Assessing National Opportunities to Sustain School-Based Health Centers

Foreword

This issue brief was produced by the National Assembly on School-Based Health Care to catalyze conversation among national, state and local SBHC partners, advocates and consumers as to the potential direction for a national policy agenda to sustain school-based health centers.

This catalog of *current* programs and funding that support improved outcomes for the health, well-being and education of children and youth should serve as a roadmap for establishing direction for national policy.

The listing is not exhaustive, and is organized through a distinctly federal lens, as is the program's related political (Congress) and administrative (agencies) jurisdictions.

Input from state and community partners is critical to a fuller understanding of how these federal policies and appropriations "trickle down" to the program level and which of these represent significant opportunities.

Given that more than 70 percent of public health spending is derived from state and local sources, are there greater opportunities to be mined in these jurisdictions?

What national policies are needed to not only sustain our existing network of school-based health centers, but to seed growth in communities where demand and interest are high?

A number of questions follow each of the sections. State SBHC associations and their members are urged to assess the relevance and appropriateness of each potential policy target.

Document your conversations and assessments and forward results to the National Assembly office. Data will be used by National Assembly leaders and staff to inform the development of a national policy agenda.

Introduction

The majority of our field's experience with school-based health care policies is likely to be those that guide the practice and operations at the health center level – that is, policies about consent and confidentiality, treatment protocols, billing and collection, quality assurance, etc. The national school-based health care policy program is, however, about the macro-level policies that guide the financing and sustainability of school-based health care across the various domains that include children's health, education, safety and well being.

To be successful in building policies that sustain our movement, we will need to acquire a sophisticated understanding of how, why, and where policies (and related appropriations) are created, and most importantly, how they are influenced. Moreover, we will need to generate authentic advocacy from the children, families and communities who are served by these policies.

First, let us set out some assumptions that will guide our school-based health care policy pursuits.

1. **Targets should be guided by national principles**: The National Assembly has set forth principles for school-based health care that all policy targets should support. The seven principles assert that school-based health care support the school; respond to community need; focus on the student; deliver comprehensive care; advance health promotion activities; implement effective systems; and provide leadership in adolescent and child health. See full description of school-based health center principles and guidelines in exhibit A.
2. **Funding for public health function is critical**: Although diversity of funding sources is valued, in its extreme form can create myriad and burdensome reporting requirements. National, state and local policies that sustain school-based health care must embrace core support for its basic functions that include care management, health promotion and education, as well care for the uninsured.

3. **Policies should reflect diversity of sponsoring agencies.** Policies that define eligibility for school-based health care financing should be inclusive of all school-based health care provider types, including public health departments, hospitals, academic medical centers, non-profit health organizations, community health centers, and even schools themselves.
4. **Third-party billing is necessary**: Patient care revenue remains a dominant funding mechanism for our nation's health care systems and should play a central role in our policy targets as well. Policy change should be directed toward payment reforms that yield compensation for the full value of school-based health care visits.
5. **All children benefit from access to comprehensive, quality health care**. Although school-based health care has been traditionally targeted to low-income neighborhoods, it is based on the fundamental truth that all children benefit from access to comprehensive, quality care.

Policies and Programs

The programs and funding that we describe here align directly with the National Assembly's best understanding of programs and policies that support school-based health centers, or by nature of their intended outcome or population focus, logically have some potential to support them. The degree to which these sources have traditionally played a role in sustainability is varied based on state and community policies and experiences (see below). The attached table describes levels of support where known.

The first two policy areas we examine are the cornerstones of national health care policy and financing that make up the health care safety net: 1) federal grants that directly fund health care service programs; and 2) publicly financed health insurance. It is well established that public insurance and publicly financed health services are dominant sources – and school-based health care advocates may argue that these merit greater attention above all others.

We also examine four additional policy domains that, while historically have not played a significant role in sustaining SBHCs, may be logical targets for expanding a health and education policy network to finance school-based health care: 3) public health promotion and disease control, 4) public education, 5) commercial insurance, and 6) social services.

