

School-Based Health Centers in Chicago

Current Status and Challenges for the Future

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I. Introduction

The Michael Reese Health Trust (MRHT) commissioned this report as a result of questions from the Grants Committee of its Board of Trustees. They requested that MRHT staff provide them information about the most effective use of Health Trust funding of school-based health centers in the future. They were concerned about the sustainability of already developed centers and the number of new school-based health centers that might need funding in the future. They wanted to know the criteria being used to determine the funding of new school-based health center requests to the Health Trust and other roles that the Health Trust might play in assisting school-based health centers to be financially viable. This report, “School-Based Health Centers: Current Status and Challenges for the Future” helps address those questions. This work has generated a great deal of interest and we look forward to sharing it with other foundations and school-based health center staff. The report is available on the MRHT website, www.healthtrust.net.

II. Health Concerns Facing Children and Youth

The health concerns of the nation’s children and youth have become increasingly complex and require interventions that are uniquely different from those applied to past generations. A century ago, infectious diseases and untreated physical defects posed the greatest threat to health and human life. Today most of these problems can be addressed in whole or in part with immunizations, antibiotics, eyeglasses, and other medical treatment. Morbidities and mortalities resulting from illness have been replaced by a new set of problems that are based in behavior and life-style choices. These risky behaviors are often referred to as the new social morbidities and include poor eating habits, tobacco use, abuse of alcohol and other drugs, physical inactivity, interpersonal violence, unintentional and intentional injury, and sexual behaviors that result in pregnancy or disease.

These social morbidities affect children and youth from all socio-economic strata, but are compounded for those who come from low-income families. Not only are higher rates of health problems associated with poverty, but poor children face greater barriers in securing care. In addition to lack of insurance, unequal distribution of physicians and other health professionals, inadequate transportation services, cultural barriers, and institutional practices all impede access to care. For example, the children to pediatrician ratio in poor neighborhoods in Chicago, is 5,887:1 in contrast to a national average of about 1,000:1. Even when physicians are present in a community, they may refuse to see uninsured or Medicaid-enrolled children. In many instances, Medicaid rules and reimbursement rates deter providers from giving care. For example, nearly half the state Medicaid programs do not pay for care by psychologists or clinical social workers, even when they are supervised by psychiatrists.

III. A Unique Health Care Delivery Approach: School-Based Health Centers

Over the last three decades, communities across the country have created school-based health centers to address the increasingly complex health issues facing children and youth. The

first school-based health centers opened in the early 1970s in St. Paul, Minnesota and Dallas, Texas. By the 1980s, there were approximately 50 school-based health centers operating in the United States. Today there are over 1500 centers in 45 states plus the District of Columbia, representing a 147% increase since 1994. This rapid growth reflects the enthusiasm schools and communities have for this approach to health care delivery.

School-based health centers are located directly in a school or on school property and are administered as partnerships between schools, health departments, and local medical, mental health, and/or social service providers. These health centers are considered 'safety net providers' because they provide health care to children and adolescents who would otherwise have limited access to services. A student's encounter with the health center is often their first experience with any health care provider. In addition to overcoming access issues, school-based health centers blend medical care with preventive and psycho-social services and organize broader school-based and community-based health promotion efforts. These centers are cost-effective in that they play a vital role in providing preventive services that reduce the potential for engagement in high-risk behaviors at an early age, reducing the need for acute care in the future.

C. Everett Koop, Former U.S. Surgeon General, underscored the important role school-based health centers can and need to play when he said, “We tend to think of adolescence as the healthiest time of life, but the shocking fact is in my professional lifetime the health of every age group of America society has improved except for teenagers. When I was Surgeon General, many of the public health issues I dealt with – smoking, AIDS, alcohol, pregnancy, and depression - had an alarming adolescent dimension... We need to start thinking of health and education as interlocking spheres. After all, isn't school the best place for a primary health care facility- available, convenient, confidential and responsible not only to the adolescent but also to the family”.

IV. Common Features of School-Based Health Centers

School-based health centers are staffed by an interdisciplinary team of health care professionals, typically a nurse practitioner or physician assistant, mental health provider, administrative personnel, and a part-time pediatrician or family practitioner. This team has a wide-range of responsibilities which may include: providing medical and mental health services; coordinating care with students' personal physicians and/or managed care plans; functioning as liaisons between parents, teachers, and students; acting as community advocates for children; and conducting health promotion activities at school and in the community. As school-based providers, they assume responsibility for the overall well-being of their patients – a much broader role than is typical of most health care practitioners.

The scope of services varies among health centers, but the majority provide comprehensive primary and mental health services, as well as health education and preventive services. Comprehensive assessments, diagnosis and treatment of acute illnesses, well child exams, mental health counseling, chronic health management, laboratory services, and prescriptions are commonplace in health centers. Though most school-based health centers provide services only to the students registered in their schools, some open their services to the young children of teen parents while others provide limited services to the community-at-large.

School-based health centers across the nation are supported through a patchwork of funding including local, state, and federal public health and primary care grants, community and family foundations, donations, and reimbursement from public and private health insurance. Schools typically provide in-kind donations of space, maintenance, utilities, and teacher and administrative support.

Research has shown that school-based health centers contribute to fewer school absences, lower drop-out rates, increased knowledge about health, decreased cigarette and pot smoking, reduced loss of work time for parents, higher compliance with immunizations and physicals, decreased teen pregnancy, improved identification and treatment of mental health needs, and reduced hospitalizations and ER visits.

V. Membership Associations for School-Based Health Centers

Both national and local membership associations have been created to support and promote the mission of school-based health centers. The National Assembly for School-based Health Care (NASBHC) is a powerful public policy advocate of school-based health care and is the nation's primary resource for professional development, knowledge, and exchange of information on inter-disciplinary school based health care and services. NASBHC has Centers for Advocacy & Public Policy, Technical Assistance & Training, and Evaluation & Quality.

