



Sustaining School Based Health Centers

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Abstract

School-based health centers (SBHC) help to make healthcare affordable and accessible by providing health services to young people where they spend most of their waking hours: at school. Research to date suggests that SBHCs can significantly expand access to healthcare, particularly for families in low-income communities, and reduce healthcare costs. Because of these benefits, the Affordable Care Act of 2010 recognized SBHCs as a federally authorized program and provided a one-time mandatory appropriation of \$200 million for SBHC capital expenses. Unfortunately, keeping the doors of these centers open can be difficult for the health organizations that operate them in partnership with schools (Keeton, Soleimanpour, & Brindis, 2012). This report explores how five SBHCs, established through the Elev8 initiative in Chicago Public Schools (CPS) in 2009, have weathered a myriad of challenges and key lessons they have learned along the way that have helped to sustain their work. Based on the information collected, the strategies that appear to have been most beneficial to sustaining the five Elev8 SBHCs include:

Finding common ground. The SBHCs and their host schools learned over time to limit the scope of services the centers provided to those of greatest concern to both the health providers and the school community.

Establishing SBHCs where demand is high. Because SBHCs rely heavily on third-party reimbursements, SBHCs in schools and communities with a large number of potential patients, including both students and community members, are more sustainable.

Building strong ties among health center and school staff. Keeping lines of communication open among health and school staff—through regular health committee meetings or through health and school liaisons—can build trust and reduce tensions over time.

Executive Summary

School-based health centers (SBHC) help to make healthcare affordable and accessible by providing health services to young people where they spend most of their waking hours: at school. Because of these benefits, the Affordable Care Act of 2010 recognized SBHCs as a federally authorized program and provided a one-time mandatory appropriation of \$200 million for SBHC capital expenses. The number of SBHCs throughout the country has grown significantly since the 1980s with public and private funding support. According to a recent School-Based Health Alliance survey, SBHCs reach more than two million children and adolescents in over 2,300 centers nationwide (Price, 2017). Research to date suggests that SBHCs can significantly expand access to healthcare, particularly for families in low-income communities, and reduce healthcare costs. Unfortunately, keeping the doors of these centers open can be difficult for the health organizations that operate them in partnership with schools (Keeton, Soleimanpour, & Brindis, 2012).

This report explores how five SBHCs, established in Chicago Public Schools (CPS) in 2009, have weathered a myriad of challenges and key lessons they have learned along the way that have helped to sustain their work. It draws on interviews and observations that Chapin Hall at the University of Chicago conducted between 2008 and 2014 to document the implementation of Elev8 Chicago, a community schools initiative that included the establishment of the five SBHCs, as well as follow-up interviews conducted in 2018.

Like SBHCs across the country, the Elev8 SBHCs have faced several significant barriers to sustaining their work. These include: reconciling the different priorities of schools and health centers, coordinating the various stakeholders in the SBHCs, dealing with the instability of both the schools and the health provider organizations, and maintaining adequate financial support.

Based on the information collected, the strategies¹ that appear to have been most beneficial to sustaining the five Elev8 SBHCs include:

Finding common ground. The SBHCs and their host schools learned over time to limit the scope of services the centers provided to those of greatest concern to both the health providers and the school community. The SBHCs focus on the health issues of greatest concern to the schools: compliance with school district physical and immunization requirements, behavioral health, and general physical healthcare. They provide services to students mostly during non-academic time periods to minimize time out of class. In return, the schools help the SBHCs to sustain themselves economically by assisting in the collection of parental/guardian consents, tolerating the use of the health centers by community members, and reducing expectations for the SBHCs to provide non-reimbursable services such as health education.

Establishing SBHCs where demand is high. Because SBHCs rely heavily on third-party reimbursements, SBHCs in schools and communities with a large number of potential patients, including both students and community members, are more sustainable. Sprigg (2017) recommends a potential patient population of at least 500 Medicaid-eligible patients in the school where the center is located, in nearby schools, and in the community. Several of the SBHCs established through Elev8 see students from neighboring elementary schools to boost their utilization.

Building strong ties among health center and school staff. Inclusion of key health and school stakeholders in the planning of a new SBHC is important, and memorandums of understanding can clarify roles. Yet, unforeseen challenges generated by personality and territorial issues may still arise once the SBHC begins operations. However, keeping lines of communication open between health and school staff—through regular health committee meetings or through health and school liaisons—can build trust and reduce tensions over time.

A lot of people who may not go anywhere else will come here because they feel like this is their clinic. They trust the people in the clinic. They trust the process.

