Evaluation of the Impact of School-Based Health Centers

June 2023

ORSIMPACT

Missions Accomplished

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Executive Summary

For the past 25 years, Interact for Health, an independent foundation dedicated to promoting health equity in Ohio, Kentucky, and Indiana, has worked to expand access to health care for children and communities through SBHCs. In that time, they helped to open and sustain 43 SBHCs throughout the region, which have provided more than 350,000 primary care visits since 2015.

Interact for Health engaged ORS Impact to conduct an external strategy-level evaluation of the impact of SBHCs in addressing the health needs and closing health equity gaps among school-age children. The evaluation set out to answer three overarching questions:

1. What has been the impact of SBHCs on increasing access to health care in Greater Cincinnati? What has been their impact on narrowing disparities in access? How do these compare to other places?
2. What has been the impact of SBHCs on improving student outcomes in Greater Cincinnati? What has been their impact on narrowing disparities in outcomes? How do these compare to other places?
3. What factors have facilitated or constrained the ability of SBHCs to achieve or evaluate these outcomes?

Between August 2022 and March 2023, ORS Impact conducted key informant interviews with medical, educational, and system partners; facilitated community conversations with students, parents, and school staff; reviewed documents describing SBHC policies and practices both within and beyond the Greater Cincinnati region; and analyzed regional reporting data from SBHCs and statewide and national datasets. This report presents a synthesis of data and findings from that evaluation and offers recommendations to strengthen local SBHC practice and inform the community and broader field of school-based health.

Key Findings

School-based health centers increase health care access and improve health outcomes by reducing or removing many of the barriers experienced by the students, families, and communities they serve. Improved access to care within the Greater Cincinnati region has been fueled by **increased system-level commitments** to offer an expanded range of care, provide transportation, telehealth, and mobile services, increase SBHCs located in rural areas, and serve community members in addition to students. Despite closures, reassignment of staff, and severely limited hours in many locations due to COVID, these commitments have contributed to:

- An 81% increase in the number of SBHC sites since 2015
- A 540% increase in the total number of users receiving services at SBHCs since 2015
- A 189% increase in the number of behavioral health visits since 2017
- A 199% increase in the number of vision users since 2017
- A 182% increase in the number of dental users since 2019
- Immunization rates dipped slightly between 2019 and 2021 but remained above national targets.

While data related to health outcomes is more limited than for access indicators, the rate of immunizations, BMI, and positive depression screens all **meet or exceed national targets and benchmarks**. Opportunities for increasing the scope and utility of outcomes reporting are identified within the recommendations offered.

Beyond the numbers, the voices of students, parents, and community members shed insight into how their interactions with SBHCs shape their perceptions of access and outcomes they experience as a result of the services they receive. Students and parents expressed feeling relief and appreciation at having a **consistent and routine source of care** and noted the importance of convenience, affordability, and caring and respectful relationships. Students reported feeling an increased sense of **belonging and engagement** at school and more **empowered about decisions regarding their health**. And for students and parents alike, feeling that they were listened to and that everyone was welcomed and treated the same contributed to a sense of **increased trust** and **lack of stigma** attached to seeking care.

The voices of **educational partners** and **medical providers** provide insight into system-level factors that either constrain or facilitate their ability to provide services. Factors identified as supporting SBHCs' ability to expand access and improve outcomes include:

- Aligning services with district goals and frameworks such as Educating the Whole Child and Multi-Tiered Systems of Support
- Operating within a wider system of care to connect students and families with a range of services
- Allocating backbone support to convene and coordinate partnering organizations
- Finding "easy wins" to earn the trust and buy-in of students, families, and organizational partners
- Pay-for-performance incentives
- Cultivating cross-sector collaborations to support integrated workforce development

Commonly cited challenges and constraints include:

- Complex and variable funding, eligibility, referral, and reporting requirements
- Lack of data alignment and interoperability

- Persistent staffing challenges particularly in high need areas and specializations
- Differing perspectives regarding the meaning and implications of health equity
- Political sensitivities around issues such as reproductive health, gender-affirming care, and immigration status of patients

Recommendations

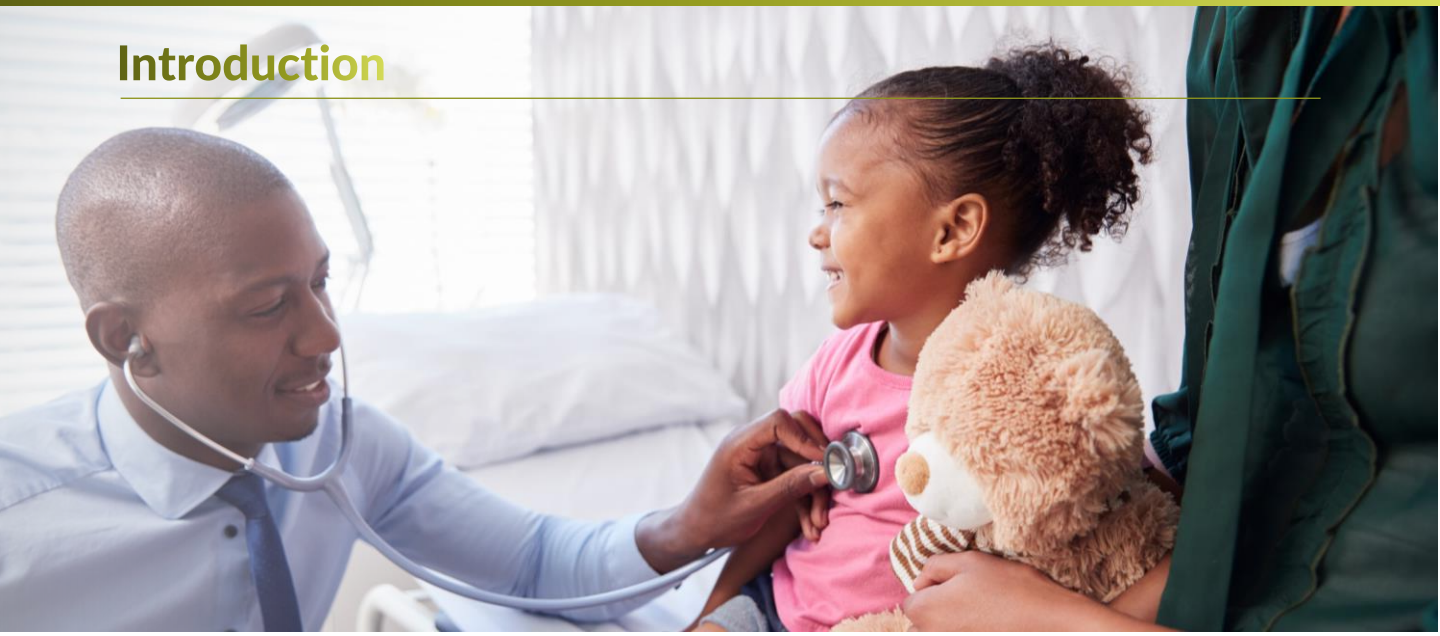
Five recurring themes emerged during this evaluation as key factors shaping the impact of SBHCs. Each theme is characterized by what we term "creative tensions" between competing priorities. Unlike dichotomies in which one priority is valued or pursued at the expense of the other, the concept of creative tensions recognizes the validity of different priorities while acknowledging the potential challenges and tradeoffs involved in pursuing both. For each theme and associated tension, we offer recommendations for future action informed by innovative and impactful approaches being employed by SBHC providers and partners, both within and beyond the Greater Cincinnati region.

Table 1: Key Themes, Creative Tensions, and Recommendations

Theme #1: Health Equity and Access
Creative tension: Promoting universal access while also providing targeted support for prioritized populations.
Recommendation 1: Expand telehealth, mobile care, transportation services, and the scope of services co-located in SBHCs, particularly dental, vision, and mental health and behavioral health care
Recommendation 2: Explicitly align SBHC services with strategic goals and statewide frameworks to which districts have already committed
Recommendation 3: Employ the Thrive Rural Equity Framework to bridge the gap between universal access and targeted support for priority populations (defined by race, income, sexual orientation, or geography, etc.)
Theme #2: Student and Family Engagement
Creative tension: Proactively inviting student and family involvement while acknowledging that individuals and communities may have a legitimate basis to mistrust the educational and/or medical systems based on their prior history
Recommendation 4: Apply asset-based, student-ready frameworks to facilitate equitable family engagement strategies
Recommendation 5: Employ proactive outreach and marketing strategies, including advertising in ethnic news media and local news outlets
Theme #3: Coordination, Collaboration, and Integration
Creative tension: Providing access to complementary services while managing multiplying system constraints
Recommendation 6: Create multiple and varied opportunities for medical providers and educational partners to exchange information, learn each other's systems, and engage in barrier busting
Recommendation 7: Allocate dedicated FTE to provide backbone support to facilitate regular convenings and information sharing among different partners

Theme #4: Staffing and Capacity
Creative tension: Leveraging innovative practices while maintaining professional standards
Recommendation 8: Support Grow Your Own pathways for paraprofessional clinical and support staff
Recommendation 9: Cultivate partnerships with local postsecondary and higher education institutions to support an integrated workforce development model
Recommendation 10: Employ a braided-funds approach to leverage multiple funding streams with differing eligibility requirements
Theme #5: Assessment and Reporting.
Creative tension: Honoring local autonomy while acknowledging the benefits of accountability, alignment, and shared learning
Recommendation 11: Redesign utilization reports to allow for deeper outcomes analysis and provide training to ensure consistent reporting across sites
Recommendation 12: Align local metrics with regional, statewide, and national datasets
Recommendation 13: Apply an equity lens to defining and assessing quality of care and reinstitute the Kentucky Parent Survey culturally responsive care module

