Floor Plan

E. Shared Use Agreements

A shared use agreement, usually in the form of a memorandum of agreement or memorandum of understanding, is typically used to outline and formalize the relationship between the health center service provider and the host school, and the responsibilities of each member of the agreement. The National Assembly on School-Based Health Care has developed various shared use agreement models for school-based health centers to follow, covering matters such as space allocation, utilities provided, security services, maintenance and custodial services, health care services, patient load, and many other possible items. The National Assembly on School-Based Health Care samples or models are provided in Appendix 2.

F. Funding Sources

In 2001, the National Assembly on School-Based Health Care launched a national survey of health center financing, with approximately one-third of all centers responding. The findings revealed that school-based health centers collect an average of \$169,000 in revenue annually, with the following major sources of funding: state government (29%), city/county government (20%), in-kind (17%), private (14%), patient revenue (12%), and federal government (8%). Of all the respondents, 20% were currently operating with only one source of funding; 21% had two sources of funding; and the largest number (27%) had three sources of funding. It was also estimated that in-kind sources were understated, due to the fact that many programs do not place monetary value on “hidden” contributions such as rent-free space, utilities, or custodial services provided by the schools in which they are located.

Sources of revenue were also analyzed by frequency of mention. Of all respondents, 60% reported receiving revenue from their state government; 33% from their local government; and 21% from the federal government. Among private sources of funding, 21% of respondents received money from state or local foundations; 20% received cash from the sponsoring agency; 11% received cash from United Way or other community campaign; 9% from special events or other fundraising; 7% from corporate donations; 4% from earned income; and 3% from national foundations.

Most (62%) school-based health centers reported patient billing. For patient revenue by source, 56% of respondents reported revenue from billing Medicaid, including Medicaid managed care; 33% from billing private insurance, including commercial managed care; 21% from collecting directly from patients and their families; 13% from State Child Health Insurance Programs; and 3% from Civilian Health and Medical Program of the Uniformed Services. Another 13% reported patient revenue from other sources, including state-funded programs for the medically-indigent.

V. CONCLUSIONS

This research found that there are a wide variety of health care services and programs offered throughout the D.C. public schools, ranging from part-time (and in some cases full-time) nursing care at every school to fairly comprehensive school-based health centers at three of the schools. The services and programs are funded by a variety of sources, including federal government grants, D.C. government appropriations, private (i.e., foundation) grants, and patient billing. There are also a variety of entities that operate these health services and programs, including local hospitals, D.C. government agencies (Department of Health; Mental Health; and Human Services), and managed care organizations.

However, despite the wide range of services, programs, and funding sources, there are significant problems within the current health care system in the D.C. public schools that limit the system's effectiveness. One significant problem is the poor state of health care facilities, equipment, and supplies, particularly for nurses. Another problem is the lack of information sharing between and among the various health care entities operating in the public schools. And a third problem is that there is no clear chain of accountability within the system to be responsible for its performance and direction.

Concerning school-based health centers in particular, D.C. has not followed the national trend of a significant growth in the number of these centers over time. There are currently only three school-based health centers in the well over 200 public schools (traditional and charter) in the District, with plans at this time for only two new centers, to the author's knowledge. However, given the Facilities Master Plan and excess space within DCPS, and the new City Build initiative for charter schools, there is a definite opportunity to open new school-based health centers in the District's public schools in the near future. Medical Homes project efforts to identify primary care needs geographically in the District and to develop criteria for new clinics will help to inform which schools to target for additional school-based health centers.

Concerning specific school-based health center practices, there are strong similarities between the District and national trends in some areas, but little or no similarity in others, with a couple of areas unclear. The areas of strong similarity are school types housing school-based health centers, and service provider types. For the former, D.C. is similar to the national trend of initially locating them in high schools, but more recently locating them in elementary schools. For the latter, D.C. is similar to the national trend in that various organizations types sponsor school-based health centers; specifically, a federal-sponsored, a health department-sponsored, and a nonprofit agency-sponsored in the District.