-School Principal

¹ This report is focused primarily on non-financial strategies. For more on financial strategies to sustain SBHCs, please see Keeton, V., Soleimanpour, S., & Brindis, C. (2012) and Price, O. A. (2017).

Introduction

Multiple obstacles stand between low-income families and good health care. Certainly medical bills are a problem. But for many, just accessing care can be daunting. The closest clinic may be several bus rides away and closed during weekends and evenings. Just taking a child to be seen for an ear infection could take all day and mean lost wages and school time. And some families do not trust health providers, perhaps due to poor experiences with them in the past.

School-based health centers (SBHC) address such challenges by providing health services to young people where they spend most of their waking hours: at school. Some SBHCs also offer healthcare to adults residing in the school's neighborhood. By providing care in the community and within the familiar location of a school, SBHCs can build trust among and provide a convenient and reliable option to low-income families. As one school principal with an SBHC told us: "A lot of people who won't go anywhere else will come here." Because of these benefits, the Affordable Care Act of 2010 recognized SBHCs as a federally authorized program and provided a one-time mandatory appropriation of \$200 million for SBHC capital expenses.

Unfortunately, keeping the doors of these centers open can be difficult for the community health organizations that operate them in partnership with schools (Keeton, Soleimanpour, & Brindis, 2012). This report will explore how five SBHCs, established in Chicago Public Schools (CPS) in 2009, have weathered a myriad of challenges and key lessons they have learned along the way that have helped to sustain their work.

We begin with a brief summary of evidence on the health, financial, and academic impacts of SBHCs. We then provide an overview of the five SBHCs established as part of a community schools initiative in Chicago called Elev8 Chicago. Next we describe the methods we used to document the progress of Elev8 in general, and the SBHCs in particular, and then discuss the key barriers to and facilitators of SBHC sustainability, based on our findings and those of others who have studied them. We conclude by discussing the strengths and potential pitfalls of the strategies the Elev8 SBHCs employed.

The Impact of SBHCs

The number of SBHCs throughout the country has grown significantly since the 1980s with public and private funding support. According to a recent School-Based Health Al-

What Is A Federally Qualified Health Center?



Federally Qualified Health Centers (FQHCs) are community-based health care providers that receive funds from the U.S. Department of Health and Human Services to provide primary care services in underserved areas. They must meet a stringent set of requirements, including providing care on a sliding fee scale based on ability to pay and operating under a governing board that includes patients. Federally Qualified Health Centers may be community health centers, migrant health centers, health care for the homeless, and health centers for residents of public housing. FQHCs receive an enhanced Medicaid reimbursement rate and thus becoming an FQHC enhances the viability of SBHCs.

liance survey, SBHCs reach more than two million children and adolescents in over 2,300 centers nationwide (Price, 2017).

Evidence from various studies suggests that SBHCs can significantly expand access to healthcare, particularly for families in low-income communities. SBHCs also appear to improve immunization rates, health outcomes for children with asthma, and adolescent mental health and health behaviors (Keeton et al, 2012). Additionally, McNall et al. (2010) found that, compared to other students, those who use SBHCs report greater satisfaction with their health, more engagement in physical activity, and more consumption of healthy foods.

SBHCs can also lead to cost savings. Using Medicaid data, both Adams (2000) and Guo (2010) compared health care costs for students who did and did not use SBHCs. They found that students who used SBHCs had lower Medicaid expenses. Guo estimated the net social benefits of an SBHC program in four school districts to be \$1,352,087 over three years, saving Medicaid about \$35 per student per year. The cost savings were particularly pronounced for students with asthma, leading to an estimated cost savings of \$970 per child. More recently, Ran conducted a review of 21 cost and/or benefit studies completed between 1985 and 2014. Ran concluded that the total annual benefit per SBHC ranged from \$15,028 to \$912,878, leading to net savings ranging from \$30 to \$969 per visit (Ran, Chattopadhyay, & Hahn, 2016).

There is also some evidence on the impact of SBHCs on the academic progress of students. Walker et al. (2009) found that students who used SBHC physical health services experienced greater improvements in their attendance than students who did not use these services, and students who used mental health services experienced greater improvements in their GPAs than others. On the other hand, Kerns et al. (2011) used the same data set to examine the association between SBHC use and the likelihood of a student dropping out but did not find any evidence for such an association. More recently, Chapin Hall re-



searchers examined the effects of SBHC use by employing chronic absence in third grade as a proxy for the presence of health problems. They found that students who were chronically absent in third grade and used the SBHC during middle school had significantly higher attendance than students who were chronically absent in third grade but did not use the SBHC (Rich et al., 2018).

