Realizing the Potential of School-Based Health Centers:

A Research Brief and Implementation Guide

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Introduction

Around the country, children and youth in low-income neighborhoods face significant health risks and challenges accessing health care. In 2017, 18% of children lived in poverty and 52% of public school children were eligible for free or reduced-price lunch.[1,2] Youth in poverty and uninsured youth are less likely to have a routine place for preventive care and less likely to have had a well-child visit in the past year.[3] Chronic conditions and special health care needs are more common among children in poverty, children of color, and children on public health insurance.[4] [5] Low-income families are also more likely to live in low-quality housing, which is associated with exposure to mold, lead, and other adverse conditions that can increase health risks.[6] These health and economic disparities are being further exacerbated by the coronavirus pandemic.

Unaddressed health needs impact students' ability to learn and participate in school.[7] Students with chronic health conditions are more likely to miss school due to the symptoms of their illness or to medical treatment during the school day—asthma in particular is the leading cause of chronic absenteeism. Students may also become chronically absent if they frequently miss school due to mental, oral, and behavioral health issues or due to acute illnesses such as the flu. School-based health services, often delivered by a school nurse, can help manage students' health needs during the school day. School-based health centers (SBHCs) are a specific type of school-based health service, often delivered by a physician, that can provide comprehensive medical care, referrals, and serve as a medical home. SBHCs bring together health and education sectors to improve students' academic and health outcomes and provide needed services to the community.

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The Education Redesign Lab (EdRedesign) produced a two-part research brief series in order to explore the role of SBHCs in the U.S. education system and uncover their potential to promote children's health and wellbeing. EdRedesign aims to expand access for children, particularly those affected by poverty and systemic racism, to important health and other vital services by partnering with mayors, superintendents, and community leaders to build stronger systems of supports and opportunities. This first brief introduces SBHCs and examines their key characteristics and impact on student outcomes. It then analyzes relevant federal and state policies and their implications for SBHCs, in addition to spotlighting select state and local policies related to school-based health services. The document also

includes an implementation guide outlining the necessary steps and decisions to consider for those interested in establishing a SBHC in their school or district. The second brief explores how the coronavirus pandemic is affecting SBHCs with a look at key policy changes. It also highlights two different SBHC approaches, observing both challenges and opportunities for students and families accessing health care services in the midst of the global pandemic.

What are School-Based Health Centers and What is Their Impact?

School-based health centers (SBHCs) are primary care centers affiliated with one or more schools that provide medical, and often mental health, services to students and community members. The first SBHCs were established in the late 1960s and early 1970s as the War on Poverty led to the introduction of Medicaid and drew attention to the medical needs of school-aged children living in poverty. Since then, SBHCs have expanded to schools around the country. During the 2016-17 school year, there were 2,584 SBHCs in 48 states, D.C., and Puerto Rico, more than double the number in 1998.[8]

Who do SBHCs Serve?

SBHCs predominantly serve low-income students and students of color. Many SBHCs also serve the broader community. According to the School-Based Health Alliance, over 60% of SBHCs serve individuals who aren't students enrolled at the school where the center is based, including faculty or school personnel, families of student users, students enrolled at other schools, and out of school youth, among others.[9] Schools with SBHC access have higher percentages of students who are black, Hispanic, and eligible for free and reduced-price lunch than the national average for public schools; nearly half (46%) of SBHCs are in urban settings, and over a third (35%) are in rural settings.[10]

What Services do SBHCs Offer?

All SBHCs provide primary care services by definition, with most offering additional services through a variety of delivery models. During the 2016-17 academic year, 65% provided behavioral health services and 41% had an expanded care team, which offers at least one of the following, in addition to primary care and behavioral health services: oral health services, vision care, nutrition services, or other health coordinators.[11] In some states, SBHCs may provide reproductive health services, though this practice is often controversial.[12]

The most common delivery model is a co-located center that is physically located at a school; these account for approximately 80% of all SBHCs. Telehealth-exclusive SBHCs, which deliver primary care services remotely, have become increasingly common in the last several years and now comprise 11.5% of all centers. The growth of SBHCs in rural areas is related to the adoption of this approach. Telehealth delivery is becoming more widely used in the wake of the coronavirus pandemic. Two other SBHC delivery models are far less common. School-linked models, which have a fixed site near a school, and

mobile models, where a van parks on or near a school, comprise 3% and 4% of SBHCs, respectively. This brief will focus on the establishment and implementation of co-located SBHCs.

How do SBHCs Benefit Students?

Research on SBHCs primarily documents their impact on student health and academic outcomes. Currently, the evidence base is strongest for health outcomes, which are often easier to measure. However, there is emerging evidence for improved academic outcomes as well.

There is a large and growing research base documenting the effects of SBHCs on students' health outcomes. A systematic review by the CDC found that SBHCs are associated with improved health care use, including a 15.5 percentage point increase in immunization and a 12 percentage point increase in other recommended preventive screening and counseling.[13]

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The review also found notable benefits for students with asthma, including a 70.6% reduction in asthma-related hospitalization and 15.8% decrease in asthma-related emergency visits.[14] Another review notes that student use of SBHCs has been associated with increased health promotion, increased contraceptive use, and improved mental health outcomes.[15]

Research suggests SBHCs are associated with improvement in students' academic outcomes,[16] but the research base is smaller and more limited due to difficulties connecting student health and academic data.[17] The CDC's systematic review found SBHCs were associated with a 29% decrease in high school non-completion rates and a 4.7% increase in students' GPA.[18]

Studies have also shown an association between SBHC use and higher levels of school connectedness,[19] particularly for students of low socioeconomic status.[20] Some studies suggest there may be differential effects on academic outcomes by subgroup, including the type of services used at SBHCs. One study found use of medical SBHC services was associated with increases in attendance, while use of mental health SBHC services was associated with increases in GPA.[21] One literature review identified that

mental health services at SBHCs may reduce mental health care disparities among students who have experienced trauma.[22]

How are SBHCs Funded?

Establishing and sustaining a SBHC requires planning for startup costs and operating costs. Funding can come from a variety of sources, including federal and state grants, health care institutions, private grants, financing from community development financial institutions, in-kind donations, and Medicaid reimbursements.

Startup costs include building or renovating physical spaces that will meet the needs of providing medical care and administrative support. For example, building design considerations include creating access to the SBHC from outside the school in order to protect confidentiality and allow community members to enter and exit, ensuring proper school safety by installing locks, and adhering to other regulations. Substantial time for planning is another startup cost that SBHCs may accrue. Other costs include furniture, electronic and office equipment, and medical equipment.[23] Federal, state, and foundation grants are commonly used to assist with startup costs. For example, the federal Health Resources and Services Administration (HRSA) has a grant program to assist with capital renovations for SBHCs,[24] and Interact for Health, a Cincinnati foundation, provides local SBHC grants, including one-year planning grants for the medical partner to create a business plan.[25] Community development financial institutions represent another source of startup financing. These institutions support the construction of Federally Qualified Health Centers (FQHC), some of which sponsor SBHCs.

Operating costs are closely tied to hours and staffing, which involve both medical and administrative services. According to a CDC economic evaluation, salaries and benefits account for an estimated 80-90% of SBHC operating costs, which are determined by hours, staff positions, and cost of living.[26] Across 14 studies, SBHC operating costs ranged from $16,322 to $659,684 per year.[27] SBHCs that have a clinic or hospital as a sponsor can be helpful since these entities already have the infrastructure in place and expertise to handle administrative duties such as processing insurance claims. Sustainably covering operating costs requires maximizing revenue. Among FQHC-sponsored SBHCs, which receive higher Medicaid reimbursement rates, insurance reimbursements for billable services account for a substantial portion of revenue.[28] To maintain financial sustainability, SBHCs need an “active patient population” with high levels of insured patients—particularly students who are eligible for Medicaid or the Child Health Insurance Program (CHIP).[29, 30] According to the previously mentioned foundation Interact for Health, the “productivity level necessary to financially sustain one nurse practitioner and one front-office person” is an average of two well-child check-ups and six to eight other visits per day that the SBHC is open.[31]

Funding for SBHCs varies by community, with some national trends. A survey of state investments in SBHCs in fiscal year 2017 found that 16 states and Washington, D.C. reported making investments specifically in SBHCs, an increase of 7% since fiscal year 2014.[32] According to the School-Based Health Alliance's most recent census, 51% of all SBHCs were sponsored by FQHCs.[33] Along with the increase in telehealth-exclusive centers, there was also a slight increase in SBHCs funded by hospitals or medical centers. Notably, no telehealth-exclusive SBHCs were funded by FQHCs. The most common sources of funding for SBHCs are federal, state, and local grants, as well as foundation grants. Billable services are also key elements of SBHC funding, with 85% of SBHCs billing patients or insurance providers.