With long-term sustainability as our goal, it seems reasonable to argue that no option or opportunity should be taken off the table. Perhaps the next wave of funding may come from high-level public health efforts to reduce obesity (such as the administration's "Steps to a Healthier US"), violence, or substance use. Or perhaps facilitated conversations with national insurers (modeled after successes in California and Maine) may lead to greater access to health insurance markets.

Publicly financed personal health and mental health services

Because SBHCs are a health service delivery model, we look first for alignment with public policy targets devoted to the provision of direct care (as opposed to insurance). Congress has authorized (and reorganized over the decades) a number of direct service programs for uninsured, low-income and hard-to-reach populations to assure the delivery of preventive health services, including primary care, family planning, perinatal care, immunizations, etc. The result: national networks of community, migrant and rural health centers, family planning clinics, and public health department "moms and babies" clinics. Although not a centerpiece, school-based health centers have been supported through these national policies – some more so than others. The health service grant programs described below are the foundation of the public health safety net for low-income families.

POLICY TARGETS – Historic Support of SBHCs	
Publicly financed health services to assure access	HIGH
Publicly supported health insurance	MOD-HIGH
Public health to affect behavioral change, prevent disease	LOW-MOD
Private sector health insurance	LOW
Education	LOW
Social Services	LOW

Primary Care: Public Health Service Act (PHSA) Section 330
Begun as neighborhood health centers in the early 1960s, the nation's publicly financed primary care system comprises community health centers, migrant and rural health centers, health care programs for the homeless and public housing residents, and school-based health centers. As federally qualified health centers, Section 330 programs directly receive federal grants based on health center users. The Bush administration has made the expansion of 330 programs as a priority for its health care agenda. An additional $200 million has been made available to communities interested in expanding primary care access in medically underserved areas. In addition to federal (and often state) grants, Section 330 programs receive Medicaid reimbursement based on a unique methodology that ensures full compensation for the cost of delivering care, are covered by Federal Tort Claims Act (FTCA), are eligible for federal drug pricing discount, and have access to the federal "Vaccines for Children" program.

School-based health centers are not authorized in PHSA Section 330 (i.e. set in statute by Congress); rather Congress includes them in the consolidated grant program through the appropriations process. The current level of funding (an estimated $20M) supports 76 school-based health centers. SBHCs may also be included as Section 330 grant programs under the sponsoring community health center's scope of project. The federal Bureau of Primary Health Care estimates that approximately 300 SBHCs are financed through this arrangement.

The advantages of affiliating SBHCs with Section 330 programs are evident: 1) a predominant and long-term source from one payer; and 2) enhanced Medicaid reimbursement that reflects the full cost of delivering care. The primary disadvantage of this policy target: federal requirements for health centers, which includes a consumer governance board, makes the majority of SBHC sponsors (i.e. hospitals, academic medicine, schools, etc.) ineligible to apply.

Learn about Section 330 programs

Maternal and Child Health: Title V Social Security Act
The federal maternal and child health block grant (also known as Title V or MCH block grant) is an amalgamation of previously authorized categorical programs devoted to improving the health of women, children, youth and families. The MCH block grant was a product of the Reagan federalism era, which decentralized federal programs and gave states more decision-making on federal tax dollar spending. Today, the program is a state-federal block grant, with states required to match $3 (at a minimum) for every $4 in federal funds provided. States must spend 30 percent of funds on preventive and primary care for children and youth, and 30 percent on services for children with special health care needs. Block grant funds can be used for health services and related activities including planning, administration, education, evaluation and purchase of technical assistance. States may elect to distribute funding to political subdivisions on a formula basis, or competitively based on evidence of need.

In several states and local health departments, allocation of the MCH block grant has played a central role in school-based health center sustainability. In its 2001 state SBHC policy survey, the Center for Health and Health Care in Schools estimated that $10.5M of the MCH block grant was directed to SBHC in 14 states. The range was quite wide, from a low of $56,000 in Oregon to $3.9M in New York.

Learn about Title V MCH Block Grant.