The Elev8 SBHCs

Each of the five SBHCs that are the focus of this report opened their doors in 2009 as part of the Elev8 Chicago initiative. Atlantic Philanthropies originally conceived of and funded the Elev8 initiative in four locations around the country, including Chicago. Similar to other community school efforts, the goal was to bring together “schools, nonprofits, philanthropy, parents and members of the community to ensure that students have the resources they need to succeed in school and in life” and to “improve the educational, social and economic outcomes for middle school students and their families.” (Atlantic Philanthropies, 2009) All five Elev8 Chicago sites were established in low-income communities on Chicago’s south and west sides and were organized around four pillars of activity: (1) extended-day learning and academic enrichment; (2) preventative healthcare services; (3) family economic and social supports; and (4) parent and community engage-

ment. In each of the five communities, Elev8 Chicago was established as a partnership among the school, a lead community agency, and the health provider.

Atlantic Philanthropies funded the construction of health clinics in all participating schools. Each of the centers is operated by a community-based health provider and qualifies as a federally qualified health center (or FQHC, see insert on page 9 for more information). The Elev8 initiative aimed to, among other things, integrate medical and school services, boost health advocacy efforts, and increase enrollment of children in health insurance programs. See Table 1 on page 11 for information on the services provided by each center.

All five centers serve both students and the community at large. Four of the centers are open 8-9 hours per day five days per week. One center is open three days a week, and its hours change often. Additionally, four of the centers have expanded their staffs at the centers to serve more patients over time.

Since the SBHCs opened there have been some significant changes in the leadership and operations of the schools and the health providers. For example, Chicago Public Schools turned over the operation of one school to a non-profit organization as a “turnaround” school. Also, the original health provider for two of the schools ended the partnership due to budgetary concerns, and two new providers stepped in.

Method

The report draws on interviews and observations that we conducted between 2008 and 2014 to document the implementation of all aspects of Elev8 Chicago, including the SBHCs. Beginning in 2008, we observed and documented afterschool programs, school meetings, implementation meetings, cross-site meetings of site directors and health center partners, health committee meetings, and special events at schools and other locations. In 2009, we began conducting the first set of annual interviews with key planning and implementation stakeholders; respondents included school principals and assistant principals, site directors, social workers, teachers, extended day program staff, and parent leaders. Stakeholders were asked to participate in one interview each year for the 3.5-year implementation period. The interview protocol was common across communities, and included questions about the community and school contexts, the structure of the local Elev8 partnership, the plans for and implementation of Elev8 activities, efforts to integrate partner activities, and the sustainability of Elev8.

To understand barriers to and facilitators of the sustainability of the SBHCs nine years after their work began, we also conducted interviews in 2018 with representatives of four of the five SBHCs and all of the five schools that house them, as well as a consultant who worked with all five school sites.

	Supreme Health Services Cisneros Middle School	Promise Medical Center Basquiat Elementary	Neighbor Health Centers Anderson Charter	Abundance Medical Center Dehesa Academy	Central Health Services Ellison Elementary
Student Patients	30%	20%	90%	unknown	50%
Community Patients	70%	80%	10%	unknown	50%
Physicals and immunizations	✓	✓	✓	✓	✓
Acute health care	✓	✓	✓	✓	✓
Behavioral health care	✓	✓	✓	✓	✓
OB/GYN	✓	✓	✓		
Health education	✓	✓			

Note: The health provider and school names used pseudonyms.

Findings/Results

Like SBHCs across the country, the Elev8 SBHCs have faced several significant barriers to sustaining their work. These include: reconciling the different priorities of schools and health centers, coordinating the various stakeholders in the SBHCs, dealing with the instability of both the schools and the health provider organizations, and maintaining adequate financial support. We discuss barriers related to each of these challenges and the facilitators that helped the SBHCs, to varying degrees, overcome the barriers. We also draw on existing literature describing both barriers and facilitators.

Conflicting Priorities

Barrier: Schools and health providers are focused on different issues.

Health organizations and schools have different priorities, legal requirements, and modes of working, and these differences can lead to conflicts. Moreover, they are not accustomed to working in tandem. As Dryfoos (1994) notes:

Most SBHCs are perceived by the school as an ‘add-on,’ a valued property presented to the school by some community agency but not integral to the workings of the school . . . Teachers will not allow children to leave classes to go to clinic appointments. Custodians resist keeping doors open after school hours. Principals, especially if they are assigned to the school after the clinic is already located there, may be lukewarm about the idea and fail to foster coordination. Social workers feel threatened. Whose case is it? What records can be shared?