Introduction



Background and Context

School-based health centers (SBHCs) provide elementary, middle, and high school students with health care services on school premises or at off-site centers linked to schools. Medical providers generally offer primary and preventive care, including well-child visits, vaccinations, and sports physicals, along with mental health care and sick visits. Providers at SBHCs often manage chronic illnesses, such as asthma, mental health conditions, diabetes, and obesity, and they provide referrals to specialists as needed.[1]

SBHCs can be a powerful tool for closing health equity gaps. Health equity means everyone has a fair and just opportunity to be as healthy as possible.[2] Among the many factors that can either contribute to or constrain an individual's or community's opportunity to be healthy, access to affordable and quality health care services plays a critical role.[3] Children and youth from households with lower incomes often experience challenges accessing health care and other basic needs and services. School-based health centers increase health care access and improve health outcomes by reducing or removing many of the barriers experienced by the students, families, and communities they serve. Providing health services in schools increases access for students and school communities and reduces barriers, such as transportation, parents having to take time off from work to take their children to appointments, and students having to miss instructional time at school.[4]

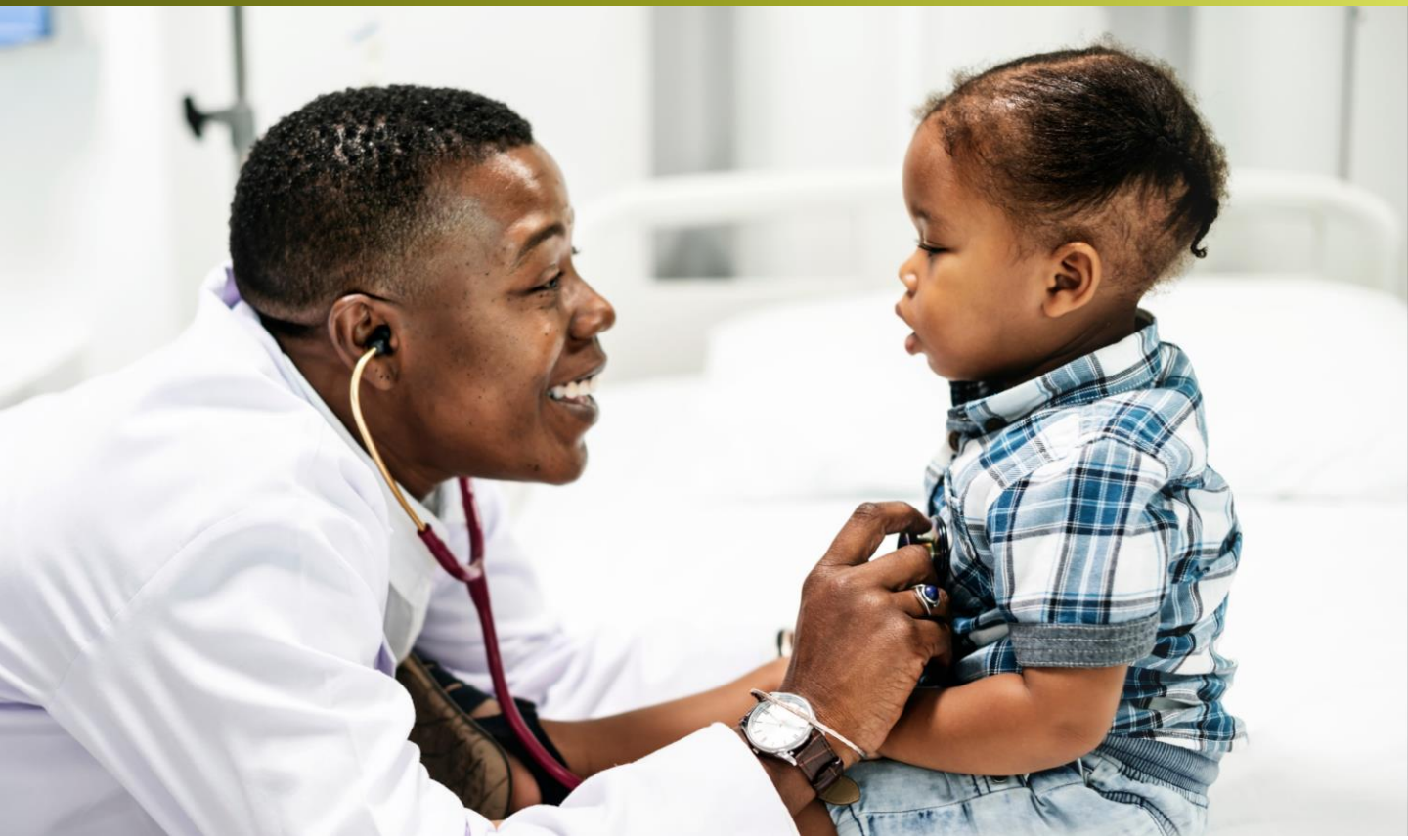
1. County Health Rankings & Roadmaps. (n.d.). School-based health centers. Retrieved from https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/school-based-health-centers.
2. The Health Collaborative. (2021). Greater Cincinnati and Greater Dayton Regional Community Health Needs Assessment. Retrieved from https://healthcollab.org/chna-reveals-regions-priorities/
3. Centers for Disease Control and Prevention. (2022). Social determinants of health at CDC. Retrieved from https://www.cdc.gov/about/sdoh/index.html
4. Interact for Health. (2022). Years in review 2018–2022: What happened, results and lessons learned.

For the past 25 years, Interact for Health, an independent foundation dedicated to promoting health equity in Ohio, Kentucky, and Indiana, has worked to expand access to health care for children and communities through SBHCs. In that time, they helped to open and sustain 43 SBHCs throughout the region that provided more than 350,000 primary care visits since 2015.[5]

Interact for Health engaged ORS Impact to conduct an external strategy-level evaluation intended to:

- evaluate the impact of SBHCs in addressing the health needs and closing health equity gaps among school-age children in the region, and
- disseminate findings and lessons learned to strengthen local SBHC practice and to inform the community and broader field of school-based health.

5. Interact for Health. (2022). Years in review 2018–2022: What happened, results and lessons learned.



Research Questions, Methodology, and Data Sources

The evaluation employed a mixed-methods design blending both qualitative and quantitative data and approaches to address the following questions:

1. What has been the impact of SBHCs on increasing access to health care in Greater Cincinnati? What has been their impact on narrowing disparities in access? How do these compare to other places?
2. What has been the impact of SBHCs on improving student outcomes in Greater Cincinnati? What has been their impact on narrowing disparities in outcomes? How do these compare to other places?
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Key data sources included the following:

Quantitative Data

- Site specific: Primary, Dental, and Vision Care Utilization Reports from SBHCs in Greater Cincinnati, 2016–2022
- Regional: Greater Cincinnati Child Wellbeing Survey, Kentucky Parent Survey, OSBHA Parent/Community Survey, and Interact for Health Productivity Survey and Grantee Reports
- State and national: National Survey of Children's Health, National Institute for Child Health and Human Development, and Annie E. Casey Foundation Kids Count Data Book

Qualitative Data

- Key informant interviews with medical, educational, and system partners
- Community conversation interviews with students and parents/guardians
- Community conversation focus group with a local school decision-making committee (LSDMC) comprised of students, parents, and school staff
- Case study interviews and document review associated with spotlight practices recommended by key informants
- Document review of SBHC policies and practices from community comparators in other states

Combining qualitative and quantitative data and approaches provided opportunities to corroborate findings derived from multiple data sources, identify and address potential gaps in different types of data, and yield deeper and more nuanced understanding of the complex interplay between individual, organizational, and system level-factors.

Constituent engagement is a key characteristic of the ORS approach to evaluation, and we strive to include multiple voices and perspectives. For the community conversations, we reached out to a system partner who personally referred us to SBHC staff members in the Greater Cincinnati region. Those staff then connected us with students and parents who were willing to speak with us about their experience with SBHCs. Gift cards were provided to compensate community members for sharing their valuable time, experiences, and perspectives as part of the evaluation.

Data analysis included coding the interview and focus group transcripts for recurring themes and key insights from across multiple data sources. Upon the completion of our data collection and analysis, we conducted a strategic debrief in which we shared findings, hypotheses, and draft recommendations with Interact for Health, grantees, and community partners. Attendees of the strategic debrief provided insights and feedback on the findings and preliminary recommendations that were then incorporated into the final report.

Limitations

While there is a large amount of quantitative data available, much of it is utilization data speaking to access to services more than outcomes for patients. Where outcome data is available, many of the metrics being collected and measures are not standardized, aligned with statewide or national datasets, or disaggregated for different priority populations. As a result, the scope of claims regarding outcomes and how they compare across different populations and regions is limited.

