



Rutgers Center for
State Health Policy

**Creating Sustainable School-Based
Health Centers:
A Report on Clinic Financing**

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Silberberg, M, Fox, K, Huston-Wong, J., and Cantor, J. *Evaluation of the Newark School-Based Youth Services Program. Part II: Report on Health Clinic Enrollment and Utilization, Academic Performance, and Teacher Perceptions*. Rutgers Center for State Health Policy, Forthcoming.

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Creating Sustainable School-Based Health Centers: A Report on Clinic Financing

Mina Silberberg, Ph.D.
Joel C. Cantor, Sc.D.

Executive Summary

In 1997 the Healthcare Foundation of New Jersey (HFNJ) began establishing school-based health centers in the city of Newark. Maintaining these clinics will require creating sustainable funding. This report describes what was learned about developing sustainable funding through thirteen key informant interviews conducted by the Rutgers Center for State Health Policy (CSHP). The goals of the key informant interviews were the following:

- To learn what programs in other states are doing to finance their clinics, and the perceived advantages and disadvantages of these approaches;
- To understand respondents' perceptions of the role of SBHCs in their states' health care systems;
- To learn what conditions help to facilitate sustainable financing; and
- To identify aspects of the current environment in New Jersey that will affect prospects for developing sustainable funding and identify lessons from the experiences of clinic programs in other states.

To address these goals, we interviewed thirteen key informants, including researchers, government officials, and administrators of state programs. We chose four states that were front-runners in the use and financing of school clinics but that differed in their approaches to financing; these were New York, Delaware, Connecticut, and Colorado. At least two individuals were interviewed from each state. In addition, we interviewed a representative of New Jersey's School-Based Youth Services Program (SBYSP), a state-grant-funded program that together with the HFNJ project defines the current landscape of school-based health centers in New Jersey. Interview protocols were semi-structured and tailored to the respondent's area of knowledge, but were designed to address the four issues delineated above. The following summarizes our major findings.

Creating Sustainable Funding

The Importance of a Diversified Funding Base

The most important and consistent message of the interviews was to diversify the program funding base. Diversity, according to respondents, promotes sustainability, prevents clinics from becoming overly reliant on any one funding source, builds on the strengths of the individual funding sources, and allows clinics to provide a broad range of services and to serve both insured and uninsured students.

Funding Sources

Possible funding sources include the following:

- Medicaid and Children's Health Insurance Program (CHIP): through contracting, carve-outs, Early and Periodic Screening, Diagnosis, and Treatment Program;
- Private insurance;
- State or federal grants or municipal funds. Federal grants include Maternal and Child Health Block Grants, Safe and Drug-Free Schools funds, and the Temporary Assistance for Needy Families program;
- Sponsor in-kind donations;
- School district in-kind donations;
- Foundation monies, including hospital conversion funds and United Way;
- Tobacco settlement revenues;
- Payment for service provision, e.g., contracting with schools to provide school nurses;
- Consumer payment; and
- General fundraising.

Third-Party Payment

Respondents agreed that third-party payments will not cover all or even most costs. Researchers estimate that, at most, one-third of SBHC expenses can be covered by third-party payment; although that level was not reached by any of the study states. Furthermore, contracting with managed care organizations (MCOs) is difficult to arrange, requiring an infrastructure that many clinics may not currently possess; an investment by sponsors who may not understand clinics or who see them as a "drop in the bucket" of their operations; and a set of arrangements that allow clinics, sponsors, and MCOs to work together effectively to provide care. There may also be disincentives to participation for both MCOs and clinics. State mandates, therefore, are insufficient for generating

adequate contracting. Nonetheless, many respondents still see it as appropriate to pursue third-party payment, and managed care contracting in particular, as part of a larger funding strategy. They argue that reimbursement through Medicaid, private insurance, and other third parties promotes accountability and efficiency, and shows that SBHCs provide a valued service.

While mandates are not sufficient for contracting to occur, in some places they have not proved necessary. In Colorado, the promise that SBHCs can improve plan performance and broaden networks has been a selling point for HMOs. Non-profit HMOs may also see SBHCs as consonant with their mission.

Operational conditions necessary for contracting to work include:

- A highly developed record-keeping system and infrastructure for communication with MCOs;
- An effective approach to confidentiality that still allows for needed communications,
- Adequate quality assurance;
- Clear “product definition” so MCOs know what they’re buying;
- A sponsor that understands contracting and is willing to put forth effort on behalf of the clinics; and
- Conformance to MCO requirements.