The areas of little or no similarity are operating standards and guidelines, and facility size, design, and equipment; and the areas of unclear similarity are shared use

agreements and funding sources. For operating standards and guidelines, the District has none while standards exist at the federal level and in several states. For facility size, design, and equipment, the District school-based health centers are significantly lacking in spaces and equipment, particularly in the case of the Brightwood center. For shared use agreements, while it is known that such agreements do exist between the service providers and DCPS for the existing school-based health centers, the agreement details of are not known because the actual agreements were not obtained. And for funding sources, while it is known that the District school-based health centers use of variety of sources overall, and are lacking in patient billing, not enough details on the District school-based health centers funding sources are known to make a good comparison to national practices.

VI. RECOMMENDATIONS

The goal of the Medical Homes DC project is to expand the reach and improve the quality of health care services for low-income and uninsured District residents. We see school-based health services as an integral part of the primary care safety net, and would like to develop a closer working relationship between DCPS, providers of health services in DC public schools, and the larger system of primary care providers who serve low-income residents.

Based on our review of the health services available in DC public schools, we make the following recommendations for strengthening school-based health services and creating a stronger relationship with the rest of the primary care safety net:

1. *Facilities, equipment, and supplies:* the state of school health care facilities and supply stock, particularly for nurses, needs to be improved in order to provide a consistently higher level of care. This will require more funding (both operating and capital) at the very least, starting with the nurses program.
2. *Information sharing between and among the various health care entities operating in the public schools:* better coordination is necessary between the many different organizations providing health care services in the schools in order to achieve a more integrated system. Information technology should be used to connect the various players, such as school nurses and school-based health centers, to share things like patient medical records.
3. *The chain of accountability within the health care system that is responsible for its performance and direction:* there should be one person or office within either the District's school system or health department that is responsible for overall school-based health care. This is *absolutely essential* to assure accountability for the system's performance.
4. *Opening more school-based health centers:* these centers have the potential to greatly improve the accessibility of health care services for low-income children. DCPS and primary care providers should take advantage of DCPS' facilities modernization program by opening more school-based health centers in order to bring more health services to District residents.
5. *School-based health center operating standards and guidelines:* District-wide standards or guidelines for school-based health center operations should be developed, such as there are in several states. This would be a step towards improving center services, staffing, facilities, and information and fiscal management, among other things.
6. *School-based health center patient billing:* school-based health centers should consider increasing their capacity and practice of patient billing, in order to address a shortage of funding for these centers

7. *The communication and involvement of D.C. public schools in the Medical Homes DC project:* the Medical Homes project would like to develop a closer working relationship with DCPS and providers of health services in DC public schools. Our goal is develop strategies that both strengthen school-based health services and create stronger links with the rest of the primary care safety net. We are particularly interested in working with DCPS to develop more school-based health centers.

VII. APPENDIX 1: STATE STANDARDS FOR SCHOOL-BASED HEALTH CENTERS

Source: National Assembly on School-based Health Care – June 2000

The examples of state standards presented here are a composite of several states' standards and guidelines. They do not represent any one set of standards, but a synthesis of many.

Principle, Mission, Goals

- Centers are based on local assessment of needs and resources.
- Students with the highest prevalence of unmet medical and psychosocial needs should receive top priority for establishment of a center.
- Centers should provide primary medical, social, and mental health services, as well as health education, promotion, and prevention services.
- School-based health centers should be organized through school, community, and health provider relationships.
- A school-based health center should be available and accessible to all enrolled students when classes are in session and ought to have 24-hour coverage through an on-call system when the center is not open.
- School-based health centers should respect individual family values and diversity during the planning of service.
- School-based health centers should educate the larger community and the school concerning the health needs of youth and children.
- School-based health centers must be integrated into the school's health program.

