THE SCHOOL-BASED HEALTH CARE POLICY PROGRAM: CAPSTONE EVALUATION

Outcomes, Impact, and Lessons Learned

2004-2010

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Table of Contents

Page

Executive Summary i

Introduction and Background 1

- Challenges Facing School Based Health Care………………………………… 2
- Genesis of the School-Based Health Care Policy Program Design…………. 3
- Vision and Intended Impact…………………………………………………… 4
- Strategy for Policy Change……………………………………………………. 5
- Implementation………………………………………………………………… 6
- Framework for Evaluation…………………………………………………….. 8
- Structure of the Report………………………………………………………… 9
- Environmental Context……………………………………………… 9

Part I. Outcomes and Impact

- Advocacy Capacity of State and National Associations for School-Based Health Care……………………………………………………………… 11
- Community, Including Youth, Engagement in Policy Advocacy…………… 23
- Visibility of School-Based Health Centers………………………….……… 31
- Federal and State Policies for School-Based Health Centers………..……… 37
- Funding for School-Based Health Centers…………………………..……… 46
- Efficiency and Quality of Care ..…………………………………………… 48
- Access to School-Based Health Care……………………………………… 51

Part II. Lessons Learned and Conclusions

- Lessons Learned…………………………………………………………...… 53
- Conclusions………………………………………………………………... 59

Attachments (bound separately)

EXECUTIVE SUMMARY

Vision of the School-Based Health Care Policy Program:

"School-based health care will be financially stable, available and accessible to all children and families and supported as a consumer-centered model of quality care in communities throughout the United States."

Background

More than seven million children in the United States have no health insurance, and many more have limited access to health care because of other systemic and structural barriers to care. Uninsured children are more likely to have no usual source of care, to receive late or no care for health problems, and to report unmet health needs than children whose families have health insurance. Low-income children of color face particular inequities. Not only is quality health care more difficult for them to obtain, but they are disproportionately exposed to the environmental and social conditions that contribute to poor health in the first place.

There are solutions to these problems. School-based health centers (SBHCs) provide one. SBHCs reflect the convergence of public health, primary care, and mental health care in a setting that students can easily access: in schools. SBHCs have grown from a handful of projects in the early seventies to over 1,900 centers serving two million students per year in 48 states and territories. SBHCs serve some of the most vulnerable populations of children and youth in the country, including significant numbers of uninsured and underinsured youth with limited access to health care. Numerous professional organizations and the majority of the voting public support providing health care in schools. SBHCs have proven their ability to deliver preventive, primary, mental health, and oral health care, providing a cost-effective way of meeting the health care needs of some of the nation's most historically underserved children.

Despite their success, SBHCs have had a challenging time maintaining the revenue base needed to sustain and expand their services. This difficulty reflects several factors: inadequate reimbursement from public and private insurance, insurance policies that fail to cover needed services, the historical absence of organized national, state, and community advocacy for policy change, and, foremost, the absence of federal and state policies to sustain and expand SBHCs.

Program Design and Implementation

In 2004, the W.K. Kellogg Foundation launched the School-Based Health Care Policy Program (SBHCPP), a multi-site initiative to advance advocacy and policies that would sustain SBHCs in communities throughout the United States. The program sought to have an impact on policy at three levels: (1) at the local level, by engaging and empowering communities, including youth, in policy advocacy for sustainable, consumer-centered school-based health care; (2) at the state level, by building the capacities of state SBHC associations to serve as leaders in policy advocacy and to provide technical assistance, resources, and support to local advocates; and (3) at the national level, by building the

capacities of the National Assembly on School-Based Health Care (the "Assembly"), the sole national organization representing SBHCs, to elevate the visibility of SBHCs nationwide and serve as the conduit for state and local advocates to the federal policy arena.

To help build the SBHC associations' capacities for advocacy, the Foundation convened a team of consultants with expertise in the following areas to provide training and technical assistance to grantees:

- Community engagement, including youth engagement
- Multiculturalism
- Organizational development
- Strategic communication
- Health and education policy
- Resource development
- Evaluation

The Foundation awarded $26 million to national, state, and local entities to participate in this six-year initiative. Nine geographically and politically diverse state associations representing SBHCs received funding, as did the National Assembly. State-level grantees included associations at different levels of organizational development: some had stronger infrastructures than others; some had made at least initial steps into policy advocacy and showed potential for growth. Participating states included California, Maine, Massachusetts, Michigan, New Mexico, New York, and Oregon, and, in the earlier years of the program, Louisiana and Maryland. The state grants included funding for 40 community partners, including the Navajo, Laguna Pueblo, and Acoma Pueblo sovereign nations in New Mexico. Each community partner, in turn, developed partnerships with youth, community leaders, and other local individuals and groups to engage in community-based advocacy campaigns.

The SBHCPP was implemented during a period of major political change and economic downturn and instability in the United States. The program sought to advance its vision and goals against the backdrop of two presidential administrations with vastly different policy agendas and goals; shifting party majorities in Congress and state government; and a series of economic crises that led to major reductions in spending and support for a broad range of social policies and programs.

Most of the state associations had little operating revenue at the program's start and operated primarily as informal, voluntary organizations. Many had no or few staff, and most had informal boards that often consisted of only a few SBHC clinicians. While experienced in health care, the associations' staff, volunteers, and board members had limited experience in policy advocacy. The National Assembly and the state SBHC associations' historical work focused on serving their members and responding to policy threats to funding, rather than on building proactive policy campaigns to advance

sustainable school-based health care. Many of the state associations, which might have provided a national voice to build the SBHC movement, instead struggled to survive and to maintain basic services and operations.

Results of the SBHCPP

Growth in capacity for policy advocacy. Much changed in the course of the SBHCPP. The National Assembly and state SBHC associations made major strides in developing their infrastructures and capacities to support policy advocacy. Most of the SBHC associations established legal independence from their fiduciaries. Most expanded and diversified their staffs and governing boards to broaden their base of expertise in advocacy and better represent the multicultural populations they serve. All adopted more inclusive and democratic practices to empower their stakeholders, including youth, to participate in and guide organizational decisions and practices. The SBHC associations also became increasingly proficient in utilizing the SBHCPP core strategies for policy advocacy.

State SBHC associations established community and youth advisory boards in all of the participating communities to develop and implement community-based advocacy campaigns. The SBHCPP's "community partners," which often were comprised of staff members from the SBHCs or the organizations that sponsored them, played a pivotal role in connecting the national and state associations to youth, parents, local community groups, local policy officials, and others. In most communities, youth advisory groups flourished and became dynamic and self-directed bodies. Youth emerged as leaders in policy advocacy in advancing not only local, but state and federal policy.

Findings from project-level evaluations, as well as from the SBHCPP's "Youth Voice Project," a multi-state series of videotaped interviews and conversations designed and implemented by youth, provide a compelling portrait of the youth experience in the SBHCPP. Young people described the program's impact on their sense of connection with school, their motivation to do well academically, and their confidence and efficacy in influencing policy decisions. As one community partner commented, "Youth have taken what we've given them and run with it. It's a movement being driven by the youth."

The program also showed evidence of an emerging "policy network"— a network of stakeholders, community groups, youth, other advocates, and policy champions who shared the goal of advancing policies favoring SBHCs and who took action in policy advocacy. These partnerships formed at the federal, state, and local levels, as well as between and among these levels. Partnerships formed among allies for children's health, as well as among new sources, including the health and education communities, two groups that are vital to the future of school-based health care but have a history of working independently of one another. This emerging policy network created powerful sources of advocacy for SBHCs in communities, in state government, and in the federal policy arena. National, state, and local advocates made significant strides in increasing the visibility of SBHCs, nation-wide.

Impact on policy. Participants in the SBHCPP played a major and often a leadership role in helping to achieve several path-breaking policy outcomes for school-based health care:

School-based health centers are recognized in federal law. The Children's Health Insurance Program Reauthorization Act (CHIPRA), signed into law by President Obama shortly after his inauguration, establishes, for the first time, a legal basis for reimbursing SBHCs for their services. In addition to recognizing and defining "SBHCs," CHIPRA specifically recognizes tribal entities and governments as providers of school-based health care. This precedent-setting achievement paves the way for SBHCs to be reimbursed for the services they provide.

The Patient Protection and Affordable Care Act (P.L.111-148), signed into law in March 2010, includes authorizing legislation for school-based health care. The Act includes two important provisions for SBHCs: language authorizing a federal SBHC grant program, and an appropriation of $200 million to support SBHCs' construction, renovation, and equipment needs. This law sets the foundation for federal legislation to designate funds to support SBHCs, a critical policy change needed to sustain and expand SBHCs nationwide.

State funding for SBHCs increased in every participating state in the SBHCPP, despite the magnitude of the economic downturn in the course of the program's implementation. Funding for SBHCs in one state grew from $2.5 million in 2004 to $7.0 million in 2010; in another state, the budget for SBHCs grew by almost $4.5 million between the 2005 and 2009 legislative sessions. Through leveraging state dollars to obtain a federal Medicaid match on federal funds, revenue for SBHCs in another state more than tripled, increasing from $3.7 million in state funds in 2004 to $14.2 million in combined state and federal match funds by 2010.

Local policy, including policies in schools and SBHCs, is increasingly responsive to the demands and needs of local communities, including youth. Community and youth advocates made significant strides in establishing consumer-centered policies in schools, school districts, and in SBHCs. Youth made inroads in protecting their rights to privacy and confidential services and in establishing healthier nutritional choices in their schools. They helped to expand access to behavioral/psychosocial health care, reproductive health care, health education, and other community-wide services.

Lessons Learned

The six years of the SBHCPP offer a range of experiences and lessons for philanthropy and advocates for school-based health care. The SBHCPP showed the important role that philanthropy can play in serving as a catalyst for policy advocacy and change for vulnerable youth and communities. It showed the impact that entrepreneurial and vision-driven leadership can have on creating major change in complex policy advocacy initiatives. It underscored the impact that opportunities afforded by the U.S. Internal Revenue Service's "Project Grant Rule" can have on enabling philanthropy to advance and support far-reaching policy advocacy initiatives. It underscored the role philanthropy can play in

leveraging relationships and building partnerships to advance consumer-centered policy goals. Not least, the SBHCPP made vividly clear how extensively philanthropy can empower communities – particularly young people – to develop their voice and emerge as leaders and champions for policy change.

The program also provided a range of lessons related to implementation. Among other things, the SBHCPP showed the importance of developing training and technical assistance services that are adaptable to emergent needs and the range of support required by organizations at varying stages of readiness for policy advocacy. The program showed the importance of offering adequate opportunities for cross-site communication to foster innovation and advance understanding among grantees and between grantees and philanthropy. It made clear the importance of developing policy networks within and among the federal, state, and local levels and the impact community partners have in linking and engaging communities, including youth, throughout advocacy. It showed the need for readiness by project leadership to offset a tendency for "transactional" advocacy in favor of advocacy that is strategically "transformative" and whose effects are likely to endure.

Recommendations

The report provides three overarching recommendations for continued work to advance advocacy for school-based health care. First, *focus on achieving transformative versus piecemeal change*. The experiences of the SBHCPP, in concert with lessons learned from other past policy initiatives, suggest that "transactional" advocacy is more likely to become transformative when several conditions are met, including the following:

- The overarching, guiding vision is linked to all aspects of the work, rather than serves as a backdrop to the work.
- Multiculturalism is an encompassing frame within which all other strategies are designed and implemented, rather than as an isolated approach for broadening diversity.
- Participatory processes and democratic systems of decision-making are institutionalized policies, rather than informal or occasional practices.
- Policy advocacy reflects a systematic plan for integrating core strategies in ways that build off of one another, rather than a collection of activities that are not well connected.
- Training and technical support services are themselves integrated and designed to be "transformative" through helping grantees (a) systematically translate principles into a strategic plan of action; and (b) show the interconnections among the core strategies, rather than teach each of the core strategies in isolation of others.

Second, *apply lessons learned from past social movements to accelerate the momentum for policy and systems change in support of school-based health care*. Past social movements offer a range of lessons on the factors and conditions that help to create broad-based movements for

change and continuing leadership in policy advocacy. We provide several basic tenets and findings of a social movements frame and encourage analysis of their implications for advocacy and action for school-based health care.

Third, *utilize public health principles and practices to expand the scope of SBHCs' impact and support.* SBHCs are commonly viewed as a "doctor's office in a school" – a description that, while apt, casts a narrow light on the role SBHCs can play in improving children's health and well-being. SBHCs are well-positioned to increase their impact beyond diagnosing and treating individual students (the "medical model") to encouraging prevention and health promotion for the student-body overall (a "public health" model). Wide-scale campaigns are needed to support SBHCs in this broader social context, one that encourages an expansive role in prevention and health promotion for students school-wide.

Conclusions

Despite the short duration of the SBHCPP, its accomplishments have been considerable. The SBHCPP set in motion a strategy that helped to obtain federal legislation that recognizes SBHCs, authorization for a federal grants program for SBHCs, $200 million in appropriations for SBHCs' construction, renovation, and equipment needs, and a range of state and local policy changes for SBHCs – all in short order and within an environment of wide-scale reductions in support for social programs and policy. As a result of the SBHCPP, state SBHC associations and their partners are emerging from the background of state politics to become recognized forces in the forefront of policy advocacy and the communities they serve. There is a growing awareness among state and national policymakers of the role SBHCs play in protecting the health of some of the nation's most vulnerable children and youth: SBHCs have moved from a model of care that few policymakers understood or cared much about to one that is winning support, even from the country's most conservative members of the policy community. Perhaps most strikingly, the voice of young people has been heard in their communities and among educators and administrators in their schools and districts. Their voice has been heard in state legislatures, in governors' offices, and by members of the U.S. Senate and House of Representatives. The SBHCPP has helped to establish a foundation for continued work to improve the quality and equity of health for vulnerable children, youth, and communities for years to come.

Introduction and Background

More than seven million children in the United States have no health insurance,[1,2,3] and many more have limited access to health care because of other systemic and structural barriers to care.[4,5,6] Uninsured children are more likely to have no usual source of care;[7,8] to receive late or no care for health problems, and to report unmet health needs than children whose families have health insurance.[9] Low-income children of color face particular inequities.[10,11,12,] Not only is quality health care more difficult to obtain than for other children, but they also are disproportionately exposed to the environmental risks that cause poor health in the first place.[13]

There are solutions to these problems. School-based health centers (SBHCs) provide one. SBHCs reflect the convergence of public health, primary care, and mental health care in a setting that students can easily access – in schools. SBHCs serve children regardless of their insurance status or ability to pay, improving children's access to care. By helping to enroll children in health insurance, SBHCs reduce the number of uninsured children. By being located in schools, SBHCs provide a ready source of care when it is needed, enabling health problems to be prevented and/or detected early. By helping to keep children healthy and in school, SBHCs reduce absenteeism and enable children to focus on learning, rather than on problems with their health. Through viewing health holistically, SBHCs recognize and address the societal problems children bring with them to school. By being located predominantly in communities with concentrated levels of poverty, SBHCs help to reduce health inequities and foster a culture that recognizes a broader commitment to the health and well-being of all children.

SBHCs have won the endorsement of numerous professional organizations[14] and are supported by the substantial majority of the voting public.[15] SBHCs have proven their ability to provide access to preventive, primary, mental health, and oral health care, providing a cost-effective way of reducing unmet need among some of the nation's most historically underserved children.[16,17,18,19] Policymakers, too, have become attentive to the role SBHCs can play in improving children's health in some of the most vulnerable communities in the country.

"School systems are not responsible for meeting every need of their students. But when the need directly affects learning, the school must meet the challenge."

Carnegie Task Force on Education, 1989[20]

Basic Facts about SBHCs

SBHCs have grown from a handful of projects in the early seventies to now serving more than two million students per year in over 1,900 centers in 48 states and territories.

Almost 70% of SBHCs report that more than half of their student population is eligible for the National School Lunch program, a common indicator of poverty among children and youth.

Seventy percent of the student body in schools that have SBHCs are non-White. They include Hispanic/Latino (36.8%), Black (non-Hispanic/Latino) (26.2%), Asian/Pacific Islander (4.4%), Native American/Alaskan Native (1.7%) and "other" (1.4%) youth.

Increasing numbers of SBHCs are open year-round, with many keeping before- and after-school hours. SBHCs are extending their services to other members of the community, including youth from other schools, out-of-school youth, and youths' family members.

SBHCs are housed at all school-levels: in elementary schools (20%), middle/junior high schools (15%), high schools (30%) and a mix of elementary, middle, and high schools (21%). They are located in urban (59%), rural (27%), and suburban (14%) communities in all regions of the country.

Source: National Assembly of School-Based Health Centers, School Year 2007-2008.[21,22]

"School-based health centers offer an excellent solution to the systemic barriers that impact health outcomes in this

vulnerable population. At no other setting is access as convenient, familiar, or integrated as in a school setting, where daily attendance is mandatory.

By providing in-school access to desperately needed health care and related wellness education, students/adolescents are able to receive appropriate care in a timely manner.

Because the students/adolescents and providers interact on a daily basis, in a familiar setting, they are able to establish trusting and supportive relationships that facilitate compliance and continually influence healthy lifestyle choices."

Executive Director of a State Association for School-Based Health Care

Challenges Facing School-Based Health Care

Despite their track record of success, a variety of barriers have prevented SBHCs from being available to all children in the United States:

- The historical absence of designated federal or state policies that authorize and fund SBHCs.
- Public and private insurance programs that do not reimburse all services provided in a school-based setting. When they do, they tend to pay less than the costs to SBHCs of providing services.
- Lack of infrastructure and capacity by SBHCs to bill Medicaid, the Children's Health Insurance Program (CHIP), and other insurers for the services they provide.
- Complicated hurdles from managed care for billing and securing reimbursement.
- An historically weak network of SBHC associations and other stakeholders organized to advocate for change.
- The relative silence, in the past, of a demand for change, despite the magnitude of children's unmet needs for health care and the persistent inequities in health status.

At the beginning of the program, both the National Assembly on School-Based Health Care (the "National Assembly") and the state SBHC associations, which might have served to fuel and sustain a national voice for SBHCs, instead often struggled to survive. In 2004, most SBHC associations operated on minimal or no funds and were staffed and governed by a part-time group of SBHC clinicians who volunteered their time. SBHCs were not well known or understood by policymakers at any level, whether local, state, federal or tribal, nor did they attract much attention in the media, among children's advocacy organizations, or even among members of the educational community within the schools that housed them. While SBHCs were of significant interest to their clientele – youth, parents, and some community members, and attracted the attention of some foundations, researchers, and health practitioners, they generally remained behind-the-scenes and low on the radar screen. They had little to no base of sustained support or strength of advocacy that called attention to a need for significant change in policy.

Without any permanent form of support for SBHCs, SBHCs kept their doors open through building a patchwork of revenue sources, primarily by securing the following:

- **Non-SBHC line-items** in federal, state, local, tribal, or private institutional budgets.
- **Privately funded grants** from foundations and corporations.
- **Direct or in-kind contributions** from local sponsoring agencies, including community health centers, hospital/medical centers, or local health departments, as well as from host schools, mental health centers, and other institutions that own, oversee, operate, set practice protocols, or otherwise support SBHCs.
- **Publicly-funded reimbursement** for patient care.

- **P.L. 105-17, the Individuals with Disabilities Education Act (IDEA**), as amended in 1997.

As these sources of financing for SBHCs have themselves felt the impact of economic downturns, SBHCs have become vulnerable to reduced revenues, service reduction, and in some cases, closure.

Genesis of the School-Based Health Care Policy Program (SBHCPP) Design

In the early 2000s, the W.K. Kellogg Foundation initiated several projects to explore strategies for meeting the health care needs of children in vulnerable communities by providing comprehensive health care in schools. The Foundation funded policy analyses, interim grants, and, most importantly for the SBHCPP, a prototype policy project designed to inform the Foundation about strategies for achieving policy and systems change. Among other things, the prototype project and related work found the following:

- Local communities, including youth, can have a major impact on policy outcomes when empowered and equipped for policy advocacy.
- Policy advocacy is strengthened when state/community partnerships are linked with a national entity that is knowledgeable and in touch with national decision-makers.
- Improving access to the nation's health programs and resources and reducing health disparities requires integrating multiculturalism throughout the work.