The goals of the health organizations that operate SBHCs, which are strongly influenced by their funding sources, may lead to conflicts with the school. Third-party reimbursements from public and private insurance are important to the operations of SBHCs. As a result, their decisions are not necessarily based on the long-term economic, educational, and social value of improving the health of students (Price, 2017). Rather, their focus has to be on providing as many reimbursable services to as many patients as possible. Thus they might steer clear of non-reimbursable services and invest more time in collecting consents from students to increase the number of reimbursable visits.



In the years following the implementation of the health centers, both the community agencies involved in Elev8 and the schools pushed for the health centers to be involved in school events, staff trainings, health classes during school, and health-related programs after school. Indeed, Atlantic Philanthropies envisioned this type of integration from the start of the initiative. Although the health centers willingly participated in some of these activities to boost usage of health center services, they resisted time-intensive activities because they diverted staff from billable work. The impression that the health centers were not integral members of the school community increased when, during the early years, the centers opened their doors to nonstudent patients, further convincing some school staff that the centers did not prioritize students.

The original Atlantic Philanthropies grant provided funds for both the construction and start-up operations of the SBHCs. However, after the initial grant period ended, Atlantic Philanthropies no longer provided supplementary funds for health activities in the schools. The lack of funds led to tenuous three-way partnerships between the school, the health providers, and the lead community agency at most of the sites. Without this funding, the health partner agencies were understandably even less motivated to step outside of their normal operations to integrate their work with the school. As one stakeholder described at this time, “you’ve got to show the health centers that there is a reason for them to put energy into being connected to Elev8.”

Facilitator: Narrow the focus of SBHCs on services important to both health providers and schools.

These initial conflicts have faded over time as the SBHCs and schools appear to have come to an implicit agreement on the role of the SBHCs. This role is one that serves both the schools' and the health providers' interests. The SBHCs focus on the health issues of greatest concern to the schools: compliance with school district physical and immunization requirements, behavioral health, and general physical healthcare. They provide services to students mostly during non-academic time periods to minimize time out of class. In return, the schools help the SBHCs to sustain themselves economically by assisting in the collection of consents, tolerating the use of the health centers by community members, and not expecting much in the way of non-reimbursable services such as health education.

Health providers continue to participate in some school events primarily for outreach to increase center usage. However, the centers occasionally contribute to school health classes and wellness committees and offer ongoing programs that promote health such as running or yoga classes.

Not all of the schools have reached a detente with their SBHCs on mental health care. During the course of our documentation of Elev8 Chicago, school faculty and community partners emphasized that behavioral health services were perhaps the most needed and helpful component of the Elev8 project. In 2018, the schools continued to be grateful for the added behavioral health support provided by the SBHCs, although at Dehesa school staff stressed that the need for consistent behavioral health services remained significant due to the reduced and inconsistent hours of the health center. Similarly, Anderson staff noted that their behavioral health care needs remained higher than the health center and school staff's capacity to meet them.

Coordination Challenges

Barrier: Schools and health providers have different policies and procedures.

All of the Elev8 sites have faced coordination challenges. Differences in priorities, discussed above, have fueled some of these challenges. For example, shortly after its SBHC opened, Anderson's interest in student safety conflicted with the health provider's interest in protecting students' confidentiality. Students were required to sign in at the office and provide personal identifying information before accessing health services so that staff could monitor student whereabouts. However, this procedure had to be revised due to privacy concerns. Similarly, at Dehesa, tension between the school and health provider emerged from an unclear referral process for behavioral health services, and poor communication between the school social worker and the health center psychologist. Questions such as when students could be seen, what kind of information could and should be exchanged between the two partners, and who was responsible for patient follow up contributed to a strained relationship between school and health center staff

They're welcoming. They are bilingual, which really helps our families feel comfortable and able to communicate. So when you walk in, there is a level of warmth, it doesn't feel sterile.

-Assistant School Principal

Facilitator: Hold regular meetings to coordinate efforts.

The sites developed various strategies to overcome coordination hurdles, including the establishment of health committees and the appointment of school-health center liaisons. All sites were initially required to hold monthly health meetings where health center, school, and community agency staff would discuss policies, procedures, and programs related to health at the school. However, by 2012, the only health committees still meeting regularly were at Ellison and Cisneros, although informal communications and one-on-one meetings among health partners and other Elev8 partners occurred, to varying degrees, at all of the sites. At one site, significant tension between the school and health center staff reduced the number of meetings. At another, the health center's focus on seeing as many patients as possible reduced their staff's availability for meetings. At a third site, a key funder of the lead agency objected to reproductive health services provided by the Elev8 health center partner, which made it difficult for lead agency staff to work closely with the health committee.