Levels of Service

- Because school-based health center programs often have different sites and employ different models according to the needs of individual schools within a school district each center will receive a different level designation.
- For the purposes of contracting with managed care organizations each program will also receive a different designation.
- Designations will be assigned according to the manner in which services are organized and delivered.

Staff Requirements

- School-based health center employees must be licensed, registered and/or certified health professionals, trained and experienced in community and school health.
- On site staff should include: Nurse practitioner or physician assistant, consultant physician, an individual trained to handle psychological problems, medical support staff, a substance abuse specialist, and a health educator.
- Staff must continue their medical educations and be evaluated annually.

- The Staff must be trained in general first aid such as CPR and the Heimlich maneuver.

Facility Requirements

- Procedures for the availability of primary care providers: Facility must provide 24-hour coverage, 12 months/year.
- Access to routine, urgent and emergency care, telephone appointments and advice
- Service ought to occur at a convenient time for both students and parents, including before and after school hours.
- Appointments should not disrupt classroom time.
- Respect cultural and linguistic diversity by employing those health care providers versed in cultural diversity.
- Centers cannot discriminate against prospective consumers based upon race, color, religion, national origin, age, handicap, sex, or ability to pay.
- Centers must operate within an appropriate physical plant with waiting room, office space, examination and treatment rooms, secure area for confidential materials, and a pharmaceutical and storage space.
- Centers must comply with laws and regulations governing health facilities, specifically regarding infection control, disease control, and laboratory operations.
- The physical plant must have current fire and building safety certificates and appropriate liability coverage.
- Centers must have telephone and fax access.

Governance

- School-based health centers ought to establish and maintain an Advisory Board consisting of individuals from school administration, the school nurse, the medical community, the student body, the local health department, parents, clergy, youth service agencies and community leaders.
- The board will not meet less than annually and the minutes will be retained and available for inspection.
- The name and address of groups with financial interests in school-based health centers will be made available to HHS with proof of liability coverage for staff, clients, and facility.
- Organizational charts and plans must be created to establish center hierarchy and to describe the responsibilities according to the center's governing principles.

Consent

- Protocols require the written consent of a parent or guardian, except when minors may provide consent under the law or the student is 18 years of age or older.
- If a student gives consent, he/she must be competent to do so.
- School-based health centers must establish a timeframe for the renewal of written consent.

Scope of Service

- Basic medical services: well child and adolescent exams, immunizations, health education, nutrition education, services specified by EPSDT and GAPS, diagnosis and treatment of acute illness and injury, laboratory tests for pregnancy, STD's, and primary prevention, prescriptions and dispensation of medication, monitoring of chronic conditions.
- Reproductive health services: abstinence counseling, gynecological examinations, diagnosis and treatment of STD's, family planning, birth control, cancer screening.
- Basic Mental Health Services: mental health assessment, counseling, crisis intervention, violence prevention and education, and referral to a continuum of mental health services.
- Substance abuse services: assessment of substance abuse problems, education regarding prevention, counseling, and referral to a continuum of substance abuse services.

Medical Records & Confidentiality

- School-based health centers must create a health record system that ensures consistency, confidentiality, storage and security of records.
- The centers' health records must be maintained in a current, detailed, confidential, and organized manner.
- The centers' health records must include sufficient information to justify the diagnosis and treatment and accurately document all health assessments and services provided to the student. Included among these entries ought to be: signed consent forms, personal/biographical data, a medical history, laboratory findings, diagnoses, treatment plans, referrals and follow-up care.
- Students and families shall be educated upon the center's confidentiality regulations and will be given the opportunity to approve or refuse the release of personal information.

Relationship with Community

- The school-based health center must involve the family in health care decisions sometimes in the case of consent, but also to understand the nature of family structure and dynamic that can influence the student's health, illness, disability, or injury.
- The school-based health center must integrate itself into the school environment and both must operate with each other in a spirit of collaboration.
- The school-based health center ought to recognize its connection with the community at large and respect the community's views into its policies.
- The school-based health should use local Departments' of Health expertise as resources.
- Other entities the school-based health centers may maintain regular contact with include: the back-up facility and local Departments of Social Services.

