



SCHOOL-BASED HEALTH CENTERS:

National Census School Year 2007-2008

PURPOSE AND SUMMARY

The National Assembly on School-Based Health Care's (NASBHC) 2007-2008 Census is the 11th request for data from school-based health centers (SBHCs) since 1986. The Census:

- Provides a better understanding of the role of SBHCs in meeting the needs of underserved children and adolescents,
- Collects relevant trend data on demographics, staffing, operations, prevention activities, clinical services, and policies,
- Creates a national database of programs.

Data for the 2007-2008 Census were collected from October 2008 through October 2009. The 2007-2008 Census identified 1,909 clinics and programs connected with schools nationwide, including:

- **School-based programs:** Partnerships between schools and community health organizations that deliver health care to students within a fixed site on a school campus.
- **Mobile programs:** Programs without a fixed site that rotate a health care team through a number of schools.
- **School-linked programs:** Health care programs that are formally or informally linked with schools to coordinate and promote health care for students on campus; clinical services are not provided on the school site. These programs (n=86) were not included in this report.

Sixty-four percent (n=1226) of known programs responded to the survey. Efforts were made to confirm that health centers that did not complete a survey were open during the 2007-08 school year. With a few exceptions, the analysis in this report includes programs that provide, at a minimum, primary care services (n=1096). However, all programs (n=1226) – including those that do not provide primary care services – are included in the mental health and health promotion/prevention sections of this report.

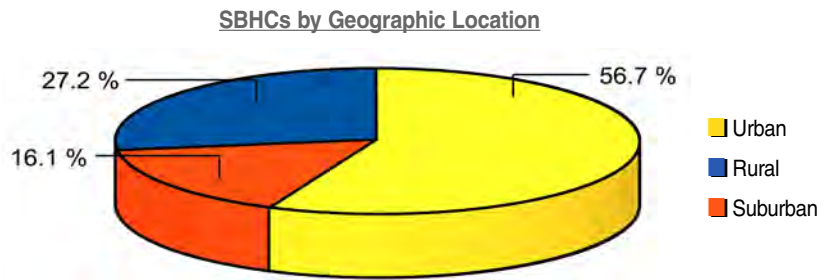
Changes between the 2004-05 Census and the 2007-08 Census include:

- A growing number of SBHCs serve schools with atypical grade combinations.
- An increase in SBHCs that see members of the community beyond the schools they serve.
- A rise in SBHCs that are using health information technology (HIT) to support their work.
- An increase in SBHCs with staffing models other than the traditional three staffing categories of Primary Care, Primary Care – Mental Health, and Primary Care – Mental Health PLUS. While more needs to be learned about the structure of these programs, the majority are programs that provide only mental health services.

LOCATION OF SBHCS (n=1096)

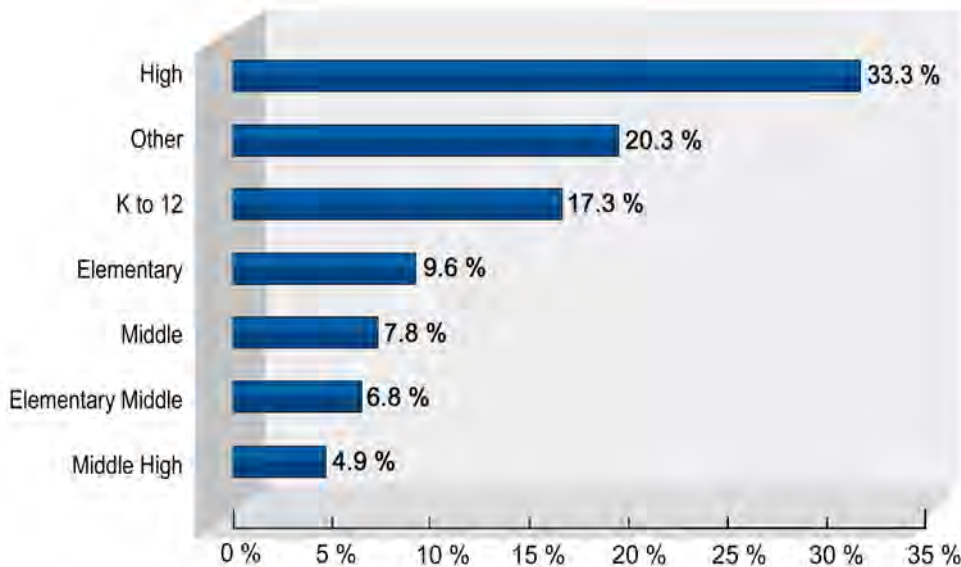
A majority (96%) of the SBHCS are located in the school building, while 3 percent are in a separate facility on school property. Only 1 percent are mobile, or non-fixed.

SBHCS are located in geographically diverse communities, with the majority (57%) in urban communities. More than one-quarter (27%) of SBHCS are in rural areas.