Finding Funds

Good public relations are essential for finding funds. If possible, clinic sponsors should bring elected officials and potential funders physically to the clinics. Also, because of turnover among officials and personnel, public relations efforts must be continuous.

SBHC proponents have found “hooks” that have helped in obtaining clinic funding, such as the promise of improved HMO performance described above. In Delaware, the legislature was partly influenced through a connection made between teenage behavioral health and the state’s high teen pregnancy and infant mortality rates.

It helps if a champion can be found for SBHCs (e.g., the governor). However, SBHC sponsors must play this champion role on a more micro-level, taking an entrepreneurial approach to clinic financing. Community support must also be garnered. Stakeholders should be brought to the table to develop clinics or arrange financing.

The Role of Clinics and the Model of Care

Respondents see clinics as a means of assuring student access in the face of continued uninsurance, logistical barriers (transportation, parental availability, etc.) and student distrust of

office-based providers. Also, SBHCs often provide services that are not covered through students' health plans.

Clear product definition does not require only one model of care. States or SBHC associations can define multiple models or variation within clear parameters.

Politics and Governance

Role of State Government

There are a number of roles that state government can play in promoting SBHCs, developing sustainable funding, and facilitating high-quality clinic care:

- Facilitation: convening stakeholders, catalyzing activity;
- Regulation of clinics;
- Funding of clinics, including allocating federal grants;
- Mandating MCOs to contract with clinics;
- Encouraging participation of MCOs and clinics in contracts; and
- Evaluation.

Associations of School-Based Health Centers

In some states, school-based health centers have formed associations that have played three main roles:

- Public relations and advocacy;
- Technical assistance to sponsors and SBHCS, for example with MCO contracts; and
- Quality assurance.

The New Jersey Context

Key features of the New Jersey context include:

- There is a state-funded School-Based Youth Services Program in high schools, which emphasizes social and behavioral health services;
- Services are now free, creating a challenge for establishing a payment system;
- Clinics are not currently receiving fee-for-service reimbursement, making it easier to move to managed care contracting;
- A number of constituencies support the SBHCs in NJ but have not historically made them a top priority;

- The Abbott rulings require the state to provide health services where need is established, but this has been difficult thus far; and
- At the time of the interviews, staff of the New Jersey Medicaid program declined to be interviewed because there was no policy activity in this area. The New Jersey Association of Health Plans also declined for equivalent reasons. The new Administration appears interested in expanding the role of SBHCs in the state.

Recommendations

Based on the key informant interviews, initial recommendations are:

- Pursue a diversified funding base, regardless of current state policy;
- Promote clear product definition or “branding” of the clinics without requiring one uniform model;
- Assess and enhance clinic record keeping, communications infrastructure, confidentiality procedures and quality assurance;
- Consider the establishment of an association of school-based health clinics in the state;
- Explore other opportunities for collaboration with the state SBYSP;
- Seek sponsors who understand contracting, will feel a stake in the SBHCs, and have the capacity for and interest in entrepreneurship; and
- Continue current efforts to educate potential allies about the clinics.

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Introduction

In 1997 the Healthcare Foundation of New Jersey (HFNJ) began establishing school-based health centers in the city of Newark. Maintaining these centers, however, will require creating sustainable funding. This report describes what was learned about developing sustainable funding through thirteen key informant interviews conducted by the Rutgers Center for State Health Policy (CSHP).

Background

First appearing in the United States during the 1970s, school-based health centers (SBHCs) provide a range of primary and preventive care services, generally including medical and mental health care, and sometimes dental as well. The number of school-based clinics has grown rapidly, with a recent national survey identifying 1,380 clinics.¹ School-based clinics are financed primarily by grants from public and private sources although a small but growing portion of funding comes from public or private insurance.

In 1997, the Healthcare Foundation of New Jersey, in partnership with the Newark School District and the St. Barnabas Healthcare System (which includes Newark Beth Israel Medical Center and Newark Children's Hospital), began establishing health clinics in the Newark Schools through the School-Based Youth Services Program (SBYSP). Five clinics are now operating through this program – four at elementary/middle schools and one at a high school. Clinic services at the participating Newark schools are available at no cost to students whose parents or guardians sign consent forms. Each clinic has a full-time pediatric nurse practitioner, social worker, and administrative assistant. Administrative and clinical support and oversight is provided to the clinics by Children's Hospital through a program director, three physicians, a psychiatrist, and a dentist.