Continuity of Care

- School-based health centers shall develop relationships with other health care

providers and managed care organizations, and specifically have a written agreement with those organizations whose enrollees receive service at the SBHC.

- School-based health centers must manage the exchange of medical information between the center and entities such as the student's primary health care provider, managed care organization, and relevant school staff.
- The school-based health center must adhere to a regulated system of referral to alternate health care providers when it cannot provide the necessary services. Such a referral and its medical outcome must be recorded in the student's record.
- The school-based health center staff is encouraged to participate in health education as offered by the school.

Fiscal Management

- Inventories, budget analyses, and overall cost calculations to be conducted annually.
- School-based health centers must be able to obtain data about Medicaid and third party eligibility, and aid qualified families in the enrollment process.
- Encounter forms should be available for all billable visits, and a mechanism should be in place that ensures such billing.
- Agreements ought to be negotiated with the managed care plans that cover students who receive service at the school-based health center. These agreements must include how these third parties will reimburse the school-based health center.

Quality Assurance

- School-based health centers will develop and implement a quality improvement program that monitors and evaluates the appropriateness, effectiveness and accessibility to the services it provides; the quality of services provided to the students; and the positive/negative health outcome effects.
- School-based health centers must create a quality improvement plans with goals, objectives, and work plan to be reviewed annually.
- The quality assurance coordinator's responsibilities include: maintaining records of licensing credentials, chart review, complaint and incident review, and corrective actions.
- The center staff must engage in continuing medical education.
- The center staff will be subject to performance evaluations.

VIII. APPENDIX 2: SAMPLE SCHOOL-BASED HEALTH CENTER MEMORANDA OF AGREEMENT

Source: National Assembly on School-based Health Care

Sample 1: Memorandum of Agreement between Any Public Health Commission and Any Public Schools District

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

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

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

Terms of Agreement

1. Public School and _____ agree to provide the following at no cost to the Public Health Commission:

-Space at _____ in Health Suite Room _____ as renovated and presently defined as shared reception area, one examination room, shared bathroom, shared clean and dirty areas, office, and storage. In addition, when possible and at the discretion of the Headmaster, the _____ will provide space for additional counselors and/or health educators as arranged with the _____ Headmaster.

-All utilities.

-Security services: i.e. services of school safety officers as needed.

-Routine maintenance and repairs (e.g. light bulbs, windows, ceiling tiles, towels, toilet paper).

-Rubbish removal (Non-hazardous waste).

-Telephone line

-Two telephone extensions.

-Custodial services

-Annual alpha list of students and their class schedules, updated as necessary.

-Immunization information on students enrolled in the SBHC at _____

2. PHC will provide the following at no cost to PS or _____:

-Comprehensive school-based health center services as defined in the consent form and in compliance with PS policies.

-Health care equipment and supplies for use in the SBHC.

-Proper maintenance and disposal of hazardous waste.

-One direct phone line.

-Computer equipment and maintenance of same.

-Appropriate staffing for the SBHC (with training and licensing as warranted)

- Medical supervision of staff.
- All billing responsibilities.
- Medical malpractice insurance for all appropriate staff.

3. PHC agrees to allow the PS to list the names of the SBHC and the PHC in catalogs, brochures and correspondence as the entities operating the ANY SBHC, subject to the prior approval by PHC for such use.

4. PS agrees to allow PHC to list the name of the ____ in catalogs, brochures and correspondence as the host and collaborating agency for the SBHC, subject to prior approval by PS for such use.

5. PHC agrees that it has complete responsibility over the operation of the SBHC at _____.

6. PHC agrees to serve patients under age eighteen (18) with parental consent or, alternatively, with self-consent in accordance with _____ laws. Patients eighteen (18) and over may sign their own consent forms.