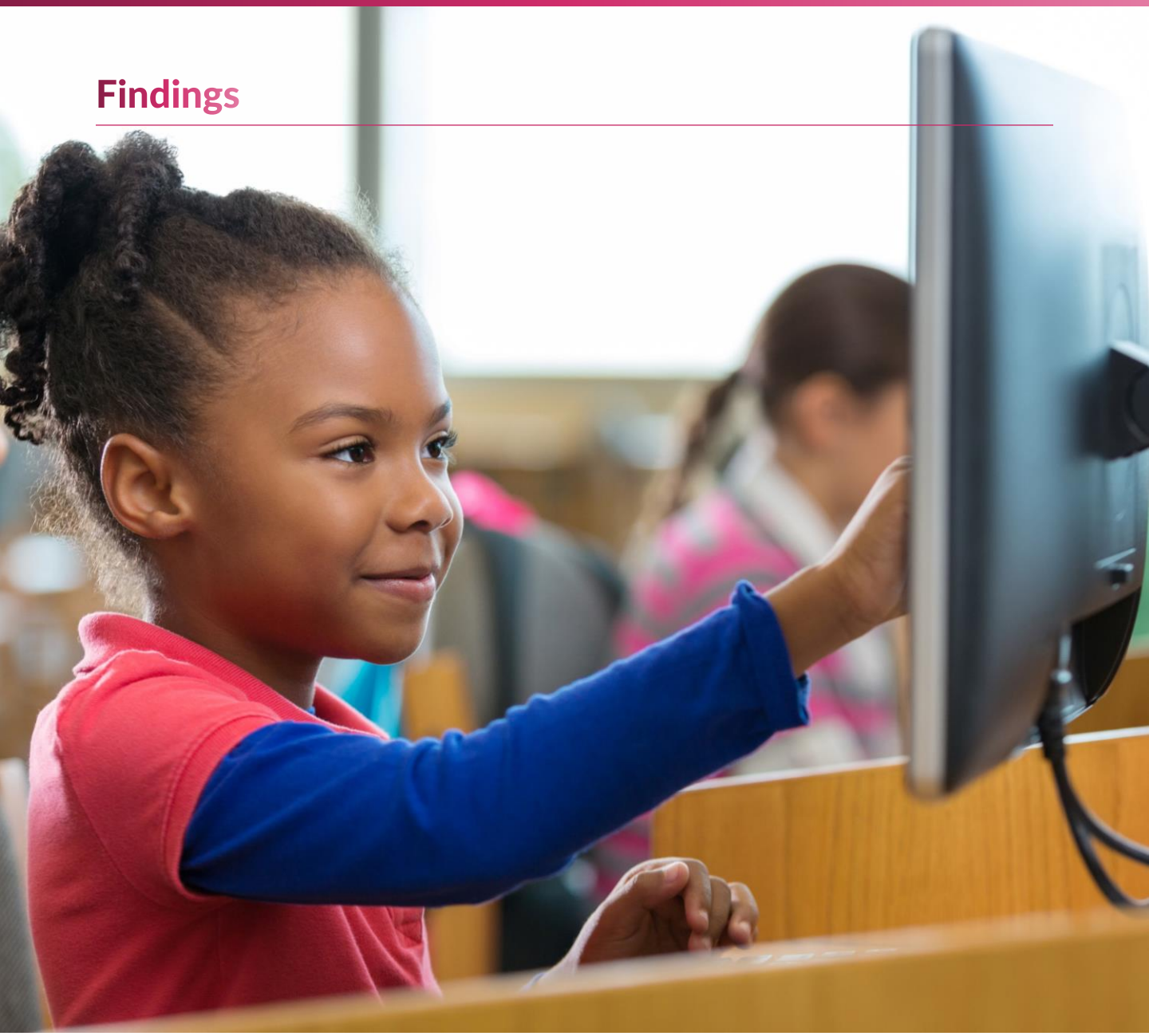
Qualitative findings presented in this report are exploratory due to limitations in sample size and representation. Because recommendations for community conversation participants and spotlight practices were based upon referrals, we spoke mainly to users and staff from SBHCs that are perceived as "doing well."

Layout of the Report

In the Findings section that follows, we present quantitative and qualitative data that describes the impact of SBHCs on access and outcomes for students and community members. We then discuss system-level factors that either constrain or facilitate SBHCs ability to increase access, improve outcomes, and narrow disparities. Finally, we provide an in-depth case study intended to shed insight into the decision-making processes and strategic considerations through which one district and set of committed partners mobilized support, leveraged resources, and secured follow-through and accountability for integrating mental and behavioral health care services for all students.

In the Implications and Recommendation section, we offer insights and describe creative tensions related to five key themes: (1) Access and Equity; (2) Student and Family Engagement; (3) Coordination, Collaboration, and Integration; (4) Staffing and Capacity; and (5) Assessment and Reporting. The term "creative tensions" is used to acknowledge both the validity and challenges posed by competing priorities surfaced through interviews and review of data. The recommendations offered are informed by innovative approaches to addressing those tensions being employed by SBHC providers and partners both within and beyond the Greater Cincinnati region.

Findings



Interact for Health has been working since 1999 to expand access to sustainable health care services for students and families in the Greater Cincinnati region through the support and expansion of School-Based Health Centers. In recent years, that effort has included particular attention to integrating vision, dental, and behavioral and mental health care services in addition to primary care; expanding into rural and suburban areas; serving adults and community members in addition to students; and supporting innovation and uptake of promising practices by offering pay-for-performance incentives. What impact have these efforts had upon expanding access and improving health outcomes? And what organizational and system-level factors facilitate or constrain their ability to do so?

Increasing Access and Narrowing Disparities

Increasing access: What the data tells us

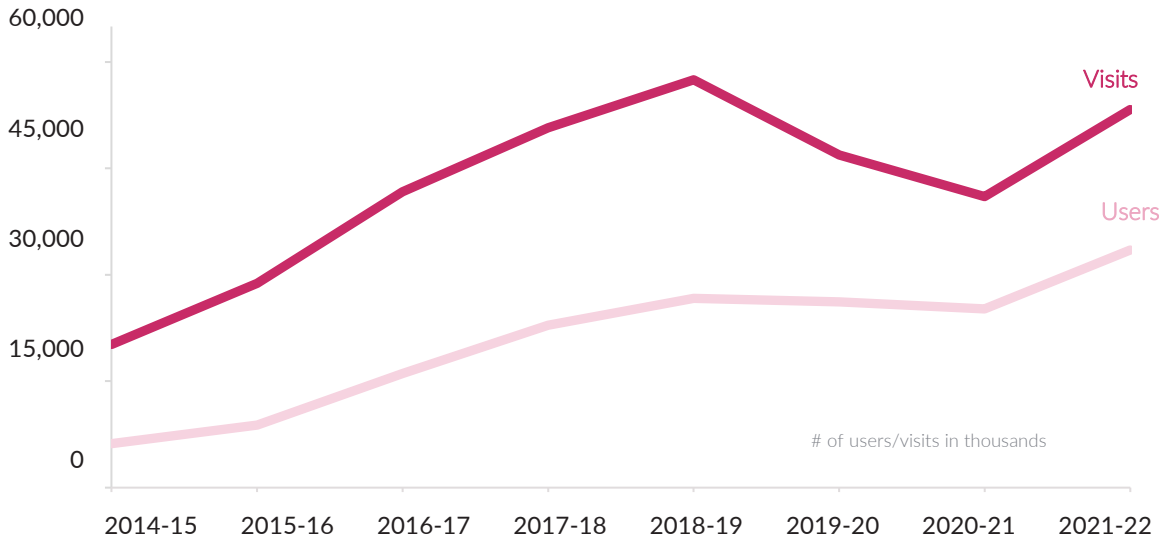
Data and insights in this report are from SBHC sites in the Greater Cincinnati region that report data to Growing Well. While other sites have existed in the region during this time period, they are not included in this report due to the lack of data.

Between 2015 and 2022, the number of SBHC sites throughout the greater Cincinnati region has increased from 21 to 38, **growing by over 80%**. Despite a temporary dip during COVID-19 pandemic, the total number of users receiving services at a SBHC has grown from 6,200 in 2015 to 33,500 in 2022, an **increase of 540%** over a seven-year time span.

Table 2: School-Based Health Centers, 2015–2022

Year	Sites	Providers	States	Counties
2015	21	5	1	1
2016	25	7	1	2
2017	29	7	1	2
2018	32	8	1	4
2019	35	9	2	7
2020	34	9	2	7
2021	37	10	2	7
2022	38	11	2	7

Figure 1: Primary Care Visits and Users, 2014–2022



In addition to the overall growth in the number of patients being served, the **range of services** received has also expanded. For students seeking primary care services, the average number of well-child checks performed at each site increased 284% from 125 to 353 since 2015. Meanwhile, the number of **dental and vision** users has grown steadily, with dental users increasing 182% in the 3 years since 2019 and those receiving vision services almost doubling since 2017. Attention to reproductive and sexual health is reflected in the doubling of chlamydia screenings over the past 5 years.