The funding provided to establish the Newark SBYSP by the Healthcare Foundation of New Jersey is seed money, and it is the aim of the program partners to secure funding through other sources. The Foundation commissioned this study to gain insights into the development of sustainable funding from the experiences of other states and expert observers of the national SBHC movement.

The goals of the study were the following:

- To learn what programs in other states are doing to finance their clinics, and the perceived advantages and disadvantages of these approaches;
- To understand respondents' perceptions of the role of SBHCs in their states' health care systems;
- To learn what conditions help to facilitate sustainable financing; and
- To identify aspects of the current environment in New Jersey that will affect prospects for developing sustainable funding and identify lessons from the experiences of clinic programs in other states.

Methods

To address these goals, we interviewed thirteen key informants, including researchers, government officials and administrators of state programs. Through our review of the literature and conversations with experts, we chose four states that were front-runners in the use and financing of school clinics but that differed in their approaches to financing: New York, Delaware, Connecticut, and Colorado. At least two individuals were interviewed from each state. Appropriate respondents were identified through the research literature and through the recommendations of other respondents.

While we wished to interview New Jersey stakeholders from a variety of sectors, however the Medicaid office and the Association of Health Plans declined the interview because at the time there was no policy activity in this area. We did interview a representative of New Jersey's School-Based Youth Services Program (SBYSP), a state-grant-funded program, that together with the HFNJ project defines the current landscape of school-based health centers in New Jersey.

Interview protocols were semi-structured and tailored to the respondent's area of knowledge, but were designed to address the four questions delineated above. In general, there was a great deal of consensus on key issues among the respondents. When that is not the case, we have noted points of dissent.

Findings

Creating Sustainable Funding

Operating costs per clinic vary, but tend to be in the ballpark of \$150,000 to \$200,000 annually. How can the funds be found to meet these expenses?

The Importance of a Diversified Funding Base

The most important and consistent message of the interviews was to diversify the program funding base. This message came from respondents in states with both diverse and more homogenous funding bases. Diversity, according to respondents, promotes sustainability, prevents clinics from becoming overly reliant on any one funding source, builds on the strengths of the individual funding sources, and allows the clinic to cover a variety of services for a variety of clients.

Delaware and Colorado illustrate the opposite poles of the funding diversity continuum. Delaware has a monolithic funding base [see Table 1]. The first center in that state was opened in 1985 with funding from The Robert Wood Johnson Foundation. However, with the strong backing of then Governor Carper, the state initiated a program to grant-fund an SBHC for every high school in the state. All the high schools but two have taken advantage of the program. Currently, 27 schools have SBHCs, to which the state appropriates \$4.7 million. One school also supports its clinic through federal monies from a Maternal and Child Health Block Grant.

At the other end of the spectrum, Colorado SBHCs have a highly heterogeneous funding base. The largest share of support comes from local in-kind donations (primarily from sponsors). Other major sources include foundation grants, contracts, and school district support. Third-party payment makes up a little less than 10% of the funding.² At one of the state's and the country's oldest SBHC programs, funding comes from third-party and out-of-pocket reimbursement, state and federal grants, United Way, city funding, Temporary Assistance for Needy Families (TANF), in-kind donations from the school district, earned income (e.g., by providing nurses to the schools), and fundraising.

Such a heterogeneous funding base clearly requires a great investment of time to develop and sustain. On the other hand, while Delaware's state appropriation is invaluable, this monolithic funding arrangement has a downside as well. Recently, respondents report, program advocates wishing to expand the centers to elementary schools were denied funding from The Robert Wood Johnson Foundation on the grounds that their single funding source made them highly vulnerable to political change. In fact, with the recent change in the state's governorship, advocates are concerned that the program has lost a crucial locus of support. They worry as well that the clinics may not respond adequately to this possibility, as having a committed source of funding has made them complacent, leading to little entrepreneurship around funding development.