7. PHC agrees that it will, to the extent permitted by law, protect the confidentiality of any and all information received from students who seek services at the school-based health center unless disclosure is necessary for the health and safety of the student and/or other persons.

8. The SBHC and PS staff will work cooperatively.

9. Either the PHC or PS may terminate this Agreement for any reason or without reason upon at least ninety (90) days written notice to the other party. However, if an academic semester has commenced or is within sixty (60) days of commencing, such notice of termination shall not be effective until completion of said semester. Either party may also terminate this Agreement at any time if the other party defaults in any of its material obligations hereunder, but only if such default shall have continued for a period of ten (10) days after the receipt of a written notice thereof from the other party. Further, PHC may terminate its obligations immediately and without liability, in the absence, withdrawal or termination of availability of funds from the Grantor or other external Funding Source, if any, or authorization from the Funding Source to expend grant moneys for the purposes described in this Agreement. Nothing in this paragraph shall be construed to limit or alter PHC's responsibility to transition PS students to continuing and appropriate health services, upon termination of the PHC's obligations under this Agreement.

10. This Agreement constitutes the entire understanding and Agreement between BPHC and BPS with regard to all matters herein. This Agreement supersedes in the entirety any and all previous agreements, whether written or oral, between the parties.

11. This Agreement may be amended only in writing signed by all the parties hereto.

12. All notices and other communications required or desired to be given shall be given personally, or sent by telefax, registered or certified mail, postage prepaid, return receipt requested to the persons at the addresses set forth below. Notices will be deemed received (a) on the date delivered, if delivered personally; (b) when sent by telefax (if confirmation notice is sent by registered or certified mail on the same day; or (c) three (3) business days after posting, if sent by registered or certified mail:

Public Health Commission: _____
School Health Programs
Public Health Commission
Street Address
City, State, Zip

Public Schools: _____
Superintendent of Schools
Public Schools
Street Address
City, State, Zip

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

13. This Agreement shall be governed by the laws of _____.

14. Nothing herein shall create or be deemed to create any relationship of agency, joint venture or partnership between PHC and PS. Neither party shall have the power to bind or obligate the other in any manner except as expressly provided in this Agreement.

15. The parties' attention is called to General Laws _____ (the Conflict of Interest Law). No party shall act in collusion with any other party, person or entity to circumvent such law.

16. Neither party shall be liable to the other or be deemed to be in breach of the Agreement for any failure or delay in rendering performance arising out of causes beyond its reasonable control and without its fault or negligence. Such causes may include, but are not limited to, acts of God or the public enemy, fires, floods, epidemics, quarantine restrictions, strikes, freight embargoes or unusually severe weather.

17. If any provision of this Agreement is declared or found to be illegal, unenforceable, or void, then both parties shall be relieved of all obligations under that provision. The remainder of the Agreement shall be enforced to the fullest extent permissible by law.

18. Any waiver, expressed or implied, by either party of any rights, terms or conditions of the Agreement shall not operate to waive such rights, terms or conditions or any other rights, terms, or conditions beyond the specific instance of waiver.

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

Executive Director
Public Health Commission

Date

Superintendent of Schools
Public Schools

Date

Headmaster

Date

Sample 2: Memorandum of Agreement between Any Contractor and Any Managed Care Organization

THIS AGREEMENT is made and entered into on the _____ day of _____ between _____ (MCO) and the _____(Contractor).

Witnesseth

WHEREAS, as part of its community service, _____ (Contractor) operates a School-based Health Center Program (‘SBHC’) providing primary medical care, behavioral health care and health promotion services to students at _____ (School).

WHEREAS, _____ (Contractor) desires to participate in the _____ Program, consistent with the _____ State SBHC Standards.

WHEREAS, _____ (School) is willing to provide the physical site and necessary custodial and maintenance services to support the SBHC program, with _____ (Contractor).