Relevant Federal and State Policies

Federal and state policies affect the provision of school-based health services, including school-based health centers. The federal Health Information Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA), for instance, both have implications for sharing student information and data. The current global pandemic, however, has recently led to waiving some regulations to support flexibility related to telehealth delivery. Meanwhile, in the last several years, policy changes at the federal level have opened opportunities for prioritizing and expanding access to school-based health services—as well as school-based health centers—for students.

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These federal policies affect both health care and education and include the Affordable Care Act (ACA), Medicaid, and the Every Student Succeeds Act (ESSA). Though these changes have been influential, many federal policies set requirements which can be further expanded upon by states. As a result, the policy environment for SBHCs can differ significantly by state. The following section examines the implications of these federal policies for SBHCs and provides a brief snapshot of select state and local policies governing these centers.

Affordable Care Act Shifts Structure of Health Care Systems

Policy changes through the Affordable Care Act (ACA) have implications for SBHCs. The ACA includes provisions to change the reimbursement structure for health service providers to focus on outcomes-based care. As part of this change, insurance providers are incentivized to provide more preventive care. The ACA also has provisions to incentivize better coordination of care through promoting a patient-centered medical home model.[34] A third significant element of the ACA is the requirement that nonprofit hospitals have community benefit agreements. The law requires such hospitals to conduct community needs assessments every three years, enact plans to address community needs, and create financial assistance policies.[35] One way that hospitals can spend their community benefit funds is by sponsoring SBHCs.

Medicaid Policies Reimburse School-Based Health Services

Changes in federal Medicaid regulations and state Medicaid plans also present potential opportunities for SBHCs. For over thirty years, schools have been able to receive Medicaid reimbursements for school-based services provided to students with an Individualized Education Plan (IEP) or Individualized Family Services Plan (IFSP). However, services available to all students free of charge that were provided to Medicaid-enrolled students without an IEP or IFSP were not allowed to be reimbursed by Medicaid. This is known as the "free care rule."[36] In 2014, the Centers for Medicare and Medicaid (CMS) issued a letter to state Medicaid agencies which removed the free care rule and clarified that school-based health services available for free to all students and provided to Medicaid-enrolled students could be reimbursed by Medicaid.[37] As a result, school-based physical, mental, and behavioral health services for all students enrolled in Medicaid may now be covered under Medicaid's Early and Periodic Screening, Diagnostic, and Testing (EPSDT) provision for children and youth through age 21.

While CMS's reversal of the free care rule came from the federal level, the degree to which this change has been implemented differs by state. Many states had written the free care rule into their state laws or state Medicaid plans, which may still prevent schools from using Medicaid to cover free services to eligible students.[38] These state-level policies would need to be changed in order to allow the free care rule reversal to take effect. A review of state Medicaid plans in 2016 found three states which explicitly prohibit coverage for free services, 23 states with provisions that create barriers to coverage, and six states whose Medicaid plans may allow coverage but have other policies that could cause barriers to coverage.[39] Even for states whose plans do remove barriers related to the free care rule, the process of Medicaid billing may pose other barriers for schools and districts. For example, a 2018 survey of school superintendents found that administrative paperwork was a significant barrier, particularly for rural and smaller school districts.[40]

Every Student Succeeds Act Broadens School Quality Measurement

The 2015 Every Student Succeeds act (ESSA) requires state education agencies to include rates of chronic absenteeism—the percentage of students who miss at least 10% of school days—in their state report cards. Additionally, states are required to choose one nonacademic indicator of student success or school quality for their accountability plans. Thirty-seven states and Washington, D.C. chose to use chronic absenteeism rates as their indicator in this category.[41]

Research shows strong links between health and chronic absenteeism.[42,43] Students with chronic health conditions are more likely to miss school.[44] Research suggests that asthma is the leading cause of absenteeism, accounting for one third of all missed school days.[45] The cumulative effects of absenteeism on student educational outcomes may also ultimately lead to poor health outcomes. Chronic absenteeism, particularly in middle grades, is related to high school completion,[46] which in turn has implications for students' long-term health.[47] In fact, educational attainment is one of the most influential social determinants of health, and high school graduation rates are one of the high-priority indicators in the Department of Health and Human Services' Healthy People 2020 initiative.[48] Therefore, ESSA's broadening of school quality measurement and the common use of chronic absenteeism may facilitate the growth of more SBHCs in order to address students' health needs and help them not miss school.[49]

HIPAA and FERPA Protect Student and Patient Data

The federal Health Information Portability and Accountability Act (HIPAA) protects the disclosure of patients' physical and mental health information by health care providers. Under HIPAA, SBHC staff cannot share student health information with school staff unless a parental consent form has been signed.[50] The Family Educational Rights and Privacy Act (FERPA) protects students' personal information and educational records held by a school or district. Under FERPA, school staff cannot share written educational records with SBHC staff without a parental consent form, although there are some exceptions to this rule.[51] As noted earlier, new ways of adhering to HIPAA and FERPA are being explored due to the relaxing of regulations during the coronavirus pandemic.

HIPAA and FERPA are federal laws, but states may have additional laws governing health and educational privacy that may impact collaboration among SBHC and school personnel. For example, the Illinois Mental Health and Developmental Disabilities Confidentiality Act requires more strict protection of mental health records. Privacy of student information is further complicated in states with laws that allow minor consent for certain types of health services, such as reproductive health and mental health.[52]

Notable State and Local School-Based Health Services Policies

While federal health and education policies affect SBHCs, many policies pertaining specifically to SBHCs are implemented at the state level. As of September 2017, 45 states had enacted laws or regulations that address the provision of school-based health services, of which 19 specifically address SBHCs or school-based clinics.[53] Among those that do address SBHCs, there are variations by state. Select states, in addition to one city, are highlighted below in order to illustrate the range of policies governing SBHCs.

Delaware requires a SBHC in every public high school and provides state funds for startup costs.[54] State regulations require state-designated SBHCs to provide physical and mental health services, health and nutrition education, and to promote vaccinations among students. SBHCs may provide reproductive health services, though this decision is left to the local school boards. The regulations also address staffing, billing, quality improvement, and information sharing between SBHC staff and primary care providers.[55] When the law was passed in 2016, only three public non-charter high schools in the state did not have a SBHC. As of February 2018, one of the remaining schools without a SBHC was slated to receive "$228,900 in state funding for its wellness center next year, plus $5,000 in start-up costs."[56] In fiscal year 2017, Delaware spent $3.9 million on SBHCs, a 33% decrease from fiscal year 2014.[57]

California passed legislation in 2006 and 2008 to support the expansion of SBHCs. The School Health Centers Expansion Act created a state grant program and a state SBHC support and technical assistance center.[58] However, no funding has been allocated for either program.[59] In 2016, the state Department of Public Health used existing, unspent dollars to provide one-time funding for the school health center support program. The funding helped to establish an interdepartmental SBHC work group within the Department of Public Health, though the lack of ongoing funding limits the function of the group. A coalition is currently working to obtain one-time funding from the state to create planning and construction grants for new SBHCs.

Illinois passed legislation in 2007 that tasked the state Department of Human Services with establishing 20 new SBHCs and building capacity in existing SBHCs.[60] As of 2019, the state Department of Public Health oversees 66 certified school health centers as part of its School Health Program. Illinois regulations address 14 elements of school-based or school-linked health centers, including scope of services, staffing, access, and student rights and responsibilities.[61] The regulations require all centers to have an advisory board that is involved in the establishment of the center and outlines membership and meeting requirements. Additionally, centers must adhere to quality improvement standards, which are specified in the regulations.