Buoyed by the range of experiences and lessons learned from the prototype project, broader literature, and past initiatives, the SBHCPP was born.

SBHCPP Vision and Intended Impact

SBHCPP vision: "School-based health care will be financially stable, available and accessible to all children and families and supported as a consumer-centered model of quality care in communities throughout the United States."

The SBHCPP's is fueled by a vision that strives for a future in which health inequities are eliminated and all children have quality health. Achieving this vision requires broad-based change. The areas of intended impact, described below, served to guide the work in the initiative. These areas of impact also serve as the organizing scheme for presenting progress made in the SBHCPP in this report.

Areas of Intended Impact

STRENGTHENED SBHC ASSOCIATIONS
State and national school-based health care associations are strengthened in their ability to promote quality health care, inform policy, share best practices nationally, and serve the operational and programming needs of their members.

ENGAGEMENT BY COMMUNITIES, INCLUDING YOUTH, IN LOCAL POLICY
Local communities, including youth, are shaping the content, quality, delivery, and financing of health care in their communities.

INCREASED VISIBILITY OF SBHCS
Strong, sustained national and state visibility of the issues affecting school-based health centers.

FAVORABLE POLICIES FOR SBHCS
State and national health care and education policy supports school-based health centers as appropriate models of consumer-centered health care.

EFFICIENT AND HIGH QUALITY CARE
Efficient and high quality delivery of health care by school-based health centers.

IMPROVED FUNDING
Strengthened school-based health centers with stable and diverse funding streams that more appropriately support this model of health care delivery.

IMPROVED ACCESS TO CARE
Improved and sustained access to quality services for children and adolescents and in some cases, the broader community.

Strategy for Policy Change

The SBHCPP was developed in the context of the guiding principles and philosophy of the W.K. Kellogg Foundation. According to the Foundation:

> *"Advocacy helps to shape public opinion and public policy and in doing so can lead to systemic, long-lasting change. Advocacy can also lead to innovation and/or efficiencies, new resources, stronger community voices, increased community participation, and the achievement of foundation and grantees' goals."*

The W.K. Kellogg Foundation and the SBHCPP conceptualizes "policy" expansively to extend beyond legislative policies to include regulatory, budgetary decisions and public agency practices; court decisions and rules; private institutional governance; and the formal positions of educational, religious, civic, or professional organizations. Policy advocacy in the SBHCPP focused on the content of new policies, strengthening or implementing practices, reshaping programs, or assuring accountability through monitoring for policy effectiveness and improvement.

The SBHCPP provided the associations with the flexibility to pursue policy goals of greatest priority to them, as long as their work focused on the program's vision and any of the intended areas of impact. To make progress in these areas, the SBHCPP utilized several "core strategies," below, and as described further on pages A-3 and A-4 of the Attachments.

Build organizational infrastructure and capacities for policy advocacy. The SBHCPP provided resources, training and support to help the SBHC associations develop policies, systems, staffing, and governance for effective policy advocacy. The program also supported the National Assembly in its work to build a nationally unified and integrated policy advocacy campaign for SBHCs, to provide a bridge between the local-state partnerships and the national policy arena, and to develop the national voice for school-based health care.

Engage and equip communities, including youth, in community-driven advocacy to inform policies in which they have a direct stake in the outcomes. In partnership with the SBHC associations, the SBHCPP sought to build a consumer-centered SBHC movement through engaging communities with existing SBHCs to advocate for policies that support and advance school-based health care.

Build bridges between the historically-siloed health and education communities to strengthen collaborative advocacy for policies that advance children's health, well-being, and readiness to learn.

Build capacity of SBHC associations, their community partners, and youth for strategic communication to increase the power of their voice, messages, and campaign for policy change in support of their needs and work.

Develop and sustain the resources needed to strengthen organizational and consumer capacity for policy advocacy. Building resources requires developing relationships and partnerships with those who have a stake in or power over influencing progress toward achieving the program's guiding vision. It also requires securing diverse and sustainable revenue streams, as well as building the capacities staff, volunteers, and technology.

Improve quality and impact through applying a "multicultural lens" throughout the work. SBHCs operate in multicultural communities composed of diverse populations by race/ethnicity, immigrant status, language, and socioeconomic status. Most the SBHC providers and SBHC associations, in contrast, represent

mainstream society. Adopting a multicultural lens provides a bridge between the two. "Multiculturalism," as conceptualized in the SBHCPP, represents the process of recognizing, understanding, and appreciating cultural similarities and differences at the personal, interpersonal, institutional, and cultural levels.

Increase the impact and effectiveness of organizational development and policy advocacy through evaluation. The SBHCPP supported two levels of evaluation: *project-level evaluation*, conducted by consulting evaluators to the SBHC associations support planning, management, and advocacy; and *program-level evaluation,* conducted by consultants to the Foundation to determine collective impact and opportunities for improvement. Page A-72 provides examples of opportunities for utilizing evaluation to support the work in the SBHCPP.

Provide training and technical assistance to help build capacity for policy advocacy. The SBHCPP engaged a team of consultants (i.e., the "Resource Team") to support the SBHCPP associations' work in each of the program's core strategies. The SBHCPP Program Director provided direct assistance to grantees as well, particularly in identifying potential opportunities for policy advocacy and change. Pages A-5 through A-12 describe the training and technical assistance provided in the course of the program.

Implementation

In late 2003, the W.K. Kellogg Foundation issued an invitation to the existing 20 state SBHC associations to apply to participate in this program. Unlike typical project grants, the SBHCPP was designed to be a multi-level, multi-site "initiative" – i.e., a major investment that sought not only to support the work of individual SBHC associations and communities, but to increase the collective impact in policy and systems change. As such, participants in the SBHCPP faced a fairly extensive set of requirements, as follows.

Expectations of the SBHCPP Grantees

Participate in a site review and submit a work plan that met several program requirements.

Form partnerships with five local communities with SBHCs and provide resources and support to these community partners to assist in the development of their capacity.

Organize and mobilize the constituencies of their SBHCs, including youth.

Build support at the national level, serving as a bridge from local SBHCs and communities to state and national education and health care policymakers.

Build statewide partnerships with advocacy organizations and related associations to advance policy and financing solutions to long-term sustainability.

Develop diverse financing strategies and partnerships that by years four and five would begin to sustain the state association.

Partner with the National Assembly to advance a strategic national and state policy agenda.

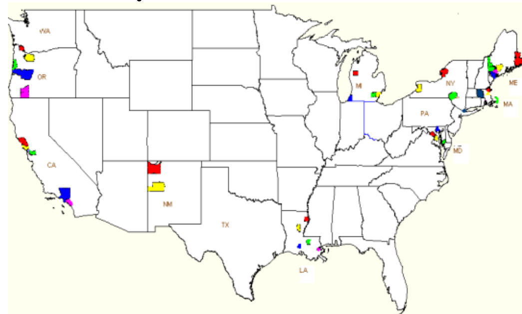
Engage in strategies with the National Assembly and W.K. Kellogg Foundation to develop and implement a communication and evaluation plan that supports the policy agenda as well as the ongoing work.

Build capacities within the National Assembly to serve as the conduit to the national policy arena, thus providing a foundation for developing a nationally unified and integrated policy advocacy campaign.

Site selection and program launch. Based on the strength of their proposed work plans and the information gathered during the site visits, the W.K. Kellogg Foundation awarded $26 million to national, state, and local entities to participate in six-year initiative. Nine geographically, culturally, and politically diverse state SBHC associations received funding. State-level grantees included associations at different levels of organizational development: some had

stronger infrastructures than others; some had made at least initial steps into policy advocacy and showed potential for growth. The state grants included funding for 40 community partners, which include the Navajo, Laguna Pueblo, Acoma Pueblo sovereign nations in New Mexico. The map that follows shows the participating states in the SBHCPP (California, Maine, Massachusetts, Michigan, New Mexico, New York, and Oregon and, in the earlier years of the program, Louisiana and Maryland) and the locations of the community partners who worked with them in the SBHCPP. The Attachments provide additional information on the participating state associations and community partners (see pages A-13 and A-20, respectively).

Participating States and the Locations of Their Community Partners, SBHCPP



The SBHCPP was launched on June 19-21, 2004, at the annual convention of the National Assembly in New Orleans, Louisiana. The three-day kick-off meeting included presentations and discussions designed to build partnerships, create a shared understanding and commitment for the vision of the SBHCPP, and clarify program expectations.

Rules and opportunities governing policy advocacy. Included in this kick-off meeting was a presentation by the Foundation on what is and is not allowed by the Internal Revenue Service (IRS) in a policy-based program funded by a private foundation. Given that the SBHCPP is designed to achieve systems and policy change, it was essential that grantees understand and strictly abide by the IRS rules and regulations governing "advocacy" (which is allowed) versus "lobbying" (influencing legislation, which is prohibited using Foundation resources). While the prohibitions on utilizing Foundation funds to support lobbying are absolute –Foundation resources were not used to support lobbying – the IRS allows, under "Project Grant Rule," circumstances in which private foundations can make general support grants to nonprofit organizations whose work may include lobbying, if those grants are not earmarked in whole or in part for lobbying. This provision was of essential importance in enabling SBHC associations that may lobby (and hence fell under Project Grant Rule) to participate in the SBHCPP.

Framework for Evaluation

This evaluation is guided by two central questions: (1) What inroads did the SBHCPP make in achieving the program's vision and intended areas of impact? and (2) What lessons were learned during the program's six years that may be helpful to philanthropy in developing future policy initiatives and to SBHC advocates in their continued advocacy for SBHCs?

Methods. The primary strategy for evaluating progress toward the program's intended areas of impact was to synthesize, summarize, and analyze outcomes and impact as reported by the SBHCPP associations and community partners. Members of the evaluation team reviewed and coded information from a variety of sources to describe the work and identify themes and variations in grantees' findings and experiences. The lead author reviewed team members' coding decisions and descriptions of the work for accuracy and consistency, following up with them when necessary to discuss and reconcile any differences in interpretation.

The primary sources of information were the capstone progress and evaluation reports prepared by the National Assembly and state SBHC associations. The evaluation also drew from a detailed synthesis and analysis of findings conducted

for a companion report,[1] and from an annual survey conducted by the National Assembly of the state SBHC associations' experiences and progress in policy advocacy from 2004-2008. The survey enables comparisons between the SBHCPP-funded and non-funded states on a variety of areas of relevance to the program during its first four years. Pages A-38 – A-60 provide background information on and findings from the survey. Page A-36 describes the evaluation methods and range of sources used to inform this report.

This report provides a 30,000 foot view of the program's work and impact. Other sources provide additional detail and information on the program, its achievements, challenges, and lessons learned at a more detailed level.

Caveats. As is common with most evaluations, several factors should be considered when interpreting the results.

First, as is inherent in any form of qualitative work, the potential exists for interpretative error or bias in the descriptions and analyses of grantees' experiences, outcomes, and perspectives. To minimize this possibility, multiple sources of information were used throughout the process of review, and findings were cross-checked against the array of records on the progress and experiences in the SBHCPP. In addition, the SBHCPP Program Director provided copies of this report to the Executive Directors of the SBHC associations, to check for factual accuracy and appropriate interpretations of the findings. Inaccuracies were corrected by the lead author of this report.

Second, evidence of "progress" and "impact" often required subjective assessment given that the SBHCPP did not utilize cross-site benchmarks or quantifiable expectations of performance. The findings and analyses offered in this report are suggestive of progress based on the evidence provided, rather definitive or conclusive according to an objective set of standards and measurable goals.

Third, what constitutes the "collective" or "program-level" experience was often a moving target depending on how many associations, community partners, youth, or others pursued a given policy goal or strategic approach and/or reported on their experiences. Some goals were shared more or less universally (e.g., building capacity for advocacy through expanding and diversifying expertise in staffing and on the board), while other goals and strategic approaches were specific to a single state or community. In addition, the policy agendas of some associations were more extensive than others, resulting in frequent references to their work. Thus, the main referent of this evaluation – the outcomes and impact of the "program" – may at times refer to the work of all program participants, while at other times refer to the work of only a few, as is noted throughout the report.[23]

Policy Advocacy Framework. The evaluation framework was influenced by recent advances to the field of evaluating policy advocacy, particularly the "*Advocacy and Policy Change Composite Logic Model*," a model developed by an Institute of the Council on Foundations to "explore and document the 'how' and 'so what' of advocacy and policy change evaluation."[24] This model reflects the work of representatives of foundations and others with experience in both evaluation and in policy and advocacy grant making to "develop a common language for discussions about what foundations are funding and what is being learned from evaluations of policy advocacy work." The model provides a useful frame for identifying and analyzing advocacy work and the interconnected factors that have a bearing on policy outcomes and systems change. Page A-35 of the Attachments provides a diagram of the model.

[1] The School-Based Health Care Policy Program: Program Evaluation, 2004-2010."

The Institute identified several guiding principles for policy change evaluation. Three of these principles (which also are shared more widely in the broader literature) are summarized below.

Focus on contributions to policy outcomes, not attribution. Given the complex set of factors that influence the policy process, it is more productive and meaningful to evaluate contributions to policy outcomes, rather than to try to attribute cause-and-effect to a single foundation, organization, advocacy strategy, or other source.

Include outcomes that involve building grantee capacity to become more effective advocates**.** Capacity-building improvements, such as building skills in policy advocacy or strengthening relationships, create lasting impacts – and help to improve the grantees' effectiveness in future policy and advocacy projects, even when a grantee or initiative fails to change the target policy.

Do not use evaluation to compare advocacy and policy grantees**.** While grantees can be asked to submit data and information on the same or similar measures, comparisons between grantees often do not make sense out of their specific environmental or programmatic context. The same result on the same measure may mean success to one state, for example, but represent a disappointment for another. The purpose of a program-level evaluation is to learn from the collection of projects, rather than to evaluate the respective merit of them individually.

Structure of the Report

The report discusses the strides made in the SBHCPP in each of the program's areas of intended impact. What follows is not an exhaustive tally of achievements, but illustrative of the kinds of accomplishments the National Assembly, the state SBHC associations, their partners, and local communities, including youth, have made. The quotes throughout are drawn from SBHC associations' annual reports and other sources as noted. The report concludes by describing some of the broader lessons learned from the past six years that are relevant to future initiatives and to ongoing policy advocacy for school-based health care.

Environmental Context

The School-Based Health Care Policy (SBHCPP) was implemented during a period of major political change and economic downturn and instability in the United States. Shortly after the program was launched, the 2004 elections resulted in a second term for George H.W. Bush as President, Republican majorities in both the House and the Senate, and a plurality of Republican governors. To explore the implications of this political landscape for the SBHCPP, the W.K. Kellogg Foundation and the National Assembly on School-Based Health Care ("the National Assembly") invited 12 leading policy experts to join in discussion and offer advice. The majority of experts advised that the SBHCPP stay off the national radar screen and "not rock the boat" given the intense opposition the SBHCPP could expect to arouse from the Republican leadership. As will become evident in this report, this advice was not heeded. In a two-week period in 2005, for example, the National Assembly and state SBHC associations conducted over 100 meetings with members of Congress and their staff and held two Congressional briefings to increase awareness for SBHCs and build support for a demonstration project designed to strengthen SBHCs' sustainability.

In addition to the political change, the growing costs of the military actions in Afghanistan and Iraq were fueling the economic crisis that extended to virtually all sectors of the economy. Major financial institutions and manufacturing industries, including the auto industry, were in deepening crisis, presenting continued threats of closure and layoffs in near precedent-setting proportions. Federal, state, and local budgets for safety net programs were often vulnerable to cuts, as were revenue streams to large-

scale discretionary programs, including the National Institutes of Health, the Food and Drug Administration, the Environmental Protection Agency, and federal aid to states and cities.

Facing economic crises of their own, state and local governments experienced severe budget shortfalls and were strained to find the resources to support the growing demand for services and assistance. Many communities and individuals found themselves in personal financial crisis as well, experiencing high rates of unemployment, reduced support and aid from government programs, and growing threat and reality of home foreclosures. In 2005, Hurricane Katrina, the third most intense hurricane in the history of the United States, displayed with vivid clarity what is possible when inadequate preparation, poverty, and failed coordination between and among federal, state and local agencies converge. With growing national and international tensions and challenges, the country was on the path toward landmark political change.

The midterm 2006 elections brought Democratic majorities in Congress. House members elected Congresswoman Nancy Pelosi, an ardent advocate of safety net programs, to become Speaker of the House, which helped open the door for SBHCs to gain visibility on the national agenda. Congressional supporters of SBHCs, especially Senator Debbie Stabenow (D-MI), intensified their work to advance a federal program for school-based health care, including legislation to establish a federal SBHC grants program. Then Senator Obama was also an ally of SBHCs. While a Senator, he cosponsored *The Health Schools Act of 2007,* a bill sponsored by Senator Stabenow to ensure payment under Medicaid and the State Children's Health Insurance Program for covered items and services furnished by SBHCs. SBHCs were gaining traction in the Congressional arena.

The 2008 national elections introduced significant political change with the country's first African American President and an increase in the margin of the majority of Democrats in the Senate and House. The Obama administration responded swiftly to the opportunities the election afforded to advance his policy agenda. Within its first year in office, the administration passed several pieces of historic legislation: the Wall Street "financial bailout"; the American Recovery and Reinvestment Act (2009), which provided $140 billion in state relief; and, significant for SBHCs, the reauthorization of the Children's Health Insurance Program and the Patient Protection and Affordable Care Act, as will be described later in this report.

Although the economic stimulus programs reduced the immediate threats of broad-scale economic crisis, the country continued to experience severe economic problems of historic proportions. In response to revenue shortages, most states adopted even more massive cuts in spending than in earlier years, including sometimes significant cuts to safety net services to vulnerable populations. Health reform itself became controversial for what some conservative Republicans believed was too an expansive role for government.

At the program's close, the mid-term 2010 elections again brought pendulum changes in the political climate as the Republicans recaptured the House and Republicans again became the dominant party in the majority of state chambers.

It has been in this climate of economic downturn and volatility, shifting party majorities, and changing policy agendas in Congress and the Presidency, that the SBHCPP sought to secure policies that favor and support sustainable SBHCs. It has also been in this environment that the SBHCPP has left its mark, including federal legislation that recognizes SBHCs, a federally authorized program for SBHCs, and a range of state and local policy achievements, as will be described on the pages that follow.

Part I: Outcomes and Impact of the School-Based Health Care Policy Program

ADVOCACY CAPACITY OF STATE AND NATIONAL ASSOCIATIONS FOR SCHOOL-BASED HEALTH CARE

Intended impact: State and national SBHC associations are strengthened in their ability to promote quality health care, inform policy, share best practices nationally, and serve the operational and programming needs of their members.

When the SBHCPP began, organized policy advocacy SBHCs was typically limited, reactive, and sporadic. The National Assembly and state SBHC associations focused primarily on serving their members, rather than on establishing and building their role in state and federal policy advocacy. Few members of Congress or other national or state organizations or policy entities had SBHCs on their agendas, nor was much attention paid to organizing community-based groups in state level advocacy. Few members of state legislatures knew much about school-based health care or why it should be on anyone's policy agenda, including their own. No other national organization had advocacy for SBHCs on their radar screen, nor was there much attention paid by the media or the general public to issues related to the presence or absence of comprehensive health care in schools.

Development of Infrastructure to Support Policy Advocacy

To equip SBHC associations and their community partners to reverse these patterns, the SBHCPP provided resources and technical assistance to build their infrastructures and strengthen their capacities for advocacy and policy change. The discussion that follows provides examples of the kinds of changes that occurred as a result.

The SBHC associations formalized their organizational commitment to policy advocacy. One of the striking changes that occurred in the SBHCPP was the evolution of the SBHC associations from membership-driven organizations into organizations whose missions gave priority to policy advocacy. In 2004, for example, the National Assembly's mission was "To promote and support school-based health centers to ensure that all children receive high quality, comprehensive health care." Their mission now has a different emphasis: "To improve the health status of children and youth by advancing and advocating for school-based health care." This shift draws attention to the National Assembly's commitment to improving children and youth's health, as opposed to serving SBHCs. It highlights policy advocacy as a means to improve the quality of children and youth's health, and focuses on school-based health care for children and youth rather than on the centers themselves. The National Assembly notes that this revised mission serves as the guide throughout its work: "everything we do is for the purpose of advancing the mission."