NOW, THEREFORE, in consideration of the mutual covenants and obligations contained in this Agreement _____ and _____ agree as follows:

Article I: Obligations

1.1 Program Services. _____(Contractor), either itself or through its subcontractors shall provide medical and behavioral health services limited to Exhibit ____ to Enrollees (as defined in this Agreement) at _____ (SBHC(s)) in accordance with the terms of this Agreement and the _____ program. The services provided as part of the _____ Program shall include, but not be limited to, primary care services, behavioral health services, health promotion and risk reduction services. _____(Contractor) shall use its reasonable best efforts to assure that the SBHC is operated and administered in substantial compliance with all applicable Federal, State and local laws.

1.2 Enrollee. An Enrollee shall be any person who is currently a _____ member and enrolled in School or family dependent thereof. Each enrollee must have a properly executed Consent Form/Application (“Parental Consent and Member Consent”) on record at the SBHC(s).

1.3 Family Dependent. Shall mean a dependent child of an enrolled member who is entitled to _____ Benefits.

1.4 Hours of Operation. The SBHC shall provide services during normal hours of operation (insert definition of normal hours of operation for each SBHC).

1.5 Emergency Care. _____(SBHC) providing services pursuant to this Agreement shall respond to emergency care situations by stabilizing the situation until an emergency medical technician is on-site. Emergency care provided in this Agreement should be limited to the extent of services available on-site. Critical emergencies determined by the on-site nurse or clinician are to be referred by the school to Emergency Medical Services (911).

1.6 Quality Initiatives. _____(Contractor) agrees to cooperate with all of _____(MCO) Quality Assurance requirements and activities. The Contractor and the MCO shall work together to develop and maintain continuous quality improvement activities in the SBHC(s).

1.7 Staff. _____(Contractor) shall provide competent, qualified medical and behavioral health providers to administer, coordinate, and provide health and health-related services pursuant to the SBHC program. During the Term of this Agreement, _____(Contractor) shall utilize providers, who are appropriately licensed to practice in the State of _____ and are members of the MCO staff or otherwise credentialed by the MCO.

1.8 Credentialing of SBHC Staff. _____(Contractor) will require its Licensed Individual Health Care Providers to adhere to the following requirements in connection with their professional credentials: 1) Licensed Individual Health Care Providers shall be duly licensed to practice in the State of _____, within the scope of their license, and maintain themselves in good professional standing at all times; 2) _____(Contractor) agrees that either it will carry or it will require its SBHC Licensed Individual Health Care Providers to carry comprehensive general liability insurance in reasonable and customary amounts and either (i) to qualify as a health care provider entitled to the protection of applicable Federal or State malpractice law(s) or (ii) to carry professional liability insurance in reasonable and customary amounts. Certificates of coverage and proof of qualifications shall be available for inspection by the MCO; 3) _____(Contractor) agrees that to the extent required by the Social Security Act and regulations there under, all persons or organizations with whom it arranges to provide services hereunder shall be certified to provide basic and supplemental health services under Title XVIII, Title XIX and Title XXI of the Social Security Act, known as the Medicare and Medicaid program respectively; and 4) otherwise satisfy the current credentialing standards of the _____(MCO).

1.9 Program Expenses. _____(Contractor) shall be solely responsible for all costs associated with the operation of the SBHC program, including, but not limited to, costs of personnel, telephone, when not provided by the school, supplies and materials utilized in the SBHC program.

1.10 Confidentiality and Informed Consent. _____(Contractor) shall assure that all services rendered to Enrollees shall be confidential in nature and any records generated as a result of any services being rendered to Enrollees shall be confidential and not disclosed without prior written authorization, except as otherwise required by State and Federal law. Confidential services shall be provided in compliance with all requirements related to confidentiality and informed consent for minors, including those at _____. Notwithstanding this provision, _____(Contractor) shall provide the MCO such data and statistical information as required under Section 2.2 and 2.4 of this Agreement.