Many centers have joined together to develop state chapters in order to share information and promote advocacy on a local level. In 1996, the Illinois Coalition for School Health Centers (ICSHC) was organized to advocate for the development, stabilization and expansion of school based and linked health centers in Illinois. The ICSHC organizes awareness building events, advocacy days and media campaigns to better educate decision makers and the general public about the effectiveness of school health centers. In addition, the ICSHC provides professional development and networking opportunities to discuss the future of school based health services.

The membership of the ICSHC and key leaders in the field of school-based health care have been instrumental in affecting positive change in Illinois. They have worked collaboratively with the Illinois Department of Human Services and the Illinois Department of Public Aid to institute a more stable and long-term state funding structure for centers in Illinois, develop state standards for school-based health centers, and create a special designation for school-based health centers which was intended to facilitate billing Medicaid/managed care patients. The ICSHC currently has a grant from the Chicago Community Trust to assess the feasibility of centralizing administrative services for the Chicago area school health centers in order to promote sustainability.

VI. Standards for School-Based Health Centers

The leadership of the National Assembly for School-Based Health Care has developed a set of principles and goals designed to establish a national standard for the field. These principles provide guidelines by which to benchmark programs, define the essential elements of a school-based health center and provide a framework for accountability and continuous improvement.

According to the National Assembly, successful school-based health centers encompass the following elements:

- ***Support the school*** – are built upon mutual respect and collaboration between the school and the health provider to promote the health and educational success of school-aged children.
- ***Respond to the community*** – are developed and operate based on continual assessment of local assets and needs.
- ***Focus on the student*** – services involve students as responsible participants in their health care, encourage the role of parents and other family members, and are accessible, confidential, culturally sensitive, and developmentally appropriate.
- ***Deliver comprehensive care*** – an interdisciplinary team provides access to high quality comprehensive physical and mental health services emphasizing prevention and early intervention.
- ***Advances health promotion activities*** – takes advantage of its location to advance effective health promotion activities to students and the community.
- ***Implements effective systems*** – administrative and clinical systems are designed to support effective delivery of services incorporating accountability mechanisms and performance improvement practices.
- ***Provides leadership in Adolescent and Child Health*** – increases expertise in adolescent and child health and inform and influence policy and practice.

In 1997, the Illinois Department of Human Services (IDHS) developed standard guidelines for opening and operating school-based health centers in Illinois. These standards provide a uniform definition for what constitutes a school-based health center, outlining requirements for organizational structure, policies and procedures, compliance, scope of services, staffing, access, data collection, student's rights and responsibilities, reporting, and finance. For example, all school-based health centers must have advisory boards that meet quarterly, the centers must be open 12 months a year and have a plan for providing 24 hour access to providers, and the physical plant must comply with all laws for health facilities. These standards avoid variability in facilities, operations, range of services, and staffing across sites, maintains quality assurance, and helps show payers and policy makers that school based health centers are solid providers of documented quality.

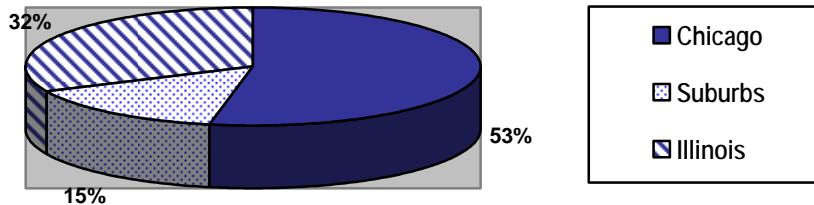
In 1999 the Illinois standards were adopted by the Joint Committee on Administrative Rules and are now used as a standard for IDHS certification of health centers. All school health centers funded by IDHS must be certified. IDHS conducts administrative and clinical audits of programs annually. Illinois is recognized as a national model of excellence and is only one of eight states to officially adopt standards.

VII. Status of School-Based Health Centers in Chicago

Location: The first school-based health center in Illinois was established in 1982 at Austin High School with funding from the Robert Wood Johnson Foundation. Today there are a total of 47 school-based health centers in Illinois, 25 of which are operating in Chicago and 7 in

the suburbs (see *Appendix A* for complete list of schools). School-based health centers in Chicago are located in public schools, predominantly in high schools (18 high schools, 1 middle school, and 8 elementary schools). Approximately, 24% of the centers are located on the north side, 44% on the west side, and 32% on the south side of the city (see *Appendix B* for map of school-based health centers).

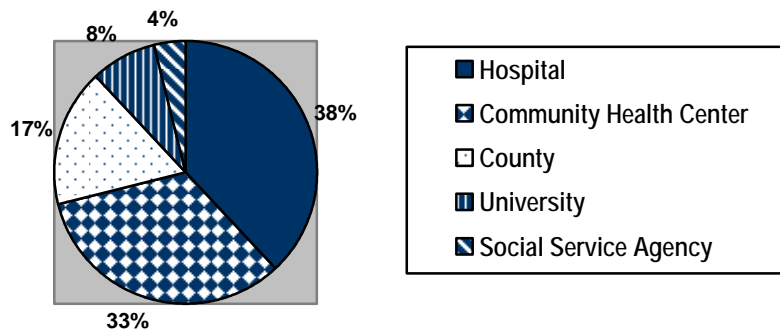
Chart 1
Distribution of School-Based Health Centers throughout Illinois



Sponsorship: School-based health centers are most typically sponsored by a local health care organization, such as a hospital, health department, or community health center. Other community partners may include universities and social service agencies.

In Chicago, 9 centers are sponsored by hospitals (Advocate Illinois Masonic Medical Center, Children’s Memorial Hospital, Rush Presbyterian St. Luke’s Medical Center, Mercy Hospital, and Swedish Covenant Hospital), 4 are sponsored by Cook County (Hektoen Institute, Bureau of Health Services), 2 by the University of Illinois (Neighborhoods Initiative Division of Community Health), 7 by Community Health Centers (TCA Health, Inc, Lawndale Christian Health Center, Erie Health Center, Access Community Health Network, Alivio Medical Center, and Heartland Health Outreach), and 1 by a social service agency (Youth Guidance).