Like their national counterpart, most of the associations recast their mission and vision statements in several key ways: (1) to explicitly recognize their commitment to policy advocacy; (2) to emphasize the healthcare needs of children

beyond the needs of SBHCs; and, often, (3) to make the connection between health policy and education policy, an emerging emphasis that will be discussed throughout this report. Increasingly, the associations' measures of "success" lay not so much in how well they serve SBHCs, but in the kinds of health and education policies they helped to advance in support of the children and communities that SBHCs serve. As one state SBHC association described,

"We have moved from a technical assistance organization to one that knows how to engage in policy advocacy – today advocacy is second nature. We can't underestimate how important that knowledge base is to everyone."

Most established legal independence from fiduciaries, allowing the SBHC associations to have greater autonomy over the development and implementation of their organizational priorities and policy agendas. Among other things, this independence afforded greater freedom of advocacy in areas that may have been controversial for some of their fiduciary agencies to otherwise support.

The associations modified their governing rules to allow their boards to recruit members needed for effective policy advocacy. Whereas past boards were comprised largely of SBHC clinicians, they now reflect greater professional diversity, frequently including, for example, educators, financial specialists, communications experts, managed care plans, business, public health practitioners, and/or public policy. In general, board members are also more reflective of the race/ethnicity, gender, and geographic diversity of the populations they exist to serve.

The organizations diversified their staff with qualities needed for effective policy advocacy. At the program's start, only two of the associations had executive directors, one of whom was limited to a quarter-time position; the rest were led and staffed almost exclusively by volunteers. All of the associations operated informally, most without job descriptions or organizational policies to guide their work. The small group of individuals who worked at the associations rarely had experience or training in policy advocacy or organizational development.

Most of the associations have grown since then, some strikingly. The National Assembly now has 11 staff members, one state association has nine staff, and another now has 12. Several hired staff with experience in the program's core strategies, including strategic communications, resource development, and community organizing, for example.

Most adopted more participatory, inclusive, democratic practices for agenda-setting and decision-making to strengthen the voice of the diverse constituencies, including youth, in guiding organizational decisions and practices. Two organizations formed statewide youth advisory boards, for example, with one extending youths' involvement following their graduation and into the college years.

Increased Proficiency in Utilizing the Core Strategies

In addition to building their internal infrastructure, the SBHC associations also strengthened their capacities for policy advocacy. Several examples of how they did so follow.

The state SBHC associations formed partnerships with local communities. The state SBHC associations worked closely with five community partners to build capacity for local policy advocacy. These partners included SBHCs or groups of SBHCs, though sometimes included the entities that sponsored SBHCs. These partnerships played a key role in serving as the

interface between the SBHC associations, community members, including youth, the Foundation, policy officials, and others in local policy. They also were essential in mobilizing and supporting the work of youth and other communities in policy advocacy.

Youth became active leaders in policy advocacy in most of the SBHCPP communities, typically via collaboration with their community partners. At the program's start, it was rare for the state associations and others to engage youth in policy advocacy for school-based health care in an organized way at any level – local, tribal, state, or federal. Communities, including youth, did not have a presence or voice in state or federal policy advocacy for SBHCs. By the end of the program, it was uncommon for youth not to engage in policy development and advocacy. Youth participated extensively in trainings on leadership development and in strategies for policy advocacy in the course of the program; one state trained over 3,000 youth in advocacy skills, for example.

The associations made strides in collaborative policy advocacy between the health and education communities.[ii] Early in the program, health and educational communities rarely joined forces in policy advocacy, despite the interconnections between children's health and educational achievement and the policy opportunities for collaborative advocacy. In 2004, for example, 29% of the SBHCPP-funded state associations reported that they did not engage teachers, school administrators, and staff in "grassroots advocacy for SBHCs" at all. By 2008, all reported that they engaged these groups at some level. These percentages compare with 40% of the non-funded SBHC associations who reported that they did not engage the education community at all in either year. (See page A-42 for additional detail.) By 2010, all of the SBHCPP associations indicated that they strengthened communication and/or collaboration with members of the education community. Examples of the ways they collaborated include the following:

- Developing communication campaigns that cut across each other's work, such as emphasizing the role that SBHCs play in keeping children healthy and ready to learn or that schools can play in fostering children's health.

- Joint participation in planning collaborative advocacy on areas of mutual interest, such as serving on steering committees of partner associations.

- Shared planning and interactions between officials in the state departments of health and education.

- Sharing positions on policies of mutual interest, such as policies that favor providing on-site mental health services, or the provisions in the reauthorization of the Elementary and Secondary Education Act that encourage collaboration between schools and health systems to promote the development of SBHCs.

- Exploring and/or seizing opportunities in education policy to advance SBHCs, such as the National Assembly's recent webinar series highlight advocacy opportunities for federal education reform.

- Participating in forums to advance discussions or understanding in areas of shared responsibility, such as conferences to

[ii] Depending on the state and community, the "education community" included principals, teachers, superintendents, school administrators, school boards, outreach workers, school nurses, staff members from state education departments, city-county education agencies, and university faculty specializing in K-12 education, as well as the associations that represent these professionals or organizations.

re-frame school drop-out or bullying as public health issues.

> *"This new connection between health and education is a paradigm shift. The shift in the thinking of school nurses, principals, teachers who used to think of SBHCs as interloper of sorts now are the very people who want one."*
>
> State SBHC Association

All of the associations made strides in increasing their capacities for strategic advocacy and communication. At the beginning of the SBHCPP, the SBHC associations' policy advocacy and communication campaigns tended to include piecemeal and often passive tactics, such as isolated and periodic letters to legislators, petitions, and press releases. By the program's end, the associations and their partners, including youth, became more strategic and systematic in their strategic approach to communication and advocacy. For example, they tailored their messages, messengers, and channels of communication to resonate with particular audiences, and utilized evidence-based research to support their messages. They developed and disseminated fact sheets, issue papers, policy analyses, policy alerts, list-servs, electronic newsletters, sample talking points and templates for communicating with legislators and the media, among other audiences. Some associations hosted webinars, developed toolkits, provided PowerPoint presentations, and posted audiovisual presentations on their enhanced webpages, which often featured youth sharing their experiences about the role SBHCs played in their lives. One association created a "story bank" of videos and written stories from a culturally diverse group of youth, parents, and providers, for example, to share experiences and stories about the impact SBHCs have had on themselves and their peers.

Some of the SBHC associations made striking success in resource development; others had difficulty. A significant challenge in many young organizations, true in the SBHCPP as well, is the necessity of securing a sustainable base of resources to support the organization's work. This is a challenge in normal economic times, let alone in times of nationwide economic crisis. Although the SBHCPP provided fuel for organizational development, the extent to which the SBHC associations leveraged these resources into sustainable base of revenue varied widely.

With guidance from the SBHCPP, the associations used an array of strategies to develop organizational resources. Several developed business plans to guide the process and develop organization-wide strategies for securing a sustainable base of resources. Several built relationships with other foundations to secure new grants. A few associations obtained government contracts to enable them to provide expanded technical assistance and capacity building for SBHCs in their state. A few sought sponsorships for their annual conferences and developed relationships with individual donors. Some sought payment for specific membership services and state contracts to provide training to the field. Some earned revenue via conferences and special events.

While many of these strategies produced significant results, they were often self-limiting and vulnerable to reduction or elimination, as was the case with short-term grants or non-continuing donor contributions. As is clear below, however, there were some striking exceptions.

Resource Development: Examples of Innovation and Success

The SBHC association in Michigan developed an innovative centralized billing and reporting service that, as the program's completion, was serving 28 SBHCs, billing more than $2 million in service fees for SBHCs, collecting more than $600K on SBHCs' behalf, and generating $200,000 each year in revenue for the association. The association has partnered with Kresge Foundation to explore the feasibility of a national center for billing and reporting.

According to the association's Executive Director,

"We started a billing and reporting service that not only benefits SBHCs in their state but is now becoming a model for other states … (We) secured an agreement from the state Medicaid office and Department of Community Health to provide the SBHC association with 1% of all funds appropriated for SBHCs toward a technical assistance contract. Each year, the association receives roughly $100,000 to provide technical assistance to the field. This rate increased to $140,000 after the state allocated additional funding for SBHCs in 2008."

California's SBHC association also made significant strides: "…We have received revenue from 21 funders and more than 300 organizations, individuals and companies during the six year grant period. By contrast, before the project we had only two major funders and a small list of donors. In 2004, before receiving the WKKF (the W.K. Kellogg Foundation) grant, our budget was approximately $125K. After receiving the grant it rose to $425K of which $300K or 70% was from WKKF. In 2010, our budget is $1 million with just $94,000 from WKKF."

The SBHC associations made progress in applying a "multicultural lens" to their work. In the early years of the SBHCPP, all of the SBHC associations participated in a five-day training on the principles of multiculturalism. Unlike more traditional approaches to "diversity training," the SBHC model emphasized that individuals and organizations need to consider comprehensive, multi-level needs and opportunities to secure deep-rooted, sustainable change. The success of organizational and policy development and advocacy depends, this model suggests, on applying a "multicultural lens" throughout the work – a lens that recognizes, understands, and appreciates one's own cultural background and the cultural backgrounds of others. In the course of the work, many made strides in translating the model's ideas into practice.

- Several of the associations adopted more inclusive and participatory processes for decision-making. As one executive director described, multicultural development is now an "organizational value, applied in board recruitment, staff hiring, mental health training, strategic partners enlistment, and community engagement." The association is also "more intentional about multicultural development in policy work" by diversifying their staff.

- Most of the associations integrated multicultural principles into their products and strategies, developing materials, webpages, and training programs. They also increasingly engaged multicultural populations in the development of these materials. An example of this is the "Native American Toolkit," a compilation of educational and informational materials and tools developed primarily by Native Americans to advance policies that support Native American children and youth.

- Most engaged multicultural populations of youth in policy advocacy and, to varying degrees, the broader multicultural communities and strategic partnerships representing multicultural populations.

The SBHC associations utilized evaluation to strengthen organizational development and, increasingly, to support policy advocacy. When the SBHCPP was initiated, none of the state SBHC associations had an evaluator on staff or under contract. The Executive Directors of the associations had limited, if any, experience in designing and managing evaluation, particularly in the context of policy advocacy. It was fairly common in the program's early years for executive directors to provide their evaluators with wide latitude over the specific focus, structure, and implementation of the evaluations. It also was fairly common for evaluators to serve in roles other than strictly "evaluation," such as providing consultation in strategic planning, organizational development, basic research, and/or other functions needed by the associations' leadership.

This began to change in the course of the program. Evaluators and the association directors and staff worked more collaboratively on focusing evaluation work in ways that were useful to management and decision-making, rather than on program monitoring or other more basic kinds of tracking functions. Evaluators examined a range of topics of direct relevance to organizational capacity building, including assessments of need among SBHCs and the youth and communities they serve; barriers to third-party billing and reimbursement; members' needs for training and technical assistance; governance development issues; and changes in stakeholders' understanding and views of SBHCs, for example. The evaluations also investigated stakeholders' assessments of the associations' performance, programs, services, products, training and technical assistance, and events, including some of their work in policy advocacy.

During the final year, the project-level evaluators focused their "capstone" evaluations on the outcomes and/or impact of policy advocacy in an area of central importance to the associations' work. The SBHCPP Program Director encouraged all of the capstone evaluations to investigate the role and impact of youth as a part of their evaluations. Findings from these studies are integrated into this report. An overview of the topics they explored follows.

Focus of the Capstone Evaluations

The National Assembly: The outcomes, impact, and lessons learned from the National Assembly's policy advocacy to secure legislation to authorize a federal SBHC grant program via the perspectives of 12 Congressional staffers who were engaged in the process.

California: Changes in the base of the associations' support in the course of the SBHCPP, impact on policy outcomes, and lessons learned.

Maine: The impact and outcomes of engaging youth in policy advocacy work in four Maine school districts.

Massachusetts: The impact, implications, and lessons learned from the policy work aimed at reframing dropout as a public health issue.

Michigan: The outcomes and impact of policy advocacy related to obtaining reimbursement for mental health services, including the effects of youth engagement strategies.

New Mexico: The outcomes, impacts, and policy implications of the youth advocacy effort to secure a statewide program for peer-to-peer suicide prevention for Native American youth.

New York: The approval and implementation of Medicaid reimbursement for SBHC social work services in New York State, youth engagement in policy advocacy, and the role of youth advocacy in achieving policy change related to Medicaid funding for social work services.

Oregon: The outcomes and impact of youth advocacy and participation in Legislative Day and the impact of the policy advocacy on SBHC growth and sustainability.

The associations became more proficient at providing training and technical assistance services to promote policy advocacy by others. To engage and equip the field to advocate for policies that favor SBHCs, all of the associations expanded their training and technical assistance programs. In 2008, the National Assembly's State SBHC Association Assessment, for example, found the following. (See page A-46 for additional detail.)

- All (100%) of the WKKF-funded associations provided training to their members in *youth engagement* in advocacy in 2007-08, compared with half (50%) of the non-funded states.
- Half (50%) of the WKKF-funded associations provided training in *parent engagement* in advocacy, compared with less than one-third (30%) in non-funded states.
- All (100%) of the WKKF-funded associations provided training in how to *meet with elected officials*, compared with less than one-third (30%) of the non-funded states.
- Three-quarters (75%) of the WKKF-funded associations provided training in how to *conduct site visits* and how to *manage the media*, compared with 50% and 40% of the non-funded states, respectively.

Many SBHC associations provided training programs on strategies for building effective campaigns for policy advocacy, establishing youth boards, training youth advocates, strengthening leadership skills, and organizing effective advocacy days, for example. The National Assembly also hosted a series of visits by the state associations to Washington, D.C. to "show them the ropes" of federal policy advocacy and to organize meetings between them and members of Congress and their staff to educate policymakers on school-based health care.

All of the associations made significant strides in building partnerships with others, including policy officials and key decision-makers over SBHC policy. At the program's initiation, most of the SBHC associations had a limited number of partners, owing in large part to their greater emphasis on serving members, rather than on working with other organizations and advocates to advance a policy agenda. Many of the relationships among policy advocates for SBHCs, consumers, and members of the policy community were informal and episodic, rather than constituting a central part of the associations' advocacy agenda. For the most part, neither the SBHC associations nor the SBHCs had formed the kinds of networks and relationships needed for effective advocacy.

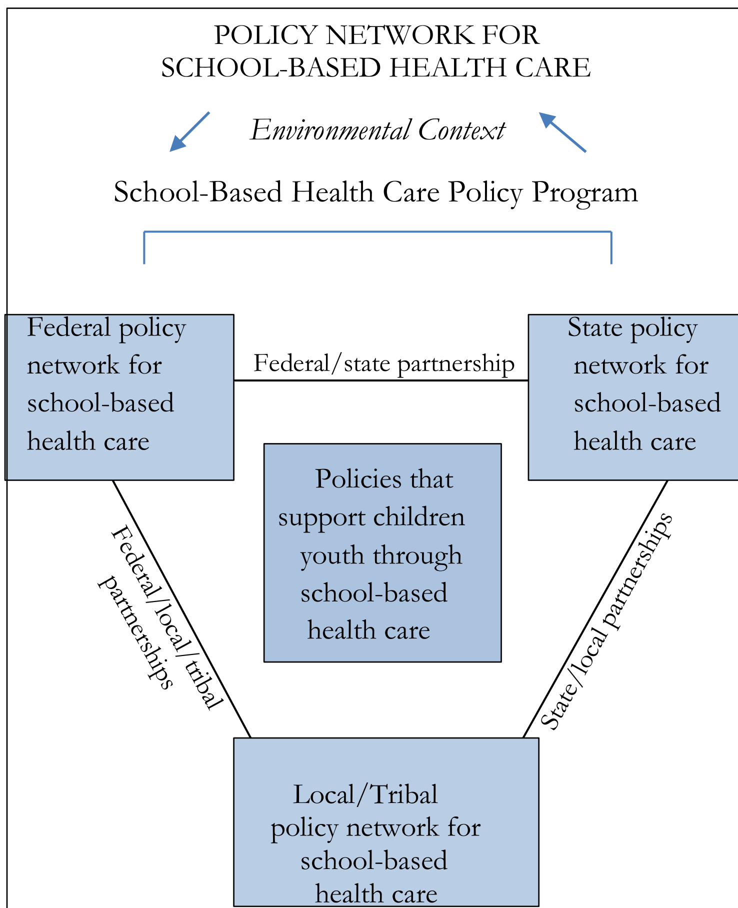
Towards the program's close, most of the associations made it an organizational priority and, increasingly, part of their organizational culture to build and sustain relationships with the diverse group of organizations, individuals, and policy decision-makers in a position to influence the future of SBHCs. Though the level of progress in building relationships varied, the associations showed marked movement from forming passive relationships to more proactive and reciprocal partnerships for policy change.

As the work continued and sphere of relationships grew, there were increasing signs that a "policy network" was emerging around school-based health care – a network of stakeholders and decision-makers who had (a) a shared goal of advancing policies that favor SBHCs and (b) demonstrated willingness to take action on behalf of SBHCs.

"We have vastly different partnerships with other advocates than we did prior to the Kellogg grant when we were virtually unknown."

State SBHC Association

The graphic that follows depicts: (1) three-interconnected policy networks – those forming at the federal, state, and local/tribal levels; (2) the partnerships forming among these three levels – i.e., federal/state, federal/local, and state/local; and (3) the role that these multi-level networks and partnerships are playing in influencing policy outcomes for SBHCs. The diagram also frames the SBHCPP in its larger environmental context, which both influenced the work, as well as was influenced by it.



Federal policy network for SBHCs

Particularly in the last few years of the SBHCPP, the National Assembly and state associations made it a priority to strengthen and expand their relationships with national organizations and federal policymakers to advance their policy goals. Examples of the kinds of relationships that emerged include the following.

National organizations:

- **National Association of Community Health Centers**, whose role was pivotal in helping to craft and advance authorizing legislation for SBHCs that ultimately made its way into the Patient Protection and Affordable Care Act.

- **National Association of School Nurses,** whose partnership and collaboration helped build a unified position of support for the role that SBHCs and school nurses play in increasing health in schools.

- **First Focus,** whose expertise in policy advocacy and support for SBHCs played a key role in in informing the National Assembly on various federal efforts related to SBHCs. First Focus also visited with members of Congress and their staff to advocate for favorable policies for SBHCs.

- **Organizations representing members of the educational community**, including the National Coordinating Committee on School Health and Safety, which provided a venue for building coordinated school health programs by bringing together federal departments and national nongovernmental organizations; and the Coalition for Community Schools, whose advocacy efforts helped lead to the development of recent proposals in education reform.

Policy champions. Advancing policy change also requires policy leaders willing to see that change through the policy process. While there are many examples of such "champions" for school-based health care, the following examples highlight several leaders who helped

pave the way for policies to sustain and expand SBHCs.

- **Senator Debbie Stabenow (D-MI), member of the Senate Finance committee,** played a pivotal role in introducing and/or championing most of the major federal legislative vehicles for SBHCs, including:
  - The Healthy Schools Act to secure reimbursement for SBHCs from Medicaid and the Children's Health Insurance Program;
  - Stand-alone language to authorize a federal grants program for SBHCs, which later helped shape the authorizing language in the Patient Protection and Affordable Care Act;
  - Legislation in the Patient Protection and Affordable Care Act that authorizes $200 million for capital support to SBHCs;
  - Achieving recognition of SBHCs in the reauthorization of the Children's Health Insurance Program.

  The partnership between Senator Stabenow and the Executive Director of Michigan's SBHC association has been key to securing favorable policy changes for SBHCs not only in Michigan, but nationwide.

- **Representative John Dingell (D-MI**), Chairman of the House Energy and Commerce Committee, played a major role in supporting the inclusion of SBHCs in the Children's Health Insurance Program Reauthorization Act, among other policies.

- **Senators Olympia Snowe (R-ME) and Susan Collins' (R-ME)** both co-sponsors of the Healthy Schools Act, were key in building bipartisan support for the inclusion of authorizing legislation for SBHCs in the Patient Protection and Affordable Care Act.