Family Planning: Title X Public Health Service
Title X is the only federal program devoted solely to the provision of family planning and reproductive health care. Designed to provide access to contraceptive supplies and information with priority given to low-income persons, Title X supported clinics also provide a number of preventive health services such as patient education and counseling, breast and pelvic examinations, cervical cancer, and STD and HIV screenings. Services are delivered through a network of community-based clinics that include state and local health departments, hospitals, university health centers, Planned Parenthood affiliates, independent clinics, and public and non-profit agencies. Title X service funds are allocated to the ten DHHS Regional Offices, which manage the competitive review process,

make grant awards and monitor program performance. In fiscal year 2003, Title X provided federal funds for service delivery grants to 86 public and private organizations to support the provision of comprehensive family planning services and information.

Although the precise level of support for school-based health centers from Title X is unknown, health department sponsored school health centers may find it an appropriate use of funds to provide pregnancy and STD prevention services and interventions in the school-based primary care settings.

Learn about Title X family planning program

Substance Abuse/Mental Health: Public Health Service Act Title XIX
Federal grant mechanisms for mental health and substance abuse services are organized into two separate block grants that give states discretionary spending in the areas of mental health and substance abuse prevention and treatment. These funds are often distributed to community-based agencies that focus on seriously disabled populations. Although there is no knowledge of states and communities currently using these funds to support SBHCs, recent high profile public reports have emphasized prevention and early intervention in schools as critical components of a transformed mental health system. A political window may be cracked opened for school-based health centers.

Learn about the substance abuse and mental health block grants:

Public health insurance (Medicaid and related programs)
Publicly financed health insurance - Medicaid and its more recent companion, SCHIP - is one of the largest public health expenditures of both state and federal governments (Medicare being the largest), and a significant finance mechanism for health care to low-income populations. We view public health insurance as an important school-based health care policy target for two reasons: 1) Medicaid has been a critical component of stabilizing and sustaining the aforementioned network of public primary care, maternal and child health, and family planning clinics; and 2) Medicaid-enrolled (or eligible) students constitute a large proportion of SBHC users.

Data collected anecdotally and through quantitative surveys have consistently shown that Medicaid reimbursement is commonly pursued by SBHCs, and is the largest source of patient (non-grant) revenue. However, on average Medicaid and SCHIP reimbursement account for a small percentage of total program revenue: NASBHC research in 2001 found that on average SBHCs reported Medicaid revenues totaling $14,000 (or 8 percent of total budget).

The National Assembly, since its inception, has explored Medicaid policy and its support (or lack thereof) for SBHCs in a variety of national, state and regional meetings, data collection activities, and policy analyses, the most current of which is a 2002 report entitled Medicaid and School-Based Health Centers: Partners in Access. The report details state level policies created in a number of states to establish positive, financially productive relationships between Medicaid and SBHCs.

We know from the experience of SBHCs in California and New York, as well as those affiliated with federally qualified health centers, that Medicaid can provide substantial financial support, and in some instances serve as an incentive for growing the model. We recognize, too, that public health insurance hasn't served the majority of SBHCs well. Because school-based health centers are not defined in federal law as a Medicaid provider type (required or optional), states are free to exclude SBHCs from participating in their program, or reimburse them at woefully inadequate rates.

Two national reports from the 1990s detailed potential Medicaid policy strategies to help sustain SBHCs. Rosenberg & Associates, in a 1994 paper that explored the possibilities of federal support to SBHCs represented in the proposed National Health Security Act, delineated three alternative methods of reimbursing school health programs to decrease grant dependency. Although President Clinton's ill-fated Act foundered and the policy alternatives were never pursued, Rosenberg and Associates' strategies may still have some salience with SBHC supporters. The three options are:

Option One: *Use a common fee schedule for all school-based health programs, based perhaps on a universal SBHC costing model.* Rosenberg asserts that although the construction of a

schedule would be complex, a fixed rate would be easier to administer than the other options.

Option Two: *Pay all school health programs on a cost-basis.* Rosenberg reminds us that cost reporting, as used for federally qualified health centers and rural clinics, has been useful when scope of services and staffing levels vary from one provider organization to another, when there is no reliable history on which to base reimbursement rates, and when patient populations require more intensive support services.