TYPES OF SCHOOLS WITH SBHCS (n=1096)

Types of Schools With SBHCS



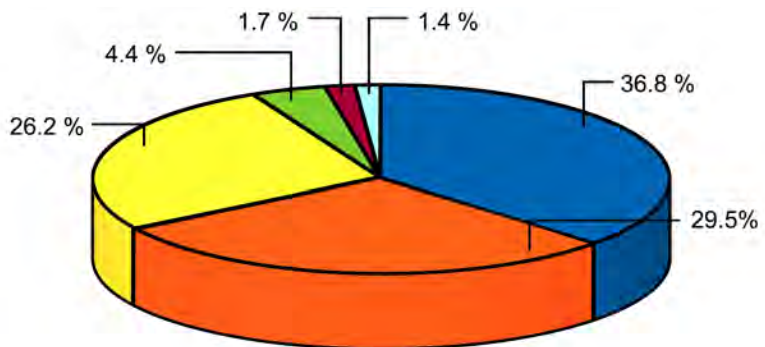
Settings for SBHCS are as varied as the types of schools in the United States. A large majority (80%) of the programs report serving at least one grade of adolescents (sixth grade or higher). A national trend over the last few years has been to redesign schools to create non-traditional grade combinations as a way to improve students' academic success. The Census shows a similar change in the number of SBHCS located in "other" schools with non-traditional grade combinations such as grades seven through twelve (20%).

STUDENT POPULATION IN SCHOOLS WITH SBHCS (n=1096)

Students in schools with SBHCS are predominantly members of minority and ethnic populations who have historically experienced under-insurance, uninsurance, or other health care access disparities.

Ethnic/Racial Profile of Schools with SBHCS

- Hispanic/Latino
- White (non Hispanic/Latino)
- Black (non Hispanic/Latino)
- Asian/Pacific Islander
- Native American/Alaskan Native
- Other



Thirty-six percent of SBHCS report serving only children who attend the school(s) they serve, a decrease from the 2004-2005 Census, where 45 percent reported serving only the student population. This trend indicates that SBHCS are expanding their ability to provide access to care to others in the community. Factors that may have influenced this trend are increased budgetary constraints and a weak economy, coupled with greater need for affordable health care in the community. Patient populations seen by SBHCS that open their doors beyond their school's students include: students from other schools in the community (58%); out-of-school youth (34%); faculty and school personnel (42%); family members of students (42%); and other community members (24%).

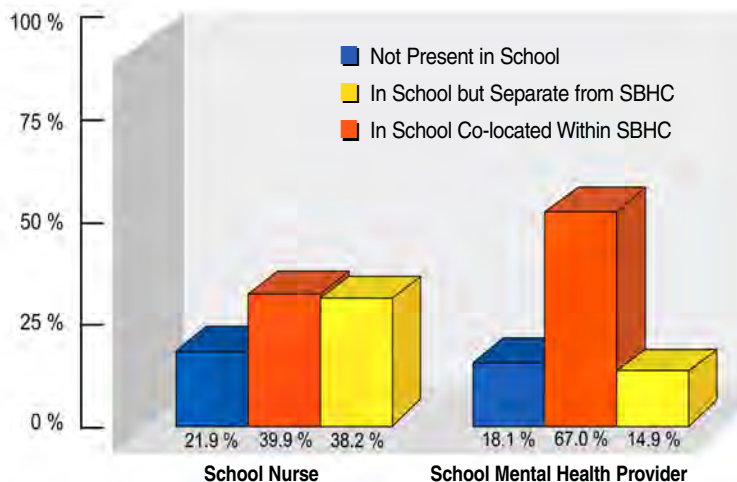
SCHOOL – SBHC PARTNERSHIPS (n=1096)

Sponsors (organizations that serve as the primary administrative home) of SBHCs are most typically a local health care organization, such as a community health center (28%), a hospital (25%), or local health department (15%). Other community sponsors include nonprofit organizations, universities, and mental health agencies. Twelve percent of SBHCs are sponsored by a school system.

SBHCs are often supported by schools and others through in-kind donations of space and services. The majority indicate that they do not have financial responsibility for construction and renovation (66%); maintenance and/or janitorial services (77%); utilities (82%); or rent (93%).

School health services and SBHCs partner to provide care for students. Census data show that over three-quarters (78%) of schools in which SBHCs are located have a school nurse. Where both are present, 40 percent are located in separate facilities while 38 percent are co-located within the same health suite.

School Staff Roles at SBHCs



Schools and SBHCs work together to ensure the safety and efficient functioning of the school by participating in emergency preparedness planning and school-wide teams.

A majority of SBHCs have emergency preparedness plans in place with response strategies to address school-based events that include:

- Medical/mental health emergencies (91%)
- Natural disasters (87%)
- School shootings (72%)

SBHCs also participate on school-wide teams:

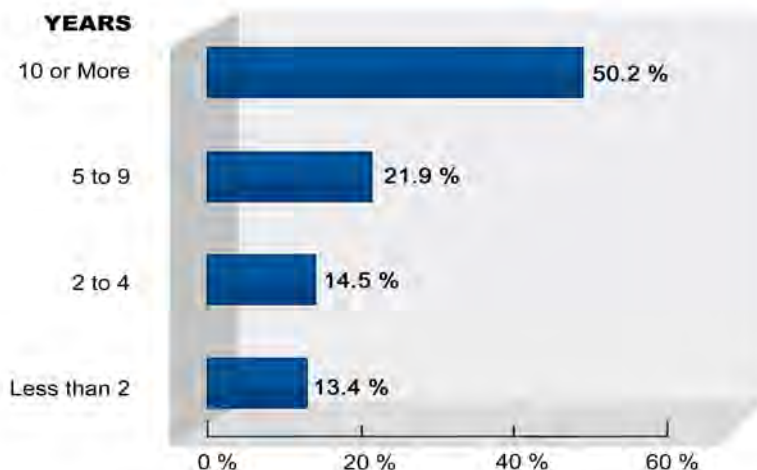
- Crisis management team (45%)
- Mandatory school/district wellness committee (35%)
- Early intervention team (32%)

Just over 80 percent (82%) of schools in which SBHCs are located have a school-employed mental health provider in the building – of these 67 percent are separate from the health center, and 15 percent are co-located with the health center.

