Joining Hands
News from the National Assembly on School-Based Health Care
Winter 2001

In this issue!

School-Based Health Centers Face National Crisis

A conversation with school mental health professionals Barbara Silverman, Erasmus High School in Brooklyn and Olga Acosta, DC Department of Mental Health

In light of the 9-11 tragedies, what are the major issues facing school-based health centers when helping students to deal with terrorism?

OA: Teachers and school personnel will need support and training to understand the likely responses from their students and to know the warning signs for when they need additional help. It is important to have forums and discussions for teachers and students. Teachers can show anxiety that can affect students.

BS: Beyond crisis intervention, which was our first response, we're going to need to be prepared for what happens when the full range of emotional responses sink in. We haven't yet seen it, and we don't really know what to expect. We expect we might see an increase in existing problems such as violence and increased gang activity as the students try to make sense of their world and try to get more control over their life.

How have school-based health centers or schools responded to the terrorism crisis? Ideally, what do you think the response should be?

BS: We have continued to do business as usual. We were initially one of the designated crisis rooms that were set up for students seeking additional support in the days following the attack. We did outreach and recruitment for an ongoing lunch support group called "Let's Talk About It." Through performance social therapy, the students create the 'stage' in which their development takes place, enabling them to tap into their competencies and capacities through crativity. It will be interesting to see if and how this session of "Let's Talk About It" might be different from sessions prior to 9-11.

OA: Ideally? Schools will have a viable crisis response in place that includes a mental health network for supporting teachers and students. It should be comprehensive and flexible enough to support the range of reactions from adults and students. Schools will foster conversations between school mental health providers and children to discuss the attacks and the feelings they arouse.

What are some of the feelings that students have expressed in response to the recent terrorist attacks?

BS: The students at Erasmus High School live in a community that experiences death, murder, and racism on a daily basis. Given that environment, the students in general have not expressed additional or different feelings from a more ordinary moment in their lives. There were a couple of Arab students who requested a safety transfer after being harassed. One teacher lost her husband, and 2 other students had relatives die in the attack.

OA: It's not atypical for students, in order to deal with their everyday lives, to develop a coping mechanism to stressors called a "numbing effect." They use this coping mechanism so they will not be as reactive to the intense stressors that they experience on an everyday basis.

Continued on page 4...

National Census of School-Based Health Centers

The national census of school-based health centers is underway this fall. Surveys were sent to more than 1400 school-based, school-linked and mobile health care programs across the country in early November. Sponsored by the National Assembly with support from the federal Maternal and Child Health Bureau, the biennial census event is the only national data collection of its kind. School-based health centers will be reporting on community and student population demographics, operation policies, staffing and services profiles, and quality assurance and evaluation activities. Thanks to all the program administrators and clinicians who have already made their census contribution.

If you haven't received a survey, please contact Deborah Hicks at the National Assembly office. If you did receive a survey and it's still on your desk, PLEASE take a few moments to complete it — and avoid the harassing phone calls!

School Health Policies and Programs Study 2000

The School Health Policies and Programs Study (SHPPS 2000) has been released. The study, sponsored by the Centers for Disease Control and Prevention (CDC), provides data about school health policies and programs at the state, district, school, and classroom levels nationwide. All 50 states, including the District of Columbia, participated. This study evaluated characteristics of the following eight components of school health programs:

- Health education
- Physical education and activity
- Health services
- Mental health and social services
- Food service
- School policy and environment
- Faculty and staff health promotion
- Family and community involvement

The full report was published in the Journal of School Health, Volume 71, Number 7, September 2001. In addition, more information about SHPPS 2000 is posted on the SHPPS web site at www.cdc.gov/nccdphp/dash/shpps/.

new staff

Joining the National Assembly staff recently are Deidre Washington, Program Associate and Deborah Hicks, Administrative Assistant.

Deidre Washington earned a bachelor of science degree at Howard University and a master of public health degree with a focus on disease prevention and health promotion at George Washington University. Prior to attending graduate school, Deidre served as Youth Program Coordinator for North Carolina Occupational Safety and Health Project.

Deborah Hicks comes to the National Assembly with several years of administrative experience. Deborah will assist with both membership and administrative duties.

