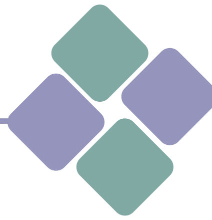

THE CENTER FOR STATE HEALTH POLICY

# Evaluation of the Newark School-Based Youth Services Program

## Part 1: Report of Stakeholder Perceptions


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# Evaluation of the Newark School-Based Youth Services Program
# Part 1: Report of Stakeholder Perceptions

## Executive Summary

### Introduction

In April of 2000, the Center for State Health Policy at Rutgers began a two-stage evaluation of three school-based health clinics in Newark, New Jersey. The clinic program, known as the School-Based Youth Services Program, was established in 1997 through a partnership between the Healthcare Foundation of New Jersey, Children's Hospital of New Jersey at Newark Beth Israel Medical Center (part of the St. Barnabas Healthcare System) and the Newark Public School System. The Healthcare Foundation funds the clinics, which are operated by Children's Hospital. This report presents the findings of the first stage of the evaluation — an analysis of stakeholder insights into the implementation of the three-year-old clinic program and their perceptions of its results thus far. Overall, the evaluation team finds the School-Based Youth Services Program to be an example of a highly successful foundation initiative. There is wide appreciation for the program and a strong feeling among the senior program management, clinic staff, school personnel, and parents that the program is "working well." Our conclusions focus on lessons learned through this initial start-up phase and considerations for building on the clinics' initial successes.

### Methods

Stage One of the evaluation research was carried out between May 17 and June 20, 2000 and included site visits to the clinics, in-depth, semi-structured interviews with 41 stakeholders, 10 focus groups with teachers and 3 with parents/guardians. Questions asked in the interviews and focus groups addressed issues of development and management of the overall program, the operation of the clinics, perceived program impact, and program changes desired by study participants. The second part of the evaluation is now underway and will include analysis of available clinic and academic performance data and a survey of teachers in the clinic schools and comparison sites.

### Program Development and Management

The early development and implementation of the program benefited from a high level of cooperation and motivation among the three program partners to overcome formidable potential barriers inherent in such a complex undertaking. The interviews revealed that since its inception two major visions of program purpose have emerged: improving educational performance and improving student health and access to care. Respondents put different levels of emphasis on different purposes and some had difficulty articulating the program purposes. We also found mixed reports as to whether the initial and ongoing planning and development process for the clinics has included adequate attention to needs assessment and has been sufficiently inclusive. In particular, some respondents expressed a concern that school nurses, teachers, and parents be more involved.

While administrative supervision, support, and programmatic development were all seen as strong at both the program and clinic levels, there are apparent weaknesses in the areas of clinical supervision and support as well as financial accountability. Some respondents also perceive a need for increased leadership on the issue of achieving sustainable funding.

### Clinic Services

The implementation of individual student services is reportedly very strong, with rates of parental informed consent and awareness of clinic services high and growing. There is a near consensus that the clinics are well utilized overall, although some respondents reported that the clinics are not reaching enough children requiring medical services and that too often children are sent to the clinic to help solve classroom discipline problems. Clinic quality is perceived as excellent, although many close to clinic operations reported confusion about or problems with the quality assurance process.

Despite extensive efforts to track and follow up on referrals to outside providers, the clinic staff reported two difficult problems with follow-up. First, coordination has been difficult between the clinics and the district's Child Study Teams, which are responsible for identifying and arranging treatment for children needing special education services. Second, many parents reportedly fail to follow up on referrals made by clinic staff to outside providers. In general, the clinics are seen as making significant contributions to the overall environment at each of the participating schools. However, some respondents feel that this contribution could be greater still. For example, health education services that the clinics offer reportedly are not well utilized by teachers and parents, despite efforts by clinic staff to publicize their offerings and expressions of interest by teachers and parents.

### Perceived Program Impact

Nearly every person interviewed reported that the clinics have had a positive impact on students' health and well being, especially in increasing their access to health, dental, and mental health services. The clinic staff are seen as facilitating improved access to services in the community, as well as providing needed services at the clinics. The clinics are also seen as having a positive impact on student health knowledge and behavior. Having the clinics at school is widely perceived to be reducing absenteeism and helping students cope with serious emotional and health problems that distract from academic performance. Virtually all of the study respondents see these impacts as leading to improved academic outcomes (e.g., grades and test scores), although few could point to specific instances where academic performance was improved directly by clinic intervention. This is not surprising given the complexity of the school environment and the early stage of clinic implementation. The clinics are also seen as promoting parental and teacher well -being and improving the school environment overall.



### The Morton St. School Model

Beginning in November 1999, students at the Morton St. School were given access to the clinic at the Quitman St. School. Sharing clinics among several schools is envisioned as a way of expanding the program. Interviews revealed that in its first six months, the shared-clinic model at Morton St. has had several start up problems. These include limited enrollment in and use of the clinic by Morton St. students, low levels of awareness of the program, and logistical difficulties.

### Desired Program Changes

Respondents suggested a number of changes to program operations.
These include:

- Increase awareness of clinic activities among teachers and parents through vehicles such as publishing a newsletter for parents and employing a community liaison.

- Expand the scope of services, particularly by adding full-service on-site dental care and increasing mental health staffing and services.
- Broaden clinic clientele to families and/or expand clinic hours (although these suggestions were controversial).
- Include more input into clinic management from parents, teachers, and other stakeholders.
- Clarify the role of clinical consultants.
- Improve program financial management, and address long-term financial viability of the program by developing strategies for sustainable funding.

## Preliminary Recommendations

Although additional evaluation activities are planned, we identified several ways in which efforts to enhance the program might be focused at this time.

- Experiment with new approaches to increasing parent and teacher awareness of and connection to the clinic.
- Experiment with new approaches to improving parental follow-up of referrals to care.
- Clarify clinical oversight roles and strengthen mechanisms for ensuring that clinical supervision is carried out as planned.
- Enhance the mechanisms of financial management.
- Turn serious attention to sustainable funding.
- Clarify the nature of the Morton St. – Quitman clinic relationship, increase awareness of service availability and logistics, address logistical problems, respond to the special circumstances of middle school students, and track the unfolding experience of the model.
- Clarify overall program goals and ensure communication to new staff.
- Strengthen mechanisms for participatory decision-making in the program and at each clinic.