Thirty percent of SBHCs partner with the school to support students with special health care needs (students with health issues that affect their ability to learn and/or attend school). SBHCs support the academic success of these students in several ways: monitor medications (95%); review medical records (94%); assist in implementing the Individualized Health Plan (IHP) (75%); and serve on the Individualized Education Plan (IEP) development committee (70%).

SBHC OPERATIONS (n=1096)

Length of Time SBHC Has Been Open



Seventy-two percent of the nation's SBHCs are five years or older, up from 41 percent in 1998 and 67 percent in 2004 – attesting to the sustainability of the model. Also, 287 SBHCs opened in the past 4 years, indicating a growth in demand for the model.

The majority of SBHCs (95%) are open during normal school hours. Beyond the school day, the Census shows that 60 percent are open after school, 49 percent before school, and 36 percent during the summer. SBHCs are typically open for more than 30 hours per week. Sixty-seven percent report a pre-arranged source of after-hours care to assist students outside of normal SBHC operating hours through an on-call service or referral to another health center.

SBHC STAFFING MODELS (n=1096)

SBHCs have a wide range of staffing models, from a provider onsite two hours a week up to seven full-time staff members onsite full time.

Centers with larger staff represent multidisciplinary teams and operate in centers open beyond the school hours. Whatever the staffing model, the presence of primary care providers – in any combination of physician, nurse practitioner, or physician assistant – is the common denominator for Census responders.

Below are the three most commonly reported staffing models for SBHCs:

SBHC Staff and Mean Hours/Week by Model

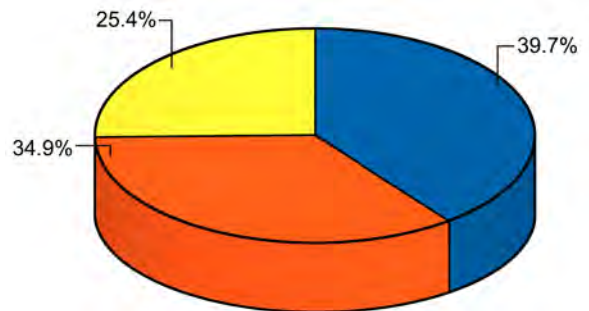
| Provider Type | Number of SBHCs (%) | Mean Hours per week | | |
|--------------------------|---------------------|---------------------|-------------|--------------|
| | | Primary care hours | PC-MH hours | PC-MH+ hours |
| Primary Care Providers | 1096 (100 %) | 24.0 | 29.1 | 33.2 |
| Nursing/Clinical Support | 996 (90.9 %) | 38.8 | 46.6 | 54.0 |
| Mental Health Providers | 818 (74.6 %) | 0.0 | 30.2 | 36.0 |
| Health Education | 204 (18.6 %) | 1.4 | 0 | 8.9 |
| Nutrition | 157 (14.3 %) | 0.6 | 0 | 3.7 |
| Dental Providers | 134 (12.2 %) | 2.8 | 0 | 8.4 |

Primary Care (PC): The primary care model is typically staffed by a nurse practitioner or physician assistant with medical supervision by a physician. While 25 percent of SBHCs with a PC model have physicians on staff, their role is largely administrative: 61 percent of those physicians report providing four or less hours of clinical services per week. Clinical support to primary care providers is offered by a registered or licensed practical nurse with assistance from a medical assistant or health aide. In a small percentage of these SBHCs, primary care staff may be augmented by social service, health education, or dental professionals. Mental health services are not offered in this model.

Primary Care – Mental Health (PCMH): The largest group of SBHCs is staffed by primary care providers in partnership with a mental health professional – whether a licensed clinical social worker, psychologist, or substance abuse counselor. Clinical and administrative support is similar to the PC model.

Primary Care – Mental Health PLUS (PCMH+): This model is the most comprehensive; primary care and mental health staff are joined by other disciplines to complement the health care team. The most common addition is a health educator, followed by social services case manager, and nutritionist.