1.11 Communication Protocol. _____(Contractor) shall refer Enrollees to off site medical facilities in accordance with the policies and procedures contained in the Communication Protocols and Care Coordination and Case Management Protocols.

1.12 Space. _____(School) shall provide adequate space, which is in compliance with the Americans with Disabilities Act, for the operation of the SBHC.

1.13 Support Services. _____(School) shall provide building support services, including, but not limited to, janitorial services and routine maintenance for the SBHC during days of operation, all without charge to the MCO.

1.14 Utilities. _____(School) shall provide heating, water and electricity to the SBHC at no charge to the MCO.

1.15 Access to SBHC program. _____(SBHC) shall allow the Enrollees to have reasonable access to the SBHC for routine and acute medical and behavioral health care visits.

Article II: Billing, Data Collection, and Submission of Data

2.1 Billing for Clinical Services. _____(Contractor) shall have the right to bill _____(MCO) and to collect payment for services, as reflected in Exhibit A, provided through the SBHC. Notwithstanding the above, Enrollees shall not be denied the opportunity to enroll in the SBHC or be denied health services based on the enrollee's ability to pay for health services rendered.

2.2 Timely Submission of Claims/Encounter Data. _____(Contractor) understands that _____(MCO) has certain contractual reporting obligations which require timely submission of claims and/or encounter data. Therefore, _____(Contractor) shall submit claims or encounter data to _____(MCO), or its designee, within 60 days of the date of services. Claims shall be submitted in a HCFA 1500 format, using ICD-9 Codes and any Medicaid-assigned codes, as reflected in Exhibit A. Encounter data should be in the same format and include the same data as a standard claim, and should be submitted within 90 days of the date of services.

2.3 Payment of Claims. When _____(Contractor) is compensated hereunder on a claims made basis, _____(MCO) shall pay such claims as follows, unless requirements more favorable to _____(Contractor) are imposed by federal law:

1. A claim submitted electronically shall be paid within 30 days from the date of _____(MCO)'s receipt of a Clean Claim.
2. A claim submitted manually shall be paid within 45 days from the date of _____(MCO)'s receipt of a Clean Claim.
3. _____(MCO) shall pay interest on its liability at the rate of one and one-half percent a month on any Clean Claim not paid within the time periods specified above.
4. If _____(MCO) is unable to determine liability for or does not pay a claim within the time periods specified above, _____(MCO) shall make a good faith effort to notify _____(Contractor) by fax, electronic or other written communication, within 30 days of receipt of the claim if submitted electronically or 45 days of receipt of the claim if submitted manually, of all specific reasons why it is not liable for the claim or that specific information is required to determine liability for the claim. For purposes of this section, a "Clean Claim" means a manually or electronically submitted claim that: (a) contains substantially all the required data elements necessary for accurate adjudication without the need for additional information from outside of _____(MCO)'s system; and (b) is not materially deficient or improper, including lacking substantiating documentation currently required by _____(MCO); or (c) has no particular or unusual circumstances requiring special treatment that prevent payment from being made by _____(MCO) within the applicable period of time specified in the Section.

2.4 Reporting Requirements. _____(Contractor) shall use its reasonable best efforts to provide to the MCO the following information on a quarterly basis:

- 2.4.1 Number of students served and the types of services;
- 2.4.2 Number of students referred to other health services and the type of services;
- 2.4.3 Any other information deemed appropriate, which does not violate the confidentiality of the Enrollee.

Article III: Medical Records and Confidentiality

3.1 Medical Records. _____(Contractor) shall require its Licensed Individual Health Care Providers to maintain adequate medical records for MCO enrollees and comply with the

standards and procedures for maintaining medical records, as found in Exhibit _____. The medical records, subject to all applicable privacy and confidentiality requirements, shall be kept in a locked, fireproof file. The medical records shall be made available to any Licensed Individual Health Care Provider treating the Enrollee and shall be made available to any committee of the SBHC or MCO, upon request, to determine that content and quality are acceptable, as well as for peer review or grievance review.