# Evaluation of the Newark School-Based Youth Services Program
## Part 1: Report of Stakeholder Perceptions

### Introduction

In April of 2000, the Center for State Health Policy at Rutgers began a two-stage evaluation of three school-based health clinics in Newark, New Jersey. The clinic program was established in 1997 through a partnership between the Healthcare Foundation of New Jersey, Children's Hospital of New Jersey at Newark Beth Israel Medical Center (part of the St. Barnabas Healthcare System), and the Newark Public School System. The Healthcare Foundation funds the clinics, which are operated by Children's Hospital. This report presents the findings of the first stage of the evaluation — an analysis of stakeholder insights into the implementation of the three-year-old clinic program and their perception of its results thus far. Following a description of the program and the evaluation process, the report addresses program operations, clinic services, and perceived results for the program as a whole. In the sections following, school-specific issues are addressed, including an assessment of the "Morton Street model" of sharing one clinic among multiple schools. Finally, possible programmatic changes and considerations are explored and topics for future research discussed. Overall, the evaluation team finds the clinic program to be an example of a highly successful foundation initiative. Our conclusions focus on lessons learned through this initial start-up phase and considerations for building on the clinics' initial successes.



### Background

In 1997, the Healthcare Foundation of New Jersey, in partnership with the Newark School District and the St. Barnabas Health Care System, began working to establish health clinics in the Newark schools through the School-Based Youth Services Program. School-based health clinics, increasingly prevalent nationwide, aim to provide comprehensive primary care services. The three Newark clinics originally funded by the Foundation were established in elementary/middle schools. The state of New Jersey had previously funded high school-based health services, but there were no such services for younger children. Nationally as well, the emphasis of school-based programs traditionally has been on high schools, a trend that is now changing.[2] The partners in the Newark program also were concerned that the clinics meet social/behavioral and dental health needs and not just provide basic medical services. A national study conducted in 1998 showed that, while most clinics offered some kind of social work or mental health services (79%), this is a relatively recent phenomenon. Only 17.7 percent of clinics offered dental care.[3]

Clinic services at the participating Newark schools are available for free to all students whose parents or guardians have signed a consent form. Each clinic has a full-time pediatric nurse practitioner, social worker, and administrative assistant. The school nurse, while maintaining her traditional duties, is also an integral part of the clinic team, triaging students who need medical (but not behavioral or dental) care. The nurse practitioners provide primary and preventive health services — physical exams, follow-up medical care, treatment of minor illnesses, chronic care management, immunizations, and nutritional counseling. Social work services include individual, family, and group counseling and crisis intervention, with a focus on bereavement/grief counseling, separation anxiety, and stress management. A dental team from Children's Hospital visits the clinics on a more than half-time basis, providing examinations, x-rays, cleanings, fluoride treatments, and dental sealants; they do not fill cavities or provide other dental

treatments. Referrals for outside care are made in all three clinical areas – medical, social/emotional, and dental — and free follow-up dental care is provided for clinic participants at Beth Israel Medical Center. Clinic participants also receive free prescription medications. In addition, clinic staff provide health education in classes, health fairs, and other venues; each year a dental hygienist makes a 30-minute presentation to every class in each school.

Administrative and clinical support and oversight is provided to the clinics by Children's Hospital through a program director, three physicians (one overseeing medical direction), a psychiatrist, and a dentist. The administrative assistant at the Quitman St. School supervises the assistants at the other two locations.

The first clinic was opened in February of 1998 at the George Washington Carver School, a kindergarten through eighth grade (K-8) school near Beth Israel Medical Center that includes the Bruce St. School for the Deaf. The second opened at the Quitman St. School in June 1999, although during the 1998/1999 school year the social worker was seeing students and efforts were begun to obtain parental consents. Funding for this clinic is also provided by the Prudential Foundation, which was already supporting community school programs there. While the Quitman St. School originally served pre-K-8, it was changed to pre-K-4 for the 1999/2000 school year. The nearby Morton St. School now serves the middle school population ($5^{th}$ through $8^{th}$ grades), and an arrangement was established in the fall of 1999 for Morton St. students to use the Quitman clinic, primarily for dental and urgent care. Quitman St. also includes the Berliner School for special needs students. Finally, in June 1999, after a partial start-up in the 1998-99 school year (providing dental care and part-time social work services), a clinic became fully operational at the Dayton St. School, serving K-8.



The three clinics were evaluated internally one year ago. The report showed an excellent rate of parental consent; reported positive assessments by students, teachers, and principals; and described a wide variety of clinical activities.

While not a subject of this report, the clinic program is currently undergoing an expansion. Two new high school clinics are slated to open, with some diversification of funding; these two clinics will be at the Malcolm X. Shabazz High School and at the Barringer High School.

## Evaluation Questions and Methods

This report represents the results of a study of stakeholder insights into the implementation of the three-clinic program and their perceptions of its results thus far. Between May 17 and June 20, 2000, 41 interviews were conducted with representatives of program funders, officials of the Newark School District, program leadership from St. Barnabas Health Care System and Children's Hospital at Beth Israel Medical Center, school clinic staff, and representatives of the schools (See Table 1).

In addition, we conducted ten focus groups with teachers and three with parents/guardians.[4] At the schools where focus groups were conducted, all teachers were invited to participate through an announcement by the principal. Parents/guardians were selected for focus groups by the clinic staff and were paid $40 to compensate them for their time. Both parent and teacher focus groups included a broad diversity of discussion participants (See Tables 2 and 3), although the parent focus groups included only parents of children who had extensive experiences using clinic services and, since they were chosen by the clinic staff, were presumably on good terms with them.[5] Interviews and focus groups were planned for all of the program schools, including Morton St., and all were completed as planned with the exception of teacher focus groups at the Dayton St. School and interviews with two principals.

Interview questions addressed program and clinic history; program and clinic procedures; clinic, community, and school differences; perceived clinic purposes; working relationships; perceptions of program strengths and weaknesses; perceived results; and desired changes. Focus groups emphasized teachers' and parents' experiences with the clinics, assessments of their strengths and weaknesses, perceptions of the results, and desired changes.

The second stage of the evaluation, described in more detail at the end of this report, will add quantitative and comparative dimensions to the study.

**Table 1: Interviewees**

| Respondent Type | Number of Respondents |
| --- | --- |
| Funders | 5 |
| St. Barnabas Health Care System/Children's Hospital at Newark Beth Israel Medical Center | 8 |
| Newark School District | 10 |
| Clinic staff and school nurses | 12 |
| School principals, administrators, and staff (3 clinic schools and the Morton St. School) | 6 |
| **Total** | 41 |



## Program Management and Development

The Newark School-Based Youth Services Program (SBYSP) is operated by Children's Hospital of Beth Israel Medical Center, which is part of the St. Barnabas Healthcare System. The Healthcare Foundation of New Jersey, in addition to providing financial support for the SBYSP, is involved in overseeing program operations; and the Newark School District also plays an important supporting role in operating the program. To provide guidance for the next stage of our evaluation, and because of the importance of the diverse partners in program operations, we asked stakeholders their perceptions of the program's purpose and assessed the degree to which they shared a common vision. We also asked about program planning and start-up activities; and overall program management, including administration, supervision, accountability, leadership, and program development/innovation (programmatic and financial).