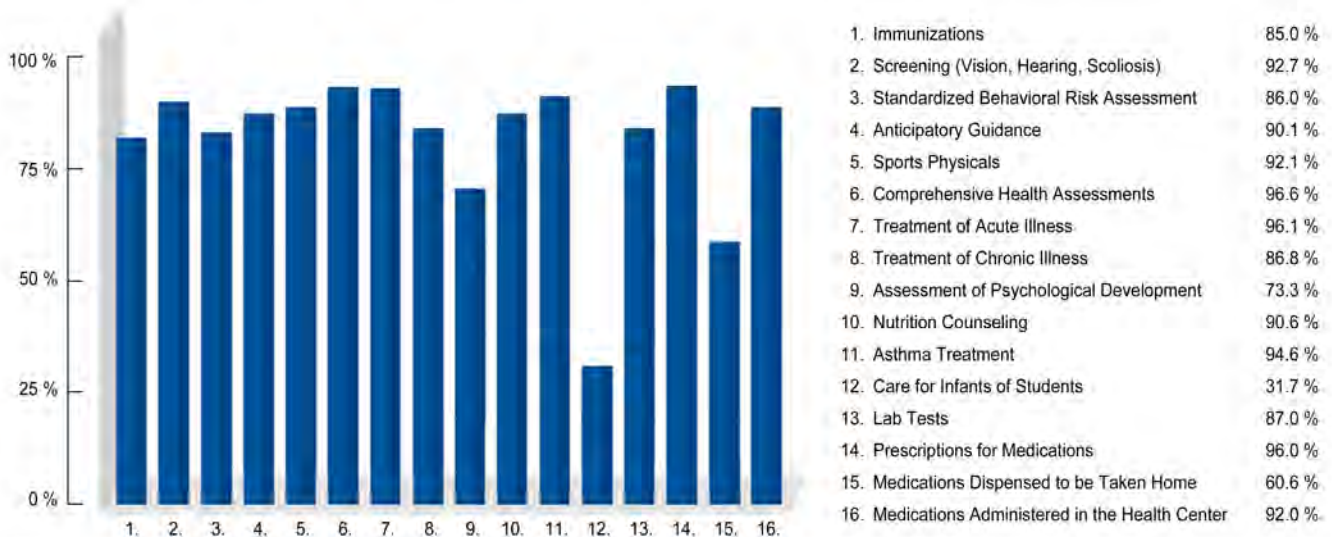
SBHC Staffing Models



PRIMARY CARE SERVICES PROVIDED ON-SITE BY SBHCs (n=1096)

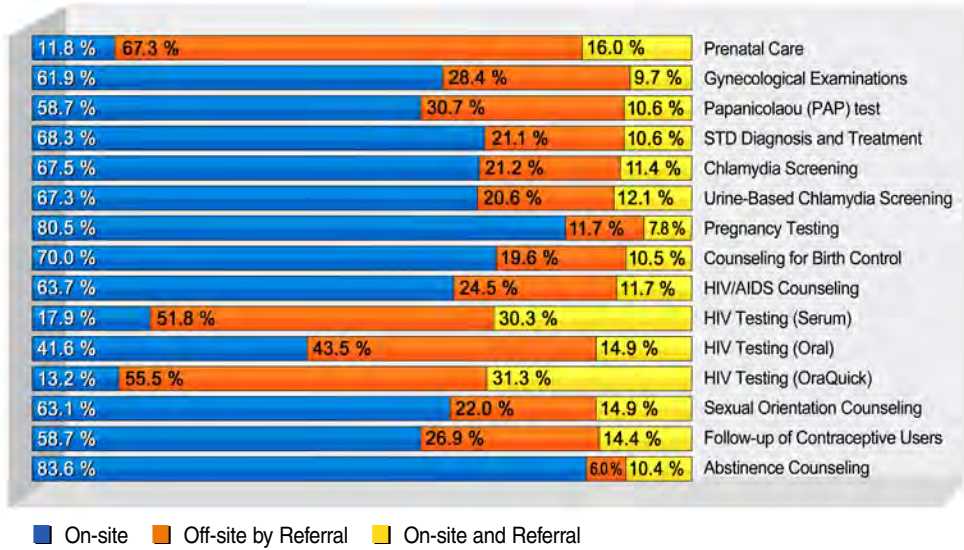
The majority of SBHCs provide comprehensive health assessments, anticipatory guidance, vision and hearing screenings, immunizations, treatment of acute illness, laboratory services, and prescription services.

Primary Care Services Provided On-site



REPRODUCTIVE HEALTH SERVICES OFFERED TO ADOLESCENTS ON-SITE (n=877)

Reproductive Health Services at SBHCs Serving Adolescents

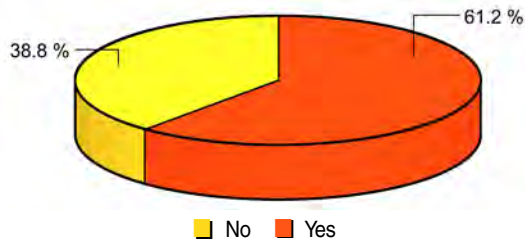


Health centers serving middle and high school-aged students are more likely than those serving younger students to offer abstinence counseling (84%) and provide on-site treatment for sexually-transmitted disease (68%), HIV/AIDS counseling (64%), and diagnostic services such as pregnancy testing (81%). A minority does not provide on-site or refer to an off-site provider for any reproductive health services. These data are reported for SBHCs serving grade six or higher.