<u>Congressional staff.</u> The National Assembly's evaluation of the authorizing legislation in Patient Protection and Affordable Care Act underscored the role that staff members play as the gateway to legislators, committees, and providing "inside" information to advocates. As one SBHC association staff member describes, staff members in "congressional offices and national partnerships… uniquely serve as (our) eyes and maintain our visibility while we are not able to physically be present."

<u>Policy officials in the executive branch</u>. Because of their role in establishing regulatory and administrative policies and rules, as well as in influencing legislative decision-making, the National Assembly and some of the state associations worked to build relationships with federal executive officials and staff. These relationships were relatively recently formed; for most of the program, the driving priority had been to secure Congressional support for advancing a federal grants program and building stronger revenue streams for SBHCs. With the passage of the Patient Protection and Affordable Care Act, the reauthorization of the Children's Health Insurance Program (CHIP), and the soon-to-be reauthorization of the Elementary and Secondary Education Act (the successor to the No Child Left Behind), SBHC advocates began to expand their advocacy to include educating and building partnerships with executive branch officials as well.

<u>State Policy Network for SBHCs</u>

In similar fashion as at the national level, state "policy networks" also emerged in the course of the SBHCPP.

<u>Governors</u> in several states played a major role in protecting and sometimes expanding and diversifying funding decisions for SBHCs; signing supportive bills passed by the state legislature into

law; increasing SBHCs' visibility in state government elsewhere; and appointing representatives to key advisory and planning committees to give SBHCs a voice in state policy discussions, for example. In one state, the Governor was the driving force behind statutory change to allow a state grant office for SBHCs to be created.

Policy officials and/or their staff members of executive departments and agencies. For many of the same reasons as with their federal counterparts, many of the state associations sustained relationships with the state departments of health and education. An unusually productive partnership occurred under the leadership of the Director of the Michigan Medicaid office, and the Executive Director of Michigan's SBHC association. In follow-up to a Children's Summit that explored funding issues for SBHCs, the Director of Medicaid established a "Medicaid Match" workgroup to explore opportunities for expanding funding sources to SBHCs. The outcome of these discussions, described later in this report, was the procurement of millions of dollars in direct support for SBHCs in the state. While possessing an unusually high level of commitment and creativity in his support for children and SBHCs, this partnership demonstrated the productive and innovative potential of collaborative work within state "bureaucracies."

Legislators, particularly those in positions of leadership, and legislative staff. As was true at the federal level, the SBHC associations often developed strong relationships with state legislators and their staff members – relationships that often became reciprocal in nature as the associations proved their value in providing policymakers with guidance on issues affecting the health of the state's children. These relationships were important in protecting state funding for SBHCs, as well as in securing a range of important policy decisions and outcomes that favor SBHCs.

Advocacy organizations for children, families, communities served not only to support the policy work for SBHC, but as conduits to policy leaders and, importantly for building SBHCs' visibility.

Statewide coalitions became valuable forums for increasing visibility for SBHCs and for building and expanding the associations' networks with other organizations and community groups. The SBHC Associations joined family planning advisory councils, minority health coalitions, safety net provider coalitions, coalitions of social justice organizations, behavioral health "purchasing" collaboratives, and sustainability workgroups, among others, for example.

Local Policy Networks for SBHCs

Local policy networks, including tribal communities, also emerged in the SBHCPP to advocate for policies that support children and communities through school-based health care. Most of the SBHCs had an advisory board consisting of parents, community-based organizations, and other community representatives who participated in setting local priorities and developing strategies for policy change. Many of these advisory boards worked to establish new SBHCs and to guide decisions about service delivery within the centers. In the course of their work, members of the youth advisory boards and/or school health councils built often enduring relationships with those in positions of power at the local level, including superintendents, principals, school boards, mayors, members of city councils, business leaders, and others.

Inter-Level Partnerships

Not only were policy networks forming within the

federal and state levels, but between them as well. Highlights follow.

Federal/State Partnerships. At the program's outset, there was little collaborative advocacy and even "some tension" between the state SBHC associations and the National Assembly. The process of determining respective roles, expectations, priorities, and strategies required ongoing discussions and adjustments, at both levels. In the course of the program, and through extensive work by the National Assembly and the state associations, a federal/state SBHC partnership took form. As the National Assembly and the associations strengthened their partnerships, so too did collaborative work increase among their broader "networks" of federal and state partners.

Greater numbers of state associations and their partners helped to shape, lead, and/or support the National Assembly's policy agenda in the course of the program. According to one state association, "the combination of the state budget deficit and the new administration in district has meant that there is significantly more opportunity at the federal level than at the state level." The SBHCPP itself helped to build and support this federal/state partnership through establishing a short-term 'social movement fund' for states to increase their engagement in federal policy work to build momentum for a broad-based school-based health care movement. As a state association explained, relationships with the National Assembly and other federal stakeholders for SBHCs were established at a "level which we sustained through other funds after that dedicated funding ended. The movement fund prompted us to develop a much closer working relationship with the National Assembly."

State-Local Partnerships. A central component of the SBHCPP strategy for securing sustainable resources for SBHCs was state associations' work to engage and equip local communities in policy advocacy for school-based health care. As a result, the local partner became increasingly involved and influential in statewide campaigns to address respond to opportunities or threats to school-based health care. One state organized "community teams" of providers and other adults to work with youth in developing such campaigns to mobilize support. Another state association worked to foster partnerships with local managed care organizations, hosting several conversations and bridging the gap between payers and providers by helping develop managed care organizations' understanding of the model.

A primary way many of the state associations and community partners built state/local partnership was through their planning and implementation of annual "Advocacy Days." The associations' annual state conferences also served as a venue for networking and collaborative planning with local participants.

"Everything that came in to work with the community partners became statewide. Though the focus was on community partners, we broadened and have a strong network; we've changed a lot of how we communicate; others agree on the role that WKKF played in building strategic communication."

SBHCPP Community partner

Federal/Local Partnerships. Early in the program, the National Assembly and local communities rarely joined forces in advocacy for federal policy. At the program's end, a bridge between federal policy networks and local communities was beginning to form. In particular, this partnership grew out of relationships being developed between the state associations and the National Assembly. According to one association member, "The cornerstone to (our state's) federal policy work was and will continue to be its community partners and the youth they serve… Community

partners played a critical role in the policy work through their work at the grassroots level. They were able to put a face to the work and give heart to the movement."

The federal/local bridge was strengthened by the ongoing advocacy of influential community leaders with connections to influential federal policy officials. For example:

- **Gail Warden**, Chairman Emeritus of the Henry Ford Health System, a personal friend to Chairman John Dingell and a long-time champion of SBHCs, played a key role in securing and informing Representative Dingell's leadership for SBHCs.

- **Lauro Cavazos**, member of the National Assembly's board and former Secretary of Education during the Reagan and Bush Sr. Administrations, was an early force behind building bridges between education and health policy in support stronger and more coherent policies for children through SBHCs. Mr. Cavazos served as the first Hispanic on the United States Cabinet and a professor of health and family medicine.

Federal/local collaborations were reinforced during the National SBHC Advocacy Days at the U.S. Congress, hosted by the National Assembly. In 2010, for example, Advocacy Day brought over 300 federal, state, local advocates to Capitol Hill to build support for SBHCs. Youth and parents also participated in the National Assembly's annual conference, provided testimony before Congress, and serving as advisers on federal policy decisions. Relationships between federal policymakers and local constituents were also strengthened through policymakers' visits to local SBHCs, visits that often left a lasting positive change in federal policymakers' thinking about the centers.

COMMUNITY, INCLUDING YOUTH, ENGAGEMENT IN LOCAL POLICY ADVOCACY

Intended impact: Local communities, including youth, are shaping the content, quality, delivery, and financing of health care in their communities

The emergence of communities in policy advocacy, particularly youth, was one of the striking achievements of the SBHCPP. This section describes key strides made in building capacity for advocacy at the local level and in affecting local policy outcomes.

" SBHCPP was the catalyst for a new generation of advocacy in our most underserved communities."

State SBHC Association

Strengthened Capacities by Communities, including Youth, for Policy Advocacy

Community and youth advisory board members engaged in campaigns for policy advocacy. In some centers, adults met with youth board members to discuss issues of greatest relevant to them both. In most communities, however, youth determined their own agendas, recruited and oriented new members, and became actively engaged in advocacy efforts not only at the local level, but in state and even federal policy circles as well. As one executive director from a SBHC association explained, "In the beginning (of the SBHCPP), we brought youth to our SBHC Awareness Day, taught them what to say and then had them meet with legislators. Today, we try to engage youth early on in the planning process–from deciding what dates are most "youth friendly" to having them take over parts of the training at the events."

"For 2009-2010, members from a high school SBHC Youth Advisory Board (YAB) helped found a unified school district's Youth Commission. The Youth Commission is the first of its kind for the district and allows the YAB to keep the school board abreast of the latest SBHC news, make the case for SBHCs in their community, and inform them of on-campus and community projects spearheaded by the YAB and other student advisory boards from SBHCs in the district."

State SBHC association

Youth assumed a leadership role in policy advocacy. Youth utilized a variety of strategies in advocating for policy change. They provided testimony at state and federal legislative hearings, hosted site visits to local SBHCs, led letter writing and signature campaigns, and helped design and participate in advocacy days and other legislative rallies. They served as spokespersons for their communities and for SBHCs in media interviews on behalf of local SBHCs, participated in organizational and policy development in a variety of formal and informal advisory capacities, and mobilized other youth to become policy activists and leaders. They had an impact in several areas, as described on the pages that follow.

"The advocacy initiative was led by youth who chose their policy priority, participated in intensive training, secured a Native American sponsor for a bill at the state legislature, provided testimony at legislative hearings, and maintained a relationship with Governor Richardson's office to ensure he did not exercise a line item veto."

"Over the six years of the SBHCPP, youth have expanded their role from local advisory roles and involvement in local fundraising, to become effective and experienced advocates for funding at the state level and advocates for SBHCs in schools where none currently exist."

Two state SBHC associations

Outcomes, Impact of Communities, including Youth in Policy Advocacy

Youth successfully advocated for healthier food choices in schools.

- High school students in a small, primarily Hispanic community in Massachusetts, whose residents are often uninsured and experience high rates poverty, launched a campaign for **healthier choices in the school district's food service**. As a result, school meals now include nutritional information and a daily 'healthy meal of the day' option that includes fresh fruit. In addition, the food services program established an after-school culinary club to teach students how to cook nutritiously.

- In the nation's largest school district, New York City, **whole milk was replaced with 1% milk in all public school lunchrooms by the Department of Education**. The decision banned low-fat flavored milk as well, allowing only chocolate skim as an alternative, resulting in one of the strictest policies in the country. The policy change was featured in a front page article of the New York Times, which specifically mentioned the role played by SBHCs.[25]

- A student leader participating in a SBHC youth advisory group for an alternative school for 15 to 20-year olds in Ann Arbor, Michigan, persuaded school officials to **replace unhealthy snacks in the school's vending machines with healthier options**.

- At a high school in Baltimore, Maryland, student members of the SBHC governing board persuaded the school to **provide more nutritious cafeteria food and to eliminate an unhealthy practice by food service staff** of freezing cooked pizzas and then thawing and later re-selling them.

- Students at a middle school in Sullivan, Massachusetts, most of whom are eligible for the Free or Reduced Lunch program, **created a community garden to grow their own food** and to learn about nutrition. Parents and local community members volunteered to care for the garden during summer recess. Students also established relationships with farmers a local farmer's market who agreed to allow them to sell their vegetables at the school.

- Another SBHC community partner, together with their high school youth advisory group in Hyannis, Massachusetts, teamed up with the school district nutritionist to create **expanded breakfast options at the school**. The school is located in a coastal town where 71% of the residents are uninsured, have some of the lowest incomes in their state, and include substantial numbers of immigrants.

"When youth are empowered to speak for themselves, adults gravitate to them, and young people become the organization's best messengers. The success of the Youth Advisory Councils of the Community Partners can be attributed to youth empowerment strategies – allowing members to conduct recruitment, orientation, meetings, trainings, and advocacy sessions with adult support."

State SBHC association

Youth improved the quality and delivery of services. A common priority: increase privacy and confidentiality.

- A major urban unified school district in California approved a student-initiated policy proposal to ensure that **students are informed of their legal rights to confidentiality** during health care consultations, diagnosis, and treatment. This approval came following a three-year student-led campaign to build awareness regarding this policy.

- In a high school in Portland, Maine, youth advocates changed a policy between the school and its mental health provider to **allow students to receive mental health services confidentially**, without requiring prior permission from their parents.

- In rural New York, students were instrumental in changing a policy to **protect student confidentiality** when seeking passes

to the clinic during study hall.

Youth improved the quality of the school environment.

- In an elementary school located in a neighborhood plagued by gangs and a lack of safe outdoor play areas, students persuaded the school principal to extend recess by 10 minutes and to devote resources to **convert a tarred lot into a painted playground**. In addition, the youth organizer, the principal and involved parents joined forces to help secure donations of play equipment, paint, and volunteer time from local high school students to paint the playground. According to the SBHC, these changes resulted in a lower rate of altercation on the playground and increased recognition of the center as an integral part of the school.

- **A SBHC at a high school in Massachusetts, obtained an agreement with school administrators to students sent to detention to attend the Center's after-school youth advisory group instead**. Staff members at the Center helped participating students learn about health advocacy work, public speaking, and develop their interpersonal skills. The group more than doubled in size as teacher referrals grew. The Center reported that referred students continued to attend beyond the detention period because they said they felt respected, were learning new skills, and were being fed nutritious food.

Youth and/or communities' advocacy improved the content of health care. The impact of community groups, including youth, on local policy was diverse and extensive. Their work helped to increase youth's access to reproductive health care, generate support and participation in a peer-to-peer suicide prevention program, and establish a student mental health initiative, for example. Examples of youth-driven campaigns to change the content of care in communities are presented in the table on page 28.

Youth and/or communities' advocacy increased financing for health care. Often with the support of the community partners, youth made strides in influencing financing for health care. Association staff members described youth's impact this way:

> "…youth began to develop the core understanding of how their voice is an important part of the budget process. Youth attended several budget hearings where they provided testimony on the value and critical need for SBHC. Additionally, students with legislative members on the K-12 Senate and House Appropriations Committee wrote letters to their members expressing their support and expectation for them to support funding for SBHC."

The variety of ways communities had an impact on expanding resources for SBHCs are illustrated on page 29.

According to one state SBHC Association, "We got $500,000 when the youth testified in 2007; legislators listen to youth; we reached our goals a lot quicker. We would not have been able to get the funds without the youth. Legislators would have seen us as working to save our own jobs."

A youth advisor agrees: "Youth voices are especially impactful at the legislative level when they testify and advocate for health related topics. Their raw emotion, stories, and perspective can make a difference when it comes to a passage of a bill."

Youth's capacities for leadership and action are recognized outside of the SBHCPP: "youth are wanted at the table for other Coalitions." As one SBHC association explained, since the SBHCPP "more adults have now caught on to getting youth involved. It's become more of the norm in adults' thinking and considering youth engagement." Another indicated that "We

now have started inviting youth into adult focus groups, they have now come in and played an active role. We now involve youth in the planning process as well to encourage more youth participation and to build bridges with the adults." Other comments reinforce these themes. One SBHC association reported that following a youth group's work on minor consent rights, "…the Board of Education…now relies on youth committee members to provide minor consent education training to all health education faculty, wellness center staff, and students in the Unified School district…"

"Youth Advisory Group members are sitting at national tables to give advice. Non-Native groups, state and nationally, are calling on the Youth Advisory Group to ask what they did. (Our) lessons learned equal technical assistance for other groups."

"SBHC youth advocacy has served as a model for other organizations serving youth and has contributed to the dissemination of youth engagement in advocacy in (our state)."

Examples of community-based–and often youth-driven–campaigns that changed the content of health care

IMPACT ON BEHAVIORAL HEALTH CARE	IMPACT ON REPRODUCTIVE HEALTH CARE	ORAL HEALTH SERVICES
Youth from the Laguna Youth Advisory Group successfully **lobbied for state funds for a peer-to-peer Native American youth suicide prevention training program** in the 2007 New Mexico state regular legislative session. New Mexico youth have been invited to present on suicide prevention at national conferences by the National Congress of American Indians, the National Indian Health Board, and the Indian Educational Association. In Calais, Maine, fifteen members of the SBHC teen advocacy group received instruction on how to start peer mediation programs in their schools. The **assistant principal utilizes these peer mediators to respond to student conflicts**. In addition, local K-8 and K-6 schools have invited the peer mediators to train students at their school.	In a youth -led campaign in a middle school in California, youth were joined by a local partner that oversees five SBHCs and a district-wide prevention network to **reverse the ban on condoms within SBHCs** in the Oakland Unified School district. Most families served by the centers have incomes less that 200% of federal poverty, face a high incidence of sexually transmitted infections, and reside in a community with a teen pregnancy rate at twice the state average. Youth advocates ("youth epidemiologists" as they came to be known) argued that restricting access to condoms was a major barrier to preventing HIV/AIDS, as well as a contributor to other risks to their health. The students presented their case to members of the board of education, who **unanimously voted to reverse the ban, a decision approved by the state administrator.** In rural Santa Rosa, California, the school board unanimously voted to **allow full reproductive health care services to be provided** at the high school health center, including contraceptive services. Seventy percent of the population in this community is Latino and one in 12 young women within this community ages 12 to 18 have a baby every year. In New York City, one of the regional chapters of the state association helped to secure support from the NYC Mayor to fund six new SBHCs to support **teen pregnancy prevention initiatives**. Their advocacy also resulted in increased support for technical assistance and support from the City's Department of Health/Department of Education School Health Office. At a SBHC in Michigan, youth and parents persuaded the school board to allow the SBHC at the local high school to **provide family planning information and education, including gynecological exams**. Prior to this work, this center, which had been in operation for more than 15 years, was not allowed to present any type of information on family planning services or education to students.	A community partner that provides comprehensive health services to residents in an eight county region in central New York State generated start-up funding to open five SBHCs in four different school districts. Their efforts to diversify funding for SBHCs resulted in three centers opening with a federal grant and one center opening as the result of funds set aside in the school budget. They also **successfully advocated for the inclusion of preventive dental services** in previously established SBHCs located in six schools in district. **TB SCREENING FOR NEW AFRICAN IMMIGRANTS** In Maine, collaborative work between school nurses and the SBHC resulted in the **establishment of a tuberculosis screening clinic for new African immigrants in the Lewiston-Auburn area.** This was particularly important due to recent outbreaks of tuberculosis among recent Somali immigrants. **H1N1 VACCINES** Several of the associations engaged the field in a broad-based effort to ease access to vaccine given the flu epidemic. Some SBHCs served as a hub for community-wide vaccination; in one community, for example, each participating community partnered with other local health centers to provide teacher immunization days, district staff days and community days for providing the vaccine. During the three-month grant period in one state, SBHCs provided H1N1 outreach and education to roughly 37,736 students and families and delivered 923 vaccinations. One state also used this effort as an opportunity for Medicaid outreach and enrollment.

Examples of community-based–and often youth-driven–campaigns that changed the financing of health care

OREGON

A group of teens raised $18,000 over a two-year period in Eugene by hosting an annual fundraising event that included a silent auction of goods donated by local businesses and art work created by students. Also in Eugene, a local self-insuring employer agreed to reimburse their community's SBHCs for mental health services provided to the children of employees.

In a rural school district, a group of students, parents, educators and community members persuaded the school board to preserve $100,000 in in-kind services provided to the Sacagawea Health Center, a community partner, despite budget cuts at the middle and high schools.

The local school district in rural St. Helens agreed to reallocate a portion of their Medicaid Administrative Claiming reimbursement to support the salary of the center's mental health provider for the year. In another instance, the school district agreed to use a rainy day fund to replace the financial support to the centers.

MICHIGAN

The Detroit Youthville Teen Advisory Board decided to focus their advocacy efforts on financial sustainability when they learned their center was facing financial challenges. A goal was set to maintain the $2 million funding in the existing state budget for the centers. The policy was successful: $1 million was secured in state funding together with a $1 million Medicaid match.

CALIFORNIA

The nation's largest publicly run health plan initiated a pilot project to reimburse 14 SBHCs on a fee-for-service basis for care provided to any of its members. The pilot resulted from extensive discussions between a coalition of Los Angeles-based SBHCs and the managed care plan. As a first step, the plan agreed to reimburse the school district and SBHCs in the county for physical exams provided to youth who were new to the school district.