Ohio law specifies that "community learning centers" include schools that work with community-based partners to provide health care and other support services to students and families.[62] Ohio law also allows school districts to contract with hospitals, FQHCs, FQHC look-alikes, or other "appropriately

licensed" health care providers to provide health services in schools and requires that employees under such contracts must have certain minimal credentials. The state Department of Education's school-based health support team has a toolkit of publicly-available SBHC resources that address initial planning processes, partnerships, sustainability, and measuring success.[63] In 2019, Ohio's budget included a new Student Wellness and Success fund which will provide $675 million to districts to support social, emotional, and physical health initiatives.[64]

New York City and New York state provide funding to SBHCs through the health care providers that sponsor them. Most providers sponsor more than one SBHC, and then determine how to allocate public funding to each of their centers. Currently, New York City's sponsors and centers account for nearly 65% of SBHCs in the state. Over the last 25 years, there have been several waves of grants from the city departments of health and education for both capital expenses and operating costs, though there are currently no new funds for either purpose. Opening new centers have stalled as a result. Health care providers in the city continue to express interest in opening new centers but must shoulder the cost themselves.

Implementation Guide:

Essential Planning Steps for Starting a School-Based Health Center

The process of planning and opening a SBHC is nuanced and lengthy. Schools and/or communities contemplating starting a SBHC should consider both common challenges and helpful practices. Addressing these factors is vital for ensuring that SBHCs have a solid foundation in place before beginning to offer services to students and the wider community. The following guide outlines a set of essential planning steps, including key takeaways and important questions for those who are considering implementing co-located SBHCs in their communities. While telehealth is becoming more widely used due to the coronavirus, the planning steps described below apply broadly to implementing co-located SBHCs that offer—but aren't limited to—in person health services. For resources on how SBHCs can incorporate telehealth services, please visit the School-Based Health Alliance website.

Evaluate the Policy Environment in your Community

Understanding key federal policies that impact school-based health services is important when considering establishing a SBHC. However, state and local policies differ greatly and have a large impact on the opportunities and constraints for SBHCs. Evaluating the laws and regulations that govern health and education in your community is critical in weighing and navigating challenges in the SBHC process.

The nature of SBHCs and school-based health services in general require collaboration between health and education sectors. Consequently, relevant policies and regulations can be scattered across state and local departments of education and public health, state Medicaid plans, and local school boards. Taking stock of existing policies can help to inform your community's SBHC strategy. Many states have affiliates that are part of the national School-Based Health Alliance; these affiliates may be able to assist you with navigating policy and other issues related to developing a SBHC.

Key takeaway

- Policies governing school-based health services differ by state and locality. Determining what relevant policies exist in your community can help determine feasibility, opportunities, and constraints when starting a SBHC.

Important questions

- What departments or agencies oversee school-based health services in your state?
- What laws and regulations exist in your state that impact SBHCs? What barriers or opportunities does your state's Medicaid plan present?
- Does your state have a School-Based Health Alliance affiliate that could assist your planning efforts?
- What school district policies related to school-based health services exist in your community?
- What local or regional health care institutions can be your partners in launching a SBHC?

Identify Needs and Build Community Support

Conducting a needs assessment to determine the highest priorities in the community can indicate whether or not a SBHC would provide the most suitable intervention. For example, a school with an existing community health center across the street would be better served by creating a formal relationship between the two rather than constructing a co-located SBHC. Similarly, establishing a SBHC in a school whose primary need is mental health care may not be the most effective investment.

Generating community support is another crucial component in planning for SBHCs. Creating an advisory planning body can help to identify the community's needs and existing resources. Community advisory planning committees should include a variety of stakeholders, including community leaders, school staff, school leaders, youth, parents, and health care professionals. Advisory councils remain important once a SBHC moves from planning to implementation, though their membership may shift as the focus changes to operation and sustainability. Notably, students are key stakeholders and should be included in advisory councils as they bring unique perspectives and can help build buy-in.

Key takeaway

- Assessing community needs and strengths should inform the strategic establishment of a SBHC. Engaging community members, including students, is crucial in this process.

Important questions

- Which health needs of your school community could be addressed by a SBHC?
- What are the most pressing health needs of students and families in your school community?
- Who should be on your community advisory council? Think about unlikely partners (e.g. law enforcement, health care CFOs, home visiting groups, etc.

Choose a Health Care Provider

Most successful SBHCs work with a local health care provider as a partner or sponsor. Health care providers are better prepared to hire and manage SBHC clinicians, acquire supplies, and process billing than schools or districts. Federally-Qualified Health Centers (FQHCs) are especially well-positioned to be sponsors because their missions and principles align with those of SBHCs and they receive higher Medicaid reimbursement rates, among other reasons. Hospitals can also be effective sponsors. Though they are not eligible for the same Medicaid reimbursement rates as FQHCs, nonprofit hospitals can use community benefit funds to supplement service reimbursements.

Finding a health care provider that is the right fit to sponsor a SBHC is a critical step in the planning process. The community advisory committee should thoroughly consider whether a potential sponsor would be a good fit. Elements to evaluate include respect for and involvement in the community, willingness to be flexible to meet the unique needs of schools, and mission alignment with the school. Finding a champion within the provider's organization who can provide leadership and support for the SBHC is also important.

Health care providers may have reservations about sponsoring a SBHC, which can make the process of finding a sponsor lengthy. Potential challenges providers may face include draining resources, navigating community politics, and adapting to the culture of a school. However, providers also benefit from being sponsors by expanding their patient base, building good community relations, and establishing patient trust.[65] Community planning committees should work closely with providers from the beginning to establish a trusting and supportive partnership for success.

Key takeaway

- Finding a health care provider that has the capacity and willingness to collaborate with school staff and support the vision of the SBHC is critical to successful implementation.

Important questions

- Do FQHCs or nonprofit hospitals currently serve your community?
- What capacity expectations or limitations will you need to consider?
- What specific needs does your community have that a health care provider should have experience with?
- What is the community's perception of the health care provider?
- What strategies can you use to work through concerns and create a strong partnership?

Ensure Sufficient Facilities

One prerequisite for establishing a co-located SBHC is determining whether there is sufficient and viable space to construct SBHC facilities. According to an individual who has substantial experience opening SBHCs in Illinois, the issue of facilities is a crucial decision point in the SBHC planning process. A school without space to build out the necessary facilities may not be a feasible site for a SBHC. This can be an especially significant challenge for urban schools which tend to have limited space.

States may have their own requirements for SBHC facilities. In Illinois, for example, a SBHC must meet all the same building requirements as a typical community health center. Since most SBHCs serve community members in addition to students, building plans should also consider how best to incorporate separate entrances and other safety measures that separate students from community members.

Key takeaway

- An important consideration in planning for a co-located SBHC is whether the school has physical space that can be constructed or adapted to meet the medical and administrative needs of SBHCs.

Important questions

- Does your school have physical space that can be constructed or adapted to meet the needs of a SBHC?
- What state or local policies govern the requirements for SBHCs and health clinics in your community?
- What services are we ultimately building a space to support in the short and long term?

Secure Startup Funding

A substantial challenge in planning for SBHCs is securing funding to create a new center. Startup funding generally includes capital costs and staff planning time, at a minimum. Sites can receive startup funding from a variety of sources such as public and private grants, financing from community development financial institutions, in-kind donations, and local tax dollars. A strong community advisory council that oversees planning can be an important component in finding startup funding. In Chicago, for instance, one community advisory council worked closely with the local government to be able to use funds from e-cigarettes and tax increment financing (TIF) to support construction of a SBHC.[66] In addition, exploring funding opportunities through community development financial institutions can be helpful. LISC's Healthy Futures Fund, for example, provides loans and new market tax credits for the construction and financing of Federally Qualified Health Centers.[67]

Key takeaway

- Startup funding is needed to cover staff planning time and capital costs and may come from a variety of sources. A strong community advisory council is essential to identifying and pursuing diverse funding opportunities.

Important questions

- What local, state, or federal funding sources may be available to provide startup funds?
- What private funding sources may be available in your community?
- What community development financial institutions may be available to provide startup support?

Create and Sustain a Funding Base

Establishing and maintaining a sustainable funding base is another common challenge for SBHCs. Third-party reimbursements, particularly from Medicaid, are critical to financial sustainability. SBHC providers often rely on high usage of reimbursable services by the school community to be sustainable. As a result, health care organizations often prioritize providing billable services to as many patients as possible.[68] This may contrast with the priorities of school staff.[69] The tension inherent in these differing views can cause conflicts between SBHC staff and school staff. For example, SBHC staff may be reluctant to engage in non-billable health promotion activities and more likely to focus on obtaining high levels of parental consent forms for students to be able to use SBHC services.