In addition to decreased vulnerability and heightened sustainability, another argument for diversity is that each individual funding source has operational and symbolic strengths. Having multiple funding sources allows a program to take advantage of these varying strengths. For example, some respondents argue that reimbursement through Medicaid, private insurance, and other third parties promotes accountability and efficiency, and shows that SBHCs provide a valued service. Some note that having a specific pot of money set aside by the state for clinics creates stability and

Table 1: School-Based Health Clinic Models and Financing in Four States

	Colorado	Connecticut	Delaware	New York
Funding Sources	In-kind (esp. from sponsors), foundation grants, contracts, school district support, third-party reimbursement, Maternal and Child Health Block Grant (MCHBG), other.	State grant, sponsor in-kind, third-party payments, MCHBG, local funds, very little private other than RWJ, other.	State appropriation. Small amount from MCHBG.	Block grant funding, Medicaid FFS; state, federal, and private grants; mail public third-party payment, in-kind
Third-Party Payment	Not mandated, but encouraged. Clinics are designated as Essential Community Providers (ECPs). Third-party revenues are estimated at less than 10% of total cost.	Mandated for Medicaid and CHIP as ECPs. Provides only small amount of funds.	No mandate. No third-party payment.	Mandate for Medicaid Managed Care has been passed but delayed indefinitely. CHIP funding under discussion.
SBHC Model	No licensure, no standard model. Receipt of state grant requires primary care and mental health, on-site clinic or on-campus. State SBHC Association assigns Levels I-III, based on hours and financing, which indicates capacity to contract with Managed Care Organizations (MCOs).	Full or part-time SBHCs, varying by state funding and operations guidelines. All clinics must have comprehensive primary and preventive physical and behavioral health (with PCP and mental health professional); health education; and social services.	Full-time center coordinator, additional professional at 30 hours, full-time administrative assistant, a few hours from registered dietitian and physician. Two models: For medical model, coordinator is medical provider, other professional is LCSW. For mental health model, coordinator is LCSW, other professional is medical provider.	Mid-level medical provider with full-time health assistant, collaboration with physician. No mental health requirement. No clinic sharing, but staff other than health assistant may rotate; with 700 enrolled students, must have one FTE primary care provider.
Role of State	-Facilitate -Administer state and federal grant monies -Encourage MCO-clinic contracts. -Fund through Medicaid and CHIP MCO contracts.	-Facilitate -Fund (primary funder) through state grant, Medicaid and CHIP MCO contracts. -License (for all clinics, with or without state funds).	-Coordinate and facilitate. -Fund (primary funder) through state appropriation. -Set standards for receipt of state funds. -Evaluate.	-Facilitate. -Fund through Medicaid and other. -Approve all SBHCs and receipt of all funds of all origins. -Evaluate.

demonstrates the state's commitment to the program. Some see foundation grants as an impetus to develop innovative programming.

Finally, in many cases, the one or two funding sources that clinics look to will not cover all desired services, or all children. For example, Maternal and Child Health Block Grants are essentially pilot funds with a heavy emphasis on paying staff salaries. Third-party payments will not cover services to the uninsured, nor much of the health education that clinics do. Furthermore, if clinics are unable to resolve some of the confidentiality issues related to third-party payments, students may avoid using them for sensitive situations. For example, one respondent described a situation in which a denial of benefits letter went home for a service that was supposed to be confidential, undermining not only the confidentiality promised to the student but the clinic's reputation. Pursuing a diversity of funding sources potentially allows the clinic to expand the roster of available services and covered children, and creates the flexibility needed to deal with the variety of situations facing clinics.

Funding sources

Possible funding sources identified through the interviews include the following:

- Medicaid and Children's Health Insurance Program (CHIP): through contracting, carve-outs, Early and Periodic Screening, Diagnosis, and Treatment Program;
- Private insurance;
- State or federal grants or municipal funds. Federal grants include Maternal and Child Health Block Grants, Safe and Drug-Free Schools funds, and the Temporary Assistance for Needy Families program;
- Sponsor in-kind donations;
- School district in-kind donations;
- Foundation monies, including hospital conversion funds and United Way;
- Tobacco settlement revenues;
- Payment for service provision, e.g., contracting with schools to provide school nurses;
- Consumer payment; and
- General fundraising.