Chart 2
Distribution of Chicago School-Based Health Centers by Sponsoring Agency Type



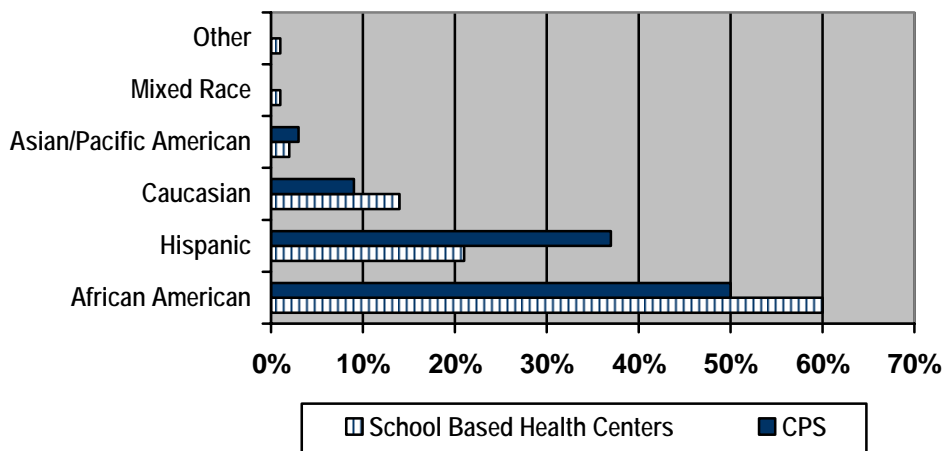
Funding: School-based health centers in Chicago, similar to the rest of the nation, are supported by a patchwork of funding sources. What sets school-based health centers apart from private practice and most other outpatient settings is the large number of distinct funding streams

that centers must tap for needed funds. These often include: publicly funded grants from Federal, state, and local government administrations; privately funded grants from foundations and corporations; in-kind contributions from school systems, community agencies and other entities; publicly funded patient care reimbursements; and privately funded patient care reimbursements from commercial insurance.

In 1985, the Illinois Department of Human Services (IDHS) embraced this health care delivery model and provided start-up funds for 5 centers in Chicago, East St. Louis, and Kankakee. Over the past 20 years, the number of state supported school-based health centers has grown to 37. IDHS grants are allocations of state/federal maternal and child health block grant and the tobacco tax dollars. These grants were initially deployed as start up funds but as communities were unable to supplant state funds with local dollars, the school-based health care community persuaded the state to change its policy in favor of longer-term support. Today, this IDHS funding represents the core funding for 15 centers in Chicago. Though most of the health centers have been creatively supplementing these dollars with funding from a variety of other sources, without state support many of the centers would not survive.

Student Profiles: School-based health centers serve largely minority and ethnic populations that have historically experienced health care access disparities. The demographics of students enrolled in Chicago’s school-based health centers closely resemble the ethnic profile of the Chicago Public School’s student body.

Chart 3
Ethnic Profile of Student Populations Served by School-Based Health Centers in Chicago



Services: All 27 school-based health centers in Chicago provide the basic tools of primary preventive care. The most common service components are comprehensive health assessments, anticipatory guidance, immunizations, treatment of chronic and acute illness, lab services and prescription services. All of Chicago’s school-based health centers, with the exception of two located in elementary schools, offer reproductive health services, pregnancy tests, and STD screenings and treatment. The majority of sites offer a variety of mental health and counseling services as well as health education. Only 4 school-based health centers in Chicago provide on-site dental services.

As part of its reporting requirement, the Illinois Department of Human Services collects quarterly data from the health centers they fund. According to the 2002-2003 annual report, the 15 IDHS funded sites provided a total of 47,361 visits and served over 11,333 students. Chart Four shows a breakdown of these visits by service type. It should be noted that the health education numbers include both one-on-one in the health center and classroom presentations.

Chart 4
Visits by Type of Service for 2002 – 2003*

Medical Services		Mental Health Services		Dental Services		Health Ed.
# Visits	# Students Served	# Visits	# Students Served	# Visits	# Students Served	# Visits
23,528	9,624	5,464	1,668	48	41	18,321

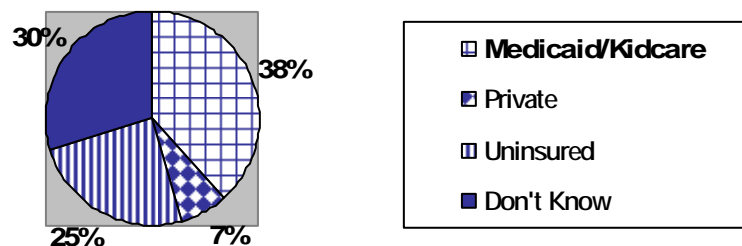
* Statistics include only those centers funded by IDHS

On-Site Training – Over 80% of the school-based health centers nationwide serve as training sites for health professionals (e.g. nurse practitioners, physicians, mental health providers and nutritionists). In Chicago, 13 sites are involved in professional training activities.

Training in a school-based health center setting offers many advantages both to the trainees, the field of child and adolescent health, and the site itself. The school-based health center setting offers trainees, often for the first time, the opportunity to work collaboratively with a multi-disciplinary team of providers and, in the case of high school centers, with a population that they would rarely see at more traditional sites. Many of these trainees incorporate a new awareness of the unique needs of children and adolescents and community partnerships into their future practices. Trainees do assist center staff, allowing additional students to be seen during a day. It should be noted, however, that trainees do not significantly add to the overall capacity of the center because they must be supervised, their schedules are often erratic, and their training cycle is generally short-term.