From the President

Gail Gall

Last week I went to Salem, a city known more for its witch trials than its proud heritage of clipper ships, to view an exhibit by photographer Kenro Izo entitled: "Sacred Places". In a lifetime of work, Izo has produced only 2000 black and white images from such haunting locations as Ankor Wat, Easter Island, and Petral. The sanctity of these locations emanates from the investment of the people who have dwelt there, attributing spirituality to the physical beauty of place, and building their own structures to mark their reverence. I have my own Sacred Places, some stored in photographic images like Copan or Mesa Verde, a handful of stones from atop an Alp, a jar of water from Seal Cove, Maine. These have meaning to me and when I close my eyes I smell salt, open myself to the silence, and pull the fog around me seeking in its mystery, safety. After all that has happened this month, the refuge of Sacred Places seems threatened: for surely the twin towers of the World Trade Center, the Pentagon, and the sleek jets have all been icons of modernity. Yet, turning away from those images, we can attend to the truly Sacred Places in our lives: the schools we work in; the clinics large and small, school cafeterias buzzing with cliques, and energy in ten different languages. We are faced with the never-ending press to interpret life's everyday as well as catastropic events to the students in ways to ensure their health and successs. So, our work continues. I know that you are hearing and telling stories, and saving them for sharing with your colleagues. The stories that you tell will be the exhibit of your work.

Since June, the staff and leaders of NASBHC have been working energetically to carry forward the work begun last year. In this issue, you will find reports of the progress of each of NASBHC's newly formed Centers. From lobbying on the Hill and in local districts, to carrying forward the Preventive Services Initiative, to creating partnerships with agencies interested in supporting our mission to nurture school based health care, activity has been constant. Many of you have been included in this process. There is much to be done. The political atmosphere has changed from focusing on domestic issues such as health care and education to war, internal safety, and recovery from disaster. Loss of jobs will mean loss of health insurance, yet children and youth will still need our services, perhaps more than ever if traditional safety nets, both fiscal, and otherwise shrink. Advocating for supportive policies, using strong evaluations to inform that process, and creating the tools to enhance your daily efforts are all on the front burner. Meanwhile, I hope for the preservation of each of your Sacred Places and for the care, creativity and commitment your bring to your work to blossom.

Gail B. Gall
Beverly, MA

POLICY news

Congressional update

The US Senate Health, Education, Labor and Pensions Committee passed the Health Care Safety Net Amendments of 2001 in August. Among the amendments to the Public Health Services Act, which authorizes the National Health Services Corps and the community, migrant and health care for the homeless programs, is a new section (Sec. 102) entitled "School-Based Health Center Networks." Senator Chris Dodd (CT) offered the amendment to provide federal support to establish statewide technical assistance centers for school-based health centers. Use of funds is defined as: coordination of federal, state and local health care services that contribute to delivery of school-based health centers; administrative support for state networks to maximize effectiveness; and technical support and training on assessment, accountability and financing issues. The bill will go to the full Senate soon. The House has yet to finalize a companion bill.

Senator Dodd, his staff, and school-based health center advocates worked tirelessly to educate Committee members about the legislation and its importance to the long-term sustainability of school-based health centers. It is a great demonstration of the power of personal connection between our elected officials and SBHCs. Special thanks to Maryland, Rhode Island, Connecticut and Massachusetts advocates whose outreach to their Congressional representatives was rewarded with enthusiastic endorsement of school-based health centers by their Senate leaders.

There is much to be done to see this legislation through to its final passage. Senate and House members must hear from you. Our message: Section 102 "School-Based Health Center Networks" must be retained in the Senate's final version of the Health Care Safety Net bill, and House Energy and Commerce Subcommittee on Health should be encouraged to include similar language in their bill. Committee leaders **Billy Tauzin** (R-Louisiana), **Michael Bilirakis** (R-Florida), **John Dingell** (D-MI) and **Sherrod Brown** (D-OH) will be most critical. For more information on how to contact Congress (including sample letters), visit the NASBHC advocacy and public policy web site.

call for LEADERSHIP

Looking to extend your already overextended workload? Plate not full enough? Vision and energy to spare? Can't get enough of conference calls? The Nominations Committee wants you! National Assembly executive leaders are bright, enthusiastic, energetic, and committed to the national mission. If this describes you or someone you know, please contact the National Assembly office to be considered for the slate of officers. This year the slate includes the following positions:

- **President-Elect:** This person will serve for three years (first year as President-Elect, second year as President, and third year as Immediate Past President) on the Board of Directors and provide leadership to assist the National Assembly in reaching its stated goals and objectives. This person must possess qualities that will enhance the mission and public position of the National Assembly.
- **Member-at-Large:** This is a three-year Board position with specific duties as assigned by the President or decided by the Board of Directors. In 2002, the National Assembly will be electing three individuals to members-at-large positions.
- **Nominations Committee:** One member to serve a two-year term.

To place your name or the name of a member in nomination for one of the above positions, send contact information to Nominations Committee, c/o NASBHC. For additional information, contact committee chair Sue Catchings at 225-355-7022 or by e-mail at serenitysu@aol.com.

NASBHC launches Advocacy and Public Policy web site

The National Assembly is pleased to announce its new Advocacy and Public Policy web site, which features news articles, publication materials, resources and tools on topics related to SBHC finance, advocacy and communications. The web site is divided into: Congressional Affairs, State Government Relations, Finance (including Medicaid), Standards, and Communications.