Though insurance reimbursements are a significant source of funding, they do not cover the full range of services that all SBHC clients need. Most SBHCs serve a high proportion of Medicaid-eligible students and families, and services that are Medicaid-reimbursable vary by state. Since many SBHC patients are uninsured or underinsured, they may need case management services or support with Medicaid

enrollment.[70] Additionally, some of the preventive services SBHCs provide may not be reimbursable through existing payment structures.[71] Public and private grants provide opportunities to fund non-billable services, but may not be a reliable or sustainable source of funding. One strategy to increase funding sustainability is to expand the patient base by allowing family and community members to use the SBHC.

Key takeaway

- High usage of Medicaid-reimbursable SBHC services is crucial in establishing and maintaining a sustainable funding base. Creative thinking and obtaining outside funding are important considerations for SBHCs that plan to provide non-reimbursable services.

Important questions

- Does your school community have a high proportion of Medicaid-eligible students and families?
- How will the school ensure sustainably high service utilization rates?
- If your SBHC plans to offer non-reimbursable services, what resources are available to provide funding for these activities?

Address School Leadership and Staff Changes

Turnover in SBHC and school staff is an important consideration in the implementation process. Changes in school leadership can have particularly significant impacts. A study of SBHCs in Chicago found that new principals and other key staff members led to changes in policies and procedures to reflect the priorities of those in leadership positions.[72] Staffing turnover can also disrupt relationships that have been developed between staff at schools and health care organizations. Establishing a school-based health team comprised of school and SBHC staff that meets regularly can help buffer the adverse effects of staff turnover. Building and maintaining buy-in among families and school staff is another way to ensure that the SBHC continues to receive adequate support even if school leadership changes.

Key takeaway

- Staff turnover is inevitable, but building broad buy-in among school community members and collaboration between school and SBHC staff can help maintain consistency.

Important questions

- Do you have the staff capacity to support a school-based health team?
- What school and SBHC staff can serve on an internal school-based health team?
- How can the school build buy-in across the broader school community to ensure continued internal champions?

Share Information Effectively

Federal and state confidentiality laws that govern the sharing of health and educational information, such as HIPAA and FERPA, can impede collaboration between school staff and SBHC staff. HIPAA and FERPA may limit information about students that can be shared between SBHC staff and school staff. Parent consent forms are a common way to navigate this challenge, but specific content and procedures will differ by community. As previously mentioned, the global pandemic has led to the relaxing of some regulations, which has implications for the sharing of student health and educational information.

Federal and state laws also address parental access to information about student health care. This is particularly relevant for reproductive health and contraceptive services. Many states have "minor consent" laws that allow minors of a certain age to access such services without parent permission.[73] Understanding the laws and regulations in your community can help determine strategies to legally and effectively share information when necessary.

Effective communication between SBHC staff and hospitals or community health providers can also be challenging. Many SBHCs use Electronic Health Records (EHR) to track and coordinate patient care. However, there are many EHR options and SBHCs may not have systems that are compatible with those used by hospitals. Lapses in communication may also occur when children return to school after a hospitalization and the hospital does not share discharge information with school health staff.[74] If school-based staff provide students with referrals to community-based mental health agencies, they may not be able to track whether students ultimately receive care.[75]

Key takeaway

- Federal and state laws including FERPA and HIPAA regulate the sharing of school and health data, which can complicate collaboration between school and SBHC staff.

Important questions

- What confidentiality laws apply to SBHCs in your state?
- What regulations have been waived due to the pandemic and how does that affect the sharing of student health and educational information in your state?
- What strategies can your school employ to facilitate legal and useful information sharing when necessary?

Conclusion

School-based health centers offer an important avenue for providing access to health care for students, especially those affected by poverty and systemic racism. Such centers can bolster children's health and wellbeing, and emerging research suggests they have academic benefits as well. Over the past several years, federal policies have created greater opportunities for states to establish SBHCs. While this policy environment is encouraging for those interested in implementing SBHCs, school districts face a number of logistical, policy, financial, and human capital challenges in creating and sustaining health centers. Communities, however, can use this guide to understand essential planning steps and make informed decisions to overcome the obstacles to implementing these important supports for children and families.

Endnotes

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Re-Envisioning School-Based Health Centers During Covid-19: A Spotlight on Innovative Approaches

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Introduction

In the United States, more than six million students and community members have access to primary health care at centers affiliated with local public schools without the need for out-of-pocket payments or health insurance.[1] The coronavirus outbreak, which caused school closures across the country this past spring, has also impacted students' and families' access to SBHCs because co-located SBHCs closed as well in many cases.[2] The Education Redesign Lab (EdRedesign) produced a two-part research brief series in order to explore the role of SBHCs in the U.S. education system and uncover their potential to promote children's health and wellbeing. *Realizing the Potential of School-Based Health Centers*, the first brief in the series, introduces SBHCs, examining their key characteristics and highlighting relevant federal and state policies. It also contains an implementation guide outlining the necessary steps and decisions to consider for those interested in establishing a SBHC in their school or district.

This second brief provides a timely look at how different types of SBHCs in two states, Colorado and Connecticut, are operating during the pandemic, spotlighting successful and distinct approaches. In both examples, telehealth is playing a significant role in increasing the breadth of and access to services. The brief explores promising practices that have increased efficiency and effectiveness and presents some of the challenges related to telehealth. Understanding how these SBHCs have responded to the pandemic and examining how their operations will likely change in the future is crucial to analyzing the impact of Covid-19 on students' and community members' ability to access health care and services.

What Are School-Based Health Centers?

School-based health centers (SBHCs) serve students in approximately 11,000 schools across 48 states, Washington D.C., and Puerto Rico.[3] There are 2,500 SBHCs across the country, most often located in school districts with higher rates of free or reduced lunches, a statistic tied to increased poverty rates.[4] Nearly 90 percent of SBHCs provide services to one or more schools designated as Title I, indicating that districts receive federal financial assistance because significant portions of their students come from low-income families.[5] SBHCs provide medical care, and some also offer behavioral, dental, and vision care directly in schools. Prior to the pandemic, over 80 percent of SBHCs were brick and mortar structures located on school property; less than 20% operated as school-linked, telehealth-exclusive, or mobile centers.[6]

First emerging in the 1960s and expanding rapidly on a national scale within the last twenty years, the mission of SBHCs is to advance health equity by meeting kids where they spend most of their time: in schools.[7] SBHC staff provide medical attention, administer educational health-related resources, and foster trust-filled relationships with students. Their implementation is beneficial by producing healthier students, which in turn, has proven to increase attendance rates, boost academic achievement, reduce the

scheduling, costs, and transportation barriers associated with health care appointments, and has redefined the importance of health for students and their families.[8]

On average, the school districts that contain SBHCs have student populations where greater than 70% of the students are of minority ethnic or racial backgrounds.[9] More than two-thirds of SBHCs serve people beyond students, including teachers, families of students, and district residents.[10] Data shows the pandemic is exacerbating existing disparities affecting people of color regarding overall health status and access to adequate resources needed for medical care. As the primary patient populations served, SBHC closures are significantly decreasing access to health care access for these individuals.[11]

How do School-Based Health Centers Operate?

SBHCs rely on partnerships with sponsor organizations that help staff, fund, and operate the clinics. These partners include Federally-Qualified Health Centers (FQHCs), hospitals or medical centers, nonprofit organizations, local health departments, schools, or other associations. FQHCs sponsor 51% of SBHCs nationally and are community health centers funded by the U.S. Department of Health to provide primary care for people who are uninsured or medically vulnerable in communities.[12] In many cases, FQHCs work with school districts to create and staff SBHCs, managing the centers, providing medical supplies, and backing funding efforts. Hospital systems are also effective and beneficial partners for communities to create, staff, and fund SBHCs. Hospital systems often utilize community benefit dollars (hospital-funded budgets for community investment) to supplement SBHC billing.