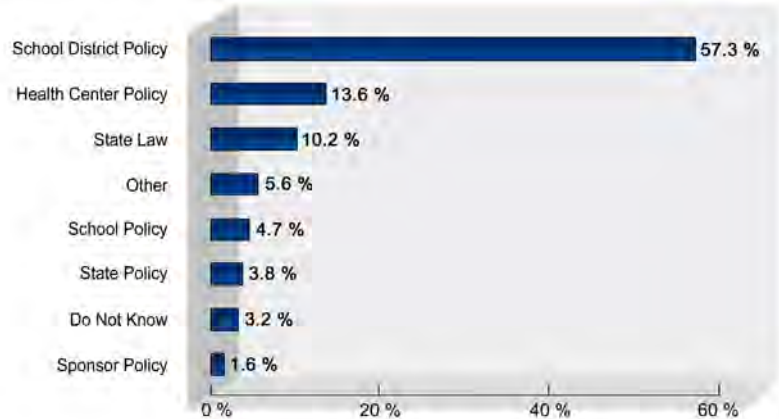
CONTRACEPTION PROHIBITION AT SBHCs SERVING ADOLESCENTS (n=877)

About 60 percent of SBHCs are prohibited from dispensing contraception – a policy determined most often by the school district (57%).

Contraception Dispensing Prohibited in SBHCs



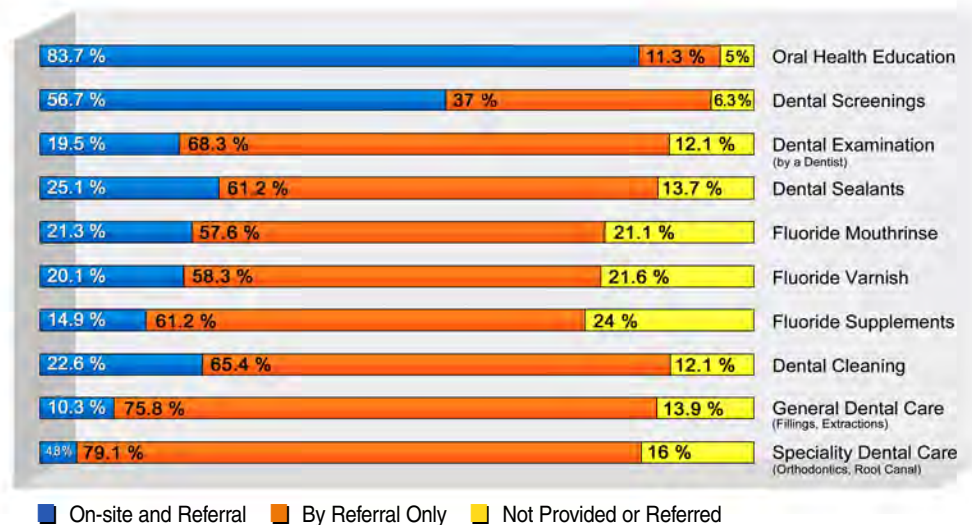
Who Prohibits Dispensing Contraceptives in SBHCs



ORAL HEALTH IN SBHCs (n=1096)

Oral health is an important component of the overall health and well-being of children and adolescents. A majority of SBHCs provide oral health education (84%) and dental screenings (57%). A smaller percentage of SBHCs provide dental examinations (20%), sealants (25%), and cleanings (23%). Very few SBHCs are equipped to provide general (10%) or specialty (5%) dental care to students. Only twelve percent of SBHCs report that they have a dental provider on staff.

Oral Health Services Provided



PREVENTION, EARLY INTERVENTION, AND RISK REDUCTION (n=1226)

Prevention, early intervention, and risk reduction activities are provided most commonly to students during individual clinic visits through services such as immunizations, vision, hearing, and scoliosis screenings, and behavioral risk assessments.

Additionally, a great majority of SBHCs provide individual-level health promotion services, as well as at small group, classroom, and school levels. The topics of health promotion activities vary widely and are based on the needs of the student population.

Prevention, Early Intervention, and Risk Reduction Strategies Offered by SBHCs

N=125 (SBHCs that serve schools with only grades K through 5)

| | Individual (%) | Small Group (%) | Classroom/School (%) | Parents (%) |
|---|----------------|-----------------|----------------------|-------------|
| Asthma | 89.8 | 31.3 | 24.2 | 29.7 |
| Nutrition/Fitness/Weight Management | 85.2 | 39.8 | 43.0 | 33.6 |
| Mental Health Promotion/Prevention | 80.5 | 32.0 | 27.3 | 25.8 |
| Injury Prevention | 78.9 | 31.3 | 37.5 | 22.7 |
| Violence Prevention | 78.1 | 39.8 | 28.3 | 24.2 |
| Resiliency/Social Skills/Skill Building | 71.9 | 40.6 | 22.7 | 20.3 |
| Sleep/Sleep Habits | 59.4 | 7.0 | 28.9 | 14.8 |
| Tobacco Prevention | 58.6 | 21.9 | 35.9 | 14.8 |
| Alcohol/Other Drug Use Prevention | 55.5 | 19.5 | 28.9 | 11.7 |
| Diversity/Multiculturalism/Race Relations | 45.3 | 14.1 | 17.2 | 7.0 |
| HIV/STD Prevention | 43.0 | 3.9 | 11.7 | 5.5 |
| Pregnancy Prevention-Comprehensive | 35.2 | 3.1 | 3.1 | 3.8 |
| Drop Out Prevention | 32.8 | 7.8 | 10.2 | 5.5 |
| Sexual Assault/Date Rape | 34.4 | 4.7 | 3.9 | 3.8 |
| Pregnancy Prevention-Abstinence Only | 25.8 | 4.7 | 6.3 | 0.8 |
| Parenting | 28.1 | 8.6 | 3.1 | 35.2 |