POLICY news

New Resources

The role of Medicaid's Early, Periodic Screening, Diagnosis and Treatment program (EPSDT) in meeting children's health care needs is the subject of two national assessments published in the last year.

The United State General Accounting Office (GAO), in a July 2001 report to Congress entitled *Medicaid: Stronger Efforts Needed to Ensure Children's Access to Health Screening Services*, concluded that EPSDT data are unreliable and incomplete, and inadequate for gauging the success of the program. The GAO's recommendations for executive action are "to strengthen the federal role in ensuring the delivery of EPSDT services and to bring greater visibility to ways that states can better serve children in Medicaid." The GAO recommends that the Administrator of CMS:

- work with states to develop criteria and time frames for consistently assessing and improving EPSDT reporting and the provision of services, including requiring that states develop improvement plans as appropriate for achieving the EPSDT goal of providing health services to children in Medicaid; and
- develop a mechanism for sharing information among states on successful state, plan, and provider practices for reaching children in Medicaid.

For a full copy of the report, http://www.gao.gov/new.items/d01749.pdf

The Center for Health Services Research and Policy at the George Washington University reported findings from a study of EPSDT that would "provide HCFA with sufficient data on State Medicaid programs and Medicaid managed care contracts to allow the Agency to estimate the costs associated with EPSDT that are over and above what Medicaid costs for children would be in the absence of the enhanced EPSDT service benefit." The report, *Federal EPSDT coverage policy: An analysis of state Medicaid plans and state Medicaid managed care contracts*, concludes with the authors policy implications and conclusions:

- The cost impact of EPSDT is derived from the broader classes of benefits specified under EPSDT requirements, greater amount duration and scope standards, and a preventive pediatric medical necessity standard.
- Ambiguities in State Medicaid Plans regarding precise distinctions between federal EPSDT standards and state plan coverage levels make determining EPSDT impact for any particular state virtually impossible when the state plan is used as the unit of analysis.
- States routinely hold MCO contractors to the full range of §1905(a) service obligations, but do not explain what this means and may not require contractors to provide explanations to families.
- Pediatric medical necessity standards are not always articulated in state contracts with Medicaid MCOs.
- States retain the authority to override coverage determination by MCOs, but it is not known from the methodology used in this study if such authority is exercised, the types of cases in which such an override is required, or whether override authority is exercised for services that would be covered even under conventional insurance or only through the unique requirements of the Medicaid program.
- It is not clear if families and providers in Medicaid managed care are apprised of broader EPSDT coverage.

For a copy of the executive summary:
http://gwis.circ.gwu.edu/~chsrp/epsdt/exsum.pdf

Clinical Institutes for School-Based Health Clinicians

Federal and national partners are joining forces to establish a series of clinical institutes designed to provide training for SBHC staff. Each regional meeting will provide two days of clinical training for SBHC staff in four specialized content areas: HIV/STD's risk assessment and intervention; comprehensive risk assessment and intervention strategies; mental health screening and substance abuse; and asthma. Meeting dates are: Washington, DC (January 28-29, 2002); Dallas, TX (February 25-26, 2002); San Francisco, CA (March 25-26, 2002);Boston, MA (April 8-9, 2002) Chicago, IL (April 29-30, 2002)

The Clinical Institutes are a collaborative effort among the following government and private entities:
Health Resources and Services Administration (HRSA), Bureau of Primary Health Care Center for School Based Health , Environmental Protection Agency Office of Air and Radiation , Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Prevention, National Association of Community Health Centers, the National Assembly on School-Based Health Care, and HRSA's Maternal and Child Health Bureau.

Additional information and online registration will soon be available at www.clinicalmeetings.com. For further information, please contact the HSHC Helpline at (888) 889-6177 or send an e-mail to skerin@jwallc.com.

SBHCs Explore FQHC Status

Many SBHCs are affiliated with our nation's extensive network of federally supported community health centers (also known as "330 clinics" named for the section of the federal Public Health Services Act that created FQHCs). The FQHC designation carries with it entitlements that many health centers find advantageous when operating school-based services, including access to providers through the National Health Service Corps, discounted vaccinations, and most importantly, enhanced Medicaid payment rates through the FQHC's prospective payment system. "There is perhaps an even more important advantage," said Darryl Burnett, deputy director of the federal Bureau of Primary Health Care's (BPHC) Center for School Health. "As the president seeks to expand the number of health care access points through federally qualified health centers, school-based health centers would be well positioned to help meet this national goal." With federal grant funds for FQHCs on the increase, school-based health centers that can meet federal requirements may be competitive as new access points.