The partnerships between FQHCs, hospitals, medical centers, nonprofits, health departments, schools, and insurance organizations ensure that the services SBHCs offer are free to patients regardless of ability to pay or insurance status. When patients utilizing SBHCs are uninsured, SBHCs may be reimbursed by a combination of public and private patient revenue sources; federal, state, and local grants; school district support; and private foundation grants. Nearly 90% of SBHCs bill Medicaid, the largest insurance revenue source for SBHCs overall.[13] Approximately 70% of SBHCs bill private insurance donations and Children's Health Insurance Programs.[14]

There are three general models of staffing for SBHCs: Primary Care only (usually staffed by mid-level providers), Primary Care and Behavioral Health, and Primary Care and Behavioral Health Expanded care team, possibly including oral, health, and vision care providers.[15] According to the 2016-2017 School-Based Health Alliance census, 41% of SBHCs have the Expanded staff model, 35% had Primary Care only, and 24% had the Primary Care and Behavioral Health staff model.[16] A significant challenge for SBHC staffing during the pandemic is that FQHCs, local clinics, and hospitals have recalled SBHC staff to work for their corresponding health organizations with overwhelmed systems due to influxes of patients and lack of

supplies. This recall leaves many SBHCs unstaffed and underfunded and will likely impact whether affected centers may reopen.

Pivoting to Telehealth During the Pandemic: Key Opportunities and Challenges

Telehealth has enabled many SBHCs that have remained open during the pandemic to continue offering services. In the spring of 2020, telehealth in the form of video-based medical appointments with a health professional became reimbursable by Medicaid in all 50 states.[17]

> *In the spring of 2020, telehealth in the form of video-based medical appointments with a health professional became reimbursable by Medicaid in all 50 states.*

The SBHCs featured in this brief have all shifted to telehealth in some capacity in order to serve patients while following health safety protocols. This shift has allowed these SBHCs to continue reaching many low-income, uninsured, and rural students who may not have access to other facilities. However, low-income, rural, and families of color—the primary populations served by SBHCs in general—face significant disparities in internet access and device availability, food insecurity, rates of job loss, and are less likely to have their own space in their homes to have private meetings with health care workers. While school administrations in regions facing these challenges may work to make adequate technology available to students, obstacles remain to reach and treat students and families in their communities.

Another challenge is that not all SBHC services are available via telehealth. While staff in Colorado SBHCs and the Community Health Center (CHC)-sponsored SBHCs in Connecticut aim to keep as many services as possible, certain services, like dental care, are challenging without in-person treatment.[18] For those services that are no longer available, many SBHCs have to complete a referral process to get patients the

services they need from other FQHCs or community clinics nearby. This added referral process may lead to more time spent on scheduling and decreased efficiency overall.

Expanded Role for SBHCs as Resource Hubs for Patients

Reaching a multitude of students in schools across the country, SBHCs have become trusted facilities and safe spaces for patients. In many cases, providers have worked for years to build strong relationships through in-person connections with students and parents. For SBHCs now operating via telehealth, providers face the question: how do staff maintain and enhance trust-filled relationships with patients without physically meeting? In an attempt to continue building relationships of trust within their communities, the SBHC websites for Colorado SBHCs and their medical sponsors and CHC in Connecticut have become resource hubs not only of coronavirus-related material but also for support pages for mental health, self-help, job-insecurity, homelessness, food accessibility. Providers and SBHC staff use their websites to compile lists of outpatient facilities, mostly hospitals and community clinics that sponsor SBHCs, that will physically admit patients who may not be insured or able to pay.[19] Ultimately, the goals of SBHCs are to continue providing care and support to those who are most vulnerable in the U.S. health care system, and while services offered and roles of workers may be adjusting, SBHC priorities are not.

Potential Cost-Savings from Telehealth

The use of telehealth in these SBHCs has the potential to more effectively and cost-efficiently deliver health care to rural areas and underserved communities while mitigating the negative health impact caused by this pandemic for thousands of individuals. The SBHCs featured in this brief have attributed a significant amount of cost-savings due to telehealth to a lesser need to buy supplies necessary to operate in-person. Examples include buying wipes to clean exam rooms, providing over-the-counter medication, or staff use

The use of telehealth in these SBHCs has the potential to more effectively and cost-efficiently deliver health care to rural areas and underserved communities…

of gloves, all no longer needed when operating via telehealth.[20] The caveat to this cost-savings benefit is that it is only economical if these SBHCs can maintain high rates of students served by being well-integrated

into schools and building strong relationships with students and parents over virtual platforms.[21] Colorado SBHCs cited that with rural and urban SBHCs offering services via telehealth, rural communities and people living in areas with low connectivity are now able to access health care and health services that were

previously inaccessible.[22] However, as previously noted, many challenges exist for connectivity from both a rural and economic standpoint. Telehealth may increase barriers to care, confidentiality, and the ability to get medications refilled.[23]

New Policies and Waivers to Support Telehealth

In order for SBHCs to successfully function using telehealth, policies and waivers related to funding and patient confidentiality have temporarily been adjusted during the pandemic. These temporary policies and waivers have been influential in maintaining previously existing services and, more importantly, expanding access to patient pools that previously did not have access and enhancing services to address patient needs more effectively. The changing policies affecting telehealth and the creative utilization of virtual care methods by Colorado SBHCs and CHC-sponsored SBHC staff in CT has enabled these SBHCs to successfully evolve and function during an era when many are floundering.

New Medicaid Policies in Response to Covid-19

In February 2020, the Center for Connected Health Policy released a report outlining adaptations to state telehealth laws and Medicaid reimbursement policies for all 50 states. Medicaid operates on a state-set reimbursement rate for telehealth services, indicating that SBHCs may be reimbursed different amounts depending on state Medicaid policy. According to the report, Medicaid will reimburse the same amount they would have if the service had been delivered in person.[24] In addition, Store-And-Forward, or asynchronous, pre-recorded health care videos, have become reimbursable in 16 states, while Remote Patient Monitoring (RPM), a type of telehealth using specific technology, has become reimbursable in 23 state Medicaid programs.[25]

As of February 2020, in Colorado, live video and RPM can be reimbursed by Medicaid, while Store-And-Forward cannot.[26] In Connecticut, where CHC-sponsored SBHCs operate, Medicaid will only reimburse live video services, not Store-And-Forward or RPM.[27] Therefore, Colorado SBHCs and CHC-sponsored SBHCs are currently offering live video telehealth services exclusively.

During the pandemic, SBHCs can only perform services that are explicitly reimbursed by Medicaid or other revenue sources; many of the policies which dictate service reimbursement vary state by state. Various states' Medicaid policies claim that they will not reimburse services previously available via SBHCs in person without in-person care visits. With many centers operating exclusively via telehealth, the changing Medicaid policies affect the potential span of care SBHCs can offer.

Efforts to Increase Policy-Related Funding for SBHCs

In April 2020, the School-Based Health Alliance, a national nonprofit organization and leading advocate for school-based health care, wrote a letter to the Congressional leaders on behalf of SBHCs across the country facing staffing and funding struggles, ultimately asking for stimulus money to long-term fund SBHC telehealth initiatives. According to the letter, “We recommend $100 million to support the continued operation of SBHCs, a critical safety net provider. This investment will help ensure that SBHCs can expand the use of telehealth and other virtual services while schools remain closed and reopen their doors fully when school resumes. Without additional assistance, many SBHCs will be forced to permanently close, leaving millions of students, particularly those in Title 1 schools, without access to health care and support services during a time when they are needed more than ever.”[28]

To further increase SBHC funding and support, the Institute for Educational Leadership (a School-Based Health Alliance partner and SBHC advocate) wrote a letter to Congressional leaders asking for funding for Title I eligible schools and Title I schoolwide schools. This letter included a statement recommending the "reopening and effective use of nearly 2,500 school-based health centers…and safe access to school district and community medical personnel to relieve hospitals of providing ongoing wellness checks and basic health and behavioral health care."[29] The letter also called for the "continuation of access to school-based health and mental health services for the parents/guardians who are losing/will have lost their jobs along with their employer-provided health care and out of school time programs necessary for parents to have safe places for their children as they continue or re-enter the workforce."[30] Advocating for expanding access to SBHC services is vital, though the priority client is always the student. Nearly one-third of SBHCs provide access to family members of registered students, and 17% see individuals from the community.[31] Parents and guardians of the children seeking care at SBHCs may be uninsured, unable to pay, and in great need of health care services during the pandemic.