Third-Party Payment

A dominant theme of the interviews was that third-party payments will not cover all or even most clinic costs. Researchers estimate that, at most, one-third of SBHC expenses can be covered by third-party payment; although that level was not reached in any of the study states. Colorado was

covering the largest share of its expenses through third-party payments, at slightly less than 10%. Furthermore, contracting with managed care organizations (MCOs) is extremely difficult to arrange, requiring an infrastructure that many clinics may not currently possess; an investment by sponsors who may not understand clinics or who see them as a “drop in the bucket” of their operations; and a set of arrangements that allow clinics, sponsors, and MCOs to work together effectively to provide care. In addition to the logistical obstacles to contracting, both MCOs and clinics may have limited incentive to participate. Disincentives for MCOs include the economic costs of contracting with clinics, the challenges of coordination, and the need to bring SBHCs into compliance with MCO requirements. Disincentives for SBHCs include the need to develop new types of infrastructure and procedures and to operate in ways that may be antithetical to their self-perception (e.g., billing). There may also be economic disincentives. In New York, for example, Medicaid currently reimburses SBHCS well on a fee-for-service basis, which is more generous than reimbursement under managed care.

New York in many ways demonstrates the difficulties of developing MCO-clinic contracting. Several years of work and dialogue went into trying to create acceptable contracting arrangements. The mandate was slated to be implemented at the end of September 1998. However, the clinics and the MCOs have not been able to arrive at agreements, and implementation of the mandate has been delayed indefinitely.

Despite its limitations as a funding source and its challenges, managed care contracting is possible, as illustrated by Connecticut and Colorado. Furthermore, many respondents still see it as appropriate to pursue third-party payment, and managed care contracting in particular, as part of a larger funding strategy. Not only is diversity of funding sources desirable (and, in many cases, necessary), but—as noted above—third-party payment is believed to promote accountability and efficiency, and to show that SBHCs provide a valued service.

How, then, can contracting be developed? While the New York case shows that a mandate is not sufficient to promote contracting, Colorado demonstrates that it is not necessary and illustrates some of the incentives for MCOs to enter into contracting arrangements. In Colorado, the state encourages contracts, but does not mandate them. The promise that SBHCs can improve plan performance has been a selling point to HMOs there. Additionally, in a community where an HMO doesn't have a big network, the school clinic can be viewed as a needed source of providers. Non-profit HMOs may also see SBHCs as consonant with their mission.

Operational conditions necessary for contracting to work include:

- A highly developed record-keeping system and infrastructure for communication with MCOs;
- An approach to confidentiality that protects student privacy but still allows for needed communications;
- Adequate quality assurance;
- Clear “product definition,” so MCOs know what they’re buying;
- A sponsor that understands contracting and is willing to put forth the effort on behalf of the clinics; and
- Conformance to MCO requirements.

Finding Funds

Good public relations are essential for fund raising. If possible, respondents advise, bring elected officials and potential funders to the clinics. Also, because of turnover among officials and personnel, public relations efforts must be continuous.

SBHC proponents have found “hooks” that have helped in obtaining clinic funding, as illustrated through Colorado’s success with MCO contracting. On the governmental side, SBHCs can be promoted as the solution to a problem. In Delaware, the legislature was partly influenced through a connection made between teenage behavioral health and the state’s high teen pregnancy and infant mortality rates.

If a champion can be found for SBHCs (e.g., a governor), this is obviously a bonus. However, SBHC sponsors must also play this champion role on a more micro-level, taking an entrepreneurial approach to clinic financing. Community support must also be garnered. Additionally, stakeholders must be brought to the table to develop clinics and arrange financing.

The Role of Clinics and Models of Care

Respondents were uniform in their view that even with the expansion of child health coverage through Medicaid and CHIP, there is an important role for the clinics. Consistently, respondents see clinics as a means of assuring access in the face of continued uninsurance, logistical barriers to service use (transportation, parental availability, etc.), and student distrust of office-based providers. Also, SBHCs often provide services that are not covered through students’ health plans. This picture of the gaps in the child health care system is an important one for defining the clinics’ role and for respondents’ arguments that state funding of school clinics alongside Medicaid and the Children’s Health Insurance Program is justified.

The literature on SBHCs and the interviews of some respondents stress the need for clear “product definition” for the purposes of explaining and marketing clinics to prospective funders and facilitating managed care contracts. However, the interviews also suggest that clear product definition does not require that there be only one model of care. First, states can define multiple models. In Delaware, for example, “medical model” clinics are headed by a center coordinator who is a medical provider and “mental health model” clinics are headed by a coordinator who is a licensed clinic social worker. Other required staffing is the same. Second, states can define minimum requirements, and allow for diversity within those parameters. For example, in New York, clinics must employ a health assistant and a mid-level practitioner; the latter can be either a nurse practitioner or physician’s assistant. The health assistant must always be on-site at the clinic, because there must always be a “health presence” and because the health assistant has access to confidential records. However, other staff may rotate among two or more clinics, depending on their enrollment. For every 700 enrolled students at the clinic, there must be one full-time equivalent primary care provider.