Recently the Illinois Primary Health Care Association (IPHCA), with a grant from BPHC, proposed to assess the feasibility of converting a number of SBHCs not already FQHC affiliated into "FQHC-look-alikes." For school-based health centers that could meet the federal standards, the designation might mean greater financial viability through Medicaid reimbursement. According to Shelly Duncan, Vice President for Community Health Services for IPHCA, the project's principle players, including IPHCA, the Illinois Coalition for School Health Centers and the state department of human services, recognized the potential fit for SBHCs as FQHC-look-alikes. The school-based health care mission to serve low income students with comprehensive primary care and preventive services is directly aligned with FQHC standards.

For Illinois school-based health center program administrators, the idea of converting to a federally recognized provider type — with all its financial benefits — had great appeal. Four SBHCs voluntarily participated in the pilot effort. Two of the four programs spoke with the National Assembly and admitted that long-term sustainability was the key motivation: "We just can't be sure how long we'll be able to rely on state public health grants," recalled Kathy Swartwout of Evanston Township High School Health Center.

A side-by-side analysis of Illinois school-based health center standards and FQHC requirements revealed a close match. A few key certification requirements that did not line up, however, proved to challenge the conversion pilot project. The two biggest stumbling blocks right out of the gate were health center governance and billing requirements. If FQHCs are to be governed independently and by a board comprising 51% of "active users," would relationships with current sponsors and partners have to be severed? "Our partners – the local hospital, school district and health department – were very satisfied with their role in sponsoring the school-based health center and were reluctant to give up that relationship," said Swartwout. The idea of a consumer board of directors was viewed as problematic by the Rock Island School Health Link Incorporated: "How does a program whose active users are kids set up a governance structure of kids?" asked Sally O'Donnell.

It is a difficult hurdle, agrees IPHCA's Duncan. "Developing an independent governing board is a big step for school-based health centers that have had management relationships with community partners," says Duncan, "but they must be their own entity." Duncan suggests however that the FQHC conversion process does not necessitate parting company with former partners. For example, the SBHC could have a management services contract with the hospital or health department to continue to provide administrative functions. As for establishing consumer-based boards, parents of users could serve as consumer representatives, suggested Burnett.

The Evanston and Rock Island sites have raised concerns about requirements to bill for all services. With limited-to-no billing and collection experience, the program representatives felt that the demands of billing all payers would require additional administrative resources and alter a policy of free access for all students. "We are committed to our mission of providing care to everyone who comes through the center doors, regardless of their ability to pay," said O'Donnell. How would setting up a billing system alter that mission, they wondered? This too has been a major shift for the school-based health centers, admits Duncan: "The school-based health centers we've been working with have been reluctant to bill, either because they haven't needed to or they didn't see it as consistent with their mission. To create these systems after years of conducting business without them represents a sea change."

The Illinois pilot project, even in its early stages, is providing a valuable lesson to the field: sustainable resources aren't going to come without a commitment to developing a business approach to long-term financing. But can successful business planning be achieved without compromising mission? The Illinois partners are committed to working out the kinks and keeping the integrity of the school-based model. And many will be watching closely to gauge the effectiveness of this approach to sustainability.

For more information about FQHC qualifications, visit the Bureau of Primary Health Care's web site: http://bphc.hrsa.gov/

SBHCs Face National Crisis (continued from cover)...

They are likely affected on a subconscious level, but may not be visibly apparent to them. We may see reactions several weeks after the disaster as a result of the accumulated stress on the student in the form of increased aggression and anger, depression and being more easily agitated.

What tools do you think school-based health centers need in order to deal with this type of crisis in the future?

BS: We don't know the extent of the emotional impact the attacks are going to have on our students, although they are likely to be continually affected through loss of family jobs, family members serving in the military, and the possibility of additional terrorist attacks. We must think in terms of how we as providers deal with this and other crises while helping our students through it. This is a clarion call for the development of more resources for the school staff and continued efforts on our behalf to work with education partners. We can offer to lead the way with more activities that give us all a chance to become more human. On 9-11 people went beyond what they thought they were capable of and we all experienced a need to express our humanness – an experience that transcended race and class. It stretched us all to go beyond ourselves. The question needs to be: how can we support people to continue to go beyond themselves, as they did that day and for a few days afterward? What approaches or strategies can we develop to sustain our sense of community? The SBHC can be a catalyst for that discussion and can lead in developing a response. This is a critical time for the mental health providers to be addressing these issues.

OA: The best tool is a well honed partnership with the school and community mental health organizations so that the full breadth of needs – from prevention through recognition of warning signs to referrals for services for young people acutely affected – can be met in a timely and effective manner.