### *Program Vision and Purpose*

Most stakeholders mentioned several program purposes. While a single vision for the program did not emerge from the interviews, two major themes were articulated: improving educational performance and improving student health and access to care. Among education-related objectives, improving classroom attendance was cited most often, although improving academic performance (grades and test scores) were also mentioned by some. Most respondents emphasized health-related objectives, including improving overall health status, health education, and access to medical, dental and mental health services. Many emphasized the importance of reaching students who fall through the cracks of the health care system.

**Table 2: Characteristics of Teacher Focus Group Participants[1,2]**

| Participant Charactaristics | School | | |
|---|---|---|---|
| | Carver | Quitman | Morton |
| **Type of Teacher:** | | | |
| Regular Classroom | 10 | 10 | 6 |
| Other | 1 | 3 | 1 |
| **Grade Levels:** | | | |
| Pre-K-Kindergarten | 0 | 3 | 0 |
| 1st-2nd | 5 | 3 | 0 |
| 3rd-4th | 3 | 5 | 0 |
| 5th-6th | 1 | 0 | 0 |
| 7th-8th | 2 | 0 | 5 |
| Multiple Grades | 3 | 2 | 2 |
| **Number of Students in Classes/ Regular Contact With:** | | | |
| 1-20 | 2 | 9 | 0 |
| 21-40 | 7 | 2 | 6 |
| Over 40 | 1 | 2 | 1 |
| **Years Teaching at Current School:** | | | |
| Under 5 | 6 | 5 | 3 |
| 5-10 | 2 | 4 | 1 |
| Over10 | 3 | 4 | 3 |
| **Total Years Teaching:** | | | |
| Under 5 | 2 | 2 | 1 |
| 5-15 | 5 | 3 | 2 |
| 16-25 | 1 | 5 | 1 |
| Over 25 | 3 | 3 | 3 |
| **Have Students in Class With:** | | | |
| Asthma | 8 | 10 | 6 |
| Other Chronic Illness | 1 | 3 | 1 |
| Serious Behavioral/Emotional Problems | 10 | 11 | 6 |
| Special Educational Needs | 5 | 11 | 4 |
| Physical Disability | 0 | 2 | 0 |
| Other | 0 | 3 | 0 |
| **Occurred During Last School Term:** | | | |
| Serious Asthma Attack or Other Acute Illness Requiring Immediate Medical Attention | 5 | 3 | 3 |
| Behavioral Episode That Required Classroom Routine to Be Stopped | 9 | 12 | 6 |
| Acute Dental Problem Requiring Immediate Medical Attention | 1 | 5 | 2 |
| **Race/Ethnicity:** | | | |
| Black/African-American | 11 | 5 | 2 |
| White | 0 | 6 | 3 |
| Other Race/Combination | 0 | 1 | 1 |
| Hispanic/Latino[3] | 0 | 0 | 0 |
| **US Born:** | | | |
| Yes | 11 | 13 | 7 |
| No | 0 | 0 | 0 |
| **Gender:** | | | |
| Male | 1 | 1 | 2 |
| Female | 10 | 12 | 5 |
| **Total Participants** | **11** | **13** | **7** |

[1] Some categories are not mutally exclusive, so totals will add up to more than the total number of participants.
[2] Respondents could choose not to answer specific questions.
[3] Could also identify a race.

**Table 3: Characteristics of Parent Focus Group Participants[1, 2]**

| Participating Characteristics | School | | |
|---|---|---|---|
| | **Carver** | **Dayton** | **Quitman/ Morton[3]** |
| **Children <18 Living at Home:** | | | |
| 1-3 | 5 | 3 | 7 |
| Over 3 | 2 | 2 | 0 |
| **# of Children Who Are Students at this School:** | | | |
| 1 | 3 | 2 | 5 |
| 2 | 3 | 1 | 3 |
| Over 2 | 1 | 2 | 0 |
| **Grades of These Children:** | | | |
| Kindergarten-2nd | 4 | 4 | 5 |
| 3rd-5th | 4 | 5 | 6 |
| 6th-8th | 5 | 2 | 0 |
| **A Child at this School Has Asthma:** | 2 | 3 | 4 |
| **A Child at this School Has Disability:** | 0 | 0 | 0 |
| **A Child at this School Is Enrolled In:** | | | |
| Medicaid | 5 | 4 | 3 |
| NJ KidCare | 2 | 1 | 1 |
| Health Insurance from Family Member | 2 | 0 | 2 |
| Other Insurance | 0 | 1 | 1 |
| No Insurance | 1 | 0 | 1 |
| **Race/Ethnicity:** | | | |
| Black/African-American | 6 | 2 | 7 |
| Other Race | 0 | 0 | 0 |
| Hispanic/Latino[4] | 1 | 2 | 0 |
| **US Born:** | | | |
| Yes | 7 | 4 | 8 |
| No | 0 | 1 | 0 |
| **Gender:** | | | |
| Male | 0 | 1 | 1 |
| Female | 7 | 4 | 7 |
| **Years Had Children at Current School:** | | | |
| 1-2 | 2 | 1 | 5 |
| 3-4 | 1 | 1 | 1 |
| Over 4 | 4 | 3 | 2 |
| **Total Participants** | **7** | **5** | **8** |

[1] Some categories are not mutally exclusive, so totals will add up to more than the total number of participants.
[2] Respondents could choose not to answer specific questions.
[3] All parents were parents of Quitman St. School children, but a couple also had children at the Morton St. School.
[4] Could also identify a race.

Most of the articulated conceptions of clinic purposes are mutually reinforcing. However, some purposes are potentially at odds with each other. For example, the objective of providing primary care for a significant number of children who fall in the gaps of the health care system presents different resource allocation priorities than the goal of providing students with services that supplement or facilitate those delivered by community-based providers. Furthermore, many respondents, particularly among those who were newer to the program, stated that they were unclear about clinic purposes or demonstrated difficulty in describing them. This lack of clarity,

combined with the diversity of responses and the points of tension in some views, suggests that clear program goals have not been adequately defined.

### *Program Planning and Start Up*

A high level of cooperation and motivation to make the clinics succeed is shared among the three program partners: the Healthcare Foundation, St. Barnabas, and the Newark School District. Consequently, formidable potential barriers to clinic planning and implementation have been overcome. Representatives of all three institutions were described in virtually all interviews as working cooperatively and creatively to navigate legal, bureaucratic, and other obstacles to the creation of the clinics. The role of the school district was particularly important during start-up and Armando Medina was seen as instrumental in facilitating program implementation.

There are more mixed reports about whether the initial and ongoing planning and development process for the clinics was based on adequate needs assessment and has been sufficiently inclusive; specifically, some stakeholders at all levels questioned whether teachers, school nurses, and parents had adequate opportunity to be involved in the design, planning and setup of the clinics, although the involvement of nurses is said to have improved.