Option Three: *Pay all school health programs in the same region on the same basis.* In other words, if one SBHC is receiving cost-based reimbursement, then any SBHC in the region would be entitled to cost-based reimbursement, regardless of sponsor agency type.

The limitations to each of these are described more fully in the report, which can be found on the NASBHC web site:

In 1998 with funding from the Kellogg Foundation, The Lewin Group explored SBHC sustainability issues in its report, "Developing a Policy Agenda for School Based Health Care Financing and Sustainability." The Lewin Group, with its considerable SBHC evaluation experience, took the position that much of the care delivered in SBHCs was "invisible" to the funders and payers – but essential to better health care, education and social service outcomes. The authors outline a proposed bundling structure – that is, a clustering or grouping of related services – that could potentially give rise to an alternative (and more comprehensive) Medicaid reimbursement methodology. The suggested categories of bundled services included:

a) *Engagement and early intervention bundle*: designed to bring child into health care system, address immediate needs, assess risk status, link to medical home;
b) *Health care consumer and wellness education bundle*: designed to emphasize health promotion, skill building for healthy lifestyle and appropriate use of health care system;
c) *Behavioral health bundle:* designed to integrate early intervention and school-based behavioral treatment and support with community intervention programs.

Public health resources to prevent disease and promote health

If there's a publicly recognized health concern, there's likely to be a public health grant program in response to it. A scan of the catalog of domestic programs reads like a public health hit list: programs for the prevention of heart disease, diabetes, cancer, injury, HIV/AIDS and other sexually transmitted diseases, tobacco use, birth defects, etc. Health promotion programs include school health, immunizations, oral health, nutrition, and physical fitness. The federal agency charged to address these public health challenges is the Centers for Disease Control and Prevention, which was funded at $6.9 billion in FY05.

As attractive as these grants may look to the SBHC community, they do not represent a significant public resource for health care delivery. Many of the categorical grant programs are limited in ability to fund little more than demonstration programs, have a very specific health problem focus, and may in fact not allow funding for direct health services. Moreover, eligibility for grants may not include local community programs, but rather are destined for state government or academic research institutions. We have detailed seven programs in the policy targets table that at present have no known application in school-based health care, but do share a common interest in children's health outcomes.

Private health insurance markets

Unlike the previously described policy targets, private health insurance markets are outside the public domain and therefore difficult to influence on matters of national policy. The fact that there are many markets also makes it a very challenging target. As we learn from the successes of states and communities pursuing relationships with commercial insurance markets, it may be that education and awareness building will be the most logical national strategy.

Education

Given that sources of education funding are predominantly state and local in origin, the pursuit of education policies that support sustainability for school-based health centers may be more fruitful in these jurisdictions. We add education to our policy catalog, however, because of the importance of school-based health care in addressing barriers to learning.

Although the federal role in education has remained minor, the centerpiece of federal education policy is dedicated to the very population most often targeted for school-based health centers: high poverty schools and low-income, disadvantaged students. The Elementary and Secondary Education Act (ESEA) is the bedrock of federal public education policy and the basis for the No Child Left Behind Act. ESEA is a collection of miscellaneous programs dedicated to improving instruction in under-performing schools. The bulk of funding ($12.3 billion) under ESEA is a formula-based grant program to state education agencies called Title I, which eligible schools can use to provide additional help to students performing below certain standards, provide additional after-school or summer programs, implement exemplary reading and math programs, reduce class size, hire paraprofessionals or provide professional development.

ESEA grant initiatives identified in the programs and funding table are programs that most closely align with student health and welfare, including safe and drug free schools (Title IV Part A), after-school programming (Title IV Part B), and drop out prevention (Title I Part H). Historically, only state and local education agencies were eligible to receive federal education resources. In the last reauthorization of ESEA, community-based organizations were added to the list of eligible entities for after-school programming grants.