After Disaster: What Teens Can Do

- Whether or not you were directly affected by a disaster or violent event, it is normal to feel anxious about your own safety, to picture the event in your own mind, and to wonder how you would react in an emergency.
- People react in different ways to trauma. Some become irritable or depressed, others lose sleep or have nightmares, others deny their feelings or simply "blank out" the troubling event.
- While it may feel better to pretend the event did not happen, in the long run it is best to be honest about your feelings and to allow yourself to acknowledge the sense of loss and uncertainty.
- It is important to realize that, while things may seem off balance for a while, your life will return to normal.
- It is important to talk with someone about your sorrow, anger, and other emotions, even though it may be difficult to get started.
- You may feel most comfortable talking about your feelings with a teacher, counselor, or church leader. The important thing is that you have someone you trust to confide in about your thoughts and feelings.
- It is common to want to strike back at people who have caused great pain. This desire comes from our outrage for the innocent victims. We must understand, though, that it is futile to respond with more violence. Nothing good is accomplished by hateful language or actions.
- While you will always remember the event, the painful feelings will decrease over time, and you will come to understand that, in learning to cope with tragedy, you have become stronger, more adaptable, and more self-reliant.

From: Project Heartland — A Project of the Oklahoma Department of Mental Health and Substance Abuse Services in response to the 1995 bombing of the Murrah Federal Building in Oklahoma City.
http://www.mentalhealth.org/publications/allpubs/KEN-01-0091default.asp

Tips for Helping Children Cope

- Encourage children to say how they are feeling about the event.
- Ask children what they have seen, heard or experienced.
- Assure children that their parents are taking care of them and will continue to help them deal with anything that makes them feel afraid.
- Help children recognize when they have shown courage in meeting a new scary situation and accomplished a goal despite hardship or barriers. Instill a sense of empowerment.
- Let children know that institutions of democracy are still in place and our government is intact. (It can also be helpful for adults to realize this.)
- Know that it is possible for children to experience vicariously the traumatization from the terrorist attack (e.g. watching TV coverage, overhearing adult conversations).

From: *Coping with Terrorism,* The American Psychological Association
http://helping.apa.org/daily/terrorism.html

SBHC and Ground Zero: Counselor Deals with Students Who Lost Parents

Mary Barrett, nurse practitioner, Norwalk High School Based Health Center, Norwalk CT

How well we know the events of 9-11. Two students at Norwalk High School have fathers missing in the rubble. At this writing, three weeks after the disaster, both students continue to hold out hope that each of their fathers will be the one improbable miracle and will be rescued, wounded but alive. There is always hope, we say, but at what point in our provision of health care do we encourage the dismissal of hope and the acceptance of the probable reality. We all are brutally aware of the reality of the situation and the pain and human reaction this implies. There is a fine line between hope and probable outcome. How does one fairly deal with this situation, with so many pained survivors?

I will not disclose names, but will refer to one of the students as "she".

The entire student body is watching TV in individual classes as the facts of the horror unfold. She hears that the World Trade Center has been attacked. Her father works on the 104th floor, she screams, running out of the classroom. She has already mentally processed that her father is in danger – she will hope for the best – her father was the best. She will take care of her mother and younger siblings…he was a great Dad…she can't believe that he is really gone…he's a strong person, somehow he'll make is out…what if he doesn't – she disagreed with him last night…what if she can never apologize…how do you go on while dealing with the unknown? QUESTION: How do I answer unanswerable questions without removing hope? ANSWER: I offer myself to be there when she begins to comprehend the horrible reality. I offer my availability to be a phone call away – day or night, which she grabs onto immediately. She proceeds to phone me at home in the evening simply to touch base and to have her fears/concerns/coping mechanisms listened to.

She is absent from school, but comes to see me in the SBHC to be heard, validated and held. She is suffering, slowly, a prominent loss in her life – one that she protectively does not want to burden her mother with. After all, she is the oldest, most mature and responsible and therefore should not break, but rather hold her emotions in check so as to be supportive of her younger siblings. (Has this young girl of 17 been able to express her reaction and fears or has she been thrust into the role of caregiver of younger siblings and sorrowing spouse?)

She is a Senior and will graduate in June. Can she hold herself up, continue to progress and succeed academically? I believe that with support she will be able to do so, maybe even better than anticipated.

She expresses that she wants to make her Dad proud, no matter what the outcome. She feels that, no matter what, he will always be there for her and I deeply support that. My father died suddenly when I was 13 and I have always sensed his support and presence in my life. She will be asked to assume a major support role in the family, but I remind her that she is still a child and need not become an adult overnight.

She asks that I be a liaison between her and the school so that class assignments will be received and accomplished in an appropriate amount of time. She does not feel ready to return to school but does not want to jeopardize her status during her senior year. Her future goals include college – unknown major at this point. Her guidance counselor has agreed to work with me to achieve these goals.

A major complaint from her is that she is now approached by people who, in the past, have not "given her the time of day." Suddenly they want to be involved in her tragic life. She takes great offense at this. She is relying on a narrow source of confidants.

She trusts me because in the past we have dealt with other tragic and personality altering events. This girl's adolescence has already been scarred and she now suffers a great insult to her American humanity.