Insurance Status: One common feature of all school-based health centers is that parents must sign written consent forms before children can be enrolled. One section of these consent forms asks for insurance eligibility. As illustrated in Chart Four, insurance eligibility is difficult to capture. Parents often do not complete this portion of the consent because they are uneasy about disclosing insurance information, even if they have coverage. Following up on insurance status is also challenging. Providers cannot rely on students because they do not know their status and the centers do not have the personnel resources to contact parents. Even if parents complete the eligibility information it is often not useful because plans change with such frequency.

**Chart 5
Insurance Eligibility**



Billing for Services: The history of billing and collecting patient care revenues in school-based health centers is relatively brief, not only in Illinois but nationally. Many of the original health centers did not bill for services because they were well-financed by private foundations and public health grants. In response to declining public funds, most health centers have accepted the fact that they must begin efforts to recover reimbursements.

Billing, however, is complicated and rewards have been disappointing. Many factors contribute to the billing challenge. As stated earlier, collecting insurance information from students and parents is challenging and burdensome; the insurance status of a large portion of the program’s population is uninsured, underinsured or unknown; many insurers require co-pay for some or all of services; explanation of benefits (EOBs) are sent to the family, potentially compromising patient-provider confidentiality; and there are not enough administrative staff at the health center. Furthermore, successful participants admit and studies support that revenue collection generally does not provide for more than 5 – 15 % of a health center’s operating budget.

The rapid growth in managed care, particularly the shift to Medicaid managed care and the increased coverage for low income and uninsured children through the State Children’s Health Insurance Program, has and will continue to significantly impact the billing potential of school-based health centers. Some of the challenges presented by managed care include; lack of understanding by managed care organizations about what school-based health centers are and are not; belief that school-based health centers are not a legitimate part of the US health care delivery system; many managed care contracts do not include preventive or mental health services; fees are less than what the program got from Medicaid before managed care; administrative burdens on staff; and time-consuming credentialing.

Encouraged by the Illinois Department of Public Aid (IDPA), the Illinois Department of Human Services (IDHS) has begun requiring all state funded school-based health centers to bill for services. In the 2002 – 2003 school year, 6 out of 15 IDHS sponsored Chicago health centers billed for services. The following chart illustrates the challenges faced by these health centers in maximizing reimbursements.

Chart 6
2002 – 2003 Revenue from Billing

Health Center	Medicaid		Private Insurance		Total	
	Billed	Received	Billed	Received	Billed	Received
Arai	\$123,220.00	\$11,188.73	\$21,100.00	\$0.00	\$144,320.00	\$11,188.73
Beethoven	\$46,546.00	\$30,135.45	\$0.00	\$0.00	\$46,546.00	\$30,135.45
Carver	\$39,420.35	\$0.00	\$1,623.00	\$0.00	\$41,043.35	\$0.00
Gladstone*	\$5,586.00	\$24,073.12*	\$9,697.00	\$8,057.50	\$27,416.00	\$33,699.62*
Roosevelt	\$56,489.00	\$23,245.00	\$55,683.00	\$0.00	\$242,152.00	\$23,245.00
Ryerson	\$74,518.00	\$79,849.00	\$6,608.00	\$4,098.00	\$122,647.00	\$93,276.00
TOTALS	\$345,779.35	\$168,491.30	\$94,711.00	\$12,155.50	\$624,124.35	\$191,544.80

*Receivables carried over from the 2001-2002 school year

In 1998, IDPA designated a special provider number for school-based health centers that were certified by IDHS. The intent of this provider number was to assist centers that meet the state standards to bill Medicaid at fee-for-service reimbursement regardless of a student's managed care arrangement. Despite this provider type designation, health centers have still met with resistance when dealing with Medicaid/managed care arrangements.

VIII. Interviews with Leaders in the Field

In August and September 2004, Millennia Consulting conducted eleven telephone interviews with selected national, state, and local leaders working with school-based health centers, representing the National Assembly for School-Based Health Centers, the Illinois Department of Human Services, the Illinois Coalition for School Health Centers, Chicago school-based health centers, and the local foundation community. The intent of the interviews was to identify challenges facing school-based health centers and their implications for the direction of future foundation funding (see *Appendix C* for interview protocol).

Participants were asked to describe specific challenges facing school-based health centers and the environmental factors that have had an influence on this health care delivery model. The following five global challenges and/or areas of concern were identified by respondents: achieving sustainable funding; potential dilution of the model; billing and inadequate reimbursement; demonstrating positive health and educational outcomes; and working within the Chicago Public School system.

Achieving Sustainable Funding – All participants expressed concern for the future viability of their centers as a result of increased competition for decreasing public funds. Participants also agreed that there are only a limited number of ways to achieve sustainability for school-based health centers. Unlike other safety net providers such as community and migrant health centers and family planning clinics, a patchwork of blended public and private financial support typically contribute to school-based health programs because no single source of funding will cover the costs of the comprehensive services that make up the essence of this delivery model.

Fifteen of the 25 centers in Chicago receive their primary funding from the Illinois Department of Human Services (IDHS). This funding has been relatively stable but does not cover the total cost of running a comprehensive center. The average funding from IDHS is \$100,000 annually. The yearly cost of running a comprehensive school-based health center can run from \$200,000 - \$400,000. Centers supplement operating costs with third-party billing and philanthropic dollars from individuals, corporations, and foundations. Finding these supplemental dollars has become increasingly challenging. All of the centers are competing against each other for decreasing philanthropic dollars. Many centers have looked to billing as a possible answer to sustainability, but national data shows that the health centers that are most successful at billing rarely see reimbursement for more than 15% of their operating costs.

Adding to this fiscal challenge are the federal guidelines established for funding school-based health centers. The majority of health centers do not have direct access to any federal grant support because these funds are restricted to Federally Qualified Health Centers (FQHC). Only seven centers in Chicago fall into this category. Even these seven centers, however, report that federal dollars will not adequately support the school-based health center model. School-based health centers sponsored by FQHCs feel secure about funding for core services, but must seek additional funds for mental health and health education services.