In response to a local/state advocacy campaign, the Los Angeles County Board of Supervisors agreed to set aside $4.8 million in county tobacco settlement funds for SBHCs and to allocate $8.6 million to school-based mental health projects to be implemented in new and existing SBHCs. This represents the first time senior staff at the county engaged with SBHCs.

In response to local and state advocacy, the West Contra Costa Unified School district provided $1.2 million over three years to establish centers in all of their six high schools. West Contra Costa County also agreed to include its three existing SBHCs and several proposed new school sites in their federally-qualified health center (FQHC) application, which enabled the centers to be reimbursed on a cost basis.

After nearly five years of local and statewide youth advocacy, the Riverbank High School mobile SBHC is preparing to open its doors. The Riverbank case study continues to be recognized widely as youth-led SBHC start-up.

NEW YORK

A community partner generated start-up funding to open five SBHCs in four different school districts. Local efforts to diversify funding for SBHCs resulted in three centers opening with a federal grant and one center opening as the result of funds set aside in the school budget. Advocates also successfully advocated for the inclusion of preventive dental services in previously established SBHCs located in six school districts.

The Mayor of New York City decided to fund six new SBHCs to carry out teen pregnancy prevention initiatives following an awareness raising campaign waged by the downstate chapter of the state association.

MAINE

A medical sponsor of SBHCs in Maine negotiated a $10,000 contract with the Auburn Board of Education to cover non-reimbursable mental health services provided by centers. The sponsor also negotiated a $20,000 contract with the Lewiston Schools superintendent to augment a center's mental health program and to subsidize expected reimbursement shortfalls for physical and mental health services. The agreement was obtained in the spring, thus marking the first time the schools made a monetary commitment to the SBHC prior to a new school year.

"I am a life-long advocate. I can't imagine giving this stuff up."

Youth participant in the SBHCPP

The following comments, provided by youth, describe the range of ways youth's work made a difference in the SBHCPP. They are compiled primarily from findings from project-level evaluators' reports on youths' experiences in the program and the SBHCPP's "Youth Voice Project," a series of videotaped interviews designed, implemented, and completed by youth. Most of the respondents quoted below were in middle school and high school.

Sense of Empowerment: Having an Impact

"Even us adolescents (a small group) can make a difference, we are heard!"

"It opened my eyes and it has given me the tools to actually realize some things like, I can change myself for the better to help others out."

"I feel like I made a difference. I feel like we definitely like did something. And, it might not be the change now, but it might be the change later."

"I learned that stating our opinion can be very helpful for legislators. I learned that they take our thoughts and ideas and think and talk about them."

"The signing of this bill, the various retreats, and educating many have motivated me to believe that I can make a difference in my community."

"I learned that if there is a legislator that doesn't know much about the school-based health clinics there is more to explain to them."

"I have been really proud of being able to go to the State House. We go to the State House multiple times a year and we have spoken in press conferences and in front of sub-committees…"

"…we played a key role in the passing of AB 2560…This bill would create a center … that would help create further expansion of SBHCs."

Having a Voice

"The highlight was when I spoke my opinion in one of the legislative meetings and I didn't feel afraid to express my opinion."

"Youth voice needs to be heard. It feels so good to talk about what [youth] are passionate about, and to have adults really listen."

"It gave us the opportunity to speak our minds and let people know where we come from and what policies affect not only the state of New Mexico but the tribes within the state."

Impact of Their Own Lives: Transformation, Confidence, Pride

"You just think of yourself as a kid and like you can't do much. But then you get involved in the group…and it gives you that encouragement and that motivation to say like 'Wow, these kids can do it, so can I."

"A lot of people look to me because of how I'm involved and out of trouble and looking for ways and opportunities to help people…they see me as a role model."

"We did a lot fund-raising and budgeting just for that trip. That trip was the highlight of my senior year as a student. Washington DC and meeting with our Senators…that was awesome! Not even just helping the health center but simply going to DC was a great educational experience."

"I could say the difference it made on my life, the way I look at things, are totally different.. The way I think about sex, and abuse, bullying. …like how I used to before like using drugs and doing a lot of things that I shouldn't have did before growing up as a teen, and now that I'm an adult I look at it and I'm more aware of it and I think by joining this group that it really did make a positive influence in my life."

"I want to say that [being in health council] was like my first step to like feeling like I could like change stuff. Because, I don't know, I just liked the atmosphere about being at a table with people who have like the same concerns as me. So, yes, that was like my first step of becoming like who I am today."

"We desired to be representatives of young people in a predominantly adult-run world, not just for the sake of having our voices heard but to empower and to give hope to one another through education, technical assistance,

and teamwork, all of which ultimately led to personal and professional development." (youth graduate who is now in college.)

"So what this policy initiative did was give a lot of [kids like me] an outlet. These students became really active and really spoke out about things they cared for."

"I had joined the Youth Board with the understanding that young people are driven and need an outlet to succeed and thrive. My involvement has also honed my organizational, interpersonal, and leadership skills and has transformed my view of my role in society."

"We put out the facts. It is up to them whether they want to listen or not."

Youth advisory member describing her attitude towards meeting with legislators

Helping Others

"I felt like I was able to help my community in ways that not a lot of people had been doing."

"I got involved because I wanted to help my community, and also like going to the health center like every day…so I'm going to join this group and then speak up and help them get what they need for the health center."

Changing Attitudes

"I feel like when [policymakers] see a female person of color advocating … they do know that there are certain people that are looking out for resources to improve their communities. We're breaking stereotypes."

"There are not many youth who are willing to share personal experiences; it's a unique thing about our group (Native American). We're breaking the silence (about teen depression, isolation, and the risks of suicide), but in a respectful way."

"The community doesn't like to talk about sensitive issues like incest, suicide. When caught with these issues, they don't know how to help these victims. The tradition is to keep quiet and it will go away. It doesn't. It keeps bubbling, and you still suffer."

"It's really given the community a chance to see their youth in a whole new light…There's not a lot of things to do [on the reservation] and so some youth are prone to getting into trouble…but with this policy initiative…it gave adults a chance to see youth active and vocal and taking charge…speaking out."

Adults agreed….

Many of the project-level evaluators evaluated the role and impact of youth in policy advocacy in their state-level work from the perspectives of youth, community partners, and others who were familiar with youth's work in the program. The program had a far-reaching impact on youth, they suggested. They noted improvements in youths' sense of connection with school, their relationships with their peers and adults, their motivation to do well academically, their career aspirations (to include health care), their leadership skills, and their sense of pride and self-confidence. They were especially impressed with youths' transformation into confident, effective leaders. A sample of their views follows.

"When we first meet with youth they are afraid to speak and then, they are testifying before the State legislators. Often they are shy or not the obvious leaders but they grow into leaders. Youth leaders inspire other youth leaders."

"Youth have taken what we've given them and run with it. It's a movement being driven by the youth."

SBHC association staff

"Beyond their effects on others, virtually all community partners report a positive impact of youth engagement for the youth themselves, describing the work as building leadership skills, "a risk protective process," and a chance to "keep kids on the right track."

Over time, youth who were shy and reticent, unaccustomed to speaking in front of adults, and lacking experience in leading, became leaders within their Youth Advisory Group, within advocate communities in New Mexico, and at the national level.

"Local youth in one state used their advocacy training to mobilize school resources to help feed kids who had not eaten the entire day. When the school failed to take action, the youth got local media attention and informed community members about the problem. The SBHC staff provided information about the problem, stats, and solutions to support the youth-led advocacy."

VISIBILITY OF SCHOOL-BASED HEALTH CENTERS

Intended impact: Strong, sustained national and state visibility of the issues affecting SBHCs

In the course of the SBHCPP, school-based health care has moved from a position of relative obscurity to one that has attracted increasing media attention and public and political support nationwide. The National Assembly and their state associations utilized multiple venues for focusing the national and states spotlight on school-based health care. They organized rallies, provided testimony at budget hearings, hosted and participated in meetings with elected officials, hosted meetings with legislative staff, launched wide-scale letter writing and call-in campaigns, visited legislators and their staff at their state and federal offices, and built communication channels with staff at the White House and state Governors' offices. Throughout their work, the associations have shown the effects of their increased capacities for strategic communication. The National Assembly reported, for example, that it sent press releases on health care reform to several hundred media contacts in the last year alone; they also reported that the Assembly's web traffic grew from 1,943 unique visitors in December 2009 to 3,173 in November 2010.

As SBHC associations have become increasingly well known, they are also increasingly sought after. The executive directors of the SBHC associations are receiving increasing numbers of invitations to serve on advisory committees, whether commissioned by governors, health or education departments, or an interdisciplinary health education and human services advisory councils. One executive director, for example, advised a state Commissioner and Board of Education in the areas of legislation, regulations, and guidelines related to instituting comprehensive health education and services in public schools.

Youth raised legislative interest in SBHCs by sharing their stories. Youth and others shared their experiences with SBHCs, whether through testimony and office visits with policymakers, participating in legislative breakfasts or state conferences, developing their own communication publications and materials, speaking out at advocacy day or conferences, sharing information at school fairs, or putting on skits about the value of SBHCs, for example. One SBHC association described a youth-led policy briefing on health issues and academic achievement, for example, which attracted more than 130 people, including numerous policymakers and administrators. In another state, 100 youth between the ages of 10 and 18 from five different communities participated in a peer-based training program to reduce suicide among Native American youth. The youth advisory group identified areas of the training model that needed to be strengthened or revised to increase its cultural appropriateness for Native American youth. They also identified the schools that would receive the training. According to the state SBHC association, youth learned to conduct research on the subject of teen suicide and existing peer-to-peer models, and develop their own talking points. They researched relevant legislative bills and lead discussions with legislators. They shared their experiences with key decision-makers. According to a staff member from the state association, "It was real. It was [the youth] telling their story, not someone else's story."

Students spoke at state and national meetings to share their experiences, often not heard from in the context of their health care needs. As one association described, the "response to the youth testimony was overwhelmingly positive. Many

people expressed their gratitude to (the association) for bringing youth voices to the process as no other organizations had done so."

"A young person…worked with his SBHC provider and nutritionist to lose more than 100 pounds. (The association) worked with the National Assembly and Senator Dodd's office to arrange an opportunity for this young person and the nutritionist he worked with to testify at a congressional hearing on effective obesity programs. Excitement captured the both of them, creating a once in a lifetime opportunity."

In one state, a six-week campaign involving calls and letter writing to members of the legislature led "one of the Association's policy consultants (to recall) legislators coming up to her saying, 'you can tell people to stop calling and writing. We are helping on this issue.'"

Two State SBHC Associations

Youth met with governors, legislators, contacted the media to build their interest in SBHCs. In one state, for example, youth met with local and state policymakers to stress importance of expanding SBHCs to include mental health services, and, as a part of those services, emphasized the importance of protecting minor's health rights. Youth used their skills in strategic communications to make their case and tailor their advocacy strategies with their targeted audiences. Youth drew attention to issues of importance via issue papers, fact sheets, talking points, press releases, toolkits, annual conferences, and other means.

In another state, community partners, youth, and other advocates gathered 8,100 youth signatures in a period of five weeks in support of SBHCs; in one high school in that state, youth themselves gathered 1,200 signatures from their peers. Youth advocates delivered those signatures, in backpacks, to the Governor's office, and were interviewed by the media, including a Spanish language station. The same state SBHC association brought youth to testify at Mental Health Commission meetings. The Commissioners expressed gratitude that youth were included in the testimony and discussions, noting how uncommon it was for youth to speak on their own behalf. In that state the Youth Board wrote and sent eight letters to the editor of which five were published. Three hundred letters were sent to House Speaker Nancy Pelosi. In 2010, five Youth Board members completed 21 federal legislative visits in Washington, D.C.

SBHCs invited legislators to visit their SBHCs and meet with youth, community members and school personnel to talk about the need for of SBHCs. Several state associations noted that the single most effective strategy for building strong and immediate support for SBHCs was to host a visit to a center by policy officials. Typically conducted by youth themselves with support from the community partners, community members, and school personnel, these visits helped convince even skeptical legislators to become supportive of SBHCs. The stories youth shared of their lives and the role that SBHCs played in improving them, alongside the first-hand tour of the centers themselves, proved a potent source of building awareness needed for action and change. According to one association, these visits "give a face to SBHCs and leave the visitor with real, vivid, and hard to forget images of these busy centers and the children and youth they serve." As one staff member noted,

> "Elected officials were very engaged in the tours and in the discussions with young people, often staying beyond their scheduled times. Further, in most cases they became champions of SBHCs committing to ensuring on-going financing and addressing issues and concerns. This was true at both the state and federal level."

In one case, following his visit to a local SBHC, a Democratic member of Congress who had

been opposed to the centers because of their role in reproductive health care, became a strong supporter. According to the project evaluator in that state, "the high school's health center and their youth advocacy council hosted a forum with (the) Congressman in November 2008. Young people, many Native American, established the agenda, selected invitees, and facilitated the dialogue… This was a pivotal event where the Congressman pledged his support."

Parents also helped raise visibility for SBHCs via indirect contact with elected officials, typically through letter-writing, phone calls, and email. Some also engaged in direct policy advocacy via state and national Advocacy Days and, in one particularly dramatic instance, direct testimony at a Congressional briefing organized by the National Assembly about the role of SBHCs in disaster preparedness and emergency relief. As staff from the National Assembly explained,

> "Army Master Sgt. Scott Dugan, his wife Jenifer, and son Patrick offered a personal perspective on the need for SBHC services at the North Country Children's Clinic in Watertown, New York. The Dugan family brought many in the room to tears, with 10-year-old Patrick Dugan delivering an unrehearsed explanation of how "Miss Erin" at his SBHC helped him to understand that his father was needed in Iraq. Scott Dugan explained that he could focus on bringing his troop of 93 soldiers back safely, which he did, when he had peace of mind about his son's health."

In another instance, a SBHC engaged Hispanic moms to participate as *promotoras* (lay health worker outreach). The center hosted advocacy training and organized their efforts to conduct outreach to other Latina parents to raise awareness of the SBHC services. The same parents then participated in state and federal policy efforts, and met with Spanish-speaking legislators in the state capitol and on Capitol Hill to advocate for funding for SBHCs.

"When we received the WKKF grant, school health centers had almost no visibility in the state capitol and staff had no experience with legislative advocacy….While we have not yet (met all of our policy goals, SBHCs) are well-recognized and supported by the administration and many members of the legislature."

State SBHC association

One of the universal activities for increasing visibility for SBHCs were state and national "Advocacy Days," also known by similar names. These events, which typically drew large and diverse groups advocates to the state capitols and Congress for a concentrated day of advocacy, served to raise legislative awareness of and support for school-based health care. Advocacy Days evolved from relatively small and contained events to including a diverse range of participants and increasingly sophisticated advocacy strategies. While the number of participants varied by state, toward the program's end one state drew as many as 500 participants. Participants tended to include a mix of representatives from partner organizations, community groups, and youth from diverse racial/ethnic and geographic backgrounds (urban and rural, and various regions within the state). Some of these events included also representation from local businesses, the banking and insurance industry, and professional associations. Many of the SBHC associations made it an ongoing priority to work toward building a wider base of support, viewing these days as opportunities for building relationships with multicultural constituents from different parts of the state and different segments of their overall populations.

Many of the evaluations from these events found them to be highly positive experiences from the standpoints of participants and policymakers alike. The following findings were typical of others, for example. After interviewing several stakeholders, the evaluator concluded that, "Advocacy Day also has an impact on legislators, putting a face to an issue, helping legislators and their staff to understand the issue in human and emotional terms, in addition to its policy implications…The personal stories that students bring to Advocacy Day are the focal point of the day for the students, adults and politicians, and work as a very effective advocacy tool."

Advocacy Days were viewed by some as the "cornerstone of policy advocacy" without which the association "would not have been successful in mobilizing Congressional members as champions for the movement." What is less well understood, however, is the relative effectiveness of most Advocacy Days in deepening relationships on an ongoing basis, in influencing policymakers' thinking about SBHCs over time, and in sustaining the enthusiasm and commitment to advocacy for SBHCs among the Advocacy Day participants.

Impact on Raising Awareness and Increasing Visibility

SBHCs have become increasingly visible in a variety of contexts: in the mainstream media, social media, in national and state dialogues about health care and health policy reform, among policy makers at the local, state, and national levels, and in educational communities and among allied and strategic partners, private, public, and managed care payers. At the legislative level, greater numbers of legislators recognize SBHCs as a viable strategy for providing health care to underserved children and youth; some candidates running for office, for example, incorporated school-based health care into their campaign platforms. Some associations noted that foundations now see school-based health care as aligned with their funding priorities, and media attention related to SBHC has grown not only in the SBHCPP-funded projects, but, increasingly, in states and communities across the country.

Stories about SBHCs are more common in the media, including press coverage of state or national Advocacy Days, youth testimony in support of funding for SBHCs, controversies surrounding the role that SBHCs play in reproductive health care, or the role SBHCs played as first responders for displaced children and families following the hurricane in New Orleans, for example. They also were mentioned by members of the policy community in their public remarks more often at the program's close than in earlier years. Two state SBHC associations described growth in attention paid to SBHCs this way:

> "The Lt. Governor is running for Governor and includes SBHCs in her campaign discussions…The (association) can now use the passage of federal authorization as evidence that (the state's) SBHCs are part of a national movement and that they are part of the solution for implementing the goals of health care reform."

> "As the old guard of superintendents retires and the new generation is moving from being teachers to principals…they have lived with the concept during their formative years… and leadership moving in is already enlightened."

In another state, an association staff member underscored the increasing expectations surrounding SBHCs as they have become more widely recognized and understood:

"SBHC's are now in the public health domain; this had not been the case six years ago. Public health invited us to the table to talk about how public health would be delivered."

As SBHCs gain recognition as mainstream providers of adolescent care, they also are finding expanded opportunities to join in the public debate about adolescent health care services more generally. As a representative of the National Assembly commented, for example, "SBHCs are legitimatized and part of health care. The SBHC model is respected. Authorization and CHIP are the outgrowth of validation by the federal government for SBHCs. People thought SBHCs were going to die-–we're now an accepted health care provider, part of the health care safety net."

Another noted that doors are opening in the primary care arena more generally for SBHCs: "we're now being called on to serve on committees for pediatric medical home advisory committee for state.*"* Another added that "managed health care organizations and private insurance companies appreciate SBHCs as being legitimate access points for their clients…Insurance companies do see a reduction in costs by having healthy kids with services being provided by SBHCs."

"SBHCs are the gold standard for adolescent health care; some SBHCS have been around for 18 years (in our state). Now some students are referring students; and teachers are referring students. After six years, people expect a new level of service. We now have kids in our schools that have always had SBHCs, and we have communities asking, "why don't we have them?..."

State SBHC association

The kinds of issues facing youth who attend schools that have SBHCs have become more visible as well. The advocacy movement for SBHCs in the SBHCPP helped to draw attention not only to issues facing the centers, but to issues facing the students who use them. Youths' work in the program cast the spotlight on a wide variety of needs, whether related to reproductive health care, the effects of poverty on hunger, issues related to school drop-out, the particular needs of certain populations of youth (such as recent immigrants or gay and lesbian youth), the effects of racism on health, and ongoing problems of bullying in schools, for example. After a suicide by a victim of bullying in one state, for example, the state SBHC association assembled a planning committee to organize a conference to identify resources and facilitate networking in schools, communities, and with families to prevent and manage school bullying. Nine weeks after the planning began, the conference was held, drawing an attendance of 350 people.

At a SBHC in Centralia, California, a variety of participants, including parents, the school district and the local county health care agency, met to discuss the high levels of demand among youth for mental health needs in this predominantly low-income and Latino community. Following their discussion, the local county health care agency agreed to explore opportunities for including SBHCs in its Prevention and Early Intervention Initiative, funded by the state's Mental Health Services Act

In another state, the Youth Advisory Committee at a high school in Ann Arbor, Michigan studied the ongoing problems of youth depression and the barriers they face in receiving treatment. In collaboration with the University of Michigan Depression Center, they hosted a program that included a skit, panel speakers and a visit to the SBHC. Continuing plans to build awareness of the magnitude of adolescent depression include working with middle school students on issues of bullying.