In 2018, only Supreme Health Services and Promise Medical Center were holding any health meetings that included school staff. The school and health center staff we interviewed felt that these regular meetings helped them to deal with various issues promptly and effectively. Neighborhood Health Centers was meeting regularly with a committee that included students but not school staff. However, a liaison in the Anderson school office regularly provided the SBHC with a list of students who were out of compliance with school district physical and immunization requirements. At Ellison, an SBHC staff member was meeting quarterly with the Ellison principal about health center operations and the needs of the school and plans to restart the health committee meetings were underway. By contrast, there were neither regular health committee meetings nor a school-health center liaison at Dehesa in 2018. The health center at this school appeared less stable than the others, having decreased hours during the same period that the others either increased hours or staff.

Facilitator: Assign staff and consultants to coordination roles.

In the first several years of the Elev8 initiative, sites had sufficient funds to hire AmeriCorps members (and other interns from similar programs) to facilitate communication and collaboration among the health center, school staff, and others. These health coordinators had a broad range of responsibilities, including raising awareness among families and school staff of health center services, tracking compliance rates for required student physicals and vaccinations, supporting special health initiatives (e.g., STD awareness campaigns), and escorting students to and from appointments. The health coordinator also arranged for students to receive onsite dental and optometric services from external providers. These types of services are often difficult to incorporate and sustain with more traditional SBHCs, because they are not billable medical services for health center staff. As members of AmeriCorps, the health coordinators were able to facilitate these services at a modest cost.

Another aid to coordination during the first several years of the Elev8 initiative in Chicago was a consultant who had extensive SBHC experience and worked with all five school sites. Stakeholders felt that this consultant was a critical support to the site health committees. In addition to chairing these site-specific meetings, the health consultant also identified looming concerns and upcoming tasks, provided background information about how other SBHCs had addressed similar issues, brought in outside partners to inform and advise, and shared information and technical assistance to ensure that sites were in compliance with state and federal laws. She also effectively reframed personal disputes into more benign operational challenges that could be deliberately addressed.

In addition to meetings at each site, the consultant organized and facilitated regular cross-site meetings of health providers from the five Chicago Elev8 sites and other key individuals (such as the school district official overseeing all SBHCs in Chicago Public Schools) for networking, information sharing, and problem solving. These meetings involved staff from the partnering health agencies, but not from school or lead agency partners. Excluding non-health organizations allowed health providers to speak openly about the challenges in their work and partnerships, concentrate on complicated issues specific to the health field, and provided a way for them to air grievances openly, learn from each other, and collaborate on solutions.

Facilitator: Time allows health providers and schools to appreciate each other and work more effectively together.

Whether established in a memorandum of understanding or less formally, Hacker (2009) advises careful planning to coordinate stakeholders during the start-up phase of an SBHC. “Potential issues and problems should be identified, agreements made, and policies developed. Both parties must demonstrate a readiness to receive and incorporate information. Together the partners must address a simple question: What must we agree to do and what must we agree not to do?” All of the Elev8 sites had such conversations prior to the opening of the centers, yet they still faced unforeseen challenges mostly generated by personality and territorial issues. However, staffing changes, the gradual alignment of goals, and the accumulation of trust have helped to minimize most of these challenges