Respondents even note a benefit to having diverse clinic models, in allowing programs to respond to the needs of individual communities and thereby maintain community support and potentially provide better service. In particular, since the provision of reproductive health services can be a controversial issue for SBHCs, allowing some community influence over what services clinics offer can be crucial for generating and maintaining political support.

It was also noted that medical and mental health services work well together. A number of respondents view the behavioral health services provided by clinics as particularly important, because students have serious mental health needs, and because behavioral health services may be insufficiently accessible or inadequately utilized outside of the school. Students often get to these services at the clinics through referral by a medical provider, and the presence of a medical provider can decrease the stigma associated with a stand-alone counseling center.

Politics and Governance

Role of State Government

State agencies and key individuals have played a number of important roles in promoting SBHCs, helping to develop sustainable funding, and facilitating high-quality clinic care:

- **Facilitation, including convening stakeholders, catalyzing activity:** In some states, government agencies or individual officials have played a central role in convincing others of the importance of SBHCs, and in bringing different players to the table to develop clinics and secure financing (in particular, to work out contracting arrangements).

- **Regulation of clinics:** State approaches to regulation vary on a number of dimensions, such as whether the state regulates facilities, professionals, or both; whether school-based health clinics have unique regulatory requirements; whether the state regulates all clinics or only those they fund; how strictly regulations define the clinic model; and what aspects of the model they specify. As with any sort of regulation, there is a tension between the goals of guaranteeing a specific product and certain quality of care on the one hand, and—on the other—the need for flexibility and for limiting burden on the sponsors and providers.
- **Funding of clinics:** States may be involved in funding clinics through public third-party payment (Medicaid and CHIP), or through state appropriations and grants. States may also be involved in allocating federal grant monies to clinic programs.
- **Mandating:** States can mandate MCO contracting with SBHCs or define SBHCs as Essential Community Providers (ECPs) and mandate contracting with ECPs. However, as noted earlier, mandating — while it may help in a given situation — is neither necessary nor sufficient for securing third-party payments.
- **Encouraging participation in MCO-SBHC contracts:** The state may stop short of mandating contracting, but may create regulatory language that encourages it or encourages some level of cooperation. In Colorado, clinics are defined as ECPs and MCOs are encouraged to contract with them. In New Jersey, the Medicaid managed care contract currently requires MCOs to develop “working relationships” with school clinics. Encouraging participation in these ways gains greater force if joined with deployment of the state’s facilitator role.
- **Evaluation:** Some states evaluate their clinic programs for the purposes of monitoring the programs or building support for them.

Associations of School-Based Health Centers

In some states, including Colorado and Connecticut, school-based health centers have formed associations that play a number of roles. These include public relations and advocacy, technical assistance to sponsors and SBHCs, and quality assurance. One respondent noted that associations can engage in efforts for which the state lacks resources. In both Connecticut and Colorado, the association was seen as invaluable. Some association roles are:

- **Public relations and advocacy:** The interviews delivered a consistent message that public relations and advocacy are important for SBHCs and advocacy must be

ongoing, because of changes in stakeholders. An association provides SBHCs with the opportunity to pool their resources for advocacy (perhaps even hiring professional representation) and to speak with a unified voice.

- **Technical assistance to sponsors and SBHCs:** SBHCs face a variety of logistical challenges to doing their job on a daily basis, to generating funds in general, and – as noted above – to establishing HMO contracts. Associations can provide technical assistance in the form of in-service training sessions, templates and models, troubleshooting and advice.
- **Quality assurance:** Quality of care is important for any health care organization; for SBHCs, documenting that quality is often a precondition for maintenance of funding. Associations can provide technical assistance in this area or can “regulate” their members.

The New Jersey Context

Based on the interviews, a number of specific features of the New Jersey context should be taken into consideration in the pursuit of sustainable funding.