### *Ongoing Program Management and Development*

To date, the current management structure has served the program well in most respects. Most stakeholders view administrative supervision, support, and programmatic development as strong; however, some see weaknesses in the areas of clinical supervision and support, financial accountability, and leadership on the issue of achieving sustainable funding.



Clinic administration, supervision and leadership take place on several levels. First, Children's Hospital and the St. Barnabas System provide operational oversight. The program manager, Rose Smith, supervises the program on daily basis, with backup from Patricia Carroll, executive director at Children's Hospital and Gerry Goodrich, executive vice-president of St. Barnabas. Rose Smith is widely viewed as successful at providing administrative support and supervision to the clinics. She was also widely praised for her programmatic leadership, innovation and problem solving. For example, upon hearing concerns from the social workers, she petitioned for and engaged a psychiatrist in the program. Similarly, she negotiated free prescription drugs for the school children in response to feedback from the clinics and the parents. This latter innovation required not only arranging for more funding, but also adeptly negotiating relationships with local pharmacists, who discounted their prices. Reflecting widespread opinion, one person described Rose as "having the children's interests at heart."

Although satisfaction was generally high, some respondents identified gaps in overall program leadership. Some identified a lack of a program "champion" or visionary (although many program participants felt that current leadership provides strong advocacy for the program), and nearly all senior informants reported that the program lacked adequate financial expertise among its management team. All program participants see a need at this point in time for a more active effort to diversify program funding.

A second level of supervision and leadership is in place for clinical activities through the three physicians, psychiatrist, and dentist assigned to the program. Reports about clinical management and leadership were quite mixed, and interview responses revealed a lack of clarity as to the roles and requirements of these positions. Program participants were confused about the extent to which clinical consultants should contribute to program management, quality assurance, case consultation, and direct services. For example, the interviews revealed conflicting expectations of how many hours consultants should be onsite, if they need to be onsite at all. Strikingly,

there were conflicting understandings of how often chart reviews should occur, and reports that sometimes they do not occur even when agreed upon. Several participants stated their desire for more structured relationships with clinical supervisors.

The final level of supervision and leadership is at the level of individual clinics. There is wide consensus that each clinic operates well, relying on cooperation among its personnel without formal reporting relationships. As is evident in the discussion of clinic services later in the report, clinic staff have been proactive and innovative in their approach to program content, strategies and procedures. Nurse practitioners and social workers at the three clinics, at their own initiative, have established monthly meetings of their respective professions. They have found these meetings to be important for inter-clinic communication and problem-solving.

One positive development in program administration has been the addition of full-time administrative assistants (AAs), who perform a variety of roles, including record-keeping, facilitation of clinic use and referral follow-up, and external communications. The work of the AAs depends upon the adequacy of procedures, resources and facilities at the clinics and the wider school. In general, the AAs report being well supported. However, several areas for improvement were identified. While the AAs have been developing their capacity to utilize a multifunction database, a few respondents cited obstacles to effective record-keeping; these include reluctance by some parents to provide insurance information (information which could potentially benefit the program in its search for sustainable funding), deficiencies in school records (e.g., student body size), and the separation of school nurse and clinic records (although this may be unavoidable). Finally, respondents reported some resource deficiencies affecting clinic operations, such as not having adequate access to a fax machine and having a telephone with an inadequate phoning radius.

Gloria Blount, the administrative assistant at the Quitman School serves as the supervisor and plays a leadership role among the administrative assistants at the other sites. Perhaps because the clinic program is small, this model appears to work well. Ms. Blount has developed a procedure manual, which together with the on-line tracking system, guides the administrative assistants' work. She also makes monthly visits to the other clinic sites.



## Clinic Services

The clinics' primary work is with individual students. The first part of this section of the report assesses clinic successes and challenges in providing these services, looking at each step of that process, from the initial tasks of obtaining parental consents and achieving parent, student, and school awareness of clinic work; to promoting effective utilization of services and providing quality care, including follow-up and continuity. In addition to providing dental, medical and counseling services to children, the clinics provide population-based services, such as educational workshops and health fairs for students, parents, and teachers. The second part of this section addresses these other activities.

### *Individual Student Services*

#### *Parent/Guardian Consent Rate*

The percentage of children with signed parent/guardian consent forms is extremely high at all three clinics: 98% at the Dayton St. School, 92% at the Quitman St. School, and 72% at the Carver School. The rate at the Quitman School rose 12 percentage points since last year.[6] It should be noted, however, that the rate of enrollment for the Berliner School is only 35%, due, according to our interviews, to the high rate of turnover in that population.

The Carver school rate, while still high by national standards, is quite a bit lower than the others. However, Carver is twice as large as the other two schools, an obstacle to reaching all families in and of itself. Furthermore, Carver clinic staff report that, perhaps partially due to the school's size, the main office has a difficult time keeping up with the highly mobile student population; this may lead to an over-count of school enrollment and therefore an underestimate of the clinic consent rate.

While the efforts of clinic and program staff are important in obtaining high consent rates, this aspect of program success is a key marker of the commitment of school district officials, principals, teachers, school nurses, and school staff, who have made sure that the consents have been sent home through official mailings and who often use their own contact with parents as an opportunity to faYilitate clinic enrollment.

*Awareness of the Clinics*

Once a consent form is signed, students actually get to the school nurse and the clinic through referrals from teachers, principals and vice-principals, self-referrals, the referrals of other children, and the initiative of parents. Many stakeholders from all parts of the program believe that awareness of the clinics is high and growing. This is attributed in large part to word-of-mouth and the positive experiences of clinic users, but also to the efforts of clinic staff (who are described as "very outreachy"), their involvement in school life (ranging from participating in extracurricular activities to having lunch with the children), the inviting, attractive clinic facilities, and the efforts of principals and other school staff. However, other stakeholders from a variety of perspectives noted that many parents and teachers are either still unaware of or are confused about the clinics. Teacher focus groups also show high levels of awareness coupled with some confusion about clinic procedures and hours. (Parents who participated in focus groups reported good knowledge of clinic operations; however, this select group had a high level of clinic involvement and thus were unusually knowledgeable.)



It was suggested by two observers that raising awareness must always be tempered by the danger of creating false expectations, or disrupting school routines. They commented that the clinics had appropriately integrated themselves into the schools "smoothly, gently, and unobtrusively" in these first years and that now might be a good moment for new approaches to increasing visibility and furthering integration into the schools.

*Clinic Utilization*

Data on use of clinic services will be explored in the next stage of the evaluation, however, the impressions of stakeholders provide useful insights into utilization patterns.

The reports of teachers, parents and others illustrate ways in which the clinics are utilized both appropriately and effectively. For example, respondents reported that a particular strength of the clinics is asthma management. The clinics are utilized for diagnosis, education of parents and children, monitoring of students' conditions and – when necessary – treatment. One parent with two asthmatic sons reported, "It's like a miracle to me...The clinic was introduced to me by [the nurse practitioner] who called me and said the services were available at the school. Now she monitors them when there's a problem...She'll ask about little things like 'Do you have a carpet?'"