Figure 2: Well-Child Checks Performed, Average per Site, 2014–2022

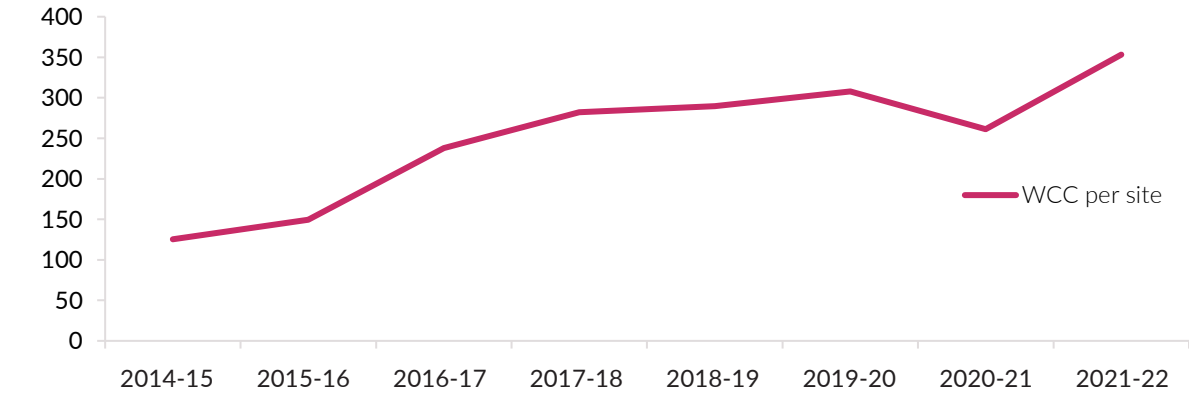


Figure 3: Dental Users and Visits, 2018–2022

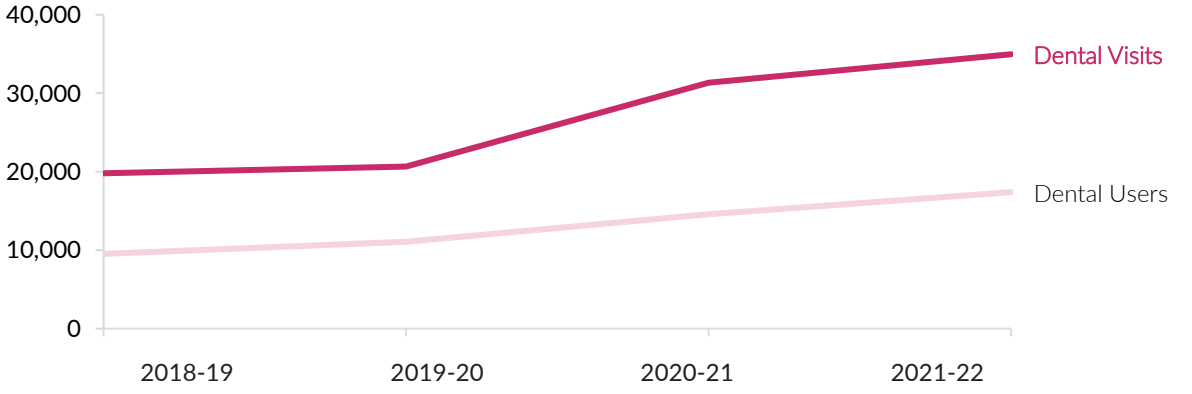


Figure 4: Vision Users, 2016–2022

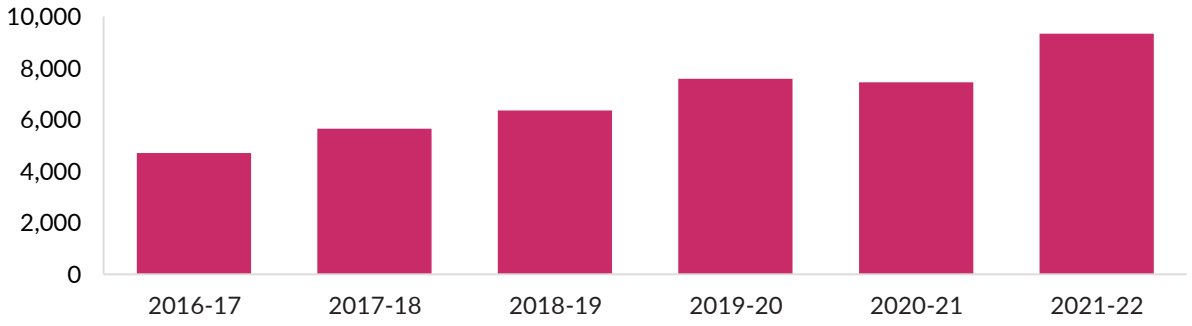
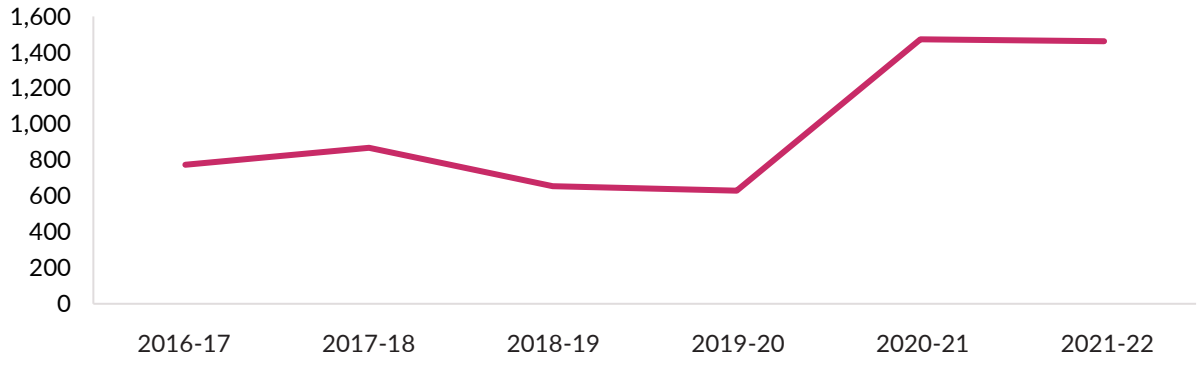


Figure 5: Behavioral Health Visits, 2016–2022



Mental and behavioral health services have risen substantially as well, with the number of behavioral health visits increasing 189% since 2017 and the percentage of patients aged 12 and older screened for depression nearly tripling from 25% to over 69%.

Figure 6: Depression Screening, 2016–2022

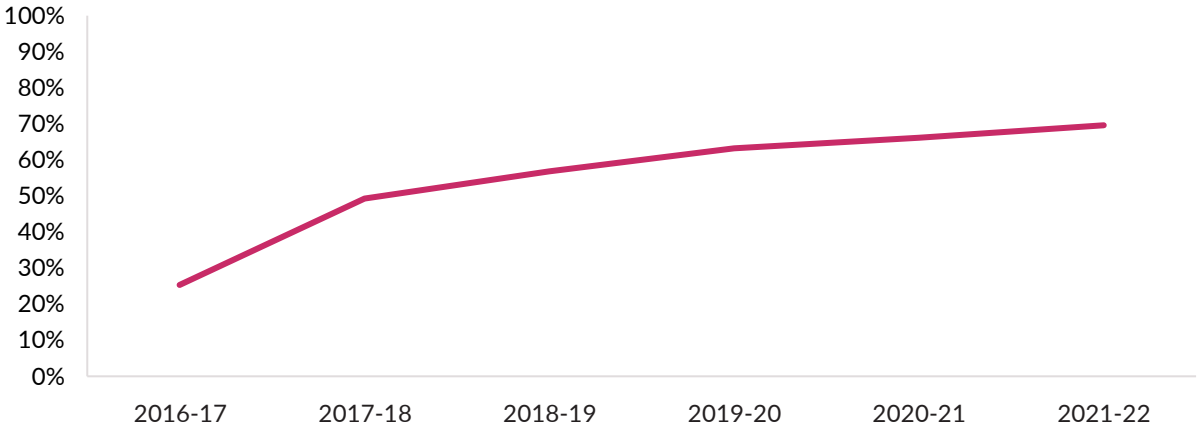
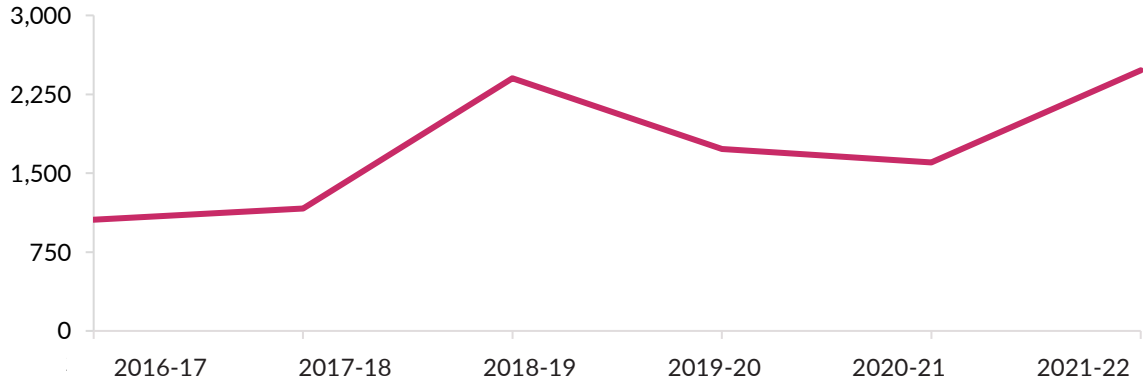