Funding $ Finance

Federal Funds for SBHC Planning Awarded

BPHC announced in October the distribution of its first ever Healthy Schools, Healthy Communities capacity development grant awards. The grant awards, totaling $639,000, were dispersed through a competitive application process. Thirteen communities successfully competed among 36 applicants for the federal planning dollars. Activities supported by the grant program include: developing community, State and local government partners; establishing commitments from other health care entities, host school and school district; planning for the establishment of services and compliance with Federally Qualified Health Center governance requirements; conducting an in-depth assessment of community assets; defining the components/standards of care; and identifying, establishing and strengthening clinical, administrative, managerial and management information system structures.

FY 2001 Healthy Schools/Healthy Communities Capacity Development Grants

Organization	City	State	Award
Sun Life Family Health Center	Casa Grande	AZ	$48,563
Family Healthcare Network	Porterville	CA	50,000
Southern Illinois Healthcare Foundation	East St. Louis	IL	50,000
Holyoke Health Center	Holyoke	MA	50,000
Ben Archer Health Center	Hatch	NM	50,000
Bedford Stuyvesant FHC	Brooklyn	NY	50,000
Brownsville Comm. Dev.	Brooklyn	NY	50,000
Open Door Family Medical Center	Ossining	NY	50,000
New Hanover CHC	Wilmington	NC	50,000
Tillamook County Health Dept	Tillamook	OR	45,037
Corporacion de Servicios de Salud	Cidra	PR	50,000
Community Health Center, Inc.	Salt Lake City	UT	50,000
Northern Greenbrier Health Clinic	Williamsburg	WV	46,300
		Total:	$639,900

The U.S. Department of Health and Human Services, Health Resources and Services Administration Grant Funding Opportunities

Oral Health Integrated Systems Development Grants

CFDA Number: 93.110AD
Purpose: The purpose of this grant is to build a service and support infrastructure at the State and community level to increase access to health services for State Children's Health Insurance program (SCHIP) and Medicaid eligible children and to develop and implement services and support systems to address the unmet oral health needs of this population.
Application availability: January 7, 2002
Program Contact Person: John Rossetti
Application Deadline: March 8, 2002
Email: jrossetti@hrsa.gov

Healthy Schools, Healthy Communities Program Competing Continuations

CFDA Number: 93.151A
Purpose: The purpose of the Healthy Schools, Healthy Communities program is to increase access to comprehensive primary and preventive health care to underserved children, adolescents and families. These grants are awarded to public and private nonprofit community-based health care entities for the development and operation of school-based health center (SBHCs).
Application Availability Date: Continuous
Application Deadline: Varies
Program Contact Person: Darryl Burnett
Email: dburnett@hrsa.gov

Rural Health Outreach Grant

CFDA Number: 93912.A
Purpose: The purpose of the Rural Health Outreach Grant is to expand access to coordinate, restrain the cost of, and improve the quality of essential health care services through the development of healthcare networks in rural areas and regions.
Application Availability Date: June 17, 2002 for FY 2003
Application Deadline: September 13, 2002
for FY 2003 competition
Program Contact Person: Lilly Smetana
Email: lsmetana@hrsa.gov

Healthy Schools, Healthy Communities Planning and Capacity Development Grants

CFDA Number: 93.151AB
Purpose: The purpose of this grant is to support communities and health care service entities through the planning process, to develop full service school-based health centers which will offer comprehensive primary and preventive health care, including mental and oral health services.
Application availability: January 1, 2002
Application Deadline: March 20, 2002
Program Contact Person: LaVerne Green
Email: lgreen@hrsa.gov

FOCUS ON States

CA SBHCs Host Legislative Site Visit

A delegation of staff from the California State Assembly toured school-based health centers in the Los Angeles area to learn about the state's more than 130 school-based health centers. A follow up meeting with state executive and legislative leaders was convened with the California Assembly to discuss site visit findings and implications for state support. Because the state historically has not funded SBHCs, advocates are hopeful that these meetings will result in state-owned long-term financing solutions for the health centers.

LA Legislature Increases Appropriation

This past legislative session, the Louisiana Legislature increased SBHC appropriations by $800,000 million, enabling the expansion of new sites in five parishes (counties), bringing the number of state-supported SBHCs to 53.

BPHC Announces New Access Points Funding

The federal Bureau of Primary Health Care (BPHC) announced availability of funding to support new access points for the delivery of primary health care services for the underserved. BPHC anticipates being able to accept applications from organizations seeking operational support for new health center access points under the Consolidated Health Center Programs (Community Health Center (CHC), Migrant Health Center (MHC), Health Care for the Homeless (HCH), Public Housing Primary Care (PHPC) and *Healthy Schools, Healthy Communities* (HSHC) Programs) authorized under section 330 of the Public Health Service Act.