In spite of a positive utilization picture overall, some respondents noted that medical services at the clinics may be underutilized due to insufficient awareness and the challenge of scheduling appointments without disrupting education. A few respondents also noted that, due to the

large number of students in the schools with emotional/behavioral health needs, many students who could benefit from the social work services are probably not receiving them.

Inappropriate utilization was also noted. A variety of observers, including clinic staff, reported that teachers have sometimes used the clinics, particularly social workers to remove disciplinary problems from class. Others noted that students might also use the clinics to avoid class. All the clinics report that they have worked on this problem. At the Quitman St. School, for example, teachers are now required to fill out a clinic referral form that requires them to follow up, thus changing their calculus for deciding whether to send a student to the clinic.

*Process and Quality of Care*

Clinic procedures receive a generally positive assessment. The system of having the school nurse do triage for medical care is generally seen to be working well, although it depends on a shared understanding of triage criteria, which is not always in place. Another important procedure is the involvement of parents in student care; the clinics utilize telephone contact with parents at various points in the care process. While parental involvement is generally seen to be crucial to pediatric care, at least one observer found the process a bit cumbersome.

Clinic and school staff have been innovative in developing additional procedures, such as the teacher referral follow-up described above. In another instance, a form was created to assure nurses of feedback on cases they send to the nurse practitioner. These new procedures have been important to solving problems and reducing potential points of conflict. More generally, collaboration between clinic staff (including nurses), principals, and teachers around individual cases seems to have been institutionalized. Principals have become particularly engaged in clinic work; some clinic staff report meeting with the principal multiple times each week.



The relationships among the clinic staff in carrying out their work are described as important and highly positive across the spectrum of stakeholders and across schools. "It's really a group effort," stated one respondent, who added, "The situations we face are interdisciplinary." In particular, staff are cited for their flexibility in working together. School nurses are integral to the clinic process and all commentators describe strong and productive relationships between individual nurses and the (other) clinic staff, despite the concerns which the nurses initially brought to this endeavor.

Continuity of care is an important concern for the clinics, which not only provide care directly but make referrals to outside providers. Achieving continuity is particularly challenging because the clinics are located in schools with high rates of student mobility and because some patients have primary care providers at other locations. The program provides inter-clinic continuity by maintaining the files of a transferring child at Children's Hospital until such time as the student enrolls at another program school. Clinic staff report that they work well with outside providers and are conscious of enhancing, not disrupting, existing physician-patient relationships in the community. They obtain feedback on appointments they have referred, although it is often difficult for them to learn about outside care which they have not arranged. The clinics have a systematic process for recording and tracking referrals, using a computer "tickler" system to remind themselves and, in turn, the parents, of appointments.

Despite extensive efforts to follow-up and track referrals to outside providers, the clinic staff reported two difficult problems. One is the challenge of getting timely follow-up for newly diagnosed special education children from the district's Child Study Teams (CST), which are responsible for arranging services for such children. This is attributed to the small amount of time the CSTs have to spend at each school, and the rules that the CSTs follow; in particular, CSTs require the diagnosis of an educational psychologist.

The second problem, widely mentioned, is the failure of a sizable number of parents to follow up on referrals (even for free care). Reported reasons for poor parental follow-up were varied and speculative; some respondents emphasized difficult parental work schedules (e.g., no or limited paid family leave), others talked about difficult home situations and competing priorities, and still others discussed inadequate awareness of the importance of health services. Overall, it was agreed that parents are least likely to pursue dental care, perhaps because it is perceived as less important than behavioral health or medical care. Whatever the reasons, parental follow-up on referrals is a subject of great frustration to the clinic staff. Clinic staff have experimented with ways to improve parental follow up, and there were some signs of hope, including an increasing number of parent calls into the Beth Israel dental clinic, following up on clinic referrals for care.

It is not possible to gauge the clinical quality of care from key informant interviews and focus groups; however, the perceptions of parents, teachers, and school staff provide insights into the non-clinical aspects of quality, and interviews with clinic and program staff provide insights into quality assurance efforts. Parents, teachers, and other school staff were enthusiastic about the quality of care in the clinics. These observers described the clinics as professional, confidential, and convenient. Clinic staff are described as warm, caring, concerned for the child's full range of needs, attentive to detail, and gently persistent in getting the children what they need. As one school staff person put it, "They take care of the child physically, mentally, and spiritually!" Parents reported that children with chronic conditions are monitored on a regular basis, sometimes daily. In interviews, clinic staff articulated a philosophy of care and concern for the whole child, and the responses of these clinic users and observers make it clear that that philosophy is both put into action and appreciated.

Reports on quality assurance procedures provide a more mixed picture. As previously noted, there is disagreement among clinic staff and their clinical supervisors about how often chart review should take place, and even when the frequency is agreed upon, review does not always occur as determined. There are also differing opinions about whether the program has agreed-upon clinical guidelines and whether these are used.



### *Other Clinic Activities*

To varying degrees, clinic staff at the three schools have participated in classroom and school-wide activities. Working within the complex structures of the schools has at times proved challenging, although there have been notable successes. These successes suggest the potential payoff of further integration into the schools and expansion of population-based activities.

#### *Classroom Education and Health Fairs*

Interviewees reported that, while the focus of the clinics is on health education as well as medical care, classroom education provided by the clinic has been limited mostly to dental hygiene. Most student education on medical and social issues occurs on an individual basis. Several staff said that while they had offered to teach health education, few teachers had sought their assistance, while teachers felt that the process for utilizing health education services was unclear. For those that mentioned them, the health fairs that the clinics sponsor in conjunction with St. Barnabas were viewed as positive for raising awareness of health issues with children and in the community.

#### *Parent and Teacher Education*

Clinic health education for parents and teachers varies by school. One clinic had initiated workshops taught by residents from Beth Israel on a number of child-related health issues such as asthma, self-esteem, and bullying. Parents in the focus groups who had attended these sessions

found them very helpful. In contrast, another clinic had tried unsuccessfully to set up education classes for parents. All clinics hope for more parental involvement in such activities.

*Involvement in Child Study Teams and Pupil Resource Committee*

As mentioned above, clinic staff are working to develop a referral relationship with the Child Study teams in at least two of the schools. At Quitman, clinic staff have also taken the lead in spearheading implementation of the Pupil Resource Committee, the first stage in identifying and assisting children with special needs.

*Quitman Wellness Committee*

The best developed example of clinic staff involvement in the broader school is the Child Wellness Committee, which was initiated in January 2000 at the Quitman St. School. The Committee has 25 members and includes representatives from every sector of the school, including clinic staff and the school nurse, parents, teachers, administrators, and other personnel, such as the lunchroom staff and security guards. The purpose of the committee is to promote a therapeutic environment in the school. It addresses issues such as bullying, teacher approaches to discipline, and other factors in the well being of the children and the school community as a whole. The committee meets twice a month, with 10-15 people in attendance at an average meeting. Respondents say that already the committee is having a noticeable effect. While others at the school had hoped to create such a committee previously, some note, it required the legitimacy of a medical clinic to initiate it.