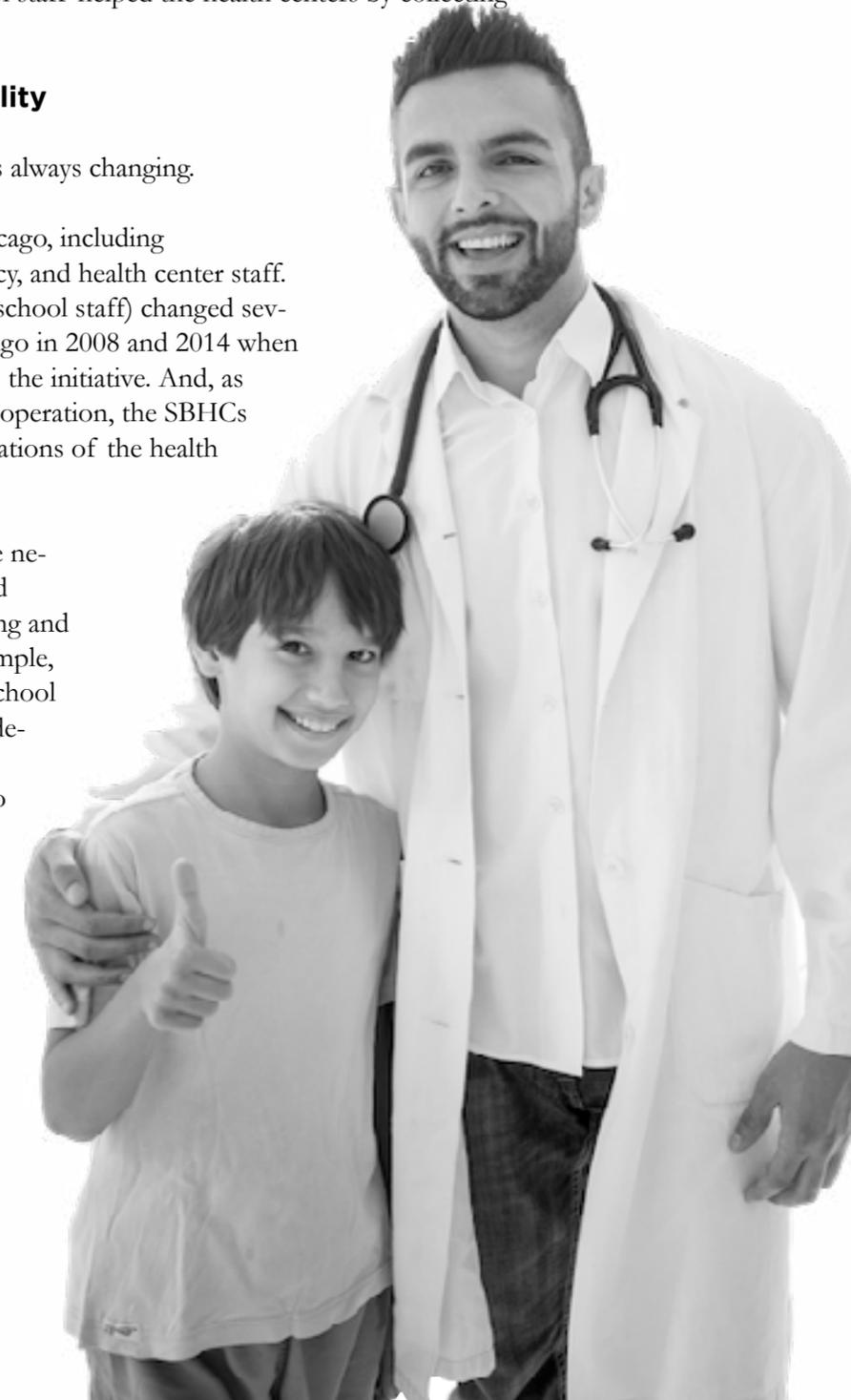
over time. By the sixth year, the health providers at each site appeared to work effectively with both Elev8 and school staff with fewer notable coordination challenges than in past years. In her observation of another SBHC, Dryfoos (1994) observed that as the program matured and the benefits became perceptible to school staff, the schools began to take on more ownership of the SBHC, helping out with the consent process and referring more students to their services. Similarly, all of the SBHC and school representatives whom we interviewed in 2018 reported that school staff helped the health centers by collecting consents and referring students.

School and Health Center Instability

Barrier: School and health provider staff is always changing.

A key challenge to all aspects of Elev8 Chicago, including SBHCs, was the churn in school, lead agency, and health center staff. The school principals (as well as other key school staff) changed several times between the start of Elev8 Chicago in 2008 and 2014 when we completed our yearly documentation of the initiative. And, as already noted, during the first five years of operation, the SBHCs experienced significant changes in the operations of the health centers and the schools.

Changes in school principals and staff have necessitated multiple changes in SBHC related policies and procedures to reflect the staffing and leadership priorities of the school. For example, at Basquiat, the original plan was that the school nurse was to triage students and make the decision to treat the student herself, send the student back to class, or send the student to the health center. When this protocol was agreed upon, the school nurse was present in the school full time. By the time the health center opened, however, school district budget cuts reduced the nurse’s hours to part-time. Confusion quickly arose as to how and when to send students to the health center in the nurse’s absence and persisted through most of the school year. Eventually, the school and SBHC agreed that school staff could send students in need of immediate care to the health center. Additionally, the SBHC would share a list of students with appointments each day, and school staff would escort them to the center.