Most participants felt that there were untapped funding sources flowing through state, educational system, and public health and mental health agencies but they concurred that pursuing these alternative avenues required extra resources and expertise. As one interviewee stated, "Even if centers identify a good idea for sustainability they may not have the capacity to follow-up on it." Staff are not trained nor do they have the time to do all the jobs required in this setting. For example, the Nurse Practitioner is often called upon to provide direct service, write grants, market the program, and provide administrative support.

Another key problem that surfaced during the interviews was "Chicago's model of one provider for one site, its piecemeal way of operating its centers." All interviewees expressed the need for centers to develop vehicles for collaboration and leveraging their resources. Participants felt there was a definite need to develop economies of scale in such areas as billing, purchasing, and administration. Examples were given of successful cost-sharing models currently being implemented in Denver and Michigan.

Potential Dilution of the Model – Interviewees stressed that the strength of school-based health centers is its multidisciplinary approach to care, blending medical care with preventive and mental health services. They saw primary care services as the wedge that allows students to come in for a service that they would not normally access, like mental health. In their view, it is this critical aspect of the model that is in jeopardy. Based on the nature of health issues seen in their centers, participants repeatedly emphasized the need for mental health services and health education. Participants are worried because, due to difficult economic times, they are being asked by their sponsors to pare back to core medical services, moving them away from what makes them a unique and effective health care delivery mechanism.

Billing and Inadequate Reimbursement – As public dollars decrease, centers are looking to billing as an important source of revenue. Though all interviewees recognized the need to bill, they unanimously expressed frustration with the current state of billing. Billing requires expertise, resources, and time. Finding the dollars to support the complicated infrastructure needed to successfully bill is a challenge for already financially strapped centers. Many participants even questioned whether the revenue return from billing would compensate the staff time needed to bill. School-based health centers that bill and collect patient revenue generate higher total revenue but also require higher revenue to support the hardware, software, staff and ongoing training needed to perform billing and collecting successfully. This is particularly true for centers sponsored by hospitals and social service agencies, who receive a far smaller rate of reimbursement for Medicaid patients than centers sponsored by community health centers and Cook County. One participant was puzzled by this lack of reimbursement equity in Illinois. He reported that states can determine their own reimbursement formulas and other states, such as New York, have adopted formulas that provide enhanced reimbursement rates to all school-based health centers regardless of their sponsorship.

It is important to emphasize here that there are strengths and weaknesses inherent to each sponsorship type. Many hospital and social service agency sponsored health centers are questioning whether they would be better off if they were sponsored by a community health center. As such they would be able to receive enhanced reimbursement rates and be eligible for federal dollars, which are now restricted to community health centers. This should not be seen, however, as a simple fix. Many challenges come with being part of a community health center. In order to comply with federal regulations, school-based health centers are often pressured by their FQHC sponsors to reach unrealistic productivity goals and reporting demands are often more rigorous. In addition, the competition for federal grant dollars is extremely fierce. Being part of an FQHC will allow centers to qualify for making an application but does not ensure grant awards.

The Health Care Financing Authority's (HCFA) free care policy and the continued growth of Medicaid/managed care plans were seen as huge obstacles to school-based health centers' success in billing. The client base for centers is primarily Medicaid eligible and uninsured patients. The HCFA free care policy states that federal Medicaid matching funds are not available for payments to a provider unless the provider has the authority to charge all patients for services rendered and uses this authority. Billing all patients presents a major problem for centers because of confidentiality issues and the large number of uninsured patients. According to one interviewee, "Parents who are not Medicaid eligible and cannot afford to pay have actually discouraged their children from using the health center once they get bills, even if the center never collects."

The growth in Medicaid managed care is seen as having a negative impact on billing in school-based health centers. Billing managed care requires centers to respond to strict plan requirements and adhere to policies and practices that conform to plan reporting policies. Interviewees repeatedly stressed the difficulty of negotiating with these entities because school-based health centers are not uniformly recognized as eligible providers and have difficulty meeting the managed care requirements. It was reported that health centers often "...lose a large chunk of money and eat managed care expenses from both private insurance and Medicaid". The

growing managed care environment is an issue even for centers that receive the enhanced Medicaid reimbursement rate. According to one participant, “Being a Federally Qualified Health Center (FQHC) helps a lot but the extent of help depends on one’s payer mix. If all patients are Medicaid it is very helpful, but if you have a mixture of Medicaid and HMO then it is a challenge”.

Yet another billing challenge cited was the lack of reimbursement for mental health, dental, and prevention services. Respondents reported that core medical services are reimbursable but mental health services are, in most cases, not covered under the current method of reimbursement. Finally, all interviewees agree that the special provider number designated by the Illinois Department of Public Aid, though intended to allow centers to bill Medicaid patients regardless of their managed care status, does not work and centers were still being denied reimbursement.

Demonstrating Positive Health and Educational Outcomes – Participants all agreed that there is a lack of solid evaluation data, nationally and locally, showing the impact that school-based health centers have on positive health and educational outcomes. It was generally felt that school-based health centers are not seen as a legitimate part of the health care system and that there is a critical shortage of outcome data that has meaning to policy makers and funders. To date, attention has focused on patient care and as a result there is limited documentation showing the value of the important medical and non-medical functions of school-based health care. Interviewees concurred that “We have lots of quality improvement activities and we follow health indicators, but we always pick ones that are measurable. These are not the ones that make the health centers unique. We need ways to measure prevention and mental health outcomes”.

The issue of sustainability rests on demonstrating the value of school-based health centers to legislators, funders, and other key stakeholders. This is of particular importance given the major emphasis on improving test scores currently being placed on schools. The viability of this health care delivery mechanism will depend in part on being able to prove concretely that time spent in the health center or with health center staff is connected to improved academic performance.