Learn about Elementary and Secondary Education Act

Learn about federal safe and drug-free schools polices and programs

Social Services

Children and youth who pass through our nation's court systems, welfare programs and child protection services are at highest risk for poor medical, behavioral and education outcomes. Programmatic ties to school-based health centers are indeed logical, but with few exceptions, efforts to link social services and juvenile justice policies and funding to school-based health centers have been rare. We identify a handful of related federal child welfare and safety programs in the table to offer communities the fullest breadth of opportunity for blending inter-agency interests and resources.

The Temporary Aid to Needy Families (TANF) program is a block grant to states for the purpose of reducing dependency of needy families with children by promoting job preparation and work and preventing the incidence of out-of-wedlock pregnancies. States have the flexibility to use the block grant in any number of ways: cash assistance, child care, education, job training, as well as a variety of other services to support work and the efforts of low-income working families. With the exception of pre-pregnancy family planning services, medical services are a restricted use of TANF funds. It may be argued that preventing adolescent pregnancies can reduce out-of-wedlock births and associated need for public support. Such was the case in New York State, where a portion of the TANF block grant ($3 million) is allocated to SBHCs to support counseling services and pregnancy prevention.

Learn more about TANF

The Social Services Block Grant (Title XX of the Social Security Act), like the previous block grants described here, is a collection of categorical entitlements programs to the states based on population. Today, authority for use of spending is strictly a state decision. Service funding must be directed at helping families achieve economic self-support and sufficiency and preventing or remedying neglect, abuse or exploitation of children. Reported expenditures (related to health and welfare of children) from states include broad categories of spending on case management, counseling, family planning, health care, pregnancy and parenting, substance abuse, and youth at risk. The Illinois Department of Social Services annually allocates $1 million of the block grant to support SBHCs.

Learn more about SSBG

Understanding Policy Targets and Implications for Funding SBHCs

Federal Health Services Grants Programs in Your State

1. How, and at what level, have federal health services programs contributed to SBHC financing in your state/locality?
2. What programmatic or legislative changes would be necessary to support long-term, sustained financing of SBHCs?

Medicaid/SCHIP

1. Describe state Medicaid agency policies related to SBHC (such as carve outs or exemption, rate setting, service provider definition, etc):
2. What is the range of reimbursement for standard visits?
3. On what methodologies are reimbursement rates based?
4. Describe barriers to Medicaid and SCHIP reimbursement that could be overcome by national and state policy advocacy.
5. Is there interest in or momentum for establishing a uniform and consistent Medicaid policy for SBHCs in your state?

Public Health Resources to Prevent Disease and Promote Health

1. Do any of the related public health programs described in the federal program and funding table directly support SBHCs in your state?

Private health insurance

1. What types of outreach has been conducted with commercial insurers in your state to establish improved reimbursement?
2. Have any private insurers established statewide reimbursement policies?
3. How can the national organization be complementary or helpful to state efforts?

Education

1. How has federal education policy supported SBHCs in your state?
2. What role does the education sector play in supporting SBHCs?
3. Are there other policy opportunities within the education domain beyond funding?

Social Services

1. Are SBHCs in your state accessing TANF and social services block grant dollars? For what purpose?

Federal Policy Targets FY04 Budget (in millions)

Health Services Grant Programs	*Total*
Consolidated health center funding	$1,600
Maternal and child health block grant	$730
Rural outreach	$29
Family planning	$240
Mental health block grant	$399
Substance abuse prevention/treatment	$1,600
Community MH Services for SED Children	$49.5
Health Promotion and Disease Control	
Comprehensive School Health Programs	$38
Immunization Program	$1,100
HIV/AIDS Prevention – Health Dept based	$323
HIV/AIDS Prevention – Non-gov't based	$78
Sexual Abstinence Education	$50
Adolescent Family Life Demonstration	$38
Steps to Healthier US	$81
Chronic Disease Prevention	$56
Education	
Title I ESEA	$12,300
Safe & Drug Free Schools	$441
School Drop Out Prevention	$125
21st Century Learning Centers	$999
Social Services	
Social Services Block Grant	$1,700
Temporary Assistance for Needy Families	$16,500