3.2 SBHC Records. _____(MCO) shall have access at reasonable times upon demand and after reasonable notice to the books, records, and papers of SBHC and SBHC Licensed Individual Health Care Providers relating to the health care services provided to Enrollees, and to payments received by Contractor or SBHC Licensed Individual Health Care Providers from Enrollees or from others on their behalf.

3.3 Copy of Patient Records. SBHC Licensed Individual Health Care Providers shall copy, upon request from Enrollees, all the Enrollee's records and charts to a successor professional corporation, medical group, or Licensed Individual Health Care Provider(s) designated by the Enrollees.

Article IV: Mutual Agreements

4.1 Cooperation. _____(MCO) and _____(Contractor) agree to maintain effective liaison and close cooperation with each other to the end of providing maximum benefits to each Enrollee at the most reasonable cost consistent with applicable standards of medical care.

4.2 Education and Outreach. _____ (MCO) and _____ (Contractor) will collaborate on any educational and outreach activities associated with this Agreement.

4.3 Marketing Materials. _____(Contractor) and the MCO shall work together on any marketing materials associated with this Agreement where the MCO's name will be used. Such marketing materials, which must be written in English and Spanish, must be reviewed and approved by the State of _____ Human Services Department Medical Assistance Division, according to _____.

4.4 Data. _____(MCO) and _____(Contractor) agree to freely and fully exchange data and cooperate in the continuing effort to refine the policies, systems, and procedures, which address the availability, continuity, and quality to care to _____(MCO) Enrollees.

4.5 Organizational Operations. _____(MCO) and _____(Contractor) respectively acknowledge that each has full and complete authority and responsibility with respect to administering its organizational operations.

4.6 Grievances initiated by an Enrollee and Individual Licensed Health Care Provider. _____(MCO) and _____(Contractor) agree to cooperate in good faith in any grievance procedure initiated by an Enrollee or Licensed Individual Health Care Provider and follow the MCO and _____ Grievance Procedures.

4.7 Provider Manual. _____(MCO) will establish and maintain a Provider Manual to describe accurately the administrative and operational policies of the MCO.

4.8 Grievances between the MCO and Contractor. Controversies or claims between _____(MCO) and _____(Contractor) (other than matters related to medical malpractice or

substantiated breach with this Agreement) arising out of or relating to the interpretation or application of this Agreement must be resolved by direct negotiations between the MCO and Contractor within six months of the date of the originating party identified the matter in dispute in writing to the other party. Should said negotiations result in failure to reach agreement within the stated six month period, parties to this Agreement shall submit said controversies or claims to Arbitration for settlement in accordance with the rules of the National Health Lawyers Association Alternative Dispute Resolution Program, and judgment upon the award rendered by the arbitration may be entered in any court having jurisdiction.

4.9 Administrative, Financial and Accounting Records. _____(MCO) and _____(Contractor) shall maintain such administrative records and such financial and accounting records as shall be necessary, appropriate, and convenient for the proper administration of this Agreement, and for compliance with any applicable state or federal rules and regulations governing managed care organizations. Such records shall be retained for at least six years, notwithstanding any termination of this Agreement, whether by rescission or otherwise.

Article V: General Provisions
(MCO to add language here.)

Article VI: Term and Termination

6.1.1 Term. This Agreement shall commence as of _____, and shall expire on _____. This agreement will automatically terminate in the event the MCO no longer participates in Medicaid Managed Care.

6.1.2 Right of Renewal. This Agreement shall automatically renew for successive one (1) year terms unless either Party provides the other Party with a written notice of non-renewal at least thirty (30) days prior to the commencement of a renewal term

6.1.3 Termination. Notwithstanding any other provision to the contrary, this Agreement may be terminated, with or without cause, by giving thirty (30) days' advance written notice of termination to the other party.