Despite the importance of evaluation, this aspect of school-based health centers has been poorly funded and the science behind it has not been rigorous. According to one interviewee, “We haven’t done pure evaluation. We know we have improved access to care but we are looking at the so what factor. We have the data and need to prove that we do more than just provide access.” This challenge is further compounded by the varied responsibilities required by health center staff, who may not have the time or expertise to conduct formal evaluations.

Working Within the Chicago Public School System – A number of the participants were optimistic that the Chicago Public Schools (CPS) may be putting health centers on a higher level and are trying to better understand the role that health centers play. For example, CPS now is asking health centers for monthly statistics. Based on past experience, however, centers are not sure if this new interest is positive or negative. Since the inception of the health centers, CPS has been a partner but has never provided any financial support. In addition, many interviewees

expressed frustration with the fact that CPS enacts mandates that negatively affect health centers. According to one interviewee, “CPS is all over the place with their ideas. There are so many revisions in their plans. We could help them guide policy but they don’t ask our input. We need to know their long-range plans, their vision for health care, and their priorities.” A recent policy affecting centers was the closing of several schools that housed health centers, requiring the centers to find new locations. Another concern expressed was the increasing emphasis on test scores, making it difficult for students to schedule appointments at certain times of the year.

The gentrification of city neighborhoods was also raised as a challenge by some interviewees. Many school health centers, particularly those that are Federally Qualified Health Centers must show that they are serving low income and medically underserved populations. With the closure of housing projects and the increase in mixed income neighborhoods, they are challenged to meet their funding requirements. The changing demographic landscapes of the city and the suburbs raises the question of where health centers are best placed in the future.

Participants were asked to describe the role that they felt foundations could play in ensuring the future of school-based health centers.

All interviewees recognized that continued philanthropic support was critical to the long term sustainability of school-based health centers. The majority of respondents acknowledged that funding needs to be focused in two areas: support of individual health centers and larger advocacy efforts. It was repeatedly stressed that both areas must be addressed simultaneously. As one participant said, “We need to make environmental changes but these changes are often slow and we need money to keep our good work going in the meantime.”

Support for Individual Centers – Most participants agreed that their core health services were not in jeopardy but that mental health and prevention services were at risk. They felt that foundations were one of the primary sources for ensuring that these non-reimbursable services are maintained. They also suggested that by funding evaluation initiatives, foundations would be helping centers secure future funding opportunities. Several interviewees also proposed that foundations could play a more active role in promoting best practices, convening learning communities to share what has been learned from grantees.

When discussing support for individual centers, participants felt that too often foundations are looking for new initiatives, which require staff to add on projects rather than maintain what is working. Another concern was that it was very difficult to “struggle to re-up every year” and that multiyear commitments allow centers to plan, implement, assess, and refine.

Support for Coordinated Advocacy Efforts – All participants agreed that the long term sustainability of school-based health centers ultimately rests with increased support from national, state, and local leaders. There was also a common theme of the need for increased collaborative efforts among health centers. Many of the interviewees felt that foundations could play a role in helping to create a bridge between this movement and different policy makers who are not fully aware of school-based health centers. The following were also suggested:

- Bring strategic partners together to look at sustainability issues and implement cost-sharing models, such as billing and purchasing.
- Create a demonstration project on the feasibility of billing with an eye towards policy change and political support.
- Provide the Illinois Coalition of School Health Centers with a planning grant to look at the long term sustainability of school-based health centers in Chicago.
- Support a person to work with the Chicago Public Schools and legislators to educate them on the value of school-based health centers.
- Fund pilot projects that test the concept of sharing resources, such as health educators and billers.
- Be a convener of a group in the city to create a unified service delivery system, which might include the Chicago Department of Public Health, the City, Chicago Public Schools, existing partners, foundations, and public service agencies.
- Build grassroots support for school-based health, such as training local partners constituency based organizations to organize advocacy days.

IX. Consultant's Observations

Illinois and Chicago are on the forefront of the school-based health center movement. Like all school-based health centers across the nation, however, they are facing serious challenges. The future sustainability and effectiveness of this innovative and unique service delivery model depends on the commitment and strategic decision making of sponsoring organizations, the funding community, and public entities. This report has surfaced several key issues that need to inform decision-making processes.

Maintaining the Uniqueness of the Model - The strength and uniqueness of the school-based health center model lies in its interdisciplinary nature, the fact that it blends physical health care with mental health services, and health education. Mental health is repeatedly seen as the number one diagnostic category in health center statistics and teaching students to make life-long healthy life choices is the driving force behind most center operations. This interdisciplinary focus is both the strength of the model but also one its greatest challenges. Public funds exist to support core physical health services. Finding funds to provide mental health and health education services, however, is much more complicated. In difficult economic times, it is these non-reimbursable services that often suffer. Without mental health and health education, however, the model is diluted and cannot have the same impact on the health of children and youth.

Sharing Lessons Learned with All Schools - The school-based health center model is a powerful vehicle for addressing all components of school health, such as mental health, safety, nutrition, health education, physical education. Many health centers in Chicago, in addition to providing services within the walls of their facility, provide health education in the classroom, work with physical education teachers and coaches, run health fairs in the community, share resources with teachers, participate in after school activities, and conduct workshops with parents. If these centers have so much potential, should not every school have such a center? This is an unrealistic expectation given the cost of operating these centers and the economic climate. Many people even doubt the wisdom of opening any more new centers without clear

sustainability plans. In addition, all schools may not need a comprehensive center. Some, such as community schools, are taking advantage of external partnerships to promote healthy schools, healthy students, and healthy communities. Ways need to be found for health centers to share lessons learned with all schools. Several interviewees raised the possibility of finding creative ways to expand existing capacity so that health centers could become neighborhood hubs for other schools, sharing resources and expertise.

Finding a Balance between Advocacy and Program Support - In order to maintain the quality of existing centers and ensure their future viability, two strategic directions must be conducted simultaneously. One is to identify ways to support the integrity of existing services and the other is to work on changing the political and funding environment to embrace this model as a legitimate part of the health care system. Until systemic change can occur, funders must support mental health and health education initiatives in the health centers. At the same time, however, advocacy efforts must also be supported to work with national, state, and local entities to expand legislation, adapt reimbursement practices, create or open up new funding streams, etc.