We talked about what we needed to change, and what we could do with limited funds and resources. We asked

ourselves what bugged us. We saw kids having kids, suicide and alcoholism within our community and our peers….Teen suicide had touched a lot of us very closely," reported two teen who themselves had attempted suicide. "Once you hit that point…it's a burden on yourself, you exclude yourself from things, when you go through the isolation. We didn't want others to go through it."

Two Native American teens engaged in the peer-to-peer suicide prevention program in New Mexico

According to a staff member of the state's SBHC association, "Youth telling their own stories, in person, was the most powerful strategy that Native youth employed. By choosing a very complex issue as their focus, youth underscored the seriousness of their role in ameliorating this problem. In addition, they were aware of the fact that tribal tradition mitigated against having a public discussion of suicide, which meant that there were social norms that youth needed to be prepared to address. Dealing with the multiple dimensions of such a complex issue had a transformative impact on the youth and Native communities…"

Others are turning to SBHC associations for information about SBHCs, and, increasingly, about the needs of at-risk populations of youth. Many of the SBHC associations reported that, since the inception of the SBHCPP, the associations have been contacted by media organizations with greater frequency, as well as by other organizations seeking data and information about SBHCs and health care issues facing youth. They are being asked to serve as "the voice of SBHCs" (and sometimes even the broader voice of health care for youth) on advisory panels and committees; they also report that their work is being quoted and cited in expanded venues.

The associations are being contacted by communities to advise on creating SBHCs and to assist SBHCs with challenging situations. As one organization explains, "…we are confidently known as the association that can easily and effectively gather youth to rally in support of school-based health services." Another indicated that "Whereas in the early days the (association) used to wait for the phone to ring, it is now receiving requests from the state level and being asked weekly by schools, school districts, and other organizations in (the state) and other states to discuss opening and funding SBHCs, and how to properly engage tribal communities." As one staff member of a SBHC association put it, "The fact that people 'outside' our field are continuing to explore ways to expand SBHCs is evidence that we are making an impact on the movement."

With increased visibility can come increased controversy, the SBHCPP discovered on several occasions. Perhaps most striking was the widespread national and local attention focused on the controversial decision by a middle school in Maine to provide access to contraceptives in a SBHC. This coverage not only put the SBHC movement in a defensive spotlight, but distracted ongoing work to advance major federal legislation to authorize a SBHC grant program, at least for the time being.

FEDERAL AND STATE POLICIES FOR SBHCS

Intended impact: State and national health and education policy support SBHCs as appropriate models of consumer-centered care

Strides in Federal Policy

In the early years of the SBHCPP, few might have predicted the degree of success over the next several years in advancing federal policies on behalf of SBHCs. In 2004, SBHCs attracted little attention in federal policy circles, either within Congress or among other advocacy groups that worked to advance the interests of children and families. Since that time, much has changed.

Federal Authorization for School-Based Health Care

As of March, 2010, advocates for school-based health centers experienced an unprecedented legislative victory: A SBHC grant program was established in the historic health reform legislation, the Patient Protection and Affordable Care Act

With the inauguration of President Obama and the momentum underway for federal health care reform, the National Assembly, state SBHC associations, and other SBHC allies focused their federal policy work on ensuring that health reform bills included language favorable to SBHCs. Creating a grant program for SBHCs provides a legal channel for allocating federal revenue in support of SBHCs nationwide and establishes the federal government's commitment to support SBHCs. This legislation represents a path breaking accomplishment that sets the stage for developing designated and ongoing federal appropriations for SBHCs.

In addition, PPCAC included a $200 million appropriation for SBHCs' construction, renovation, and equipment needs. Among other things, this funding helps sites buy licenses for electronic medical records which will help SBHCs comply with the technology mandates of health care reform. SBHCs are also eligible for the incentives for providers to become a "meaningful use provider" in the implementation of Health Reform in 2014, e.g., electronic medical records and information and insurance exchanges.

Securing authorizing legislation for SBHCs through Health Reform reflects the culmination of years of work around establishing a federal stand-alone legislation to authorize SBHCs. The *School-Based Health Clinic Establishment Act of 2007* (reintroduced in 2009), a bill to authorize a federal grants program for SBHCs, helped set the stage for the current legislation by mobilizing the field, engaging in Washington D.C.-based outreach, and building Congressional champions in collaborative and broad-based advocacy for a federal authorization program.

"We are thrilled that part of the [health reform] legislation calls for an expanded foot print of school-based health clinics," she said. "I can't think of a better way to deliver primary care and preventive care to not only students but their families than through school-based clinics. So the Secretary of Education and I have already talked about how we're going to leverage that money, how widely we can expand that foot print, and how quickly we can get it done."

Secretary of Health and Human Services, Kathleen Sebelius, speaking at the Coalition for Community Schools biannual convention, 2010. From the National Assembly's Capstone Report, 2006-2010

Reimbursement from Publicly Funded Programs

In a precedent setting decision, the Children's Health Insurance Program Reauthorization Act (CHIPRA) defines and recognizes SBHCs, establishing a legal basis for being reimbursed for services, for the first time.

Based on language provided by the National Assembly and its state partners in the SBHCPP, the Act stipulates that a state may "…provide child health assistance for covered items and services that are furnished through SBHCs," a provision that allows SBHCs to seek status as a provider eligible to receive reimbursement from their states' Children's Health Insurance Programs (CHIP).[26] The provision enables SBHCs to negotiate with managed care plans to secure reimbursement for the services they provide to CHIP enrollees.

Recognition provides SBHCs nationwide with a platform and legal foundation on which to negotiate payments and reimbursement from insurers and managed care organizations. As a staff member on the Committee that oversees the CHIP legislation noted, the fact that SBHCs are now codified into law provides a major foothold for SBHCs and opens the door for emerging opportunities for reimbursement and recognition from the federal government. This achievement enables SBHCs to broaden its revenue streams by more easily negotiating agreements for reimbursement with managed care organizations for the care they provide to the organization's CHIP enrollees. CHIPRA is expected to enable 6.5 million new children to become eligible to receive coverage by the CHIP and Medicaid.

In addition, as the National Assembly reports, "the language validating SBHCs as CHIP providers, and the existence of a statutory definition, should ease the way for the establishment of federal laws and regulations to ensure that SBHCs are reimbursed by government programs, and possibly, for the creation of a federal grant program for SBHCs."[27]

For the first time, CHIPRA provides a statutory basis for including tribal entities and governments as providers of SBHCs. CHIPRA's definition of a SBHC, as specified originally by the National Assembly and a state association in the Act's language, specifically includes SBHCs run by the Indian Health Service, the Bureau of Indian Affairs or by tribal governments. By recognizing these entities as providers of SBHC services, CHIPRA creates the legal precedent for SBHCs to be reimbursed for the services they provide to Native American children covered by these systems and programs. Complex jurisdictional issues have made this assurance difficult in the past.

The Healthy Schools Act of 2009, a bill to require reimbursement to SBHCs for services provided, was introduced into the House and Senate and referred to committee. The Healthy Schools Act seeks to secure a federal mandate to require Medicaid and CHIP to reimburse SBHCs for covered services. The Act generated significant interest and support among members of Congress and their staff, including, importantly, co-sponsorship by then-Senator Obama. While the Act did not make it to vote, work toward advancing this Act helped raise visibility for SBHCs and paved the way for including health reform in the landmark federal health reform.

As a result of a SBHC's initiative, the local provider of the Tricare program now reimburses SBHCs for covered health services received by families enrolled in the program. After visiting a SBHC in Watertown, New York, the SBHCPP Program Director alerted the National Assembly that SBHCs were providing services to military families enrolled in Tricare but were not being reimbursed for the services provided. After several appeals for change, the local Tricare program changed its policy to allow military families to request that they receive all of their family's health care from a local health care provider, such as a SBHC,

rather than from Tricare providers at the Fort Drum clinic.

When families new to Fort Drum register their children in school, they now find a memo attached to their enrollment form indicating that their children can receive all of their medical and mental health services at the SBHCs and that the providers will be reimbursed for these services. This has resulted in an increase in the number of children in military families who are receiving services at the SBHCs sponsored by the North Country Children's Clinic. This achievement was the result of the outreach efforts of local SBHC staff to both the larger Children's Clinic and the local community.

In part in response to this local initiative, the National Assembly sought to secure reimbursement through Tricare and the expansion of SBHCs on military bases.[28] The National Assembly also supported a campaign organized by the American Academy of Pediatrics to secure reimbursement from Tricare for SBHCs providing services to children nationwide enrolled in this program. The National Assembly continues to explore other opportunities for increasing reimbursement from Tricare to SBHCs.

The Centers for Medicare & Medicaid Services is considering a proposal to protect SBHCs operated by the Indian Health Service and Tribal 638 Programs from cuts in Medicaid. Triggered by a $320 million budget shortfall in the 2009 state Medicaid Program, one SBHC state association launched an aggressive proposal to contain costs in Medicaid through reducing rates, services and enrollment. Accordingly, the association intensified its campaign to protect SBHCs and state Medicaid beneficiaries from proposed cuts. It also focused on protecting the state's "Native American SBHCs" – those SBHCs that fall within the jurisdiction of the Indian Health Service and Tribal 638 Providers and that are reimbursed entirely by federal dollars. Although these SBHCs are not funded through state dollars, because these providers are subject to state decisions regarding eligibility, rates and services, they are directly affected by administrative changes in these areas.

Spearheaded by a state SBHC association and a new "champion" for SBHCs – the Executive Director of the County Off-Reservation Health Commission, a policy initiative was created to protect Native American Medicaid beneficiaries according to their unique legal and political status of tribes as provided by federal law, under the federal trust responsibility. This work has captured federal attention and is under consideration.

Integrating SBHCs into Education Policy

> *SBHCs sit at the intersection of health and education. The most successful strategies for success require NASBHC to be fluent in the languages of health care and education policy.*
>
> The National Assembly of School-Based Health Care

More members of the health and education communities are engaging in collaborative advocacy. That health and educational outcomes are interdependent is self-evident – poor health impedes learning, and poorly educated members of society are vulnerable to poor health.[29] Despite this fact – and the fact that SBHCs are housed in schools – the health and education communities have rarely worked together in policy advocacy. Policy work regarding the sustainability of SBHCs had been largely absent from the agendas of the education community, and SBHCs have historically remained disengaged from education policy, even when policy issues may have a bearing on SBHCs or children's health.

This divide began to change in the SBHCPP: the program made it a priority and explicit expectation that SBHC associations and their partners would "build bridges" between these two communities and work collaboratively in policy advocacy on behalf of developing sustainable school-based health care.

"Members of the Board of Directors were strong contributors. Through the expertise of Dr. Lauro Cavazos, former Secretary of Education, we found a way to use the language of education – especially student achievement – in our talking points."

The National Assembly of School-Based Health Care

At the program's start, the National Assembly convened a meeting of a national cross-section of experts in the fields of health and education to explore the role that SBHCs can play in influencing students' academic progress and readiness to learn. Utilizing the meeting proceedings, the National Assembly created a position statement and platform that helped formulate and launch the National Assembly's subsequent work in education policy.[30] A growing priority for the National Assembly and the state associations has been to identify opportunities for adding or modifying language in education policy to promote SBHCs.

A primary focus of the National Assembly's and some of the state associations' attention has been on utilizing the reauthorization of Elementary and Secondary Education Act (ESEA, the successor to the No Child Left Behind) as a vehicle for advancing the interests of SBHCs and for enhancing collaboration between school systems and SBHCs. The National Assembly reviewed the bills related to the reauthorization and identified areas to include SBHC language.

The National Assembly and its associations also joined forces with the Coalition for Community Schools (CCS), whose advocacy efforts led to the introduction of the DIPLOMA Act in the House and Senate ("Developing Innovative Partnerships and Learning Opportunities that Motivate Achievement.") This legislation, which the National Assembly expects will be integrated into larger education reform efforts (such as reflected in the President's "Race to the Top" initiative), served as another major vehicle for integrating language that favors school-based health care in education policy.

"The National Assembly's biggest lessons for education policy were learned in health care reform. First, the opportunity to gain support for a smaller bill and then to see it subsumed into a larger bill was a success for the movement, and one we seek to replicate. Second, we saw the importance of a large base of support inside and outside of Congress. And third, we've learned to find a succinct message and repeat it."

The National Assembly of School-Based Health Care

Other Areas of Federal Policy

The National Assembly, state associations, and their partners also made strides in other areas of federal policy, described at length in the National Assembly's annual reports and on its webpage. Examples include the following:

Increased attention to the role SBHCs can play in disaster planning and preparedness. The National Assembly used a Congressional briefing and visits with members of Congress to gain support for the roles SBHCs play as first responders to emergencies and crises. The Assembly and state SBHCs underscored the role SBHCs played in providing grief counseling and helping evacuees of Hurricane Katrina, for example, as well as managing the "silent crises" of anxiety and depression among children and youth whose parents are away at war. As a result, language was added to the Citizen and Community Preparedness Act of 2008 to ensure

that that at least one of the primary and secondary schools selected for a pilot project to be developed had a SBHC.

The National Assembly helped to secure the inclusion of a federal mandate for a Government Accountability Office (GAO) study on SBHCs as part of the Health Care Safety Net Act of 2008. The Act includes a provision that called for a study by the GAO of the economic costs and benefits of SBHCs, including impact of access in rural and other underserved areas. The study was completed in October 2010, and highlighted, among other things, the barriers SBHCs face in billing Medicaid and the role SBHCs play in broadening children's access to health care. In the course of the GAO's work, the National Assembly and some of the state SBHC associations developed ongoing working relationships with GAO. As a result, the GAO frequently turned to the associations for data, information, and analysis.

"Add to (a political climate… of entrenched partisan fighting), a crippled economy, huge deficit spending, and an impending midterm election and you get a perfect storm for status quo politics. In light of these uncontrollable circumstances, we were successful in reaching and speaking to Washington powerbrokers, on both sides of the aisle, and their aides. We were also able to give a face and voice to the millions of children, nationwide, who depend upon their school-based health center to keep them healthy, motivated, and ready to learn. We planted a seed that simply needs further cultivation, and sunnier days, to reach full maturity.

State SBHC Association

Strides in State-Level Policy

In the course of the SBHCPP, funds for SBHCs increased in every participating state, despite the states' dire economic conditions.

Increasing or Maintaining in State Funding for SBHCs

Among SBHCPP states that have a state SBHC program, five experienced a growth in revenue from the state budgets (i.e., non-mandated, discretionary spending), and one maintained state funding, despite the economic downturn. The state SBHC associations report the following changes from 2004-2010, unless otherwise noted.

- An increase of $3.5 million and $750,000 in funds for telehealth equipment and services for SBHCS. SBHCs received a base funding increase in the SBHC grant program of $2,000,000 in one year alone.
- Growth by $4.38 million between 2005 and 2009 legislative sessions.
- An increase of nearly $3 million.
- An increase in state funding for SBHCs from $2.5 million to $7.0 million.
- A $1.5 million increase for SBHCs and school nurses.
- Stabilized funding at $3.5 million, despite the fact that over the last 5 years, the state legislature has had to make more than $1 billion dollars in cuts each year.

"School-based health centers went from the easiest thing to cut (in this state) to something that everyone wants to support."

Legislative director for the State Nurses Association

Though unfunded, a state without a SBHC state office now has authorizing legislation to establish a grants program for SBHCs. Prior to the SBHCPP, the state of California did not have the legislative authority to establish a grant program for SBHCs. While funding has yet to be appropriated to support the authorizing legislation, a door has been opened to building a

grant program that provides state funding to establish, expand, and sustain the state's network of SBHCs.

Most states provided increased support for mental health care. Mental health services are among the fastest growing components of school-based health care, even though SBHCs are reimbursed for only a portion of the costs they incur in providing this care. In the course of their work in the SBHCPP, several state SBHC associations gave high priority to mobilizing support for policies that enable SBHCs to finance sustainable mental health services for vulnerable populations of children and youth. According to the National Assembly's SBHC association survey, half (50%) of all SBHCPP-funded states associations reported that they accomplished their policy goals related to securing funding or reimbursement for mental health at the state level in 2008, in contrast with 10% of non-funded states. Page A-49 provides additional details.

"Policymakers, program directors, educators, and mental health professionals increasingly view school-connected mental health as essential to schools and well-functioning mental health systems of care."

School Mental Health Services for the 21st Century: Lessons from the District of Columbia School of Mental Health Programs, Olga Price and Julia Graham Lear, Center for Health and Health Care in Schools, December 2008

Examples of Outcomes, Impact on Mental Health Policy

California: A four-year, $24 million Student Mental Health Initiative was created to pilot comprehensive mental health programs in K-12 schools.

Massachusetts, with a partner from another states secured $300,000 for mental health and substance abuse services to be provided at SBHCs, as well as a $50,000 earmark from the state's Mental Health & Substance Abuse Services to evaluate mental health and substance abuse services in five SBHCs. This is the first time that SBHCs were named solely within the state budget.

Michigan and New York: secured approval for reimbursement in each of their states from Medicaid for mental health services provided by licensed clinical social workers in SBHCs. Michigan also worked with managed care behavioral health organizations to create a special contract to allow mental health professionals with Master's degrees to provide services without an on-site psychiatrist, marking the first time the centers could bill for mental health services.

In addition, a new payment methodology for Medicaid services in Michigan now includes reimbursement for mental health services provided by social workers, as well as for other services that may benefit SBHCs, including funding for certified health educators working with diabetes and asthma patients. Michigan reported that SBHCs that historically received no payment for mental health services are now paid between $41-$70 per visit, estimated to result in annual revenue of $250,000 for the state's SBHCs overall.

New Mexico: Members of the youth advisory group led the work to secure a recurring line item of $50,000 to create a student-based, peer-to-peer suicide prevention program for Native American youth. This initiative was undertaken to reduce the significant risk of suicide that disproportionately affects Native American communities. The first suicide prevention workshop, held in May 2008, drew 100 students.

New York: the military insurer Tricare agreed to reimburse SBHCs for mental health services; the association and partners successfully advocated for recognition and reimbursement for SBHCs from Tricare, a federal health care program for military families.

Oregon: received $480,000 in state funds to support mental health services in existing SBHCs.

Medicaid and the Children's Health Insurance Program (CHIP)

Because SBHCs are located in communities in which the majority of children and youth are eligible for or enrolled in Medicaid/CHIP, these

policies have the potential for serving as significant sources of revenue for SBHCs.[31] However, because of a set of complex barriers, despite the important role Medicaid and CHIP reimbursement could play in supporting SBHCs, it has been difficult for SBHCs to obtain payment for the services they provide students enrolled in these programs. Two-thirds of SBHCs reported that third-party reimbursement represented less than a quarter of their total operating revenue in 2004-05, for example.[32]

Several of the state SBHC associations' policy targets focused on improving reimbursement policies from Medicaid and the Children's Health Insurance Program and/or blocking threats to unfavorable rates of reimbursement, benefits, or eligibility requirements. Although very few of the SBHC associations report that they accomplished their goal to "establish, increase, or maintain funding through Medicaid or other insurance mechanisms on the state level" in 2007-08 (roughly 10% indicated success, regardless of whether they participated in the SBHCPP or not, greater proportions of SBHCPP-funded than non-funded states reported achieving positive outcomes in earlier years (63 % vs. 30% in 2005, respectively, and 38% vs. 10% in 2006). Examples of these outcomes follow.

Some administrative rules have been revised to enable SBHCs to be reimbursed for services provided to youth enrolled in Medicaid. Because several administrative challenges make it difficult for SBHCs to get paid for the services they provide, a subset of the SBHC associations sought to reduce these barriers through administrative policy change. One state SBHC association and its partners helped to create a permanent Medicaid carve-out to enable SBHCs to be reimbursed for medical services provided to children enrolled in a Medicaid Managed Care Plan. Another state successfully eased the reenrollment requirements for eligibility into the program.

In a major accomplishment in one state, SBHC advocates helped to secure a change in state appropriations boiler plate language to require school-based and school-linked centers to bill for services rendered. To support SBHCs in billing third party payers, the association created the first centralized internet billing service and network for SBHCs. Without this network, the requirements of health services billing were often out of reach for most small SBHCs, which do not typically have resources or expertise to negotiate contracts with health plans. The billing service enabled SBHCs to respond to these challenges and to bill for the services they provide. The appropriations language created the legal expectation that they will. Findings from analyses of the billing service database that showed that SBHCs were not being adequately reimbursed for their services, information that then was used in making the case for increased reimbursement.

