

## **Polk Bros. Foundation School-Based Health Center Initiative**

**History** After supporting successful school-based health centers at Amundsen, Lakeview, and Roosevelt High Schools and Ryerson Elementary, the Board launched an initiative in 2000 designed to support as many as twelve new school-based health centers. The initiative would provide \$20,000 as a planning grant to each health center partnership, and then up to \$60,000 per year for four years of program support, for a total of roughly \$ 3.1 million over six years. The Foundation's decision to create this initiative was encouraged, in part, by the Chicago Public School's announcement that it was investing \$ 5 million into retrofitting roughly 25 schools for health centers as well as building health centers in all new schools.

**Intent** The partnerships intended to improve the health status of Chicago public school students by providing access to confidential, client-appropriate primary physical and mental health care services through school-based health centers and by promoting life-long healthy habits through health education. Although the initiative's first interest was serving adolescents through school-based centers in high schools and middle schools, we acknowledged that strong cases could also be made for school-linked centers and for serving pre-adolescent and elementary school children.

**Funding Process** We issued the first Request for Proposals in December 1999, with a Bidders' Conference in January 2000. We received eight proposals in February, which were read by the entire program staff. We held site visits with five partnerships and funded four of them in this first round. In the second round, we received five proposals and funded four. Of the Round 2 partnerships awarded in May 2001, one withdrew during the early months of the planning grant and another withdrew shortly after the planning year.

We realized, when we made the Round 2 grants, that we had probably exhausted the supply of willing partnerships for new school-based health centers for several reasons. First, it appeared that the few hospitals willing to underwrite additional uncompensated or undercompensated care were already engaged in school partnerships, and that larger community health centers, better compensated for ambulatory care than hospitals, were also committed to school partnerships. Second, there was some uncertainty about the future of federal and state grants to school health centers. Finally, the construction delays experienced by funded health centers suggested that the dollars allocated by CPS were shrinking.

All of the partnerships understood that once they received funding for the planning year, they were guaranteed four additional years of program support if their programs moved forward according to agreed-upon annual expectations. In part because there was no competition between partnerships for funding through the initiative, they were able to discuss problems and

solutions openly and honestly in the meetings we convened. At the last partnership meeting, one grantee observed, “This has been the most supportive funding experience I have ever participated in. Knowing that we had four years of funding made it possible to concentrate on and sustain good outcomes.”

**Reallocating Funds** Three years ago, when we realized that six partnerships rather than eight would receive full funding, we made available additional, one-time awards of up to \$15,000 for the purchase of equipment. Four partnerships made use of those funds to help equip a dental suite, furnish a waiting room, buy used wall dividers to create some semblance of privacy to students being seen in temporary space, and to pay rent on an already furnished clinic that was to have been available rent-free. Additionally, the Foundation provided a total of approximately \$3,500 in scholarships for staff to attend the National School-Based Health Care Conference held in Denver in June 2002. Finally, when one of the partnerships had to sever its relationship with an uncooperative partner, we provided funding for the remaining partners to hire an experienced consultant to help them restructure the relationship.

**Technical Assistance** Throughout the initiative, we have provided technical assistance to the partnerships through roundtables, trainings, and presentations, and through individual assistance with particular questions or difficulties. Our group meetings have included expert presentations on state and federal funding sources, health education, identifying and avoiding gang violence, adolescent mental health, needs of gay, lesbian, transgendered and questioning youth, and family planning. We organized a one-day training on Clinical Fusion, the information management software used by many school health centers nationwide, which is required for State of Illinois funding. The session was well attended and greatly appreciated by clinic personnel. During these gatherings, health center staff have the opportunity to learn from each other by sharing war stories, including both triumphs and failures.

**Cost/Reimbursement** Health centers located in high schools tend to cost less than those in elementary schools. On average, it takes about \$200,000 to operate a high school center and \$300,000 for lower and middle schools. Some of the variation across schools stems from school size, range of services, and funder requirements. The State of Illinois has a competitive, multi-year grants program which provides about \$100,000 per year to a limited number of schools. The federal government, through the Bureau of Primary Care, also provides funding for school health centers. Although these funding sources have been relatively stable over time, the grants are usually limited to three to five years.