Creating Economies of Scale - Other states have shown that collaboration between health centers has resulted in economies of scale, ensuring the sustainability of the school-based health center model. Cities such as Denver, where all health centers are under one central administration, are able to tackle many of the issues challenging individual centers such as negotiating with managed care, purchasing supplies and pharmaceuticals, and billing. As noted by one of the interviewees, Chicago's greatest weakness is its one provider – one health center structure. There is not only competition between centers for decreasing funds but also much duplication of efforts. Key leaders and stakeholders must be brought together to identify realistic ways to collaborate. This will be extremely challenging in Chicago, given the disparate nature of health center sponsors. There are many lessons to be learned from other cities and states across the country. For example, many of the states that have successfully implemented economies of scale have done so because of a mandate from a major funder. In Chicago, this would most probably be the Illinois Department of Human Services that provides significant funding for 15 centers.

The Illinois Coalition of School-Based Health Centers has received a grant from the Chicago Community Trust to explore the feasibility of centralizing administrative services and as such will be conducting interviews with school-based health center administrators and experts in the field as well as visiting Michigan, a leader in collaborative billing practices. This is a first step in addressing the issue of collaboration. In its current capacity, the ICSHC faces several challenges in moving beyond this initial step. The membership of the ICSHC is mostly health center staff and does not represent institutional decision-makers. If any centralization of services is to occur, the ICSHC must work directly with the leadership of sponsoring agencies. Given its current staff size and budget, the ICSHC does not have the infrastructure to implement and support a citywide collaborative effort.

Encouraging Collaboration among Funders – Foundations in Chicago have a long and rich history of funding school-based centers. For example, Polk Bros. Foundation has been instrumental in supporting non-reimbursable services such as mental health and health education

in a variety of health centers for over a decade. In addition, they funded a five-year initiative that provided planning and implementation dollars to six new health centers. Though this initiative will not be continued, Polk continues to be committed to maintaining its support for individual centers. The Chicago Community Trust (CCT) became involved with the work of school-based health centers in the 1980s. The focus of CCT's current health funding strategy is on promoting systemic change that will result in broad scale replication. One of CCT's most recent grants is a feasibility study of centralizing administrative services across school health centers to be conducted by the Illinois Coalition for School Health Centers. The Michael Reese Health Trust (MRHT) has funded school-based health centers annually since it began providing grants in December 1997. MRHT has supported many of Chicago's school-based health centers, responding to requests related to a wide-range of needs including planning, general operating costs, mental health, health education, and community outreach.

Interviewees stressed that the future of school-based health centers depends on financial support for school-based health centers at both the individual and city-wide/regional levels. As was emphasized in this report, there is a need for the continued funding of individual centers particularly the areas of mental health and health education. Identified needs for city-wide/regional funding included advocacy and more effective use of administrative resources such as cooperative planning, fundraising, billing systems, and evaluations. Collaborative planning and funding by government and foundation sources could allow them to leverage resources, avoid duplication, and ensure that specific health center and city-wide/regional needs and infrastructures are adequately defined and supported.

Acknowledging Changing Demographics - This report has focused entirely on school-based health centers in Chicago. With the gentrification of the city, the need for school-based health centers in the collar suburbs increases. There are currently seven school-based health centers operating in Evanston, Park Ridge, Aurora, Chicago Heights, Maywood, and Cicero. The sustainability of these centers presents an enormous challenge because they are seeing a rise in their indigent student populations but are still not seen as needy by a large part of the funding community. Though they serve an urban population in suburbia, they are not eligible for many foundation dollars, which are restricted to the City of Chicago.