New HIPAA Policies in Response to the Pandemic

SBHC teams follow newly modified HIPAA guidelines to determine which services are essential for in-person visits, whether through an SBHC or an SBHC-recommended outpatient clinic, versus those for which telehealth will suffice.[32] Last updated in March 2020, the Notification of Enforcement Discretion for Telehealth Remote Communications during the COVID-19 Nationwide Public Health Emergency put out by the U.S. Department of Health and Human Services issued updates to HIPAA policies that expanded available HIPAA-compliant telehealth platforms and enhanced existing doctor-patient confidentiality agreements. The common HIPAA-compliant platforms for telehealth meetings are Zoom, Skype for Business, Cisco, GoToMeeting, or doxy.me. Some allowable non-HIPAA-compliant platforms include Apple FaceTime, Facebook Messenger video chat, Google Hangouts, WhatsApp, and Skype.[33] Regarding doctor-patient confidentiality over telehealth platforms, the Notification of Enforcement Discretion for Telehealth Remote Communications assures that: "covered health care providers will not be subject to penalties for

violations of the HIPAA privacy, security, and Breach Notification Rules that occur in the good faith provision of telehealth during the COVID-19 nationwide public health emergency."[34] The document states that these changes do not affect HIPAA policies outside of telehealth during this emergency. The Notification of Enforcement Discretion does not have an expiration date and will exercise discretion based on the latest facts and circumstances; these changes are, however, temporary.[35]

School-Based Health Center Spotlight: Exploring Varied Approaches in Colorado and Connecticut

SBHCs vary based on their staffing, type of sponsor, and services offered, in addition to state policies affecting their operation. Since SBHCs are affected by these multiple factors, the following section will explore these components of the featured Colorado SBHCs and CHC-sponsored SBHCs in Connecticut. Given that significant variation among SBHCs exist, it is important to note that the selected examples are unrepresentative of SBHCs nationally.

In particular, the next section will examine the varied approaches that Colorado SBHCs have employed and the CHC-sponsored SBHC approach in Connecticut, highlighting available services, challenges faced during the pandemic, and promising practices for telehealth and in-person care. Because SBHCs throughout Colorado are utilizing both in-person and telehealth models of care, we refer to their SBHC approaches as "hybrid approaches." Alternatively, CHC-sponsored SBHCs in Connecticut operate solely via virtual care and thus we refer to it as a "telehealth-exclusive approach."

Colorado SBHCs: An Overview

The first SBHCs opened in Colorado in 1978 in response to Colorado's unique challenges in health care access. Factors such as high percentages of rural residents, long trips to doctor's appointments, and high insurance premium rates were barriers that prompted the implementation of SBHCs and their subsequent growth for the past forty years.[36] Colorado centers now serve more than 36,000 students annually.[37] Individual centers have different regulations about whom they can serve. However, most serve either students enrolled in the school district or all children from birth to age 21 living in the community.[38] SBHCs never deny service based on the patient's ability to pay.

The SBHC landscape within Colorado is diverse. There are 61 SBHCs across the state that each partner with medical and fiscal sponsor organizations. The staffing and funding for a given SBHC most often come from the same organization. Sponsors range from FQHCs to community health centers, hospitals, and for-profit private practices. School districts may serve as fiscal sponsors in a few cases, collaborating with other medical organizations for staffing. Fiscal sponsors determine the communities in which they will build SBHCs.

In Colorado's state budget, there is a line item supporting SBHC funding offered as a grant program run by the Colorado Department of Public Health and Environment (CDPHE). CDPHE does not recruit SBHC sites for their grant program, but any fiscal sponsor wanting to receive this funding for an individual SBHC can apply. Of the 61 SBHCs in Colorado, 52 SBHCs receive some funding via CDPHE grants; all 52 SBHCs rely on additional funding from billing revenue and other grant opportunities to cover additional costs.[39] All SBHCs in Colorado bill for services and can waive deductibles and co-pays, but many choose not to use the waiver option. Many SBHCs end up writing off services they provide, especially confidential patient visits.[40]

Colorado SBHCs help to mitigate health disparities by increasing access to health services in rural regions and being available to students who may be uninsured or unable to pay. With these same goals in mind following school and SBHC closures at the start of the coronavirus pandemic, Colorado SBHC staff swiftly transitioned their services to telehealth. Pre-COVID, only two centers in the state used telehealth; now, all centers offer telehealth services in some capacity even if the service is available in person.[41] The adoption of telehealth has been one of the only universal responses to the coronavirus from SBHCs in Colorado. Independent school district decisions and corresponding medical sponsors' directives inform the operation plans of individual SBHCs during the pandemic. In addition, there are three unique structures among Colorado SBHCs that determine their capacity to open, making universal response difficult.[42] The following section will describe various innovative strategies that Colorado SBHCs have utilized to continue serving patients.

Colorado SBHCs during Covid-19: Hybrid Approaches to Care

The three structural model types of Colorado SBHCs are: "embedded," "external access," and "free-standing." [43] "Embedded" SBHCs represent the majority of SBHCs in Colorado and are built directly into schools. "External access" structures, the second most popular SBHC form, have a separate entrance, enabling staff and visitors to access the SBHC from outside the school. The least common structures are "free-standing" centers built on school campuses as independent buildings. The response to Covid from SBHC staff has been varied both within the structural model groups and across the board. Understanding how structure influences functionality potential is essential to analyze SBHC operation during Covid.

"Embedded" centers closed alongside schools in March. Since then, most of these SBHCs remain open by operating exclusively via telehealth. Many "external access" SBHCs were open and operating in person by April, utilizing separate entrances as schools remained closed.[44] In some cases, schools were not comfortable with any presence inside school buildings, even if staff and visitors used the outside door.[45] Staffing capacity also served as a limitation that hindered "external access" centers from operating in-person. Most "free-standing" SBHCs have been open and operating since March, as school status does not affect these SBHCs. Some did not reopen, as the school district maintains final say over their operation. In one circumstance, the SBHC did not immediately reopen due to district concerns. This SBHC has recently opened, and the school district administration where the center stands has created a plan to increase confidence that if there is a future school closure, the SBHC will remain open. Both "external access" and "free-standing" structures offer telehealth services as well. In addition to these three models, there is one mobile van associated with SBHCs in Colorado that has been unable to operate during the pandemic. The Ronald McDonald foundation owns the van, and the foundation isn't allowing for the use of their mobile units during the pandemic.[46]

In Colorado, SBHCs offering in-person services have implemented a range of operational approaches to keep centers safe during the pandemic. Examples of actions taken by SBHCs in some cases include staff undertaking strict cleaning and disinfecting protocols following CDC guidelines.[47] Other SBHCs open to in-person visits have cut the hours of operation in half, set up a parking lot triage system, and take in very few patients per day.[48] In districts where SBHC in-person services remain unavailable, staff continue directing patients to their sponsor community clinics to see patients in person without insurance.[49] SBHCs in Colorado continue to offer services to all eligible patients, and there is still no insurance prerequisite.[50]

Available Colorado SBHC Services

The Colorado SBHCs that can serve patients in person maintain almost their full range of services. In a press release from the Colorado Association for School-Based Health Care, SBHC staff stated that they remain committed to "mental health and substance use counseling, consultations on sick visits, oral health screenings and triage for further dental care, immunizations and labs, screenings for comprehensive wellness and mental health, asthma checks, consultations for medicine refills, and more."[51] Some SBHC facilities split their open hours between treating sick patients and performing wellness checks or providing immunizations for healthy patients to allow for adequate cleaning between sessions.[52] The state of Colorado mandates that all SBHCs must have some form of dental screening and a referral process set up. According to the CDPHE, in the majority of Colorado SBHCs, oral dental cleanings were previously offered in 88.2% of rural SBHCs and 31.7% of urban SBHCs. In SBHCs where oral services were not available, staff could refer users to the nearest dentist's office.[53] The sites that did offer dental care before Covid have not brought it back as a part of their available in-person services during the pandemic.[54] In their telehealth model, health center workers can perform medication refills, provide individual and family therapy

sessions and psychiatric care, answer non-urgent medical questions, and assist uninsured families to obtain insurance.[55] In order to be reimbursed by Medicaid, well-child visits must have an in-person physical examination. Well-child visits and immunizations cannot be completed via telehealth and therefore are not services offered by the embedded SBHC model.