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A P P E N D I X

NATIONAL SCHOOL-BASED HEALTH CENTER POLICY TARGETS

FEDERAL PROGRAMS RELATED TO THE HEALTH, WELL-BEING, EDUCATION, AND SAFETY OF AMERICA'S SCHOOL-AGE CHILDREN AND YOUTH

Key:
PHSA = Public Health Service Act
ESEA = Early and Secondary Education Act
MCH = Maternal and Child Health
HELP = Senate Health, Education, Labor and Pensions Committee

SBHC POLICY TARGETS
Federal Health and Mental Health Services Grant Initiatives

Authorization/ Funding Level	**Eligible Entities**	**SBHC Application**	**Current Level of Support**	**Policy/ Political Issues**	**Political Jurisdiction**
Maternal and Child Health *Title V Social Security Act* *MCH Block Grant* *$730 M*	Most Title V funds are allocated to states; require $3 for every $4 fed; states must spend 30% of funds on preventive and primary care for children and youth and 30% on services for children with special health care needs.	Several states use MCHBG to fund competitive SBHC grant programs; local health departments use MCHBG to fund SBHCs	An estimated 13 states allocated $10.5 M in 2002*	No growth to block grant in past year; competition for fewer dollars	House Ways & Means Cmte Senate Finance Cmte
Primary Health Care *PHSA Sec 330* *Consolidated health centers* *$1.6 B*	Eligible applicants are public and nonprofit private entities that have the capacity to effectively administer the grant.	SBHCs are considered an eligible use of funding provided criteria are met	An estimated $18 million in 2003 to support 70 SBHCs; none funded in last round	Competitive; must meet FQHC requirements	House Energy & Commerce Cmte Senate HELP Cmte
National Health Service Corps *PHSA Section 338B* *$205 M*	Awards provide payments of up to $25,000 a year towards health professions undergraduate and graduate education loans	SBHCs may attract health professions by enrolling with NHSC	Not known; to be assessed in 2005	Fulltime placement is required	House Energy & Commerce Cmte Senate HELP Cmte
Rural Outreach *Health Centers Consolidation Act of 1996* *$28.9 M*	Rural public or nonprofit private entities that include three or more health care providers or other entities that provide or support the delivery of health care services	Rural communities have used rural outreach grants to support SBHCs; school health services	Unknown	Time limted, one time only grants	House Energy & Commerce Cmte Senate HELP Cmte
Family Planning *PHSA Title X* *$240 M*	Any public (including city, county, local, regional, or State government) entity or nonprofit private entity located in a State	SBHCs may be subcontracted with state, locality to deliver family planning	Unknown	Provider must deliver scope of Title X covered services	House Energy & Commerce Cmte Senate HELP Cmte

SBHC POLICY TARGETS
Federal Health and Mental Health Services Grant Initiatives (continued)

Authorization/ Funding Level	Eligible Entities	SBHC Application	Current Level of Support	Policy/ Political Issues	Political Jurisdiction
Mental Health Block Grant *PHSA Title XIX, Part B* *$399 M*	Funding to states to provide comprehensive community mental health services to adults with a serious mental illness and to children with a serious emotional disturbance;	SBHCs provide early identification and intervention services in mental and behavioral health	None known	Prevention and early intervention services not priority of block grant	House Energy & Commerce Cmte Senate HELP Cmte
Comprehensive Community Mental Health Services for Children With Serious Emotional Disturbances *PHSA Title V Part E, Section 561* *$49.5 M*	States/county or local governments to provide community-based systems of care for children and adolescents with a serious emotional disturbance and their families.	SBHCs serve as primary entry to system of care; case management opportunities for high needs children/teens	None known		House Energy & Commerce Cmte Senate HELP Cmte
Substance Abuse Prevention and Treatment *PHSA Title XIX Part B, Subpart II* *$1.6 B*	Funding to States to support projects for the development and implementation of prevention, treatment and rehabilitation activities directed to the diseases of alcohol and drug abuse.	Education and counseling of school-age youth to reduce risk; community-based prevention strategies	None known		House Energy & Commerce Cmte Senate HELP Cmte