APPENDIX A

List of School-Based Health Centers in Chicago

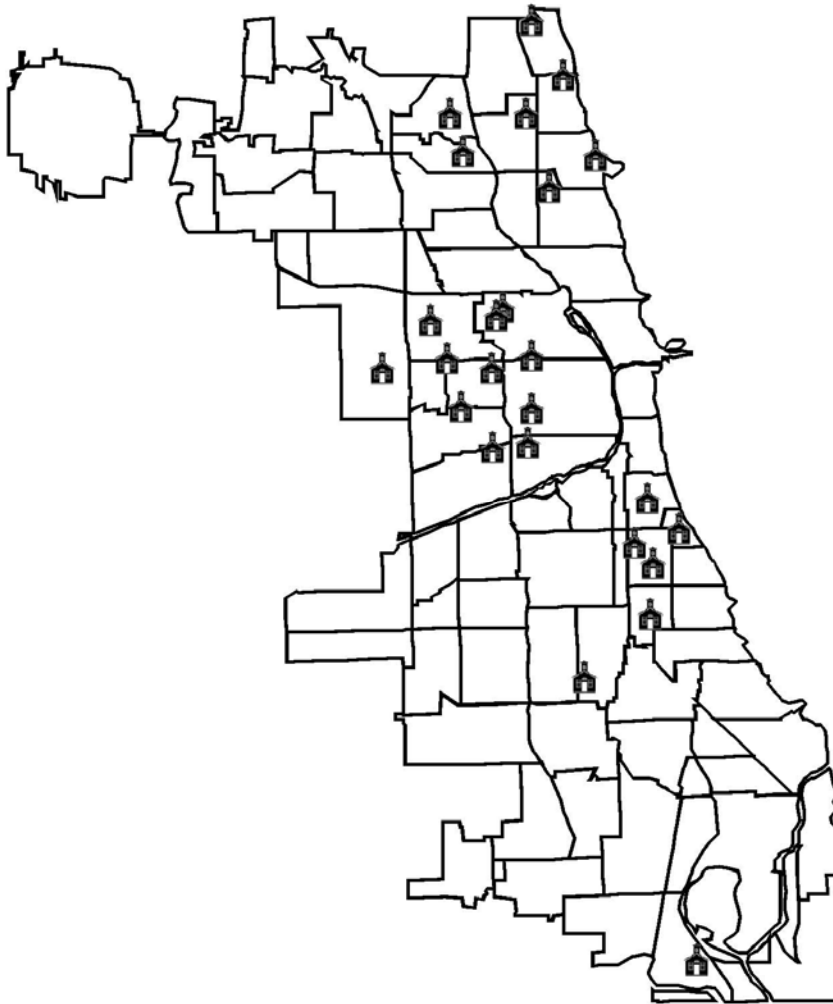
SCHOOL-BASED HEALTH CENTERS in CHICAGO

Health Center	Sponsoring Agency	IDHS funded
Amundsen High School	Advocate Illinois Masonic Hospital	✓
Arai Middle School	Children's Memorial Hospital	✓
Austin Community Academy	Cook County Bureau of Health Services	
Beethoven Elementary School	Hektoen Institute (Cook County)	✓
Bond Elementary School	Cook County Bureau of Health Services	✓
Carver Military Academy	TCA Health, Inc	✓
Crane Tech Prep Community School	Rush Presbyterian/St. Luke's Medical Center	✓
Dunbar Vocational High School	Mercy Hospital	✓
DuSable High School	Hektoen Institute (Cook County)	✓
Farrugut High School	Lawndale Christian Health Center	
Frazier Elementary School	Erie Health Center	
Gladstone Elementary School	Alivio Medical Center	✓
Jose de Diego Elementary	Erie Health Center	
Lake View High School	Advocate Illinois Masonic Hospital	✓
Northside Prep High School	Swedish Covenant Hospital	
Orr-Rezin Academy	Rush Presbyterian/St. Luke's Medical Center	✓
Phillips Academy	Mercy Hospital	✓
Roberto Clemente High School	Youth Guidance	✓
Roosevelt High School	Swedish Covenant Hospital	✓
Ryerson Elementary School	Erie Health Center	✓
Senn High School	Heartland Health Outreach	
Smyth Elementary School	UIC Neighborhoods Initiative Division of Community Health	
Suder Elementary School	UIC Neighborhoods Initiative Division of Community Health	
Young Women's Leadership Charter	UIC Neighborhoods Initiative Division of Community Health	

APPENDIX B

Map of School-Based Health Centers in Chicago

SCHOOL-BASED HEALTH CENTERS in CHICAGO



APPENDIX C

Interview Protocol

Interview Protocol

Draft Questions for school-based health center interviewees:

1. What are the three top challenges facing your school-based health centers?
2. Since you started your center, what environmental changes have happened that have had a positive and/or negative affect?
3. What policy recommendations, at the state and federal levels would be helpful for promoting and sustaining school-based health centers?
4. What strategies do you perceive are necessary to build long-term support for your school-based health centers?
5. What are your current sources of financial support? ---If you have foundation support, from whom and for what?
6. Foundations like other non-profits and government agencies are wrestling with how to use scarce resources most effectively. What role do you see foundations playing in school-based health centers?
7. If you could talk to a foundation Board member, what would you tell them are the unique services that school-based health center's bring to children versus care in clinics outside of the school community?
8. If you were a foundation officer and had \$100,000 a year to spend in the area of school-based health centers, how would you spend it?

Draft Questions for Illinois Coalition:

1. What are the three top challenges facing school-based health centers in Chicago?
2. What are the three top challenges facing the Coalition?
3. What environmental changes have happened in the recent past that has had a positive and/or negative affect on school-based health centers?
4. What policy recommendations, at the state and federal levels would be helpful for promoting and sustaining school-based health centers?
5. What strategies do you perceive are necessary to build long-term support for school-based health centers in Chicago?
6. What role do you see foundations playing in school-based health centers?

7. If you could talk to a foundation Board member, what would you tell them are the unique services that school-based health center's bring to children versus care in clinics outside of the school community?
8. If you could talk to a foundation Board member, what would you tell them are the unique services that school-based health center's bring to children versus

Draft questions for Illinois Department of Human Services:

1. What are the three top challenges facing school-based health centers in Illinois?
2. What environmental changes have happened in the recent past that have had a positive and/or negative affect on school-based health centers?
3. What policy recommendations, at the state and federal levels would be helpful for promoting and sustaining school-based health centers?
4. What strategies do you perceive are necessary to build long-term support for school-based health centers in Illinois?
5. What role do you see foundations playing in school-based health centers?
6. If you could talk to a foundation Board member, what would you tell them are the unique services that school-based health center's bring to children versus care in clinics outside of the school community?
7. If you were a foundation officer and had \$100,000 a year to spend in the area of school-based health centers, how would you spend it?

Draft Questions for National Assembly of School Based Health:

1. What are the three top challenges facing school-based health centers across the nation?
2. What environmental changes have happened in the recent past that has had a positive and/or negative affect on school-based health centers?
3. What policy recommendations, at the state and federal level would be helpful for school-based health centers
4. What strategies do you perceive are necessary to build long-term support for school-based health centers?
5. Can you identify any foundations that you feel have developed successful strategies for school-based health centers – either in terms of sustainability or program development?
6. What role do you see foundations playing in school-based health centers?

7. If you could talk to a foundation Board member, what would you tell them are the unique services that school-based health center's bring to children versus care in clinics outside of the school community?
8. If you were a foundation officer and had \$100,000 a year to spend in the area of school-based health centers, how would you spend it?

Draft Questions for Foundations:

1. What are the three top challenges facing school-based health centers?
2. What environmental changes have happened in the recent past that has had a positive and/or negative affect on school-based health centers?
3. What role do you see foundations playing in school-based health centers? Do you see the need for foundations to work collaboratively to address challenges facing school-based health centers
4. Please describe your foundation's history funding school-based health centers
5. What role do you see your foundation playing in the future of school-based health centers?