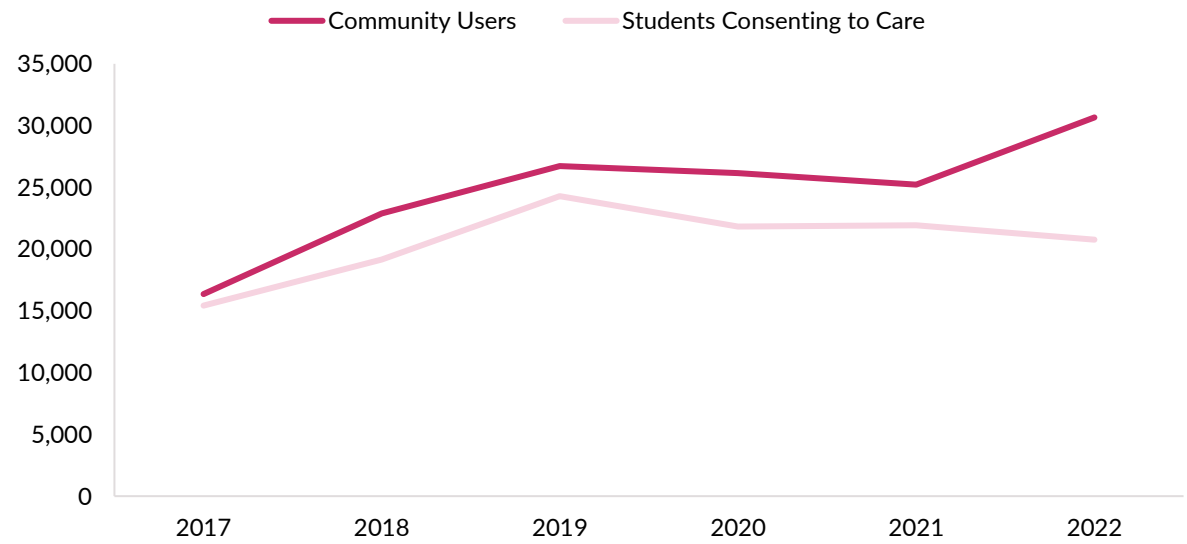
Figure 7: Chlamydia Screenings, 2016–2022



The increasing number of patients served and expanded range of services provided paint a clear picture of SBHCs expanding access to health care for students and communities throughout the Greater Cincinnati region. Examining the **mix and makeup of patients** receiving care provides a more nuanced understanding of the complex dynamics factoring into this increase.

Clearly, the COVD-19 pandemic and temporary shift to remote learning had an impact on student usage between 2019 and 2021. As seen in Figures 8, students consenting to care at SBHCs plateaued and fell slightly between 2019 and 2021. And while students remain the primary recipients of care through SBHCs, the number and proportion of **community members** receiving care have grown significantly since 2017. This trend can be seen most clearly in the steady and substantial increase in patients aged 19 or above that has almost tripled since 2018. Patients aged 0 to 4 have also increased, though at a lower rate. The number of school-aged patients, meanwhile, aged 6 to 12 and 13 to 18, fell slightly during the pandemic before rising again in 2022.

Figure 8: Student and Community Users, 2016–2022



Numerous factors affect the consent rate at SBHCs, including whether the center serves a single school or an entire district and the length of time the center has been in operation. SBHCs that serve districts often have lower consent rates but a higher number of consented students. In 2022, sites serving districts had an average consent rate of 25% compared to 69% for sites serving a single school, but nearly twice as many total students consented to care (as seen in Figure 9). In general, SBHCs in the region have adopted a target consent rate of 80% for school sites and 30% for district sites to reach financial sustainability. Additionally, Figure 10 shows that sites often grow their consent rate gradually over time. Sites that have been open for 10 years or more have higher consent rates than those that opened more recently.

Figure 9: Average Number of Consented Students, 2022

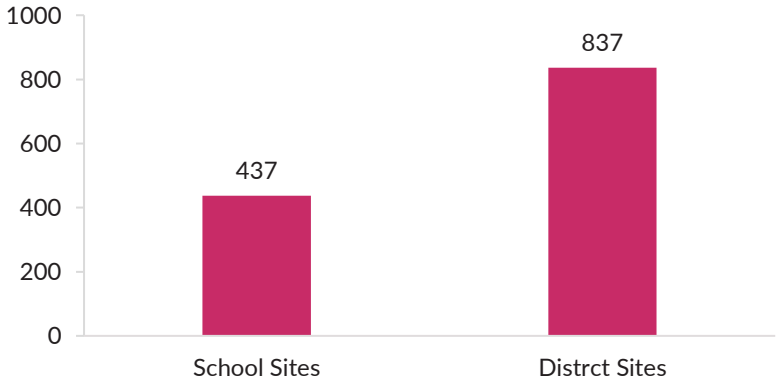
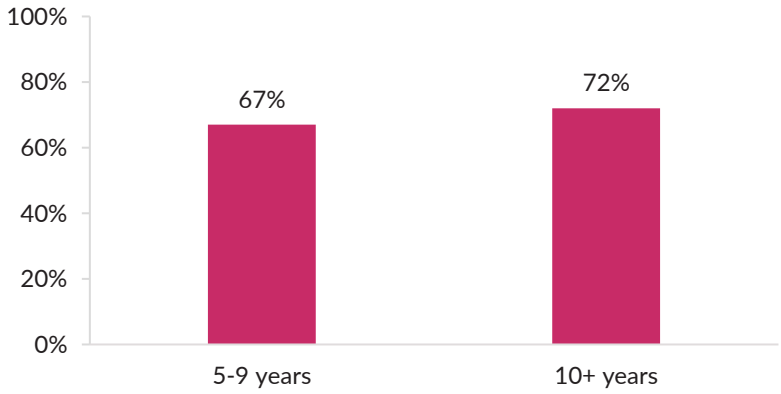
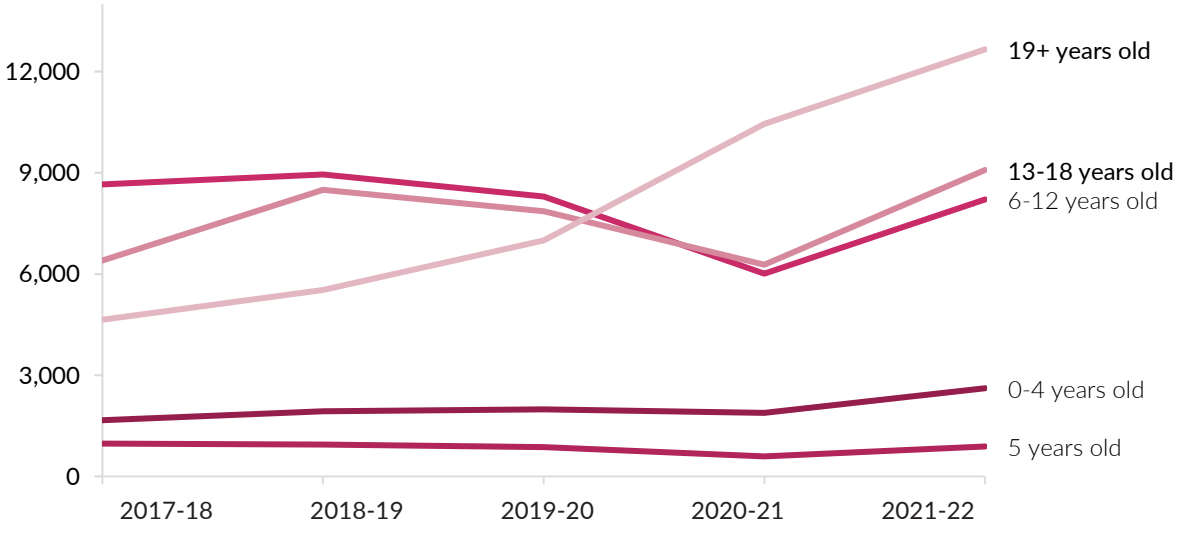


Figure 10: Consent Rate by Years in Operation, 2022*



* District-serving sites not included.

Figure 11: Users by Age, 2017–2022



Changes in the **insurance status** and **racial composition** of SBHC users tell a similarly complex story. As system partners have worked to expand the number of SBHCs in rural areas and serve community members in addition to students, the number of older, privately insured, and white users have been increasing since 2019. While the large majority of SBHC users are insured through Medicaid, that relative proportion has declined steadily since 2015, with a corresponding increase in the proportion of patients with private insurance. The racial makeup of patients being served has experienced a similar transition. In 2017, SBHCs were utilized primarily by Black and African Americans. While access to school-based healthcare has generally increased in the six years since, the pandemic appears to have had a disproportionate impact on Black and African American users, exacerbating mistrust due to historical mistreatment by the medical and education systems, whose utilization of SBHC services fell by almost 60% between 2019 and 2021.