SBHC POLICY TARGETS
Public Health Insurance

Authorization/ Funding Level	Eligible Entities	SBHC Application	Current Level of Support	Policy/Political Issues	Political Jurisdiction
Medical Assistance Program (Medicaid) *Social Security Act, Title XIX* *$182.5 B*	Financial assistance to States for payments of medical assistance on behalf of cash assistance recipients, children, pregnant women, and the aged who meet income and resource requirements, and other categorically-eligible groups.	SBHCs seek reimbursement for services delivered to Medicaid enrolled SBHC users	Exact amount unknown; NASBHC data suggests wide range of MA enrollees in SBHCs	State program with federal oversight; limited interest in policy advancement by Congress	House Ways & Means Senate Finance
Child Health Insurance Program *Social Security Act Title XXI, Subtitle J, Section 4901* *$2.6 B*	Funds to States to initiate/expand child health assistance to uninsured, low-income children via health insurance coverage that meets the requirements in Section 2103 or expanded eligibility under Medicaid program.	SBHCs seek reimbursement for services delivered to CHIP enrolled SBHC users; Outreach funds may be targeted to SBHCs for program enrollment	Unknown; NASBHC data suggests extremely limited	Most CHIP programs do not acknowledge SBHCS as eligible provider type.	House Ways & Means Senate Finance

SBHC POLICY TARGETS
Public Health Resources to Prevent Disease & Promote Health

Authorization/ Funding Level	Eligible Entities	SBHC Application	Current Level of Support	Policy/Political Issues	Political Jurisdiction
Comprehensive School Health Programs To Prevent The Spread Of HIV *PHSA Section 301(a) and 311 (b) (c)* *$38.7 M*	Eligible applicants are official States, large urban school districts with the highest number of reported AIDS cases, and national non-governmental organizations.	Health services are part of coordinated school health programs	Unknown	Does not support clinical programs	House Energy and Commerce Senate HELP
Immunization Program (317 and Vacines for Children programs) *PHSA Sections 301 & 317* *$1.1 B*	To assist States in establishing and maintaining preventive health service programs to immunize individuals against vaccine-preventable diseases	SBHCs deliver immunizations to target population	Unknown		House Energy and Commerce Senate HELP
HIV/AIDS Prevention-Health Dept Based *PHSA Section 317* *$323 M*	Funds to state and local health depts to carry out counseling, testing, referral, and partner notification: health education/risk reduction; special minority HIV prevention activities; etc	Many public health sponsored SBHCs deliver HIV/STD prevention services	Unknown		House Energy and Commerce Senate HELP
HIV/AIDS Prevention-Non-gov't based *PHSA Section 301(a)* *$77.7 M*	Local, regional and, national nonprofit organizations to implement effective community-based Human Immunodeficiency Virus (HIV) prevention programs	Street outreach; risk reduction; community intervention programs; HIV prevention care management; minority community-based prevention projects, etc	Unknown		House Energy and Commerce Senate HELP

SBHC POLICY TARGETS
Public Health Resources to Prevent Disease & Promote Health (continued)

Authorization/ Funding Level	Eligible Entities	SBHC Application	Current Level of Support	Policy/Political Issues	Political Jurisdiction
Sexual Abstinence Grant Education*Title V Social Security Act$50 M*	State Health Agency responsible for the administration of the Title V Maternal and Child Health Services Block Grant.	Health education and promotion of risk avoidance	Unknown	State-based grants	House Energy and Commerce Senate HELP
Adolescent Family Life (AFL) Demonstration and Research program *PHSA* Tit*le XX $30.7 M*	Public and non-profit organizations for delivery of care services for pregnant and parenting adolescents; to promote abstinence from sexual relations through provision of age-appropriate education on sexuality and decision-making skills	Care coordination for pregnant and parenting adolescents; Health education and promotion of risk avoidance	Unknown	Limited resources	House Energy and Commerce Senate HELP
Steps to Healthier US: A Community-Focused Initiative to Reduce the Burden of Asthma, Diabetes, and Obesity *PHSA Section 301(a) $81 M*	Public-private partnerships at the community level to support community-driven programs that enable persons to adopt healthy lifestyles that contribute directly to the prevention, delay, and/or mitigation of the consequences of diabetes, asthma, and obesity	Health education and promotion of risk avoidance for high risk youth	Unknown		House Energy and Commerce Senate HELP
Assistance Programs for Chronic Disease Prevention and Control *PHSA Sections 301(a) and 317(a), and (k)(2) $56M*	State Cardiovascular Health Programs (CVH); Arthritis State-Based Program; National Arthritis Action Plan; and, Racial and Ethnic Approaches to Community Health (REACH)	Health education and promotion of risk avoidance for high risk youth	Unknown		House Energy and Commerce Senate HELP