Changes in health center staff were also disruptive to Elev8 partnerships. For example, Elev8 and school staff expressed strong concerns about the part-time hours and inconsistent staffing at the Cisneros health center from September through December 2011. These staffing difficulties increased the already significant tension between the health provider and the lead community agency, as each remained at odds about the number of hours the clinic should remain open and who should be responsible for patient outreach. Instability continues to impact the effectiveness of the SBHCs. In the 2017/18 school year, the loss of a long-time SBHC staff member who had strong relationships with Ellison school staff and families led to a variety of difficulties coordinating with the school and providing consistent service. When this staff member was restored to her former job, operations ran more smoothly again. Additionally, Dehesa staff members feel that their SBHC would have a more positive impact on the school community if its hours were longer and more consistent.

Facilitator: Community partners and consultants can help SBHCs weather the winds of change.

We did not find evidence of particularly effective strategies to deal with churn, either in our documentation of the Elev8 initiative or in our review of the SBHC literature. However, the support of community agencies and the health consultant certainly helped the SBHCs to weather the winds of change early in the Elev8 initiative. For example, when the health provider at Anderson and Basquiat pulled out, the health care consultant provided key leadership, along with the lead community agencies, in the two schools where the departing health provider worked.

Facilitator: Establish SBHCs in stable schools and communities.

As one interviewee noted, there is often not much sites can do to counteract the effects of organizational instability. Instead, she recommended that SBHCs be established in

You don't go into this school-based health center thing thinking you are going to make a profit, because you won't. The issue is having enough funds to stay sustainable.”

-Health Provider Staff

relatively stable schools and communities by health providers with strong leadership and well-established procedures and processes whenever possible. In the absence of such stability, partners in SBHCs need to expect and prepare for ongoing renegotiations and adjustments as people and organizations change.

Funding Challenges

Barrier: Patients needs services that are not billable.

As noted, all of the SBHCs established through Elev8 Chicago rely heavily on third-party reimbursements and have narrowed their services primarily to those that are billable. Moreover, they were all established as FQHCs to take advantage of the higher reimbursement rate (see inset page 9). This reliance on reimbursements is common among SBHCs nationwide, although federal, state, city, school district, and private funds also supplement the work of some centers (Price, 2017). The reimbursement-based financing strategy presents some significant challenges to SBHCs.

Most SBHCs have to offer some services that are not reimbursed or poorly reimbursed. Low-income SBHC patients may require additional case management and/or educational or social supports, expenses that are also poorly reimbursed by insurance. Silberberg (2008) provides the example of asthma management, which requires that families be educated about how to modify their home environment and provide asthma self-care. Such educational services are not reimbursable. To provide for such needs, initial and ongoing funding in addition to insurance billing is required (Devore, 2012; Price, 2017; Silberberg 2008).

Barrier: A large and consistent flow of patients is necessary to sustain SBHCs.

The reimbursement-based strategy makes SBHCs dependent on consistently high utilization. At Ellison there were unexpected and lengthy delays in constructing an entrance to the health center to allow community residents direct access without having to walk through the school hallways. The absence of the door for the first seven years of the health center likely reduced the community's use of the health center and thus its sustainability.

Barrier: Grant funds are scarce.

Other funding sources are difficult to obtain. A few of the Elev8 SBHCs have offered non-reimbursable health supports with grant funds. However, several interviewees noted that competition for such funds is high. Public grants are also in short supply (Silberberg, 2008). A looming threat is the possibility of funding cuts for undocumented children. All Kids is Illinois' Medicaid program for children who need comprehensive, affordable health insurance, regardless of immigration status or health condition. Supreme Health Services and Abundance Medical Center serve a large number of undocumented families and thus heavily rely on All Kids reimbursement.

Facilitator: Federally Qualified Health Center Regulations and Public Funds for SBHCs.

More than 40 percent of SBHCs in the U.S. are sponsored by FQHCs. Medicaid payment only reimburses about 80 percent of community health centers' costs. If a health center qualifies as an FQHC, it receives the additional 20 percent not covered by Medicaid. To qualify as an FQHC, a health center must: have a governing board composed of more than 50 percent patients of the center, serve a medically underserved population, and offer a sliding fee schedule to patients earning less than 200 percent of the Federal poverty level. Because FQHC regulations allow SBHCs like the Elev8 SBHCs to sustain their work, maintenance of such regulations is thus critical to their survival. Although FQHCs historically have received bipartisan support, there have been threats to some of their federal funding sources such as the Community Health Center Fund, which was established as part of the Affordable Care Act. (Health Resources and Services Administration, 2006, Lewis C. R., 2017)

Facilitator: Schools and health providers can share staff.

Beyond limiting services mostly to those that are fully reimbursable and looking for grant funds, the Elev8 SBHCs have used a few other strategies to promote financial viability. For example, Promise Medical Center splits its mental health position with the school, each paying half since neither has enough to cover a full-time staff member.