Figure 12: Insurance Mix of Users, 2016–2022

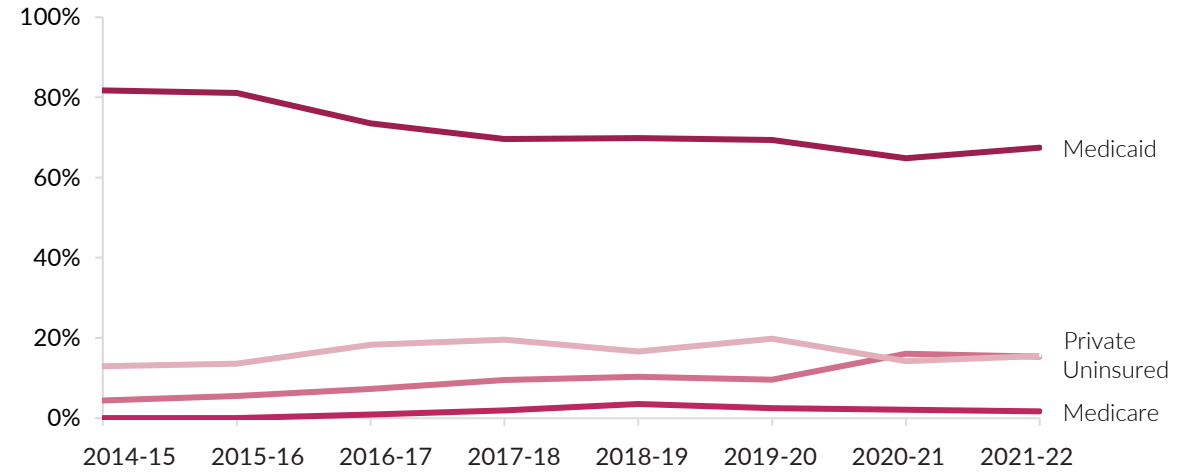
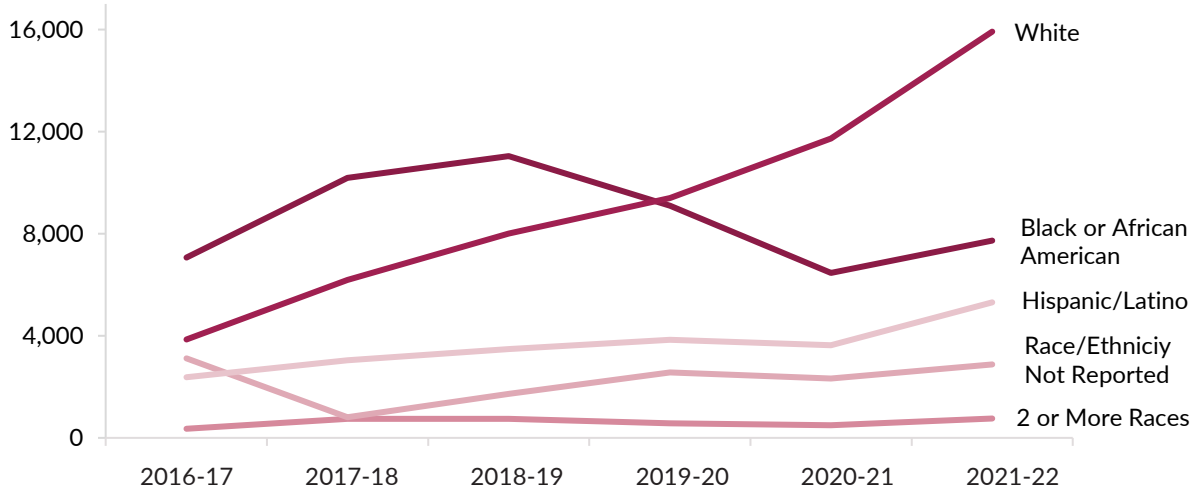
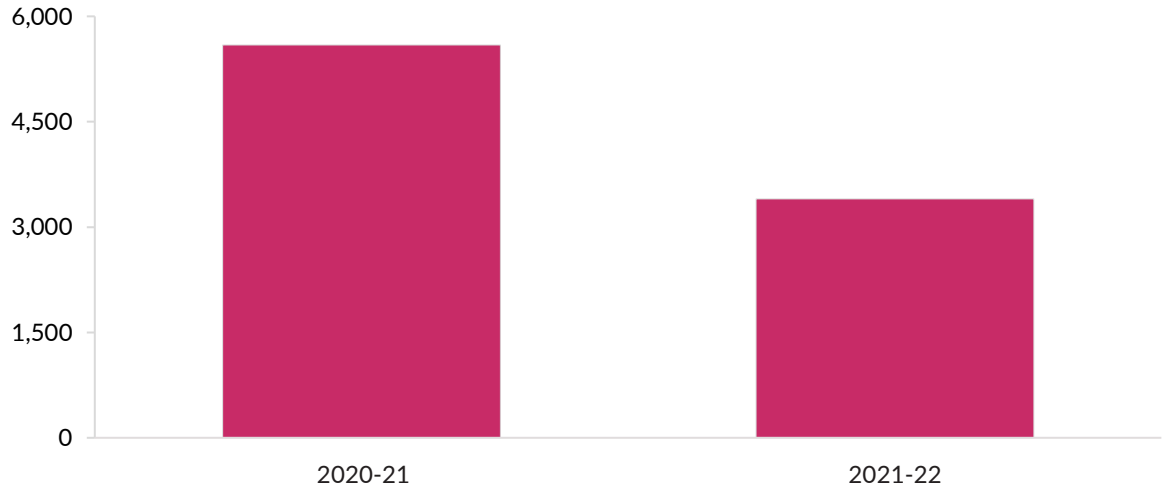


Figure 13: Users by Race/Ethnicity, 2016–2022



The commitment to broadening access has also contributed to the expansion of transportation, mobile, and telehealth services. Though the number of visits declined with the resumption of in-person instruction in 2021-22, telehealth services enabled over 5,500 visits during the period of remote instruction necessitated by the COVID-19 Pandemic.

Figure 14: Telehealth Visits, 2020–2022



Access beyond the numbers: What the voices are telling us

Students and family members interviewed about their experiences of receiving care at SBHCs noted the importance of convenience, affordability, and caring and respectful relationships. One student remarked about how the SBHC "makes it so easy to receive care . . . To be able to just come to the school where I'm already at throughout the day to get what I need so we don't have to go out of our way, that helps a lot." Another student talked about how getting COVID testing at the SBHC contributed to their ability to stay involved at school and participate in extracurricular activities: "They put COVID tests together and it was really organized. It was free for us. We didn't have to go out and take pictures of them and send them to our coaches and show them that we're negative." As one teacher explained, "A lot of SBHCs help in making sure our athletes and our artists have all the forms filled out or have the [health] checks they need so that the family isn't trying to take them to a doctor before they can play football."

A parent called particular attention to his experience accessing dental care through their local SBHC: "We used to go to the local hospital for our dental needs but that takes nine months before you have the appointment . . . I needed something that was local and that I can afford and takes Medicaid." This parent explained that they now pay $35 for a visit to the SBHC and only $350 for a crown (compared to the $2,000 it would have cost at a private dental clinic) and went on to add, "The key is [that] it doesn't come at the expense of the quality of care."

Students and parents also frequently mentioned the benefit of a system where everyone is treated the same and no one is turned away because of their insurance status or ability to pay. In the words of one student, “They greet you well, and they respect you. I think they treat everybody the same.” Another shared that receiving care through the SBHC “makes me feel like I'm the same as everybody else. Nobody's different. Everybody has the same care and access to the same services." A parent noted that before receiving care at the SBHC, her son did not like going to the doctor or dentist, but he is not afraid to go to the SBHC and ask for help because it is a place where “kids feel safe.” For students and parents alike, the **lack of stigma** associated with seeking care and the quality of relationships formed with school and center staff featured prominently in how they perceive and portray access.

Improving Outcomes and Narrowing Disparities

To what extent has increased access to health care services resulted in improved health outcomes for students and other patients receiving care at SBHCs? The range of outcomes for which there is reliable and consistent data is limited by several system-level factors that will be discussed in sections that follow. The data we do have shed insight into students' immunization status, BMI, vision, and mental health.

Improving outcomes: What the data tells us

Immunization rates are considered key health outcomes because they protect against a range of serious and preventable diseases, ranging from measles and mumps, meningitis, diphtheria, tetanus, and polio to papillomavirus, hepatitis B, influenza, and coronavirus. Prior to the pandemic, the number of students vaccinated through SBHCs in the Greater Cincinnati region increased steadily and substantially, more than doubling from 8,703 in 2015 to 17,601 in 2018. Meanwhile, the average rate of immunizations remained steady at 96% through 2018 before beginning to decline with the onset of the COVID-19 pandemic. From 2019 to 2021, students' immunization rate dropped 10 percentage points, from 96% to 86%, likely precipitated by political controversies associated with the introduction of additional vaccine requirements. Judged relative to national targets established though the Office of Disease Prevention and Health Promotion, immunization rates remain above the 80% target for routine vaccination coverage levels among adolescents.