In the same state, all elementary SBHCs are required to have mental health services and almost all middle and high school SBHCs have a mental health provider on site. The state association worked with the state Medicaid office to overcome historical roadblocks SBHCs faced in billing Medicaid for services provided by mental health providers. This work proved successful and, over this last year, all SBHCs across the state began billing for their services.

The National Assembly and some states worked to block proposed regulations by the federal Centers for Medicare & Medicaid Services that would have limited Medicaid reimbursement for particular health care services. One state's work to reform its health system resulted in a new payment methodology by Medicaid – the Ambulatory Patient Group system, designed to encourage

prevention and primary care to reduce emergency room use and hospitalization. Through ensuring that SBHCs are recognized as providers by Medicaid, the state SBHC association helped secure new streams of reimbursement to SBHCs for the services they provide to Medicaid-enrolled students. The association has received initial reports from SBHCs that, because they are now reimbursed for a full range of primary care services as opposed to a flat reimbursement rate, their revenue has increased as a result.

Through leveraging state dollars to obtain a federal match to drawdown federal funds, one state's revenue for SBHCs more than tripled. As will be discussed further in the next section, in 2004, funding for SBHCs was $3.7 million. Despite reductions in state funding for SBHCs, total funding rose to $14.2 million by 2010 because of $9.3 million added through the Medicaid match program. Under the leadership of the State Medicaid Director and Executive Director of the state SBHC association, a working group successfully secured a federal Medicaid match waiver on the state general funds appropriated in the state K-12 budget, most of which were directed to SBHCs to support outreach and health education services provided to Medicaid-eligible or Medicaid-enrolled students.

"State appropriation funding provides a significant return on investment for the funding provided. The state draws down an additional $3 federal contribution for every state dollar invested; this is a continuous match, unrelated to any temporary stimulus enhancement. By using the existing school system infrastructure, costs are at the margins; it's an efficient and effective use of limited funding."

State SBHC Association

Some improvement in private insurance and managed care reimbursement and support. Most SBHC users who have health insurance are covered by public payers. However, some children and youth are enrolled in private insurance programs, thus representing an additional revenue stream for SBHCs. Half of all respondents to the National Assembly Census reported that they bill private third party insurers,[33] even though the proportion of children covered by private health insurance has declined over the last few years,[34] in part reflecting the increasing rates of unemployment. SBHCPP-associations reported in substantially greater proportions than non-funded associations that "establishing, increasing, or maintaining funding through private insurance mechanisms" has been on their state policy agendas (see page A-49). In 2008, for example, 63% of SBHCPP-states reported that private insurance was on their state policy agendas for 2008-09 (up from 13% in 2007) in contrast with only 10% of non-funded states for both years. Examples of the results of the SBHC associations' work to negotiate more favorable policy agreements with private insurers include the following.

- Some SBHC associations negotiated arrangements with private managed care and private insurers to secure reimbursement for SBHCs for services. One association, for example, secured an agreement with the state's private health plans to reimburse for services provided by SBHCs, to certify center providers, and to continue to waive the requirement for prior authorization by primary care physicians.

- In another state, negotiations between the state SBHC association and two major private insurance plans made it easier for SBHCs to work with managed care to obtain reimbursement for their services. Through its managed care division, the State Medicaid office agreed to include language in their bid package and contracts requiring state managed care plans to reimburse SBHCs for services provided to Medicaid patients. Another state SBHC association successfully secured reimbursement from some of the

states' private insurers for mental health services provided by SBHCs.

Other areas of progress. State SBHC associations and their partners engaged in policy work to advance various other priorities on their policy agendas as well. Examples follow.

- In one state, youth members of the SBHC advisory board made inroads in state policy discussions surrounding **reproductive health care** by challenging restrictive state level policies that prohibit contraceptives from being distributed on school property. The youth researched, developed, presented, and defended a proposal to state legislators that would allow school boards to decide whether a high school's SBHC can prescribe and dispense contraceptives. Another state SBHC association and its partners helped to **defeat a Joint Order that would have required a bill to obtain parental consent** for all adolescent prescription medication.

- Another state SBHC association brought attention to emerging work to reframe **school dropout as a public health issue** and the role that SBHCs can play in this campaign through reducing dropout by keeping children healthy and in school. Drawing on the work of Nicholas Freudenberg,[3] the association convened a diverse base of representatives from the education and health communities, among others, to participate in a forum to advance discussions surrounding this work. According to the forum's planners, "educators got the message that SBHCs don't cost the school district anything and that there are services that help keep students in school. Health folks got the message that we should all work better to assist schools in meeting their mission."

- **An independent commission appointed by the state legislature to increase access to care for low-income, under- and uninsured state residents, appropriated $2 million in 2008** to support two new start-up SBHCs; expand mental health services; support for nurse practitioners; and improve access to dental services. The Commission is comprised of non-profit insurers, non-profit health maintenance organizations, hospitals, physicians, and others whose are knowledgeable about state health care issues.

- State SBHC associations were also involved to varying degrees in **states' health care reform work,** particularly in the effort to include SBHCs in the discussions and legislative language. In one state, members of the association's board of directors testified on behalf of SBHCs at four hearings on health system reform and universal coverage. The testimony emphasized the uniqueness of the SBHC model, especially for treating adolescents, the cost-savings of the SBHCs, and state policy changes needed to support SBHCs. The association reported that the testimony was met with a favorable response and helped to increase the visibility of SBHCs among. A representative from another state noted that SBHCs are receiving significant and increased attention in discussions surrounding health care reform in that state as well.

[3] See, for example, Freudenberg, Nicholas, *"Re-framing school dropout as a public health problem*." PowerPoint presentation for the Massachusetts Coalition of School-Based Health Centers, Boston, MA, May 8, 2008. http://www.mcsbhc.org/attachment/Reframingschooldropout.ppt

FUNDING FOR SCHOOL-BASED HEALTH CENTERS

Intended impact: Strengthened SBHCs with stable and diverse funding streams that more appropriately support this model of health care delivery

When the SBHCPP was initiated, SBHCs operated from a mix of unstable revenue sources. Only one in every three SBHCs (36%) reported having received revenue from the federal government, and federal grant dollars accounted for an average of only 8% of all of SBHCs revenue.[35] Revenues from state grant programs accounted for just 29% of total funds, with the balance coming from local government (20%); sponsoring agencies (17%), private foundations (14%), and patient revenue (12%).[36] Participants in the SBHCPP have made inroads since then in securing policies that assure more stable and diverse base of funding for SBHCs.

The Patient Protection and Affordable Care Act (PPACA) sets the stage for providing a new and permanent federal revenue stream. The fact that SBHCs are now authorized at the federal level establishes the legal authority for funding SBHCs on a permanent basis. The authorization legislation opens the door for a federal grants program for sustainable SBHCs. A campaign to secure appropriations to support the program is underway.

PPACA appropriated $200 million in funds for SBHCs' capital needs (originally intended for operating support, but revised in committee negotiations). These appropriations provided a source of new federal revenue for capital improvements, construction and equipment needs.[37]

The reauthorization of the Children's Health Insurance Program (CHIP) strengthened the foundation for stabilizing funding through recognizing SBHCs as potential providers of health care. This legislation provides the opportunity for SBHCs to secure agreements with states and managed care providers to secure funding on a permanent basis. The fact that Indian health entities are identified in the legislation also increases the potential diversity of funding for SBHCs within the Indian Health Service and other entities that that serve Native American youth.

For off-reservation and urban Indian Health Service programs, for every dollar the state contributes, the federal government matches it with nearly four more dollars based on the current American Recovery and Reinvestment Act of 2009 enhanced Medicaid match.

Tricare provides a new source of reimbursement. As a result of a SBHC's initiative, the local provider of the Tricare program now reimburses the SBHC for covered health services received by families enrolled in the program. In part in response to this local initiative, the National Assembly made securing reimbursement through Tricare and the expansion of SBHCs on military bases a federal policy goal. Another state secured agreements by private insurers to reimburse SBHCs for the services provided to eligible enrollees.

State funding for SBHCs is more stable and diversified. Through a variety of ways, several states have broadened their base of revenue streams. Examples include the following:

- Two states supplemented their general funds with revenue from a tax on hospitals and insurers – a separate provider tax through the state's CHIP plan that provides additional protection as state budgets remain vulnerable

to reduction.

- One state allocated additional funds to state certified SBHCs to support the implementation of new prevention requirements.
- Another state extended the length of a state grant period from three to five years, protecting these state funds from the threats of budget reduction for a longer period of time.
- Two states adopted new payment systems to achieve greater equity in funding across SBHCs in the states. One state estimated, for example, that the new funding formula yielded an increase in funds in nine of 22 historically under-funded counties as they transitioned from the current to the new formula.
- One state added, via a decision by the Governor, $2.5 million to the base grant for SBHC funds and held SBHCs harmless for severe budget cuts, beyond the standard reduction to primary care services across the state. In addition, the state shifted $3.5 million of state grant funds from Temporary Assistance for Needy Families (TANF) to the Health Care Reform Act (HCRA). This shift allowed the funds to pay for a broader scope of primary care services that had not been allowed under TANF because of federal restrictions.

Improved billing, reimbursement, and payment systems broaden support for SBHCs. As a result of increased efficiencies in billing and follow-up on denials, a community partner in one state increased reimbursement by 65% after the first year of adopting these new procedures, 35% in the second year, and 17% in year three. As a result of another state association's centralized billing service, the state association now provides service to more than 20 centers and generates $200,000 each year in annual revenues.

Funding streams have expanded as a result of increasing enrollment of children and youth in the Children's Health Insurance Program and Medicaid. Increasing the numbers of children enrolled in these programs has created new revenue from services provided to these students.

Innovative approaches have been spawned for achieving increased stability in revenue for SBHCs, including, as perhaps the foremost example, Michigan's Medicaid match program, which draws $3 in federal dollars for every state dollar spent on Medicaid outreach and health education services provided by SBHC. Through maximizing these matching dollars, funding for SBHCs has been protected six years after the match was established. The Chair of the Senate Appropriations committee noted that if federal funding had not been secured, state funding for SBHCs would have been cut or eliminated. The state also received federal enhancement dollars beyond the match.

"Our state-funded school-based health centers adhere to state quality measures and pediatric standards of care, as well as those required by their partnering health systems and insurance carriers. The State requires annual performance/outcome reports and site visits as an integral component to order to maintain state funding. The State also provides experienced consultants who are assigned to each of these centers to provide continual guidance and intervention for quality improvement."

State SBHC Association, describing the standards that SBHCs are expected to meet in delivering health care

SBHC associations worked to support high quality care in SBHCs. One of the National Assembly's and the state SBHC associations' chief functions throughout their histories has been to provide information and tools to support and advance the quality of care in SBHCs. Through their annual conferences, training workshops, technical assistance, publications, webpage links, and other sources, the associations have provided the field with a broad-base of information and quality assurance tools.

Some of the guidelines and/or tools were developed before the SBHCPP (e.g., the Continuous Quality Improvement Tool for SBHCs via the Robert Wood Johnson Foundation's *Making the Grade* program). Others were developed in the course of it through support from other funders, including the Centers for Disease Control, the Maternal and Child Health Bureau, and the Bureau of Primary Health Care (e.g., the National Assembly's Quality Assessment and Improvement in School Mental Health). The SBHCPP has provided support for the continuing development and dissemination of these tools and new state-of-the-science information aimed at advancing the quality care in the nation's SBHCs. The SBHCPP emphasized in particular the importance of advancing consumer-centered care in SBHCs – care that equips and empowers consumers, including youth, to play an active role in making personal health decisions, and that is responsive to the comprehensive needs of consumers in the context of their family and culture.

The state SBHC associations used a variety of approaches to support high standards of quality in SBHCs. One state association established board committees and/or staff functions responsible for monitoring quality and assessment of SBHC services. Another state association used the state's quality review process as a means of integrating the voice of the community in the state standards. Virtually all asociations expanded their training and technical assistance services to SBHCs in the course of the SBHCPP. Some built their capacities to gather, track and analyze data on quality and other indicators of SBHCs' work.

Several associations also developed materials, guides, and links for SBHCs to use in strengthening their own work. In concert with the National Center of Youth Law, for example, one state SBHC association developed a primer on sharing school health information in light of the "complex interactions of (privacy regulations of) HIPAA and FERPA in school health programs, including SBHCs, school-based mental health programs, and school nursing services." Among other things, the toolkit includes sample consent and release of information forms and related instructions for school health programs subject to either law.

The same association developed toolkits to enhance quality in other areas, including guidelines for obesity prevention programs and for increasing collaboration between SBHCs and local public health departments and community clinics. Because the state does not have a funded state office for

SBHC, the association also researched, produced, and disseminated standards for the state's SBHCs. Among other things, the guidelines outlined minimum and recommended medical, behavioral health and oral health services.

Measures to assure quality of care. Many of the state SBHC associations worked closely with the state departments of health and occasionally with the U.S. Departments of Health and Human Services and/or Education to support their agendas for quality assurance and improvement, as the following examples illustrate.

Improving Standards of Practice: Examples from One State SBHC Association's Work

In concert with the U.S. Department of Education, three pilot school districts, and the school's health centers, one state SBHC association helped to develop a statewide and a district-wide mental health referral policy. This effort resulted in approval by the State Board of Education of the first statewide mental health policy to be implemented by local school districts. The state's school districts now have three different model policies and procedures to use when providing and coordinating mental health services.

In concert with the state health department, the same association helped to:

- Institutionalize a standardized depression screening protocol within the SBHCs;
- Implement an oral health exam protocol within the SBHCs and integrate oral health exam questions apart of health assessments and physical exams;
- Establish program requirement to conduct Guidelines for Adolescent Prevention (GAP) Services and Assessments and/or use of another risk assessment tool and conducted annual GAP trainings for the field;
- Establish an HIV training specific to SBHCs;
- Establish mandatory STI and HIV testing requirements for SBHCs; and
- Support a statewide Chlamydia study examining identification and treatment standards.
- Develop a Body Mass Index screening protocol to guide nutritional counseling (through another grant) and, with the funder, to identify the elements of a medical home model.
- Establish a credentialing process for SBHC providers working with health plans to streamline the process. Since credentialing is a mandatory requirement to bill for all services by all health care plans, the association is now using the national credentialing requirements and clearinghouse.

Examples of the kinds of work others engaged in to advance the quality of SBHC services include the following:

- One association implemented performance reporting and clinical improvement systems based on state SBHC standards for care.
- Some associations offered continuing education units to physicians, nurses, social workers and health educators.
- In another state, the evaluator participated in a collaborative effort to establish statewide benchmarks for continuous quality improvement, developing more meaningful data collection in quarterly reports, and outcome measures to test the effectiveness of SBHC clinical practices.

- The field at-large is preparing to incorporate PPACA's requirements for electronic medical records into their practices, which will have an impact both on the quality and efficiencies of care through improved and more accessible reporting.

"…(The association's) implementation of performance reporting, clinical quality improvement systems and education based on state SBHC standards has helped legitimize SBHCs and support sustainability…"

State SBHC association

Measures to encourage efficiency in the organization and delivery of care have intensified. The SBHC associations' work to strengthen efficiency in the operations and delivery of care in SBHCs assumed a variety of forms. Several associations developed guidelines to improve billing and reimbursement. A few collaborated with others in the field to identify strategies for improving efficient operations for increasing productivity for sustainability. Some developed feedback systems to SBHCs and systems for monitoring performance. Many modified their billing practices in response to findings from studies conducted by project-level evaluators. Of particular value, at least one of these studies found, was to assign billing functions to a designated staff specialist.

"SBHCs were lucky if they received 10% of what they billed for (at the start of the program). With the addition of a billing specialist whose sole focus was on billing for SBHCs and following up on denied claims, steadily over the years, (the association) was able to increase the rate of reimbursement from approximately 10% to 40% over the last six years."

State SBHC Association

Several associations utilized new technology to increase the efficiency of their operations. Some SBHCs made staffing changes to increase clinical efficiencies. For example, one community partner redesigned its staffing model to allow for a nurse practitioner from a federally qualified health center to rotate through the SBHC, a change that saved $150,000 and makes medical services for families of the students enrolled at the center available year round.

Another state association explored opportunities for integrating mental health with other primary care services. The association analyzed the potential efficiencies and cost savings of integration and provided a replicable model for SBHCs statewide and made a case for future funding. Some state associations helped to disseminate online guides to improve practice management, such as the *Practice Management Improvement*, a training package that provides "comprehensive SBHC practice management quality improvement process in five areas: facilities, business operations, human resources, care management, and practice compliance."

ACCESS TO QUALITY HEALTH CARE

Intended Impact: Improved and sustained access to quality services for children and adolescents and in some cases, the broader community

"SBHCs improve children's access to health care services by reducing financial and other barriers to care, especially for children who are poor or uninsured."

General Accounting Office, 2010[38]

Several indicators suggest that the SBHCPP helped to improve access to quality health care for children and adolescents.

The number of SBHCs in SBHCPP states has grown at a significantly greater rate than in non-participating states. Since 2004, the increase in funding in the course of the SBHCPP from state budgets, supplemented by local and public/private sources, has enabled 201 new SBHCs to be opened nationwide as of 2008 and others that are in the planning stages. Of this total, the SBHCPP-states accounted for 111, or 55% of the growth in SBHCs even though the participating states represented 42% of all SBHCs in 2007-08. The table that follows shows the expansion of SBHCs during this time period. As is clear, the percent change in the number of SBHCs in states that participated in the SBHCPP (16.0%) was nearly twice that of non-participating states (8.9%).

These numbers, of course, provide only an approximate indication of changes over time: they reflect 2008 data and do not reflect changes since then; they include environmental and other factors not connected with the SBHCPP; and they reveal only aggregate changes, covering instances in which states lost SBHCs in the course of the program. For example, 12 non-SBHCPP states and the District of Columbia experienced a net decline of 57 SBHCs in their states during the three-year period, compared with the one SBHCPP-state that experienced a net loss of one SBHC. Regardless of the caveats or limitations of interpretation, however, the trends show favorable growth of SBHCs and encouraging changes for the SBHCPP.

SBHCPP-Funded vs. Non-Funded States	Number of SBHCs (School Year)		Percent change
	2004-05	2007-08	2004-05 – 2007-08
Funded (n=9)	695	806	16.0%
Non-funded*	1013	1103	8.9%
TOTAL	1708	1909	11.8

* Includes 36 states, the District of Columbia, Puerto Rico, and the Virgin Islands.

"The best and most exciting outcome of this project is the number of children and youth served through (the state's) SBHCs and how that number grew as the direct result of the SBHCPP and efforts of (the state SBHC association). The state maintains statistics on the number of users and demographics of children and adolescents served. While (the association) has just begun maintaining numbers of users served through non-state-funded school- based health centers. In 2004, approximately 75,000 children and youth were served through SBHCs and in 2010 more than 200,000 users were seen through the centers. In addition, approximately a third of the centers also serve other family members such as parents and siblings."

Executive Director of a SBHCPP association

The scope of services available at the SBHCs has grown. In addition to the increased number of SBHCs available, the scope of services available to youth and the larger community in existing SBHCs has increased as well. Increasing numbers of SBHCs are now providing access to behavioral health care, care aimed at health promotion and risk/disease prevention, reproductive health care, oral health care, case management and coordination, and other community-wide services such as screening for tuberculosis, and H1N1 vaccinations. This broadened scope of services among SBHCs in the SBHCPP is consistent with the expansion of service capabilities of SBHCs

throughout the country. In a state that provides both full-service SBHCs and "limited clinical care" centers (centers that provide individual health screening, case finding and referral, and health education), a new model of care is evolving to broaden access to care even in these "limited" care providers: school wellness programs. As a result of discussions between that state's SBHC association and state officials, the association explains that the model "will assist schools, parents, and other health professionals in the assessment, identification, planning, implementation and evaluation of health needs of the school community to direct services to create a healthy school environment." The required components include "nursing services; mental health counseling/services; individual and group health education using evidence-based curricula and interventions; and school staff training and professional development relevant to these areas."