Challenges during Covid-19

Colorado SBHCs have experienced multiple challenges during the pandemic. Initially, the number of patients utilizing Colorado SBHC services overall dipped substantially in March and April. Many patients canceled preventative care appointments in March and April, and for the centers that remained open to in-person visits, staff noticed a hesitancy in patients to want to schedule new appointments or enter facilities. When patients had canceled appointments, SBHC providers were rescheduling visits for May and June. After a few months, word circulated that most centers remained open to in-person visits or telehealth via SBHC websites, state-wide press releases, school news blasts, and word of mouth. As a result, the number of patients served in May through July increased compared to March and April.[56] When patient numbers were down in the first months of the pandemic, many centers reported that they were losing money. Some SBHCs have reported a silver lining of telehealth as cost-savings on supplies, typically necessary for in-person treatment, as previously mentioned. The recent spike in patient numbers and cost-savings may have a significant positive impact on revenue for Colorado SBHCs.[57] The long-term cost-savings analysis has not yet been made available.

Another obstacle that many SBHCs face addresses the rural and mountainous areas in Colorado that experience internet connectivity challenges. Ultimately, recognizing this barrier has led to state-level policy changes in Medicaid and HIPAA that now allow services via phone and chat, not requiring audio and visual, a temporary and unique change for Colorado.[58] According to the newly updated state telehealth laws and Medicaid policies previously mentioned, the definition of telehealth in the state of Colorado is: "telemedicine is the delivery of medical services and any diagnosis, consultation, treatment, transfer of medical data or education related to health care services using interactive audio, interactive video or interactive data communication instead of in-person contact."[59] The idea of "interactive data communication" includes services without the typically required audio and visual factors. With Medicaid contributing as patient-related revenue in more than 80% of urban Colorado SBHCs and 60% of rural SBHCs, changes to Medicaid policies have a huge financial implication for SBHCs.[60] A significant policy change in response to Covid has been allowing FQHCs, Rural Health Services, and Indian Health Services to bill for telehealth. For those FQHCs that are medical and fiscal SBHC sponsors, this policy change has been pivotal in increasing revenue and breadth of services during the pandemic.[61]

Another major victory is enacting the Colorado State Bill 215 of May 2020. The bill states Colorado's commitment to "expanding access to high-quality, affordable health care for low-income and uninsured residents" through lowering insurance premiums for those buying insurance on the individual market via

the state's reinsurance program.[62] Regarding beneficial temporary policy changes, many SBHC staff members advocate making these changes permanent, like State Bill 215, to ensure that the most vulnerable populations can maintain access to care after the pandemic is declared over.[63]

For the embedded model of SBHCs operating exclusively via telehealth, the main struggle has been providing well-child visits and immunizations. Medicaid policies in the state of Colorado will not allow for reimbursement for well-child checks without an in-person exam. Typically, necessary immunizations are administered during well-child checks and require in-person services as well. Because these centers do not see patients in-person, staff cannot offer well-child visits and immunizations at these clinics, which has a significant negative impact on student populations in these districts who may go years without check-ups as a result of this policy.[64]

SBHC staff members were also concerned that behavioral health screening would be arduous during this time as, in the past, screening occurred via iPad questionnaires after visitors checked-in for their appointments. However, recent data shows that clinics are still screening for behavioral health at the same rates as before the pandemic.[65] The company that completes the data work for CDPHE-funded SBHCs and one additional Colorado SBHC is currently launching a new online screening platform to be utilized by these SBHCs. Youth engagement with online behavioral health screening is high, which is encouraging as the new screening platform rolls out.[66]

CHC-Sponsored SBHCs during Covid-19: A Telehealth-Exclusive Approach

Founded in 1972, the Community Health Center (CHC) is a state-wide Federally Qualified Health Center (FQHC) in Connecticut, serving as a medical and fiscal sponsor to over 180 SBHCs across the state.[67] CHC places licensed health care providers in school clinics who then work in conjunction with students' primary care providers to provide medical care in schools to over 17,000 students annually.[68] There are about 160 CHC staff in CHC-sponsored SBHCs. At a minimum, the staff combination in a given CHC-sponsored SBHC is a Nurse Practitioner and a Medical Assistant. Some CHC-sponsored locations also provide behavioral or dental health services.

Following public school closures in Connecticut, CHC-sponsored SBHCs closed and were almost immediately approved to shift to telehealth.[69] The CHC SBHC staff describe that, before Covid, they were already working "remotely" within schools in a sense, utilizing Zoom to communicate with SBHC staff across the state and within CHC's community health centers. At the same time, internally and pre-COVID, the CHC staff had already piloted a small telehealth delivery model for psychiatry and had developed a

small framework for staff to work remotely, both of which eased the quick transition to telehealth.[70] Thus, while CHC brick and mortar centers continue providing limited in-person care in their 18 brick-and-mortar facilities during the pandemic, CHC SBHCs transitioned from exclusively serving students in person to exclusively using telehealth in all school locations in the wake of the pandemic. CHC-sponsored SBHC staff could send texts or calls to existing patients, but not to new patients. CHC-sponsored SBHCs regularly communicated with superintendents and principals to emphasize the importance of reaching out on their behalf to parents and students to let them know that SBHC offerings remained available for new students.

After demoing multiple telehealth products, the CHC team committed to using Zoom for telehealth. Zoom provides a fully encrypted platform meeting HIPAA standards and guidelines. CHC staff have added extra protection levels by making meetings password-protected and enabling waiting rooms so providers must approve patients before appointments begin to maintain doctor-patient confidentiality. CHC equipped each provider with a Zoom account and set up internal Zoom support groups to help providers with related issues. To address technology and internet disparities that serve as barriers to care in many Connecticut communities, CHC staff recognize that the most successful way to connect with patients has been by targeting patient or parent smartphones. Zoom offers the ability to create custom, tailored links, making it easy for patients to input the link into a smartphone browser to connect with their CHC-sponsored SBHC health care worker.

Available CHC-Sponsored SBHC Services

Many of the services offered by CHC-sponsored SBHCs pre-pandemic remain available through telehealth. Services have changed most significantly in the mental and behavioral health sectors. There was a sense of urgency for behavioral health specialists to make services available as soon as possible to support increased levels of anxiety and possible abuse resulting from stay-at-home orders.[71] HIPAA recently approved group therapy through Zoom. Behavioral health specialists have developed innovative approaches to engage with students, specifically with little kids, where staff had previously relied on in-person interactions for therapy (e.g., playing catch or doing art). Patients can call a triage hotline and speak to available CHC providers, and CHC staff answering phones at SBHCs and community health centers offer behavioral health counseling services to every caller regardless of the initial purpose of the call. According to a nurse practitioner working as a triage nurse, 40% of patients offered behavioral health counseling accept the service.[72]

CHC-sponsored SBHCs cannot provide dental care using telehealth, so SBHC staff refer patients seeking oral care to CHC's mobile dental clinics, though there may be a small fee required for all patients. CHC has redeployed a significant portion of the dental teams previously working in SBHCs. These staff members retrain to work in other sectors of care where they can be more useful. For example, many dental hygienists from CHC-sponsored SBHCs have relocated to the brick-and-mortar community clinic's staff to perform

temperature checks of incoming patients and staff at the door and ensure that clinics abide by CDC guidelines. CHC redeployed many nurse practitioners as well. One nurse practitioner described her new role as "completely different" from the job she had a month ago; she now works in one of CHC's community clinics with adults instead of with the high school-aged students with whom she had previously worked.[73]

Some nurse practitioners now answer phone calls in triage lines, providing essential Covid-related information and ensuring that callers have accurate information about the virus. To screen for the virus, CHC has created a comprehensive question protocol asking individuals about symptoms, travel, and exposure to Covid. Callers may be sent to a separate Covid triage line if they affirm that they may have the virus and are subsequently offered an urgent visit on the spot. These calls help disseminate factual information about Covid, and staff members feel as though they are helping to not overwhelm hospital and community health sites.[74]