*Involvement in School Activities*



Clinic and program staff have begun integrating themselves into the life of the school in a number of non-health specific ways, as well. One clinic staff person, for example, coaches the school's debate team. Rose Smith, the SBYSP director, is joining a school management team. Such efforts not only create greater awareness of the clinic, but increase clinic and program staff's understanding of the needs of the students and the schools. Potentially, they will also create further opportunities for collaboration.

## Perceived Program Impact

Stakeholders were asked about perceptions of program impact on student health and well being, on student academic performance, and on parents and the overall school environment. Although clearly one should not rely solely on reported perceptions to judge performance, the perspectives expressed by our diverse interviewees and focus group participants are very encouraging.

### ***Student Health and Well-Being***

Nearly every person interviewed felt the clinics have had a positive impact on students' health and well-being, especially in increasing their access to health care and social services both at the school and in the community. Parents, in particular, said that the clinics have helped them to obtain services they would otherwise not have received. Most parents said that there are minimal health services in their community and that those that are available are not of high quality. Transportation has been a major barrier to care, particularly for the Quitman and Dayton St. school populations. Having the clinics at the school has made it easier to access care. One respondent said, "I use the clinic to treat [my son's] ear infections because the doctor is far away. It's very convenient." Most reported increased access to social and dental services as well as medical. "They provide toothbrush kits. That is a benefit! Some kids have to share toothbrushes at home!" "They

provided psychologic help and therapy over the loss of my daughter." Several also mentioned increased access to prescription drugs and eyeglasses.

The majority of respondents also felt the clinic had increased access to other services in the community. According to a clinic staff member, "A lot of services may have been there, but parents didn't know what kids need. We have built up prevention and got parents to make wellness visits to their primary care provider, not just in emergencies." For specialty services, many cited increased access to Beth Israel Medical Center for behavioral health and dental care.

Many parents, teachers and staff also feel that the clinics have identified problems that otherwise may have gone undiscovered — particularly behavioral problems and learning disabilities. Parents cited many instances in which the clinic staff identified undetected medical, dental and social problems including bronchitis/asthma, a heart murmur, allergies, crowding of teeth in mouth, growth problem as a result of anorexia, vision problems, malnutrition, and attention deficit disorder.

In the area of medical services, many respondents reported that the clinic was particularly good at helping children manage chronic conditions such as asthma and allergies. "[We] use the clinic for prevention, otherwise we would have to race over to [the doctor], just so he could tell him to use the palm [inhaler]." A few also identified improved health outcomes. Explaining that the clinic had identified malnutrition in her child, one parent said, "He hadn't gained a pound in a year. He needed chicken/meat. Within a week, he gained three pounds."

Many of those interviewed reported that the largest impact of the clinics was on social and behavioral health. "My [son] had lots of problems, me being a single mom, it was good to have a man in the school that could talk to him. Mr. Worsley was there." One parent reported, "Kids are opening up more. Having somebody who cares about them makes a difference."



In addition several people reported that the clinic had improved children's health knowledge and behavior, particularly for dental care and medication use. According to one parent, "The nurse practitioner gave my son a prescription. I tried to read how to use it to him and he said, `No Mom I already know how to use it. The nurse told me.'"

### *Academic Behavior and Performance*

Most clinic staff, teachers, and parents reported that the largest impact on academics was improved attendance as a result of having clinic services on-site. One parent noted, "Doctors will say to keep kids home for two or three days. Now they don't have to miss a day from school. That makes a world of difference. A child can stay in school more." In addition, according to a few interviewees, clinic services have increased some children's ability to focus and improved their classroom behavior. "When kids with asthma would be wheezing, they couldn't concentrate and they'd suffer. Now they go to the clinic and get attention."

Most interviewees reported feeling that clinic services are leading to improved academic performance (e.g., grades or test scores), although few teachers and administrators could describe specific cases where services had led to better grades or scores. However, some parents could. In particular, a few parents cited the role of social work and vision services in improving academic performance. In one case, a young girl who had been sexually abused got support through the clinic. "She was an 'A' student who went down to an 'F'. Now she's on her way back up." Given the complexity of the school environment and the comparatively recent implementation of the clinics, it is not surprising that we did not hear more specific examples of clinical interventions leading directly to improved academic performance.

### *School Environment*

Overwhelmingly, parents, teachers, staff and administrators felt that the clinics' presence had improved the school environments. The confidentiality and warm atmosphere that the clinics provide and the perception that they are safe havens for children to talk about their problems were repeatedly mentioned. These contribute positively to the school atmosphere in and of themselves and by giving children with behavioral problems a place to go. One observer said, "Before we would see kids all day long just walking around the hallways doing nothing, but not now."

The involvement of clinic staff in other school activities is also reported to have led to improvements in the school environment. In particular, Quitman's Child Wellness Committee was praised by administrators, teachers and parents. Said one, "This has been the foremost value of the clinic, its advocacy for the well-being of the child, not only physical but emotional. They have created a hope-filled place. That is their legacy, that they've done a great deal to make this a child-centered friendly school." At clinics where staff are involved with the child study teams, many staff and teachers felt they had accelerated the identification of special needs, even though there were still problems with the child study team accepting their diagnoses.

A few teachers and school staff raised concerns about the clinic taking children away from classes and causing a disruption. "They pulled kids out of a Stamford test, which was crazy!" "Children are watching TV [in the clinic waiting room] during school time." Some clinic staff were aware of this tension and suggested that they needed to improve the way they factor instructional needs into their scheduling, trying to arrange doctor and dental visits during lunchtime for instance.

A few teachers said that the clinics help directly to reduce the high level of teacher stress. "They are good for me, when I have a headache, I go and talk. Even just to know someone is there. Everything falls on the teacher and we can't do it all." They even provide some medical services to the teachers, offering to check blood pressure, for example.



### *Impact on Parents*

Most of the parents indicated that the clinics had helped them considerably both in gaining access to medical services and in giving them peace of mind that their children were being taken care of. "They have taken the time to call me on the job and ask. That touched my heart for someone to care that much about my child's health." Several parents also reported that the clinic had helped reduce their own absences from work. "Both my sons have asthma. Before the clinic I would be late to work when I had to go to the doctor for the kids. Now the clinic monitors them when there is a problem. It's a lifesaver."

In many cases, parents reported getting medical care and supportive counseling for themselves from the clinic or help with access to other services in the community. In one case, the nurse practitioner had even accompanied a parent to a physician who previously had been dismissive of that parent. In general, parents felt the clinic had restored their confidence in health care after their negative experiences with community providers. "They explain here. At the hospital they tell you to come back or about insurance. Here it's not a question about insurance—it's more like a family."