N=514 (SBHCs that serve schools with only grades 6 through 12)

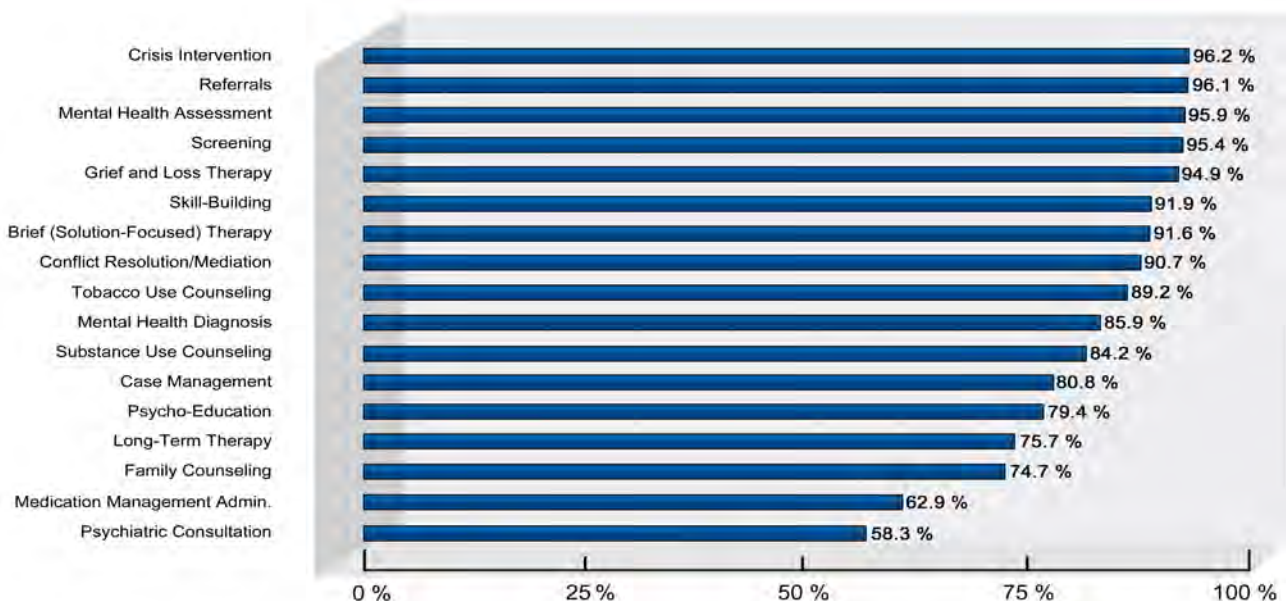
| | Individual (%) | Small Group (%) | Classroom/School (%) | Parents (%) |
|---|----------------|-----------------|----------------------|-------------|
| Nutrition/Fitness/Weight Management | 92.4 | 40.5 | 39.5 | 14.6 |
| Asthma | 91.1 | 24.5 | 20.4 | 15.4 |
| Tobacco Prevention | 91.1 | 37.5 | 45.7 | 17.9 |
| Violence Prevention | 88.1 | 44.4 | 37.9 | 8.2 |
| Mental Health Promotion/Prevention | 87.9 | 39.5 | 41.6 | 15.8 |
| Alcohol/Other Drug Use Prevention | 87.2 | 36.8 | 45.7 | 17.3 |
| Injury Prevention | 87.2 | 20.4 | 28.8 | 7.6 |
| HIV/STD Prevention | 87.2 | 31.3 | 44.7 | 9.5 |
| Resiliency/Social Skills/Skill Building | 82.1 | 40.7 | 24.3 | 8.2 |
| Pregnancy Prevention-Comprehensive | 80.0 | 30.9 | 36.8 | 10.1 |
| Sleep/Sleep Habits | 78.4 | 12.1 | 14.0 | 6.8 |
| Diversity/Multiculturalism/Race Relations | 59.7 | 26.8 | 22.0 | 3.1 |
| Sexual Assault/Date Rape | 54.3 | 19.3 | 19.6 | 4.5 |
| Pregnancy Prevention-Abstinence Only | 52.3 | 16.1 | 21.0 | 5.4 |
| Parenting | 50.6 | 26.3 | 8.8 | 14.4 |
| Drop Out Prevention | 47.5 | 12.1 | 10.7 | 6.2 |

MENTAL HEALTH SERVICES (n=1226)

Mental health and counseling services in SBHCs include mental health assessments, crisis intervention, brief and long term therapy, family therapy, teacher consultation, and case management. These services are provided when mental health professionals are included as health center staff. Primary care providers also provide mental health services such as referrals (72%), screening (59%), and crisis intervention (56%) when there is no mental health staff at the SBHC.