- **New Jersey has a state-funded high-school-based School-Based Youth Services Program.** Relative to HFNJ’s clinics, the state SBYSP program has a greater emphasis on social and behavioral health services and less emphasis on medical services. However, the state SBYSP model does – like the HFNJ model – include both components, and the models are not seen by SBYSP as incompatible.
- **Services are currently free at the HNFJ clinics and state SBYSP clinics.** This will present challenges to the institution of patient fees. Patient fees are a small revenue source, particularly if they are kept low enough not to impede access. However, there are a number of arguments for instituting them. First, some observers believe that requiring users to pay something increases the perceived value of a service. Second, some third-party payment sources will require patient co-pays. Third, Medicaid cannot be billed for services that are otherwise dispensed for free. Fourth, fees create an incentive for parents to enroll their children in Medicaid and CHIP when they are eligible but unenrolled. The downside of patient fees is that they are difficult to administer. In the New Jersey context, there is an additional challenge in that HFNJ and the state-funded clinics do not currently charge patients. The institution of fees where there previously were none is likely to meet resistance.

- **The clinics have not had to put systems in place to enable billing or meeting other reimbursement requirements.** Building this capacity will be difficult and costly.
- **A number of constituencies support the SBHCs in NJ but have not historically made them a high priority.** A number of groups and individuals – such as the Association for Children of New Jersey and many school superintendents — have been supportive of SBHCs in New Jersey. They are likely to back the the development of a more sustainable funding base; however, no group has taken this issue on as a top priority up to the present.
- **The Abbott rulings require the state to provide health services where need is established.** Documenting need and establishing that SBHCs are the most cost-effective way to meet the need will be difficult. Moreover, the availability of funds through Abbott is not clear.
- **Government and HMO industry interest in this topic has historically been small, but may be increasing.** At the time of the interviews, staff of the New Jersey Medicaid program declined to be interviewed because there was no policy activity in this area. The New Jersey Association of Health Plans also declined for equivalent reasons. The new Administration appears interested in expanding the role of SBHCs in the state.

Recommendations

Based on the key informant interviews, initial recommendations are:

- Pursue a diversified funding base regardless of current state policy. Grant funding from government or private agencies should be part of this strategy, along with longer-term funding streams (state appropriation, reimbursement). Seeking new forms of support requires an investment of sponsor administrative resources.
- Promote clear product definition (or “branding”) without requiring one uniform model.
- Assess and enhance clinic record keeping, communications infrastructure, confidentiality procedures and quality assurance practices.
- Consider the establishment of an association of school-based health clinics (including both HFNJ and state-funded clinics) to engage in public relations and advocacy, technical assistance, or quality assurance.

- Explore other approaches to collaboration with SBYSP.
- Seek sponsors who understand contracting, will feel a stake in the SBHCs, and have the capacity for and interest in entrepreneurship and advocacy.
- Continue current efforts to educate potential allies about the clinics.

Endnotes

¹ http://www.healthinschools.org/sbhcs/sbhcs_table.htm

² This is an estimate only for the clinics originally funded through the Robert Wood Johnson Foundation Making the Grade program.

Appendix

<i>Key Informant</i>	<i>Position</i>
Christel Brellochs	Consultant; formerly Director, New York City Department of Health, School-Based Clinic Program
Donna Christensen	Social Work Consultant, School and Primary Health Unit, Connecticut Department of Public Health
Bruce Guernsey	Director, School Based Health Initiative, Colorado Department of Public Health and Environment
Mary Ellen Hass	Executive Director, Student Health Services of Stamford, Stamford, Connecticut
Michael Honig	Senior Vice-President for Management Services, Healthfirst, New York, NY
Gloria James	Director, School-Based Health Centers Program, Division of Public Health, Delaware Department of Health and Social Services
Annette Johnson	Program Director, School Health Program, Bureau of Child and Adolescent Health, New York State Department of Health
Julia Lear	Director, Center for Health and Health Care in Schools, George Washington University
Claire Mallone	Formerly Health Program Administrator II, New York State Department of Health
Colleen Maloney	Specialist, Office of Medicaid Management, New York State Department of Health
Betty Pepin	President, Colorado Association for School-Based Health Care
Gregg Sylvester	Director, Eugene DuPont Preventive Medicine and Rehabilitation Institute; formerly Secretary of Health and Social Services, Delaware
Edward Tetelman	Assistant Commissioner, New Jersey Department of Human Services