Challenges related to the Telehealth-Exclusive Approach

Initially, the biggest challenge for the CHC-sponsored SBHCs was establishing contact with patients. The contact information provided to CHC staff were typically parent cell-phone numbers. At first, CHC staff called parents dialing *67 before the phone number to preserve privacy, but the response rate was minimal as the incoming caller ID would display "Blocked Number."[75] CHC responded by investing in Zoom Phone, an add-on for Zoom that allows for calling and texting via Zoom with a caller ID of a CHC main number. According to a nurse practitioner in one of the CHC-sponsored SBHC clinics, this was "very well received by parents,…teachers, and students…Everyone felt supported by these calls…It was challenging initially, but now in my third week of it, it is smooth."[76]

Most districts in Connecticut passed out Google Chrome Books to students without computer access, but school districts did not allow for the download of Zoom. Younger children in the districts did not receive Chrome Books, so instead of trying to connect via Zoom on computers, CHC pivoted to connect via Zoom on smartphones, creating custom links to make Zoom use as manageable and easy as possible for students. Another contact-based obstacle was targeting students who now had sporadic schedules, waking up at later hours, and not having much structure to their days—this required patience and flexibility on the part of CHC care providers.[77]

Another challenge involves preserving provider-patient confidentiality with an increased parent presence. In the state of Connecticut, many telehealth services require parental consent, but a few do not (i.e., reproductive health). For these unrequired parental consent areas of care, patient confidentiality was initially a struggle as one CHC-sponsored SBHC nurse practitioner described the challenge of reaching students in a way that was "private and confidential while their parents were home."[78] Staff navigating private patient relationships utilize school-provided emails, which sometimes go to both students and their registered guardians and use generic wording for a reason for contact until they can talk more openly

through Zoom. Additionally, finding enough privacy within households to have conversations with SBHC staff proved difficult for some patients. Staff learned to ask "yes" or "no" questions to protect their patients' privacy and continue building relationships of trust.

Implications for SBHCs Moving Forward

Colorado SBHCs and CHC-sponsored SBHCs have been a part of the ongoing conversations about school reopening this fall, and many have been devising plans for beginning to meet in person with students. The centers will likely continue to serve as public health and support hubs both online and in person. The featured SBHCs in this case study will most likely maintain practical aspects of their current delivery models moving into the new school year and beyond.

SBHCs beyond Covid-19: Colorado SBHCs

“Telehealth is here to stay,” according to Rebecca Gostlin, the director of clinical initiatives at the Colorado Association for School-Based Health Care and leader of the Colorado telehealth transition, when asked what the Colorado SBHCs landscape will look like in the future.[79] To Gostlin, telehealth has been transformative by broadening access to SBHC care in Colorado communities, challenging previously existing treatment methods, and enhancing and targeting services to be more productive. Centers that took the initial “plunge” into telehealth are now strategically thinking about expanding services.[80]

Colorado has many rural and low-income counties that can benefit from telehealth services offered by SBHCs due to policy amendments made in the wake of Covid. As a result of these changes, communities without clinics at schools can utilize telehealth services offered by other districts. According to a brief released by the Colorado Health Institute in May 2020, the most effective policy changes that have emerged during this period have been: the reimbursement of FQHCs, Rural Health Clinics, and Indian Health Services; the reimbursement of telephone-based visits; and the allowance of video visits over apps like Skype or Facebook Messenger that do not comply with patient privacy laws.[81] School administrations and SBHC sponsors determine which temporary policies to advocate to keep after the emergency period is declared over.

With the help of these changing policies, the behavioral health sector of care has been hugely successful with telehealth in Colorado SBHCs. Possibly due to student comfort with telehealth-related technology and increased anxiety as a result of the pandemic, the number of patients seeking behavioral health support through telehealth is high. As an example of how successful behavioral health sectors of care have been

during Covid in Colorado SBHCs, one clinic that traditionally does not offer services over the summer have decided that because their telehealth behavioral health program is running smoothly and the demand is high, they will remain open all summer via telehealth. Without telehealth, remaining open for the entire summer would not be possible as telehealth broadens reach and access and saves staff valuable money and time.[82] Thus, behavioral health services will likely continue to use telehealth as a delivery platform for care in Colorado.

One unanticipated benefit of telehealth reported by Colorado SBHCs is youth health empowerment. Telehealth allows staff to teach kids how to measure their heart rate and learn about different signs to evaluate their bodies' health. Many children have reported back feeling as if they are in control over their health in new ways.[83]

Finally, the relationships that these SBHCs are establishing and enhancing with their districts have been a silver lining. In the future, Gostlin predicts that school district faculty and SBHC staff relationships will become more interconnected because they have to with ongoing conversations about school reopening and prioritizing student health.[84] The CDPHE, as a public health leader in Colorado, released a guidance toolkit about the evolving pandemic to aid schools in their reopening process.[85] The Colorado Association for School-Based Health Care created a resource compilation for SBHCs regarding billing information, staff support, community resources, and more to aid individual centers in their response to Covid and their reopening processes.

SBHCs beyond Covid-19 in the Telehealth-Exclusive Approach: CHC-sponsored SBHCs

CHC SBHC staff highlight one great success of this period as relationships being enhanced within CHC that have made centers more efficient and interconnected. Several nurse practitioners and behavioral health professionals described the current cohesion of CHC as a feeling of "one team"; in the past, CHC's brick and mortar sites felt very separate from CHC-sponsored SBHCs. The constant conversation and support across care sectors (i.e., doctors working with behavioral therapists and nurse practitioners and dentists) during Covid influenced the CHC SBHC team's tremendous success of remaining available despite having closed facilities.[86]

Many CHC-sponsored SBHC staff engage in the school community in new ways, including writing in school newspapers, taking part in car parades of teachers, and participating in "Miss You" videos put out by schools. CHC staff are contributing to school administrations' conversations to help think through what school reopening may look like in the fall. Additionally, many CHC staff have cited developing relationships with parents as a success. Before the pandemic, limited relationships between parents and CHC-sponsored providers were common as students were seen exclusively at school, typically during the school day when

parents were not present. Now, the parent-provider relationship has become a crucial part of the communication chain between many students and CHC-sponsored SBHC staff.[87] Overall, previously limited relationships have blossomed amid the pandemic, and CHC-sponsored SBHC staff plan to continue building and prioritizing these relationships in the future.

From an administrative standpoint, CHC-sponsored SBHCs have used this time to create new templates for telehealth in electronic care as new codes have emerged regarding patient care and changing HIPAA requirements in the face of rising telehealth. Following the successful redeployment of many staff to new sectors, CHC staff members have new skills and complete "projects that they would never have worked on."[88]

The most significant change that CHC staff believe will come out of the pandemic is that CHC SBHCs will likely not return to 100% face-to-face operation. Pre-Covid, many of the CHC-sponsored SBHC staff had full rosters of patients, and the transition to the more time-efficient telehealth allows staff to expand their availability and take on new patients. CHC-sponsored SBHC staff describe that from both their experience and the experience of their patients, telehealth has been adequate for most patient needs.

The Future of Telehealth for SBHCs

The global pandemic has exacerbated deep disparities across education and health care, affecting the same vulnerable populations served by school-based health centers. This crisis, however, also offers an opportunity to expand the delivery of health care by leveraging telehealth. Though SBHC models vary, the successes of those highlighted in this brief offer valuable insights to school districts, other SBHCs, and health care providers.

Telehealth presents both benefits and challenges. It has broadened access to services for rural communities in Colorado that may not have SBHCs in their district or whose students may not have the ability to make long trips to health centers. Medicaid policy changes to service delivery now allow SBHCs to use alternative forms of communication requiring lower bandwidth internet and less need for a stable internet connection. Additional policy changes have recently become permanent that lower insurance premiums, increase insurance availability to low-income and rural families, and expand the number of health services that SBHCs can bill for reimbursement. These changes have been crucial to furthering health care support and access to populations that need it.

While there are many benefits to telehealth for SBHCs, the online format limits services that were previously more accessible and requires reliable internet and technology access to utilize telehealth services. However, the promising practices highlighted in this brief can be more broadly implemented

through SBHC advocacy and policy changes such as finding sustainable ways to increase internet access to low-income neighborhoods or introducing policies to provide telehealth over platforms that require very low bandwidth. In doing so, increased numbers of SBHCs across the country will have the potential to improve students', families', and community members' health and wellbeing.

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