In FY 2002, the BPHC will accept applications throughout the year and will conduct three funding reviews. The BPHC will target support for new health center access points to those that demonstrate a high level of need in their community, present a sound proposal to meet this need and show that they are ready to rapidly initiate this proposal. In addition, the BPHC will target support to those health centers that can demonstrate responsiveness to their health care environment and that have established collaborative and coordinated delivery systems for the provision of health care to the underserved in their communities.

To review grant applications requirements, visit the Bureau's web site and locate Policy Information Notice (PIN) 2001-18 ftp://ftp.hrsa.gov/bphc/docs/2001pins/

Statewide Initiative for Documenting Outcomes of School-Based Health Centers

Bonnie Gance-Cleveland, Debbie Costin, Julie Degenstein, Deb Crennan, Rhonda Johnston, Connie Boyle

School-based health centers (SBHCs) have been proposed as an effective delivery system for improving access to health care for vulnerable youth. Colorado has 53 school-based health center sites that have developed over the past twenty years. A statewide collaborative effort to determine the outcomes of care provided at the SBHCs was initiated to define and assure an optimal level of services provided at SBHCs, foster a degree of consistency among SBHCs, and strengthen SBHCs ability to contract with managed care organizations and other third party payers, and provide documentation to meet accreditation standards. The statewide initiative to document the quality of care and outcomes of SBHCs in Colorado was established in 1997 through the Colorado Association for School-Based Health Care (CASBHC). CASBHC evaluated the following outcomes of care: immunization status, well child and adolescent examinations, quality of medical record, evaluation of tobacco exposure, and patient satisfaction. A retrospective chart review was conducted on 25 randomly selected charts at 20 SBHC across Colorado during the fall of 1998. The following outcomes were found :

- **Childhood Immunizations:** SBHCs scored above the target compliance in Measles-Mumps-Rubella. However, they score significantly below target in Hepatitis B and Varicella.
- **Adolescent Immunizations:** SBHCs scored significantly below the target compliance in Hepatitis and Varicella immunizations.
- **Well Child and Adolescent Examinations:** SBHCs scored above the target compliance for well child care visits for adolescents 13 and older.
- **Medical Records:** SBHCs scored above 80 percent compliance in all areas except for tobacco.
- **Tobacco Exposure Assessment:** SBHCs scored significantly below target compliance among children ages 6-13.
- **Patient Satisfaction:** Eighty percent of SBHCs received grades of either A or B for all six domains of patient care satisfaction.

FOCUS ON research

Zimmer-Gembeck, MJ, Doyle, LS, Daniels, JA, Contraceptive Dispensing and Selection in School-Based Health Centers, Journal of Adolescent Health, 2001; 29:177-185, 2001.

Since delay in seeking family planning services has been linked to increased rates of unintended pregnancy among adolescents, the authors studied whether on-site dispensing of hormonal contraceptives in SBHCs can affect adolescent's use of contraceptives. Two cohorts of females were compared. The first cohort received family planning services in SBHCs in a school year before initiation of on-site contraceptive dispensing in SBHCs. The second cohort received family planning services in the same SBHCs two years later when contraceptives could be dispensed. The study included six high schools SBHCs. The authors found that among females who received more than one family planning visit at the SBHC and chose hormonal contraceptives, that on site dispensing was associated with earlier selection and consistent use. These findings held true for a subset of the population studied, however about 20% of the females studied sought family care and never selected hormonal contraceptives and another subset about 18% of the females had only one family planning visit. The authors suggest that these groups need further examination to identify and address barriers to hormonal contraceptive care.

Britto, MT, Klostermann, BK, Bonny, AE, Altum, SA and Hornung, RW, Impact of a School-based Intervention on Access to Healthcare for Underserved Youth, Journal of Adolescent Health, 2001;29:116-124.

The authors studied whether a multidimensional school based intervention including physical and behavioral health services would increase adolescent use of medical care, preventive care and decrease emergency room usage. A total of 2832 7th-12th-grade students in six public urban schools and 2036 students in six demographically matched comparison schools participated in the study. Participants completed a health status and healthcare utilization questionnaire. The authors examined the association between intervention status and outcomes in year one and year two. Over 45% of students in both groups reported not seeking medical care they believed they needed. Over the course of the study the proportion with missed care in the intervention schools did not change however the students in the comparison school reported an increase in missed care. Emergency room use decreased slightly in the intervention school and increased slightly in the comparison group. Study results confirm that many adolescents have unmet health care needs and those with poor health status are most likely to report under utilization and unmet health care needs. The authors suggest that the finding underscore the need for comparison groups when evaluating interventions and advise the need for better understanding of community level changes in perceived health care access and use.

Russell, ST, Joyner, KJ, Adolescent Sexual Orientation and Suicide Risk: Evidence From a National Study, American Journal of Public Health, August 2001, Vol 91, No. 8 1276-1280.