Mental Health Services in SBHCs with Mental Health Providers

N=878 (Total Number of SBHCs with Mental Health Provider)

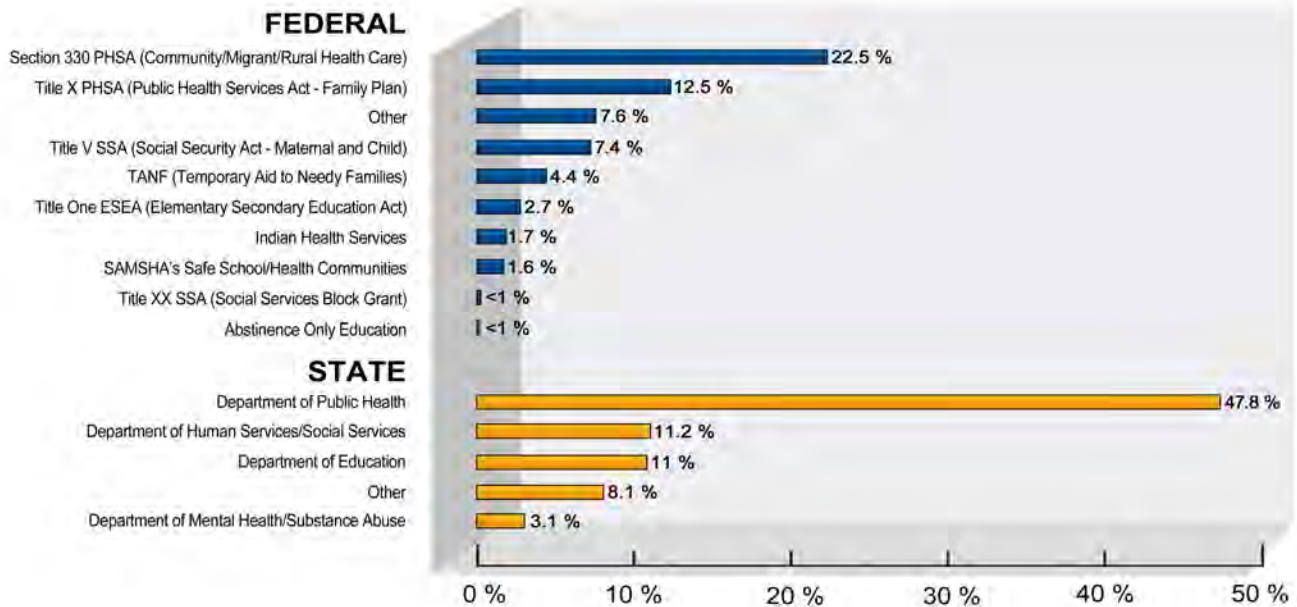


FINANCING OF SBHCS (n=1096)

The majority of SBHCS bill public insurance for health center visits, including Medicaid (81%), the Children's Health Insurance Program (68%), and Tri-Care (41%) – the health care program serving active duty service members, National Guard and Reserve members, retirees, their families, and survivors. Fifty-nine percent bill private insurance and 38 percent bill students or families directly. SBHCS (85%) also assist children and families with enrollment in public insurance programs. State policies are a major determinant of SBHC reimbursement. Improving the effectiveness of billing practices and enrolling children and families in public insurance so there is a payor has been a major focus of sustainability efforts.

SBHCS report receiving support from a variety of revenue sources not related to billing, including state government (76%), private foundations (50%), sponsor organizations (49%), and school or school district (46%). Thirty-nine percent of SBHCS receive funding from the federal government.

Source of SBHC Support Given from Federal or State Government



Managed care organizations (MCO) play a large role in SBHCS' ability to get reimbursed for services. Critical to being reimbursed for care is whether an MCO recognizes services delivered in a SBHC and whether the provider is considered to be a primary care provider or part of the recognized/approved primary care network. The census showed that 35 percent of MCOs recognize SBHC staff as primary care providers/preferred providers, while 30 percent of SBHCS indicate that MCOs do not recognize them as such.