SBHCs also are increasingly serving as a "first responder" to enable communities to have access to care in cases of community-wide crisis and trauma. This was vividly evident in New Orleans following Hurricane Katrina.[39] Following the hurricane, SBHCs, whose infrastructure was often decimated, often operated out of small, make-shift spaces, dispensing medication for children and families with immediate health care needs. SBHCs provided mental health care to families coping with issues of loss and grief, delivered eye and dental exams to those who had lost access to these vital services, and served as referral centers for linking children and families with other critically needed community resources.

Communities and parents also turned to the schools and SBHCs as safe havens and places for their children to stay while they worked to restore their and their families' homes and lives given the devastation that surrounded.

Improved access to healthier school environments. As described earlier, youth's advocacy contributed to healthier, safer, more consumer-centered policies, including improved nutritional choices in school meals and in vending machines, and more extensive opportunities for physical activities, including extended time during recess and safer playground.

Students made inroads in improving accessibility and quality through establishing more acceptable, culturally relevant care. Youth in some communities met with SBHC staff and school administrators to discuss the kinds of practices that influenced their readiness to use SBHCs. Accordingly, schools made some corrections:

- Information materials about the center and its services were available in Spanish and English;
- One community partner utilized a Hispanic outreach worker at the beginning of the summer to reach migrant families;
- Students participated in developing culturally responsive informational materials about the centers;
- They took measures to protect the confidentiality and privacy of students who visited the SBHC;
- Students helped produce a peer-friendly television and radio public service announcement in one community to reach out to and inform other students about the center's services.

SBHC associations have increased access to training and technical assistance in an array of areas. In part through the associations' successes in broadening their own base of resources, they in turn have expanded the scope of services they offer to their members. As SBHCs are better prepared to strengthen the delivery of their services, youth's access to quality and efficient care improves as a result.

Part II: Lessons Learned and Conclusions

Key lessons learned from the SBHCPP, as seen from the 30,000 foot view, are provided below.[4]

The Seeds of Change

Philanthropy can serve as a potent catalyst for promoting consumer-centered advocacy and policy change. The policy outcomes described in this report – including federal recognition of SBHCs, the authorization of a federal grants program for SBHCs, and increased state and local support for SBHCs – show the range of what is possible when philanthropy plants and nurtures the seeds for policy change. The program showed the transformation of membership-driven associations into organizations with a mission for policy advocacy, often achieving major policy results in very short order. The SBHCPP showed the transformation of communities, including youth, from being mainly recipients of SBHC services into advocates and leaders for consumer-centered care. The program showed the impact philanthropy can have on the policy process and outcomes when it is willing to take calculated risks, risks that others, including government, often are reluctant to take. These risks include:

- Providing funding and support to build nascent and largely untested organizations as a primary structure for mobilizing systemic change.
- Investing in a model of care that adopts policies that can be controversial.
- Having confidence that historically marginalized communities will step forward and serve as leaders for social change.

[4] See also the companion report, "The School-Based Health Care Policy Program, Program Evaluation, 2004-2010," for additional reflections on the program and lessons learned from the viewpoint of grantees.

Achieving programmatic goals is accelerated through vision-driven leadership. It goes without saying that directing a major policy initiative requires greater oversight and guidance than directing a traditional grant-based program. What the SBHCPP underscored, however, was the extent of the role that philanthropic leadership plays in determining the depth, pace, and direction of the work as well. Among other things, this role included:

- Maintaining consistency in the commitment to the program's vision and core strategies, and expecting the same from grantees;
- Allowing flexibility in the interpretation of the core strategies for local conditions, but expecting that the guiding principles of the strategies would be preserved and implemented throughout;
- Maintaining high expectations for well-developed and well-implemented plans for policy advocacy and, when these expectations were not met, intervening to support their correction;
- Identifying advocacy opportunities for grantees through demystifying the policy process and making the potential for policy change more visible; and
- Visiting grantees in their communities to observe opportunities and barriers for effective advocacy, and to adjust training and technical assistance accordingly.

Achieving transformative change depends upon strength of leadership from grantees. That leadership matters in influencing an organization's success in achieving its goals is self-evident. What the SBHCPP made clear, however, was the depth of the impact that leadership can have on the speed of capacity building and success

for policy advocacy. Four qualities tended to separate those leaders who had a particularly far-reaching impact on policy outcomes in the SBHCPP. These leaders were especially:

- Vision-driven: they based major decisions, whether related to policy priorities, advocacy activities, or organizational goals, on the basis of the vision and mission of the work.

- Policy-focused: they were skilled policy analysts and strategists.

- Relationship-oriented: they regularly looked beyond the organization's borders to build partnerships and networks to advance policy change.

- Adaptable and Persistent: They were determined to pursue and achieve their policy goals, finding creative solutions to roadblocks encountered along the way.

Philanthropy can leverage relationships and build partnerships, even among policy officials, organizations, communities, and individuals with little history of collaboration. Forging partnerships between the health and education communities was of particularly high priority to the SBHCPP given the central role both play to the future of school-based health care. By setting collaborative work as a requirement of the program and engaging an expert in educational policy to help grantees "build bridges," state school-based health care associations and health professionals made progress in building relationships with district superintendents, school boards, school principals, teachers, staff, and the professional associations that represent them. As these relationships continued to develop, members of the education community became increasingly inclined to invite the health community to be active participants at their tables in collaborative discussions as well.

Local communities and youth serve as powerful forces for policy and systems change when given the opportunity and support for doing so. One of the major triumphs of the SBHCPP, facilitated by the SBHC associations, was the leadership by young people in policy advocacy. While seasoned policy consultants and advocates also played a crucial role in the SBHCPP, the Foundation's investment in community-driven advocacy was a key element in increasing the visibility of SBHCs and moving SBHCs into the broader political limelight.

The SBHCPP community partners, who often were staff members from the SBHCs or the organizations that sponsored them, played a pivotal role in connecting the national and state associations to youth, parents, local community groups, local policy officials. They also played a major role in equipping local community advisory boards and youth advisory boards to become influential and self-directing forces in policy advocacy.

"Project Grant Rule," established by the United States Internal Revenue Service (IRS), enables philanthropy to advance effective and expansive policy advocacy campaigns. The SBHCPP is a complex initiative designed to achieve multi-level policy and systems change. As such, it is subject to the rules governing policy advocacy as determined by the Internal Revenue Service. The rules that prohibit a private foundation from using its resources to support lobbying, while absolute, include special circumstances that allow foundations to make general support grants to nonprofit organizations that may include lobbying in their work if those grants are not earmarked in whole or in part for lobbying. Called "Project Grant Rule," this rule provides important opportunities for philanthropy to support an array of organizations whose skills in

policy advocacy are essential for social change movements.

Implementation Lessons

Establishing a "Resource Team" of consultants is important not only in supporting grantees' work, but in supporting funders' work as well. The Program Director of the SBHCPP regularly engaged members of the Resource Team in discussions about the productivity of the work in the SBHCPP, ongoing needs for training and technical assistance, challenges encountered along the way, and strategies for managing them. The team, comprised of consultants from diverse professional backgrounds, allowed for multiple perspectives and issues to be considered in decisions of major importance. Although the decisions about the SBHCPP were made by the Director only, they were informed by often extensive analysis of the members of the consultant team.

Determining acceptable levels of variability in productivity and progress can require difficult decisions. The success of policy advocacy reflects a complex set of environmental factors and organizational and leadership capacities. Although the SBHCPP intentionally selected organizations at different levels of organizational "readiness" for advocacy, two of the original nine SBHC associations did not progress at a level the Foundation deemed sufficient to warrant funding for the duration of the program. As a result, they were funded for only a portion of the six-years – one for three years, and the other for five. Beyond that, two of the remaining SBHC associations also ended the program with significant limitations in their organizational infrastructures and capacities for policy advocacy. The difficulties may reflect a variety of factors: insufficient or mismatched training and technical support in light of the profile of needs; expectations that exceeded organizational and leadership capacities to meet; environmental conditions that impeded organizational progress; or an interaction of these or other factors.

Finding the "right" frequency, level, and venues for cross-site networking and communication requires collaborative planning between grantees and funders. Building relationships, shared understanding, and broad-scale impact requires opportunities for cross-site networking and communication. The SBHCPP organized several forums and venues to foster program-wide training and learning. Many grantees, however, called for more frequent opportunities to share experiences, network, and learn about collective experiences and progress. Fostering regular and open communication and sharing among grantees and with funders requires collaborative planning and a readiness to invest resources needed to organize and convene program participants.

Community partners played a pivotal role in the SBHCPP. They also faced ongoing challenges in satisfying the competing demands on their time. Some of the associations noted that the community partners served as the backbone of the SBHCPP – the force that enabled the community-driven campaign for SBHCs to occur in the first place. Yet, these partners frequently found it difficult to play the extensive roles expected of them in the SBHCPP while sustaining full-time jobs, which often involved serving as clinical or administrative staff in busy SBHCs. Devising strategies for supporting and balancing the expectations of these local partnerships is important in building on this core component of a broad-based SBHC movement.

Increasing seamlessness in advocacy requires preparation for staff turnover and leadership changes in the policy community. SBHC associations often faced a difficult time maintaining the momentum and force of their advocacy campaigns when staff, particularly executive directors, left the organizations. The associations and their partners faced similar challenges in maintaining continuity of impact and strength of relationships given the frequent departure and influx of new legislative officials, governorships, and executive appointments because of term limits, shifts in majority parties, and electoral changes in state and national executive leadership. Often, just as strong relationships were taking form, new officials or staffers would arrive, requiring a new process of building relationships all over again.

Some organizations developed secession plans to increase seamlessness in internal operations. The ability to prepare for and accommodate leadership change both within and outside of the organization proved of essential importance in sustaining an effective, coherent strategy for policy advocacy.

"The central lesson is the need for a diverse array of champions in the House and Senate. It is difficult to anticipate the political winds, which is why it is so important to have friends in whatever direction the winds blow. Our connections with moderate Republican members like Maine's Olympia Snowe and Susan Collins will be more important than ever, as will those with conservatives like Louisiana's David Vitter and Tennessee's Lamar Alexander."

From the National Assembly's Capstone Report, 2006-2010

Additional evaluation research on the value and impact of school-based health care will increase the power and reach of strategic communication. Though growing, the limited pool of evaluation research on SBHCs places a premium on making the most of opportunities for evaluation in ongoing work for school-based health care.[40] Increased collaboration in planning for evaluation between philanthropy and grantees would assist in identifying opportunities for evaluations that serve project-level as well as program-wide needs.

Broadening access to school-based health care among Native American youth requires advocacy informed by tribal culture, structures, organizations, and policies. While the SBHCPP made significant inroads in building support for SBHCs in the federal, state, and local policy arenas, its impact in the tribal policy arena was limited. Advancing tribal policies to expand and support sustainable school-based health care for all Native American youth requires improving the following:

- Underfunding of tribal programs and the Indian Health System;
- The lack of strong partnerships between state and federal entities and tribal organizations;
- A common lack of understanding by non-Native American advocates of tribal policies that govern Indian organizations and sovereign entities;
- Navigating the complexity of the jurisdictional bureaucracies and boundaries of mainstream and tribal health and education systems;
- The insufficient understanding and appreciation of the diversity and history of Native American culture by mainstream society.
- Dialogue around the continuing repercussions of historical tensions created by oppressive U.S. policies toward Native Americans.

Offsetting the tendency for "transactional" advocacy requires intervention from philanthropy. Many of the SBHC associations had a tendency, especially in the program's early years, to engage in "transactional" advocacy – advocacy comprised of activities or events that,

while often productive, did not build off of one another to create an integrated, cohesive strategy or plan. "Advocacy Day" rallies were particularly inclined to be "transactional" – they consumed substantial resources, produced important results, and yet tended to remain distinct from – not well integrated into – the balance of the associations' work following the event's completion. It became clear that the most robust, productive policy work did not result from the strength of one of the program's core strategies or series of discrete accomplishments, but through the ways the strategies and their outcomes built off of one another to yield a greater collective effect. Reducing this tendency to "move on," without capitalizing on the assets built from each "transaction," provides important opportunities for strengthening the efficiency and magnitude of program outcomes.

Moving Forward

These concluding pages offer three recommendations for advancing the work of the SBHCPP: encouraging "transformative" vs. transactional policy advocacy; framing SBHC in the context of public health principles and practices; and utilizing a social movement frame to accelerate the advocacy for school-based health care in the future.

"Transformative" advocacy

The experiences of the SBHCPP, in concert with lessons learned from other past large-scale policy initiatives, suggest that transactional advocacy is more likely to become "transformative" when several conditions are met:[5]

The overarching, guiding vision is linked to all aspects of the work, rather than serves as a backdrop to the work.

Multiculturalism is an encompassing frame within which all other strategies are designed and implemented, rather than as an isolated approach for broadening diversity.

Participatory processes and democratic systems of decision-making are institutionalized policies, rather than informal or occasional practices.

Policy advocacy reflects a systematic plan for integrating the core strategies in ways that build off of one another, rather than a collection of activities that are not well connected.

Outcomes are treated as inputs for continued development, not as endpoints unto themselves.

Training and technical assistance itself is integrated and "transformative" through helping grantees (a) systematically translate these principles into a strategic plan of action; and (b) "connect the dots" among the core strategies, rather than teaching each of the core strategies in isolation of the others.

A public health lens is used in program planning and policy advocacy to frame the full significance of the role SBHCs can play in keeping populations of children and youth healthy and better positioned for educational success.

Several of the main points from this model are highlighted below.

Utilizing the guiding vision as the center of the work and basis for decision-making. The SBHCPP showed that when policy advocacy is conceived through the lens of the program's guiding vision – one that is aimed ultimately at advancing the health and well-being of youth and communities – decisions about the components and the form of advocacy tend to become more

[5] See pages A-73 and A-74 for diagrams of the "transactional" and "transformative" models.

focused, strategic, aimed at longer-term and enduring outcomes. The benefits of all of the work, whether reactive, proactive, short-term or long-term, were more likely to get woven into an integrated strategic plan when the vision guides the work. When policy advocacy is not grounded in the vision, however, the work tend to take a stop-and-start and largely disconnected quality, triggered by short-term needs that may or may not connect back with or increase the likelihood of longer term improvements or sustainability.

Engaging and empowering multicultural stakeholders in all aspects of policy advocacy. Participants in the SBHCPP made significant strides in integrating multiculturalism in policy advocacy for SBHCs. Extending and deepening this work may be encouraged by:

- Recognizing and appreciating how multiculturalism affects the styles and form of policy advocacy in the first place;
- Identifying outreach and engagement strategies that are most meaningful, credible, and attractive to youth and/or adults from multicultural populations;
- Specifying the kinds of communication strategies are most meaningful and persuasive in different cultural contexts; and
- Understanding the range of implications of multiculturalism for designing and implementing evaluation of policy advocacy campaigns.[24]

Providing integrated training and technical assistance. To offset the tendency toward piecemeal and disjointed advocacy, the SBHCPP modified its approach to training and technical assistance to become more holistic and synergistic. The consultants to the SBHCPP worked increasingly as a unit, teaching one another about their own strategic areas of expertise and how their "strategy" could be more fully integrated throughout the work. While an emerging approach, this shift in orientation showed promise in promoting thinking and strategic planning in more integrated ways by grantees and consultants alike.

The SBHCPP also learned how important it is to provide not only the fundamentals of a strategy, but concrete and specific guidance in how to apply core concepts to grantees' evolving work. There is significant potential for increasing the impact of training and technical assistance by consistently linking conceptual frameworks with practical application.

Thinking beyond the medical model: adopting public health principles and practices in school-based health care and in advocacy

SBHCs are typically recognized for the role they play in serving as "a doctor's office in a school." The medical model emphasizes clinical care as the strategy for health improvement, referring children and youth to other specialists or resources as needed to address particular health needs.

The public health model offers a different though complementary lens. Rather than focus primarily on diagnosing and treating individual's problems, public health principles and practices seek to prevent poor outcomes and to promote health and healthy schools for the student body overall. While the medical model may view the restoration of a student's health as a primary intended outcome, the public health frame extends this goal to improve the quality of health for populations of children, whether in the school or the district, for example. Examples include creating school-wide wellness plans, or preventing problems of hunger and/or obesity, violence and bullying, or school drop-out. Whereas the medical model focuses on the clinical manifestations or outcomes of ill-health, the public health model focuses on

preventing and correcting the causal factors of ill-health and poor educational outcomes – "social determinants " – that influence the quality of health and well-being in the first place.

The public health model reminds us that inequities in health are perpetuated when systems of care address children's clinical conditions and then release them back to the very environments that contribute to poor health to begin with – threats created by social factors that put students at risk for a range of negative outcomes. Adopting a public health framework considers the full significance of the role SBHCs can play in keeping vulnerable populations of children and youth healthy and ready to learn.[6]

Learning from past social movements to accelerate the momentum for school-based health care

Past social movements offer a range of lessons on the factors and conditions that create broad-based movements for change. One thing these approaches share in common is the notion of "change from below," or, what activist Grace Lee Boggs calls, "the construction of power from below."[41] How thoroughly SBHC associations throughout the country have built a base of support, leadership, and infrastructure to "construct power from below" may be subject to question. Whether they have the population base and reasons to build a groundswell call for change, however, is not.

The disparities in health and inequities in access to health care based on racial, ethnic, and socioeconomic status are evident in communities in every state throughout the country. As the entities organized to represent SBHCs and the children and families they serve, SBHC associations are in a uniquely powerful position to mobilize a groundswell of support on behalf of expanding SBHCs nationwide. The evidence of SBHCs' abilities improve health equity is growing, as is a readiness of communities to join in the advocacy campaign in a collective call for change. Virtually all of the characteristics of social movements have implications for broadening the reach and impact of SBHCs and policy advocacy (see pages A-76 through A-77 for an overview of distinguishing features of social movements). The continuing need is to make the connections between what is known about building a social movement and what these points suggest for building a broad-based campaign for children. A "SBHC movement" can continue to build a sense of social will and societal responsibility for eliminating unfair and unjust health inequities through advancing a straightforward solution: providing health care at a place where all populations of children can access it, in schools.

"…The point of any one campaign is not just to win the specific demands, but in the course of the struggle, to develop political consciousness and a sense of solidarity among those involved, in order to advance toward bigger demands and broader social change….A key component in this is to challenge the ways in which opponents shape political ideas and control the terms of debate. A good campaign should expand the ideological ground, broaden the political debate, build consciousness. Campaigns are more likely to address these kinds of goals if this is a deliberate part of the strategy."

Grassroots Policy Project [42]

CONCLUSIONS

Despite the short duration of the SBHCPP, its accomplishments have been considerable. Whatever the challenges and roadblocks that have prevented further action, the SBHCPP has left a mark that few might have imagined just six years ago, particularly in a climate of significant economic retrenchment and major pendulum swings in the

[6] See pages A-75 of the Attachments for an overview of the distinctions between a public health frame and the medical model.

political landscape. Federal policy is in place that sets the stage for sustainable funding for SBHCs. The SBHCPP state SBHC associations and their partners are emerging from the background of state politics to become increasingly recognized forces in the forefront of policy advocacy and the communities they serve. As a result, state and national policymakers are increasingly aware of the role SBHCs play in protecting the health of some of the nation's most vulnerable children and youth. SBHCs have moved from a model that few policymakers understood or cared much about to one that is winning support, even from the country's most conservative members of the policy community.

Perhaps most strikingly, the voice of young people has been heard in their communities and among educators and administrators in their schools and districts. Their voice has been heard in state legislatures, in governors' offices, and by members of the U.S. Senate and House of Representatives. They have helped to obtain funds in support of mental health and suicide prevention programs, have swayed the views of politicians to support their local centers, have held Senate committee members in close attention as they shared their stories about how their local SBHC helped them cope with difficult circumstances. The hope, of course, is that their voices continue to be heard as the SBHC model of care takes root throughout the country, improving quality and equity of health for generations of children, youth, and communities for years to come.

"SBHCs are a remarkable part of our nation's health care safety net for the kids…School health centers are going to be a part of our national policy. And for the first time, we're going to see to it that we're putting money into that."

Representative John Dingell, quoted in the National Assembly's Capstone Report, 2006-2010

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