The authors studied the link between sexual orientation and suicidality using data from the National Longitudinal Study of Adolescent Health. The sample included 6,254 adolescent girls and 5,686 adolescent boys. Other suicide risk factors were taken into account including depression, hopelessness, alcohol abuse, recent suicide attempts by a peer or family member, and experiences of victimization. The authors found a strong link between adolescent sexual orientation and suicidal thoughts and behaviors.

Berti, LC, Zylbert, S, Rolnitzly, L, Comparison of Health Status of Children Using a School-based Health Center for Comprehensive Care, Journal of Pediatric Health Care, 2001, Vol 15, No 5, 244-250.

The authors compared health problems and medical coverage of homeless and housed children who used a SBHC for comprehensive care. Authors reviewed medical records of 76 homeless children and 232 housed children who were seen for comprehensive care at a SBHC in New York City. Homeless children were 2.5 times as likely to have health problems and 3 times as likely to have severe health problems as housed children. The most common problems identified in the homeless population included: asthma 33%, vision 13%, mental health 9%, and acute problems 8%. Fifty eight percent (58%) of homeless children lacked medical coverage compared with 15% of the housed population. The authors assert that these finding support the use of SBHCs for comprehensive care by under-served populations and the need for increased vigilance on the part of health care providers in caring for homeless children.

Miller, KS and Whittaker, DJ, Predictor of Mother Adolescent Discussions About Condoms: Implications for Providers who Serve youth, Pediatrics, August 2001, Vol. 108, No. 2.

The authors interviewed 907 mothers of adolescents aged 14-17 years in the Bronx, New York, Montgomery, Alabama, and San Juan, Puerto Rico to determine if the mothers had talked to their adolescents about condoms. The authors found that mothers who spoke to their adolescents about condoms had greater knowledge about sexuality and AIDS; were perceived as having enough information to talk about condoms; received information from a health related source; expressed less conservative attitudes about adolescent sexuality; had the perception that the adolescent was at risk for HIV; expressed greater ability and comfort in discussing condoms; exhibited stronger belief that condoms prevent HIV infection/AIDs; and had a more favorable endorsement of condoms. The authors concluded that parents who communicate effectively about sexuality and safer sex behaviors could influence their adolescent risk-taking behavior. The authors urge health care providers to help facilitate this communication by providing parents information on sexual behaviors of adolescents, the risks adolescents encounter, condom use, condom effectiveness, and how to talk about condoms.

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National Needs Assessment

NASBHC is conducting a national assessment of the needs and resources of the staff that work in school-based and school-linked health centers. We urge every staff member to complete a separate survey describing their individual needs for information, training, and resources. In addition we would like you to let us know about specific resources, materials, and/or expertise that you are willing to share with your colleagues in the field. The data will be used to guide the National Assembly's technical assistance and training activities over the next two years. If you did not receive a survey, please visit NASBHC's website at www.nasbhc.org, go to what's new, download a copy, fill it out, and fax it back to us at 202/638-5879.

Presentations at State Assembly and Association Meetings

NASBHC staff John Schlitt, Laura Brey, Deidre Washington and NASBHC volunteers Linda Juszczak (NY)(past president), Sue Catchings (LA) (past president), and Jill Daniels (OR) have been busy traveling the country participating in school-based health care assembly and primary care association meetings in CA, CT, MI, NC, OH, TX, and WV. Presentation topics have covered NASBHC centers and national initiatives, NASBHC principles and performance evaluation, continuous quality improvement, the preventive services improvement initiative, CPT and ICD 9 coding, effective systems, and SBHC financing.

SBHC Operations Tool Kit

At the 2001 annual meeting in Miami, NASBHC debuted the prototype of an SBHC Operations Tool Kit on CD-rom. The tool kit contains policies, procedures, and resources for administrators, clinicians, and mental health providers that can be downloaded and personalized to individual centers. Thanks to all of you that tried out the tool kit and responded to the marketing survey. Feedback from members was very positive. The final version of the SBHC Operations Tool Kit will be available in January 2002. Watch for announcements on NASBHC's and the spring edition of *Joining Hands.*

Preventive Services Improvement Initiative (PSII)

Since returning to school in the fall, the sixteen SBHCs in CA, CT, and WV have been making great progress with implementation of their site plans. Each site is taking strategic steps toward increasing the number of adolescent annual comprehensive risk assessments, biennial physical exams, and intervention/follow-up. Each state has conducted one of their two state learning sessions: WV in August, CA in October, and CT in November. CA and WV held their meeting adjunct to their state SBHC association meetings. First learning session topics included CPT and ICD coding, effective systems for intervention and follow-up, standards and quality improvement, and storyboarding successes.

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JANUARY 2002

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FEBRUARY 2002

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