Facilitator: Community advocacy can help to sustain SBHC funding.

Building community support is another way that the SBHCs have promoted financial stability. Several interviewees stressed that health providers should clearly understand the health needs of their communities before opening SBHCs and that they should look for opportunities to collaborate with other health-related organizations in the community so that they are seen as a collaborator rather than a competitor. As the School-Based Health Alliance notes, "When SBHCs engage students and their families, they become SBHC champions. They play a critical role in marketing, advocacy, enrollment, and resource development." (School-Based Health Alliance) One interviewee noted that when another Chicago public school that housed an SBHC closed down, the community "put up a stink" and CPS responded by relocating the center to another school site.

Facilitator: Establish SBHCs where demand is high.

Finally, a basic strategy is to only open SBHCs in schools and communities with a large number of potential patients, including both students and community members. Sprigg (2017) recommends a potential patient population of at least 500 Medicaid-eligible patients in the school where the center is located, in nearby schools, and in community. Several of the SBHCs established through Elev8 see students from neighboring elementary schools to boost their utilization.

Discussion

Based on the information collected, the strategies that appear to have been most beneficial to sustaining the five Elev8 SBHCs include the following.

Finding Common Ground

The SBHCs and their host schools learned over time to limit the scope of services the centers provided to those of greatest concern to both the health providers and the school community. The SBHCs focus on the health issues of greatest concern to the schools: compliance with school district physical and immunization requirements, behavioral health, and general physical healthcare. They provide services to students mostly during non-academic time periods to minimize time out of class. In return, the schools help the SBHCs to sustain themselves economically by assisting in the collection of parental/guardian consents, tolerating the use of the health centers by community members, and not expecting the SBHCs to provide non-reimbursable services such as health education.

Establishing SBHCs Where Demand Is High

Because SBHCs rely heavily on third-party reimbursements, SBHCs in schools and communities with a large number of potential patients, including both students and community members, are more sustainable. Sprigg (2017) recommends a potential patient population of at least 500 Medicaid-eligible patients in the school where the center is located, in nearby schools, and in community. Several of the SBHCs established through Elev8 see students from neighboring elementary schools to boost their utilization.

Building Strong Ties Among Health Center and School Staff

Inclusion of key health and school stakeholders in the planning of a new SBHC is important, and memorandums of understanding can clarify roles. Yet, unforeseen challenges generated by personality and territorial issues may still arise once SBHC begin operations. However, keeping lines of communication open between health and school staff—through regular health committee meetings or through health and school liaisons—can build trust and reduce tensions over time.

Although many stakeholders emphasized early on in our documentation process that intermediaries such as the health consultant, the AmeriCorps interns, and the Elev8 lead community organizations were important to the initial functioning of the health center, all five centers have continued for several years without this support (Baker, Rich, Wojnarowski, & Meehan). As one interviewee noted, intermediaries

can help when troubles arise. However, when health providers with strong administrative structures are placed in relatively stable and large schools within communities in need of health care services, intermediaries appear to become less necessary over time. The loss of intermediaries has led to the loss of some health services at some of the schools such as dental van visits and vision screenings which were coordinated by interns or community organization staff. Other schools have assigned school staff for these functions.

Another strategy emphasized early on was the regular health meetings which included health provider and school staff and, in some cases, other stakeholders such as parents or Elev8 community agency staff. The two sites that appear the most stable have continued to hold such meetings. But interviewees emphasized that relationships among school and health staff were most fundamental and that those relationships could be sustained without monthly committee meetings, which can be time-consuming for busy staff members and thus hard to maintain. Rather, ad hoc meetings between individuals, such as between the school nurse and the health center nurse and between the school social worker and the health center social worker also maintain critical relationships.

Finally, the churn in staff employed by schools and health providers appears to be a fact of life for most SBHCs. Although none of the Elev8 sites developed strategies to significantly reduce this instability, they did learn to expect change and to deal with it by consistently re-educating both school and health center staff about the roles of each in the operation of the center and sometimes renegotiating those roles to better meet the current needs of each group. Additionally, once SBHCs are firmly planted into communities, community members may advocate for their maintenance.

Low-income families face a myriad of interwoven challenges including unemployment, low wages, insufficient education, poor health, crime, and housing concerns. Unfortunately, the supports designed to help families overcome such challenges are often financially unstable and disjointed. Over the past several decades, the public and private sectors have worked to find ways to integrate and sustain such supports over the long-term. SBHCs are part of this effort. They are developing strategies to coordinate their efforts with schools and other community-based supports and bring badly-needed and sustainable health care to those most in need.

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