## Differences Across the Clinics

Comparing the three clinics and examining the individual clinics over time is useful for identifying the ingredients for success and identifying challenges for establishing new sites. Several relevant differences among the clinics, schools, and communities emerge from these contrasts. Differences in relationships between clinic staff and other key partners are cited as particularly important.

For example, one senior stakeholder said that "when the principal is a strong advocate and the school nurse is cooperative," the chances are the clinic will be more successful in serving the school. Others also cite the importance of these relationships, although at this time, the relationships with the nurses seem positive and productive at all the clinics. Although all of the principals are supportive of the clinics and work well with them, there are differences in their styles and levels of participation. In addition to the relationships with key stakeholders in the schools, another important relationship is that of clinic staff and clinical consultants. As noted earlier, there is diversity in how the clinical consultants' roles are understood, and this is mirrored in the actual relationships of the clinics with their different medical directors.

While relationships with teachers and others in the schools are also important, these seem to be similar across the clinics. A notable exception is the Quitman St. clinic that is unique in having established a Wellness Committee that builds on relationships with all of the key players in the school including those who are not typically thought of in terms of wellness activities e.g., janitors and security personnel. Another unique feature of the Quitman St. clinic, which perhaps explains the emergence of the Wellness Committee, is its location in a "Community School," enhancing integration into the school. The community school institutions also seem to have had some benefits in facilitating clinic relationships with parents; for example, the Parent Academy plays the community liaison role mentioned by the other clinics as desirable. Nonetheless, all three clinics note difficulty with parental participation and commitment to referral follow-up. Another important school characteristic is size. With double the enrollment of the others, the Carver School is recognized by many to face special challenges. Carver has a student body of 1100 and the school is filled to capacity. To escort students to the clinic for dental exams takes 15-20 minutes from the most distant classrooms, much more time than in other schools. Logically, there will also be more students seeking health services.



Another special challenge facing the Carver School is the size and configuration of its clinic space, particularly the detachment of the waiting room from the administrative assistant's office. It is widely recognized that the Quitman St. and Dayton St. clinics benefited from the lessons learned in designing the Carver clinic.

Another often cited factor in clinic work is the environment of the surrounding community. Aspects of the surrounding environment that influence the clinics are the heterogeneity of the community, degree of community involvement (as noted above), and the type of housing and other community resources. One clinic staff member stated that having a more homogeneous community helps them in understanding their students. The Dayton Street school area exemplifies another environmental factor – the degree of social isolation and "social capital". Staff there reported that this neighborhood is comparatively isolated and there is little "over the fence" socializing among neighbors, a factor seen by one observer as inhibiting parental interaction with the clinic. The geography of this area (which is bounded by a large golf course and park) also seems to have given rise to a paucity of social services and poor access to health care. Finally, while a few respondents saw the type of housing in the community as an important factor, they disagreed on its implications. One observer saw the consolidated nature of housing projects as making it easier to find parents, but another found them to be potentially unsafe. One observer also noted that available housing stock affects the class composition of the students and student mobility.

## The Morton St. Model

The clinic access arrangement for the Morton St. School has been discussed as a potential model for a fully implemented clinic program in the Newark schools. Under this model, several schools would share a single clinic site. Officials of the Healthcare Foundation described their hope to expand the program to up to ten clinics serving the Newark district.

Overall, interviews revealed that in its first six months, the shared-clinic model at Morton St. has had several start-up problems. Clinic and school staff report lower than average enrollment and minimal utilization by Morton students. One exception to the low utilization rates is the dental checkups, which are scheduled by the school guidance counselor for groups of students who are accompanied to the Quitman clinic by a paid escort. Teachers in focus groups also reported some use of medical services for emergencies such as asthma attacks. They were not aware of any children using mental health services at the clinic and most referred behavioral problems to a part time on-site Beth Israel Medical Center social worker funded through another program called Project Guide. However, most teachers felt that, since Project Guide social workers are only in the school twice a week, they were not able to meet all of the children's social service needs. One teacher noted that clarification was needed as to which cases should be seen by the clinic social worker and which should be referred to Project Guide.

Teachers and staff attributed low enrollment (only 189 of 375 eligible students)[7] to the fact that many parents were not aware of the program. The program was launched after the school's start-of-year parent orientation, and parents were only informed about the clinic through a letter distributed by teachers to be sent home with students. Middle school students may be less reliable messengers than younger children are; according to one interview, "sending things home with kids is not good, they chuck them in the garbage." Others thought the letter was too complicated and confusing. In several cases, teachers claimed they had not seen the letter at all. Most teachers, while somewhat aware of the clinics, were unfamiliar with the clinic services and logistics, and a couple indicated that communication from the school administration about the program could be improved. Teachers who were aware of the clinic and its services tended to be those that taught the younger grades who had recently transferred from Quitman St. or who had previously taught at Quitman, but this did not always translate into understanding what was available to the Morton students. In particular several teachers were not certain whether services beyond dental and emergency were available to Morton children at all.



The confusion of teachers and parents over the Morton St. School's relationship to the Quitman St. clinic mirrors inconsistencies in interviews with program/clinic staff. For example, while the letter that was sent to parents described Morton St. students as having access to the full array of clinic services, some staff described them as having access only to dental and emergency medical services. Some clinic staff suggested that they were overburdened by the needs of the students at Quitman, and were not sure of their formal relationship to Morton Street students. "We don't technically have our feet in Morton. We do dental and medical a little, but no social work. There are 659 kids at Quitman alone and the clinic can't even get to all the Quitman kids." They primarily saw their role at Morton as providing continuity of care for the children who had previously been at Quitman.

Transportation logistics present another challenge to the Morton St. model. According to informed consent materials, children may be escorted to dental screenings without a parent present but for medical problems, physical exams and immunizations, a parent or guardian must bring the child to the clinic. The informed consent letter to parents does not indicate what transportation arrangements are needed for social work services. One teacher suggested that the parental escort was a barrier. "Our problem is that students need an adult to take them to Quitman. It would be easier if we had a clinic here."

Despite these problems, teachers and staff at Morton definitely saw a need for the services and were grateful to have something available for those children who had used them. Those whose students had obtained services said that they had a positive impact. The dental hygienist's classroom education was valued. In general, teachers and administrators would like services expanded,

potentially to address more needs of middle school children such as education on substance abuse and sex education. But most would prefer services on-site and believed it would probably work better, particularly given the need for an adult to transport students to Quitman.

## Desired Changes

A number of respondents suggested or commented on potential changes in the clinics. This section of the report describes the most frequently expressed desires for and concerns about program change.