Billing public and private insurers for adolescent health services is complicated. First, Medicaid requires that providers who bill Medicaid for services also bill private insurers. While Medicaid does not send Medicaid billing paperwork to those it insures, private insurers do. As a result, parents with private insurance coverage receive information about the dates, times, and scope of services their children have received. This Medicaid billing requirement risks breaching confidentiality for adolescent patients. Second, the administrative effort to bill for services for a population that is often unaware of its insurance status often exceeds the reimbursement. Finally, community health centers are required by the federal government to bill on a sliding scale, which means that students are asked to pay some nominal fee for services although no one is ever denied services.

**Program Success and Accomplishment** To enroll at the centers and access services, students must have consent forms, signed by parents or guardians, on file. Most centers have achieved high enrollment rates, between 70-90% of their student populations, and reached these rates within two to three years. In the elementary and middle schools, about 90% of the children with signed consent forms use services within a given year. These younger students average five visits per year. At the high school level, about 70% of those enrolled use clinical services, averaging slightly less than three visits per year.

*In this last year, the six-school initiative provided 8,977 primary care visits and 2,365 mental health visits to 3,619 students. These students represent 60% of the approximately 6,000 students attending the six partnership schools. Students gained easy access to mental health services, difficult for them to find on the outside and even more difficult to manage. They found quick appointments for the immunizations and sports physicals requisite to participating in school and after-school activities. Students received family planning services in a center where their mothers and grandmothers were not going to show up in the waiting room. Finally, students with serious conditions received referrals to specialty care and assistance in utilizing those referrals.*

Energetic, imaginative staff have assumed pivotal roles within the schools. They have organized

- a skill-building retreat for 7<sup>th</sup>-8<sup>th</sup> grade girls, intended to give them confidence to resist a culture of academic failure and early sexual experimentation
- a weekly exercise and nutrition class at the local park district field house
- asthma management training
- health education classes
- nutrition programs in the middle school
- “safe prom” packages in the high schools.

Staff attended report card pick-up sessions and freshman orientation to spread the word about the centers and to encourage parents to sign consent forms. Staff worked with parents, students, and school staff to conduct needs assessments and organize advisory councils. Staff spent time with school staff, explaining the ways in which the health center supported the school’s work while reminding them that health center records were confidential and not available to staff.

One center received Title X Family Planning status, the first school-based health center in the state to be so designated. This provides better reimbursement for the center and better prescription coverage for the students. Another center found funding to install a full dental suite. All of the centers work with parents on obtaining KidCare coverage, a State of Illinois program that provides health insurance, including assistance towards premiums for employer-based insurance, for children and families whose incomes exceed the cut-off for Medicaid.

As we had anticipated, mental health services have been utilized to capacity. PBF has encouraged the centers to provide these services by requesting that the grants be used to pay for mental health services (along with dental and health education). At most health centers,

soundproof consult rooms and available providers, not student demand, have set the limit on mental health utilization.

**Advice from the Partners** Despite the seeming disappearance of the CPS allocation for build-outs before all 25 schools had new health centers, four of the six centers are housed in new, well-constructed and reasonably well-designed space. One center director, when asked about lessons learned, noted the importance of “keeping your hands and eyes on the buildout the whole time. CPS architects know about designing schools, not health centers.” Two centers, working at capacity, remain in temporary space; the space constrains the volume and variety of services they can provide. The director of one of these centers, only slightly daunted, observed, “With vision, even temporary space can work for you, although it may limit what you do.”

Other hard-won advice included making sure that

- each member of the partnership knew and accepted his or her responsibilities,
- the school understood that the health center serves students and not staff,
- co-pay policies be set when the center opened rather than at some later point,
- enrollment and consent forms were simple,
- staff enthusiasm and parental support remained unwavering.

The executive director of a social service agency, and the lead in one of the partnerships, said last year, “This is not an enterprise for the faint of heart. It requires imagination, tenacity, and a good-humored response to the absurd.”

**Summary** After we discussed the final reports and wrote to each partnership, we ended each letter with the following: “As we reviewed all of the year-end reports, we were struck by the effort each center has made to be a positive presence and participant in the larger school community. You have found resources within the centers to benefit your schools, such as the intervention developed by the social worker at one school to assist a teacher who could not maintain control in her classroom and the free five-minute massages that another health center made available to teachers during a conference day. In addition, you have found resources outside the school to cover services that are not ordinarily provided by school-based health centers, such as eyeglasses and pharmaceuticals. Your efforts make us proud of the school-based health center initiative. Thank you for your good work.”