SBHC POLICY TARGETS
Social Services

Authorization/ Funding Level	Eligible Entities	SBHC Application	Current Level of Support	Policy/Political Issues	Political Jurisdiction
Social Services Block Grant *Social Security Act, Title XX* *$1.7B*	State governments to furnish social services to (1) prevent/reduce/ eliminate dependency; (2) achieve/ maintain self-sufficiency; (3) prevent neglect, abuse, exploitation of children; (4) prevent/ reduce inappropriate institutional care	Coordination of social services provided in SBHCs	Illinois provides an earmark to SBHCs	Medical services ineligble use of funds; Limited historical use in SBHCs	House Ways & Means Senate Finance
Temporary Aid to Needy Families *Social Security Act, Title IV* *$16.5B*	State grants to assist needy families so that children can be cared for in own homes; to reduce dependency by promoting job preparation, work, and marriage; to reduce and prevent out-of-wedlock pregnancies; and to encourage the formation and maintenance of two-parent families	Coordination of social services and counseling for TANF children	New York State earmarks funds for social services and mental health	Limited historical use in SBHCs	House Ways & Means Senate Finance

SBHC POLICY TARGETS
Education

Authorization/ Funding Level	Eligible Entities	SBHC Application	Current Level of Support	Policy/Political Issues	Political Jurisdiction
Grants to Local Education Agencies *ESEA Title I Part A* *$12.3 B*	States make grants to local education agencies (LEAs) and schools to help improve instruction in high-poverty schools and ensure that poor and minority children have the same opportunity as other children to meet challenging State academic standards.	Coordination of health, mental health and social services	Unknown	Local education agencies (LEAs) only eligible for funding	House Education and Workforce Senate HELP
Safe and Drug Free Schools *ESEA Title IV Part A* *$441 M*	Federally funded state administered program that makes grants to LEAs to offer disciplined environment conducive to learning, by preventing violence in and around schools and strengthen programs that prevent the illegal use of alcohol, tobacco, and drugs,	Drug and alcohol prevention for youth at risk	Unknown	Local education agencies (LEAs) only eligible for funding	House Education and Workforce Senate HELP
School Drop Out Prevention ESEA *Title I, Part H* *$125 M*	Requires grantees to use funds to implement research-based, sustainable, and coordinated school dropout prevention and reentry programs. Allowable activities include counseling and mentoring for at-risk students.	Counseling and case management for students at high risk for drop out	Unknown	Local education agencies (LEAs) only eligible for funding	House Education and Workforce Senate HELP
21st Century Schools *ESEA Title IV Part B* *$999 M*	States make grants to LEAs and community-based non-education agencies to create community learning centers that provide academic enrichment opportunities for children, particularly students who attend high-poverty and low-performing schools.	After-school programming for target population	Unknown	Congress recently amended authorization to open eligibility to community-based organizations.	House Education and Workforce Senate HELP

SBHC POLICY TARGETS
Education (continued)

Authorization/ Funding Level	Eligible Entities	SBHC Application	Current Level of Support	Policy/Political Issues	Political Jurisdiction
Safe Schools Healthy Students ESEA Title IV, Part A *$42M*	School districts and communities to promote ongoing partnerships as a way of enhancing and expanding their existing activities relating to youth violence prevention and healthy child development.	Promotion of prosocial skills and healthy child development, safe school environments, and drug avoidance	Unknown	Discretionary grant program of DOE, HHS and Justice; 3-yr grants only	House Education and Workforce Senate HELP