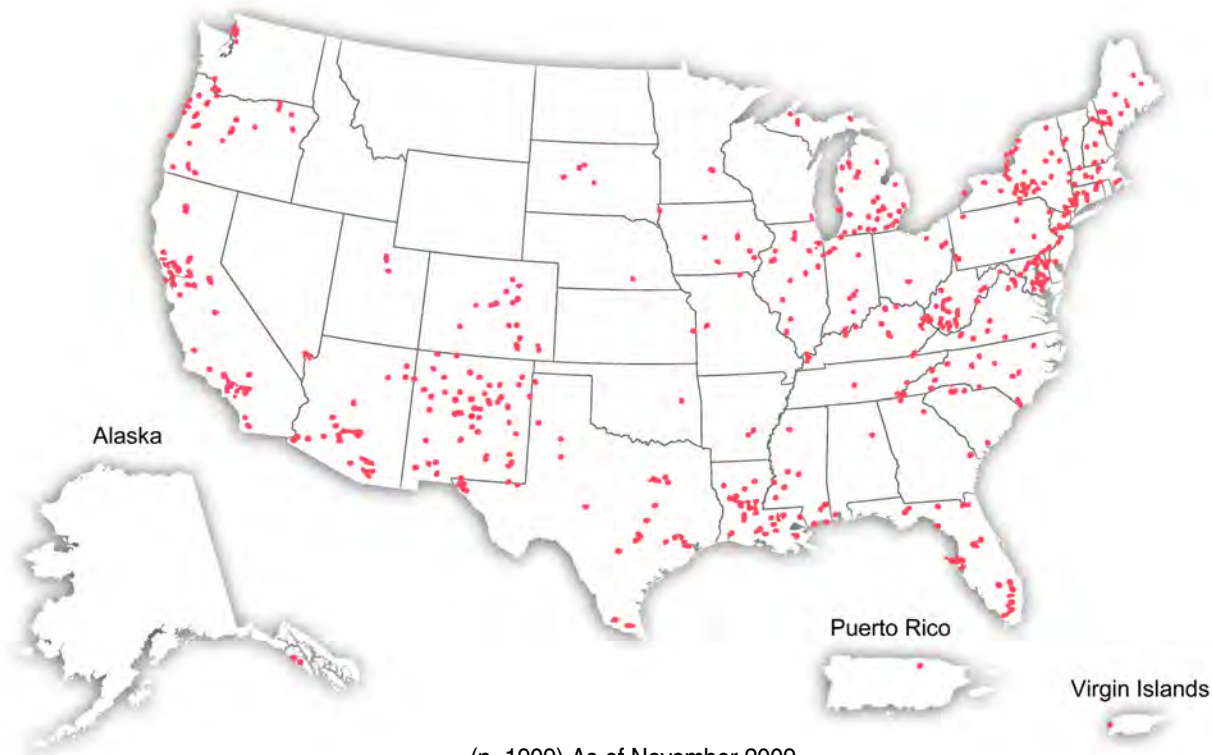
PARENT AND YOUTH ENGAGEMENT (n=1096)

Parent engagement with SBHCS begins during an SBHC's enrollment, when the SBHCS builds awareness of what kinds of services are available and the operational policies of the center in their school. However, 54 percent of SBHCS report that parents have the ability to restrict their child's access to specific services. Parents participate as valuable volunteers and contribute to their SBHC in many ways, including volunteering as an advisor or board member (40%) and participating in organizing center-sponsored health education events (24%).

Young people, often SBHC users, are also important members of their SBHC community and are engaged most frequently by participating in organizing center-sponsored health education events (29%). Many young people also participate in advocacy activities for their health center at local, state, or national levels (20%) and advise on the development, design, and delivery of health services at their SBHC (18%).

HEALTH INFORMATION TECHNOLOGY (HIT) (n=1096)

SBHCS are adopting HIT to enhance their work with more than half (56%) using electronic billing systems, and 53 percent with a management information system. A smaller number use an electronic medical record (32%) and electronic prescribing (22%) and 7 percent of SHBSCs have a telemedicine system.



(n=1909) As of November 2009

| | | | | | | | |
|----------------------|-----|---------------|----|----------------|-----|----------------|----|
| Alabama | 5 | Indiana | 87 | Nebraska | 1 | Rhode Island | 2 |
| Alaska | 3 | Iowa | 16 | Nevada | 6 | South Carolina | 7 |
| Arizona | 81 | Kansas | 2 | New Hampshire | 1 | South Dakota | 6 |
| Arkansas | 4 | Kentucky | 20 | New Jersey | 40 | Tennessee | 21 |
| California | 160 | Louisiana | 64 | New Mexico | 79 | Texas | 70 |
| Colorado | 45 | Maine | 26 | New York | 206 | Utah | 5 |
| Connecticut | 79 | Maryland | 71 | North Carolina | 49 | Vermont | 5 |
| Delaware | 28 | Massachusetts | 59 | Ohio | 17 | Virgin Islands | 1 |
| District of Columbia | 4 | Michigan | 90 | Oklahoma | 11 | Virginia | 19 |
| Florida | 245 | Minnesota | 16 | Oregon | 51 | Washington | 20 |
| Georgia | 3 | Missouri | 31 | Pennsylvania | 28 | West Virginia | 50 |
| Illinois | 62 | Montana | 3 | Puerto Rico | 2 | Wisconsin | 8 |

For a complete view of the census results, visit our website at www.nasbhc.org.

OUR MISSION

The National Assembly of School-Based Health Care (NASBHC) is the national voice for SBHCs. Founded in 1995 to promote and support the SBHC model, NASBHC's mission is to improve the health status of children and youth by advancing and advocating for school-based health care. Built from the grassroots up by SBHC staff and sponsors, NASBHC is a true reflection of the movement it supports. We advocate for national policies, programs, and funding to expand and strengthen school-based health centers, while also supporting the movement with training and technical assistance.

The national Census is conducted by NASBHC. This report was prepared by Jan Strozer, Linda Juszczak, and Adrienne Ammerman. We gratefully acknowledge the support of the Census advisors Lisa Abrams, Donna Behrens, John Dougherty, Dan Garson Angert, Leslie Mandel, Mona Mansour, Jan Marquard, and Bob Nystrom as well as the SBHC professionals who generously provided data for their programs. This report honors the work they do each day. Funding for the 2007-2008 Census was provided by the Health Resources and Services Administration's Maternal and Child Health Bureau, Office of Adolescent Health and Bureau of Primary Health Care, Office of Special Populations.

SOURCE: Strozer, J., Juszczak, L., & Ammerman, A. (2010). 2007-2008 National School-Based Health Care Census. Washington, DC: National Assembly on School-Based Health Care.

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