Figure 15: Vaccinations, 2014–2022

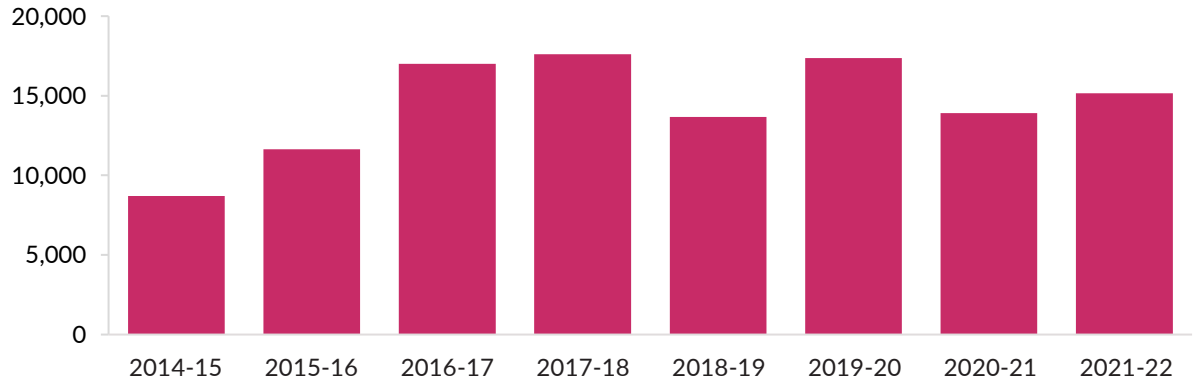
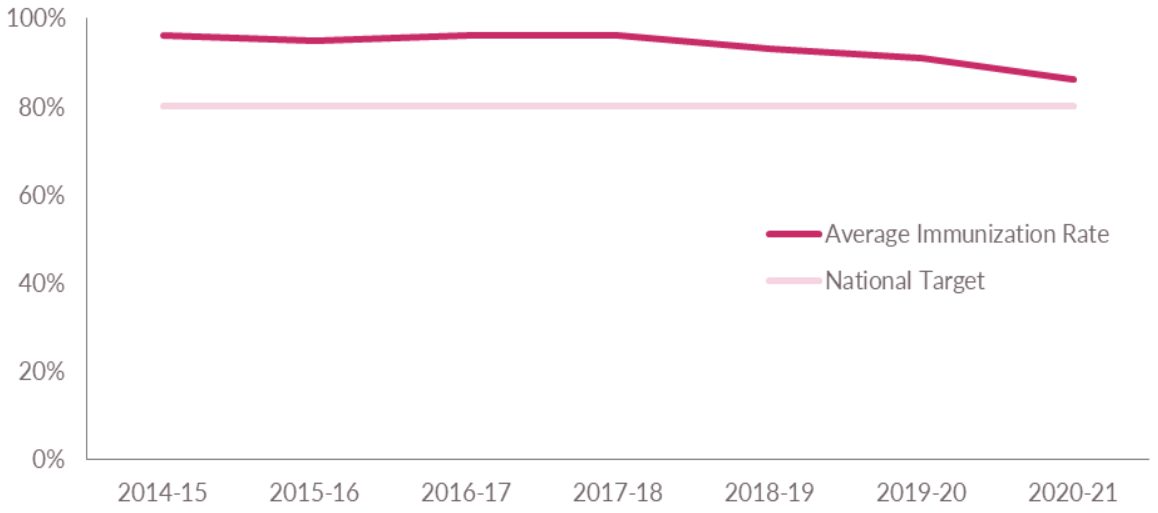
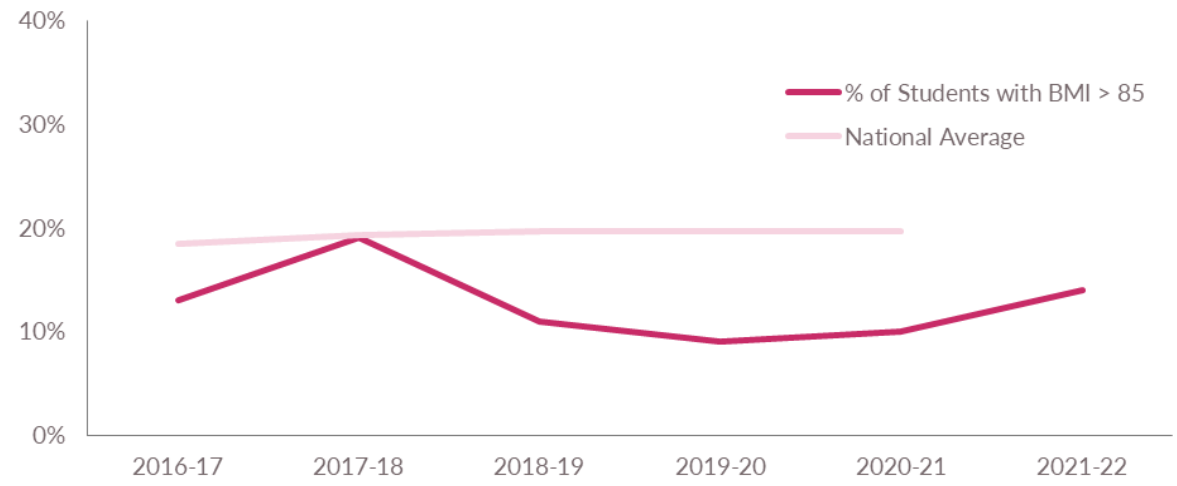


Figure 16: Rate of Immunizations, 2014–2022



Body Mass Index (BMI) is a proportional measurement of weight and height that is considered a key health variable because it is associated with chronic risk factors, such as high cholesterol, high blood pressure, diabetes, heart disease, and some cancers. BMI between the 85th and 95th percentile for one's sex and age is considered overweight, and a measure above 95% is considered obese. For students receiving care at SBHCs in the Greater Cincinnati region, the proportion of students with BMI above the 85th percentile ranged from 9% in 2020 to 19% in 2018. Both figures are below the 19.7% national average for obesity among American children and adolescents estimated by the Centers for Disease Control and Prevention.[3]

Figure 17: Students with BMI > 85%, 2016–2022

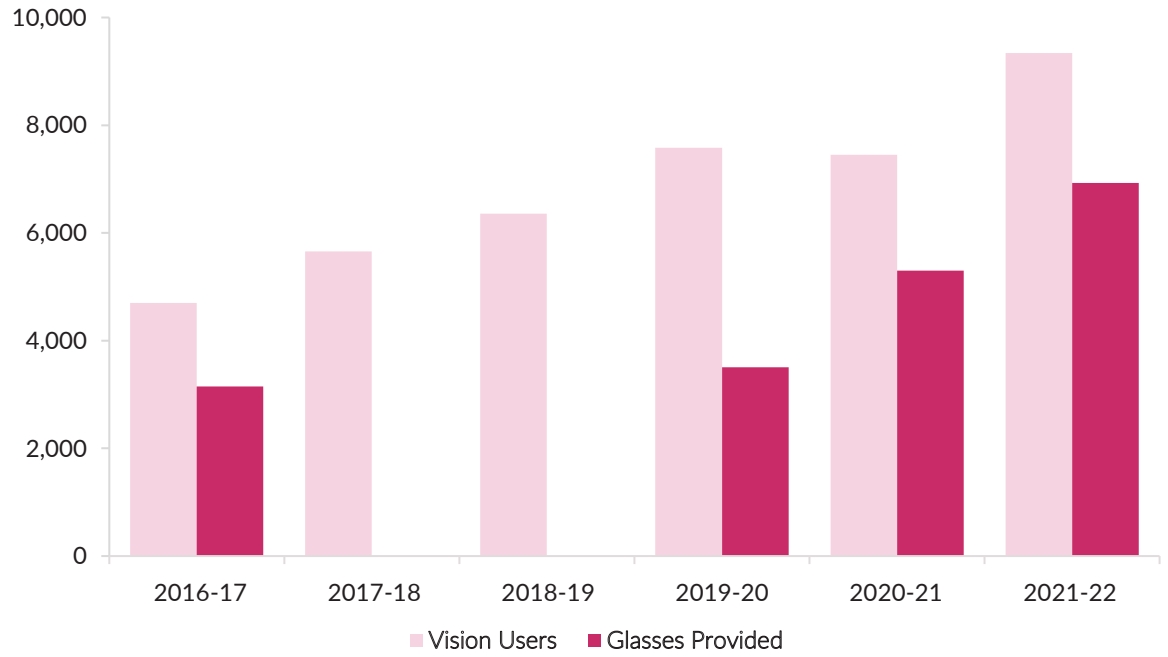


3. Centers for Disease Control and Prevention. (n.d.). Prevalence of childhood obesity in the United States. CDC website. Retrieved from https://www.cdc.gov/obesity/data/childhood.html

Vision

Given the high prevalence of reading, computer usage, and board work in schools, children with **undiagnosed vision problems** can encounter a host of difficulties, ranging from poor reading performance, comprehension, motivation, and self-esteem.[4] Fortunately, vision problems are easy to correct for once diagnosed through the prescription of glasses and contact lenses. As depicted in Figure 18, with the expansion of vision care services available through SBHCs, the number of glasses provided for students in the Greater Cincinnati region has more than doubled since 2017.

Figure 18: Vision Users and Glasses Provided, 2016–2022

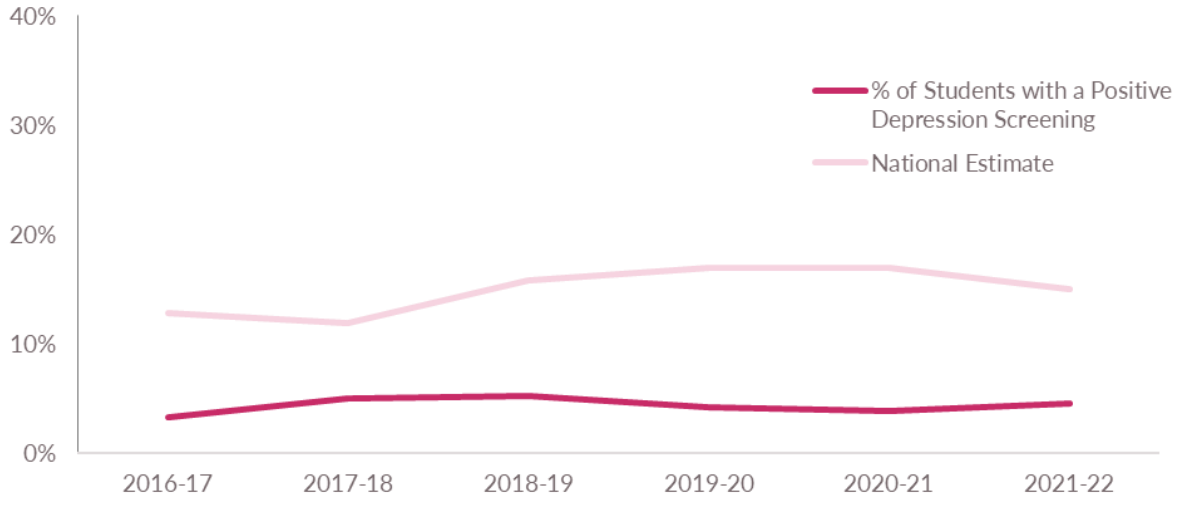


Mental health

According to the National Institute of Mental Health, 17% of adolescents aged 12 to 17 experienced at least one major depressive episode in 2020.[5] Major depressive episodes are defined as periods of at least two weeks when a person experienced a depressed mood or loss of interest or pleasure in daily activities, along with symptoms such as problems with sleep, eating, energy, concentration, or self-worth. Reported numbers of students aged 12 or above in the Greater Cincinnati region with **positive depression screens** at SBHCs range from 3.3% in 2017 to 5.3% in 2019. While those numbers fall far below the 17% estimate provided by the National Institute of Mental Health, the screening tool most commonly utilized by SBHCs (the Patient Health Questionnaire 9 [PHQ-9]): Modified for Teens), rates responses from mild to moderate, moderately severe, and severe and thus may not provide a direct comparator for the incidence of adolescent experiencing "major depressive episodes."