### *Changes to Increase Awareness of and Connection to the Clinics*

Evidence from interviews suggests that the clinics have done remarkably well in engaging parents, students and the school community, but, as discussed above, there is room for improvement. In particular, many teachers reported a lack of understanding of clinic operations and goals. Research participants offered a number of suggestions for improving awareness, enrollment, utilization and follow up, including a parent or community newsletter, more formal planning and problem-solving around clinic activities with teachers and school staff, use of the School Leadership Teams and the Assistant Superintendents to reach parents, presentations at start-of-year teacher workshops, workshops for parents with free giveaways (such as food or coupons), community-based health fairs or workshops, tours of the clinics, and paid or volunteer parent/community liaisons.

### *Changes in Staffing and Services*



Two changes in staffing and services were widely favored. These were on-site full dental care (which we understand is planned for) and increased behavioral health services – whether through the addition of another social worker at each school, on-site psychiatrist and psychologist hours, and/or psychological screening services. Respondents also made a number of other suggestions, including free eyeglasses, speech pathology, transportation for off-site care and start-of-year audiology and vision screenings to maximize their benefit. They also suggested increased use of parent volunteers and, for the Carver and Dayton St. schools, parent/community liaisons to assist with making parents aware of clinic services and facilitating their follow up of clinic referrals.

### *Changes in Hours and Expansion of Clientele*

Currently, clinics are open primarily during school hours, although summer hours are being instituted (and began last year at Quitman St.) The clinics have also established a few hours of additional time at the beginning and/or end of some school days. Several respondents would like to see the clinic open more, particularly in the late afternoons and early evenings, although one individual voiced a concern that this could create security problems. Security problems also featured prominently in the discussion of broadening clinic clientele to include siblings of school children or others, with some people favoring more of a community clinic and others adamantly against this on safety grounds.

### *More Collaborative Decision-Making*

A number of stakeholders, representing different points of view, would like to see the planning process become inclusive of a broader array of perspectives, including those of parents and teachers. Some respondents also suggest that more could be done to promote collaborative problem-solving between the clinics and the schools, and emphasized the need for augmenting vertical communications between the clinics and schools on the one hand, and the district, funders, and St. Barnabas/Beth Israel on the other – not only for overall strategic planning but for general program development.

### *Clinic Operations and Financing*

A number of clinic and program staff desire clarification of the role of clinical consultants. In addition, many stakeholders suggested that the program needed greater financial management capacity. Stakeholders from all parts of the clinic program also recognize the importance of achieving sustainable funding and express a concern that the program could disappear. They express an interest in seeing attention turn to this issue.

## Preliminary Recommendations of the Evaluation Team

Building upon the suggestions of stakeholders and our own observations, we identified five areas in which efforts to improve the program might be focused at this time. These recommendations are preliminary and based only on the interviews and focus groups with stakeholders conducted during stage one of the evaluation project.

### *Changes to Increase Awareness of and Connection to the Clinic*

- Identify means of improving parental and teacher awareness of and connection to the clinics. Begin by considering experimentation with some of the stakeholder suggestions detailed above.

### *Changes to Improve Parental Follow-up Rates*

- Seek ways of improving parental follow-up. Increasing awareness of and connection to the clinic overall should have a positive effect on this problem, particularly use of a parent/community liaison and experimenting with strategies for parent health education. Other ways of improving parental follow-up were also suggested, such as assisting with transportation to off-site care. Consideration of the options for improving parental follow-up would be an important focus for program development.

### *Changes in Clinic Operations and Financing*

- Clarify the role of clinical consultants, make role expectations clear to physicians and clinic staff, and strengthen mechanisms for ensuring that clinical supervision is carried out as planned.
- Increase attention to and staffing for financial management of the program.
- Continue efforts to achieve sustainable clinic financing.

### *Adjustments to the Morton St. Model*

- Clarify the nature of the Morton St. – Quitman clinic relationship for the staff, the school community, and parents.
- Work on increasing awareness of the clinic among parents and teachers.
- Address logistical problems with the Morton St. model and respond to the special circumstances of middle school students.
- Over the coming year, carefully track the unfolding experience with the shared-clinic model at the Morton St. School.

### *Improvements to the Planning and Problem-Solving Process*

- Clarify overall program goals and ensure communication to new staff.

- In conjunction with the current plans to create a small ***program*** advisory board consisting of representatives of key stakeholders, create stronger mechanisms for participatory decision-making in the following ways: 1) at the program level, emphasize representation of the perspectives of parents and school and clinic staff, 2) enhance mechanisms for clinics, parents, and school staff to work together at the individual clinic level, jointly addressing ongoing challenges and developing new ways in which to utilize what the clinic has to offer, 3) stress program-wide learning from individual clinic experiences.

## Next Steps in the Evaluation

The second stage of the evaluation, from July 2000 to April 2001, will add a quantitative and comparative perspective to our assessment of the clinic program. This stage will include an analysis of available clinic utilization and referral data . We will also select a matched group of Newark schools that do not have clinics and will conduct and analyze a survey of teachers for the clinic schools and non-clinic schools. Available health and education indicators for the clinic and non-clinic schools will also be analyzed. We are considering the advisability and feasibility of focus groups with children as well. Using these additional sources of information, our second stage report will build on the information summarized here to refine our recommendations.



A companion study on clinic financing is also underway. The aim of this study is to assess issues central to the debate over clinic financing by the state Medicaid and NJ KidCare programs. The financing study includes interviews with national experts on the financing of school-based health services and a survey of parents at clinic and non-clinic schools. The survey will examine the relationship of health insurance coverage to the use of school clinics and other health care services. The survey will also collect indicators of parental satisfaction with clinic services and with health services in the community for their children.

# Endnotes

[1] The views expressed in this report are solely those of the authors and do not necessarily reflect those of Children's Hospital, St. Barnabas Healthcare System, or the Healthcare Foundation of New Jersey.

[2] Lear, J.C., Eichner, N. & Koppelman, J. (1999). "The Growth of School-Based Health Centers and the Role of State Policies." ***Archives of Pediatric and Adolescent Medicine***. Vol 153, pp.1177-1180.

[3] Button, J., Rienzo, B. and Wald, K. (forthcoming) "The Politics of School-Based Health Clinics: Descriptive Summary of a National Survey." ***Journal of School Health*** . Reported in http://www.gwu.edu/~mtg/sbhcs/flsurvey.htm.

[4] At one school, an administrator participated in the teacher focus groups.

[5] In order to hear about the clinics' potential impact, it was important to have knowledgeable parents in the focus groups. For the companion financing study described at the end of this report, we will survey a group of parents representing the full range of awareness of and attitudes towards the clinics.

[6] As a point of comparison, after three years, the consent rate at 24 Robert Wood Johnson Foundation-funded school-based clinics was 70%. Brodeur, P. (1999). "School-Based Health Clinics." In S.L. Isaacs and J.R. Knickman, eds. ***To Improve Health and Health Care 2000: The Robert Wood Johnson Anthology***. pp.3-22.

[7] As reported in program records.