5. National Institute of Mental Health. (n.d.). Prevalence of major depression episode among adolescents. NIMH website. Retrieved from https://www.nimh.nih.gov/health/statistics/major-depression#part_2565

Figure 19: Students with Positive Depression Screens, 2016–2022



Additional health outcomes of interest but lacking consistently collected local data include the number of children with **asthma**, children with **diabetes**, children **whose teeth are in excellent or very good condition**, and children or teens experiencing **anxiety** or with **thoughts of suicide**. Recommendations for integrating those metrics in future reporting will be discussed in the sections that follow.

Outcomes beyond the numbers: What the voices are telling us

From the perspective of students, families, and community partners, understanding the impact of SBHCs requires listening to voices as well as scrutinizing statistics. Many expressed feeling relief and appreciation at having a **consistent and routine source of care**. Numerous voices pointed out the fact that, prior to receiving care at an SBHC, "Children who had asthma, diabetes, or other medical conditions were [going] undiagnosed." One parent described the stark contrast between that situation and what she and her son now experienced at the SBHC: "They take care of making sure that he's up to date on his flu shots, stuff like that. . . . Basically if anything's wrong with him, if he has a stomachache or a virus, anything, they will see him."

Students themselves described feeling healthier, more empowered, and more aware of the close **connection between their physical and emotional wellbeing**. One student described their experience of being diagnosed with a serious chronic health condition: "When I got diagnosed, my mental health started going down, but then they started talking to me about treatments and all that so it kind of made me feel better." In addition to feeling better mentally and emotionally, the student said an added benefit of receiving care at an SBHC has been an increase in their own **health literacy**. The SBHC

"taught me how to make my own appointments. I can't always rely on my parents when I get older. I have to learn how to do things on my own, and that helped me."

Students, parents, and community partners participating in interviews and focus group conversations frequently stated a belief that SBHCs contribute to better **educational outcomes** for students through supporting attendance, engagement, and achievement. Many qualified that belief by acknowledging a lack of clear evidence regarding "cause and effect." As one school partner explained, "I would love to say because a kid doesn't have a toothache anymore, he did better on his English test, but it's really hard to say that. There are so many factors and so many different supports to know which one was the changing influence."

Students themselves suggested that SBHCs made it easier for them to miss less school. One student said that receiving care through the SBHC at school saved him from missing school work. If the student did have to miss class for an appointment, it was "only an hour or two at the most." Another talked about dropping in at the SBHC in case of an emergency and scheduling appointments for less urgent health concerns, which he was able to do during his free periods at school.

Parents indicated that positive relationships with SBHC staff helped their children feel more engaged in school through building their **sense of safety and belonging**. One parent said that although her child had always loved school, "I'm pretty sure [SBHC staff] play a part in it because they're so positive." Another parent drew a direct connection between having access to vision care and students' ability to perform well at school: "For a kid without the right eye care, [it's] another day they can't see the board. They can't focus. It's painful." Medical and educational partners also stated the importance of students with vision problems getting glasses so that they could see the board.

The most poignant description of how SBHCs impact students' ability to focus in school was shared by a student recently diagnosed with a hereditary form of epilepsy that begins at puberty. For this student, the SBHC "helped me not worry so much about my future. . . . When I (first) got diagnosed I'd had a seizure and was worried that I might have another one. . . . Now even if I do, though, I know that the health center is there to take care of me." For this student at least, the presence of the SBHC meant he was able to focus on doing well in school and on his hopes and dreams for the future rather than constantly worrying about what might happen if he were to have another seizure.

System Constraints

As SBHCs strive to expand access to health care and improve outcomes for students and community members, a complex array of organizational and system-level factors impacts their ability to do so. This section describes resource constraints, operational and political considerations, and data challenges that complicate SBHCs' ability to provide or sustain services. That is followed by a discussion of strategies and approaches being used to navigate those challenges.

A complex and variable funding model

The funding model for SBHCs involves a delicate balancing act between districts, state agencies, private foundations, and reimbursable pay for services. As public–private partnerships, funding sources need to be reliable, sustainable, and "make sense financially" for all sides. Medical providers, educational partners, and system funders all highlighted an array of challenges that complicate those goals. To serve as federally qualified health centers (FQHC) and be eligible for services to be reimbursed through Medicaid, SBHCs must provide care to all students regardless of their ability to pay. This model relies upon high consent and utilization rates combined with a low incidence of "no-shows" to offset the cost of providing care to patients who cannot pay. Meanwhile, the ability to bill for services requires a substantial outlay of administrative time and resources due to the complex nature of eligibility, referral, and reporting requirements that vary widely depending upon the type of services being offered; the specific sources of funding; and the income, insurance, and immigration status of the students or community being served. While most medical providers are adept at understanding and navigating these complexities as they relate to their own areas of service, they can prove particularly confusing and cumbersome for educational partners who seek to meet the varied needs of their students and communities by assembling and coordinating an array of different service providers. Finally, centers that base decisions to open or expand services utilizing a high proportion of state or philanthropic funding must often race-the-clock to secure alternative sources of revenue or run the risk of closure or reduction of services once those temporary funding sources run dry.

Persistent staffing challenges

Medical providers and system partners alike highlighted the problem of persistent staffing challenges, ranging from a high number of posted positions remaining unfilled, extended length of time to hire, and limited diversity of candidates within applicant pools. Educational partners gave frequent voice to the high need and interest in offering expanded services but said that their ability to do so was limited by a lack of medical provider availability, particularly in dental, vision, and behavioral and mental health care. Medical providers agreed that recruiting and retaining staff has been a challenge, one made particularly acute by COVID-19. One provider acknowledged that "we just can't hire enough people," while another explained that the "pandemic has slaughtered the medical force." Providers also pointed out that even when they have the financial capacity to hire additional people, there are not enough candidates with the specialized training and credentials to administer diagnostic assessments needed to qualify for reimbursable expenses.

Additional challenges associated with staffing arise from the critical role that trust and relationships play in the success and sustainability of SBHCs. Turnover among district staff, especially at the superintendent level, can hinder or derail the progress of SBHCs as the new superintendent may have a different vision or strategic priorities. A new principal at a school or a new medical provider at an SBHC could also affect relational dynamics. There may also be challenges if the medical partner and the school are not a good fit. According to a system partner, "You cannot force a medical partner to choose a school or a school to choose a medical partner. It has to be a partner that they want." The partners went on to advocate for an extensive "pre-planning match-making process," which pays careful attention to matching medical partners with schools.

Limited space, entrance accessibility, and transportation

Many of the students and partners interviewed expressed a wish that SBHCs were bigger and had a greater availability for appointments so that they could serve more students and community members. Educational partners explained that not every school has space available to locate a SBHC and that others may be able to accommodate one but lack space to add additional services, such as vision or dental care. According to a medical partner, "Most of the school buildings lack space to add these types of auxiliary services." A related and frequently cited challenge is that many schools lack a separate entrance for the SBHCs, which limits their accessibility during times and days when schools are closed. This challenge prohibits some SBHCs from offering services to the surrounding community or limits their availability to school hours only. And because not all schools house SBHCs and only some offer auxiliary services, transportation to other sites is often needed in order for students to access the care they need. According to one medical partner, "Transportation is a huge barrier across the board for our patients."

The politics of equity, reproductive health, and gender-affirming care

Some partners talked about how SBHCs get "thrown into" controversies around politically charged issues. In particular, reproductive health and gender-affirming care "can be controversial," and overt references to engaging in equity-related work can be complicated in environments where the term *equity* is viewed with suspicion and equated with Critical Race Theory. Political controversies and tensions hold implications for the types of care provided and the students able to access them. As one example, a partner noted that while refugees qualify for Medicaid, undocumented immigrants do not. Meanwhile, the topic of gender-affirming care was conspicuously absent from the interviews and focus group conversations conducted.

Providers and partners expressed a diversity of perspectives regarding the role that heath equity does and should play for SBHCs. Some indicated that the commitment to health equity is satisfied when SBHCs offer care to all students regardless of their ability to pay. Others noted that SBHCs help reduce persistent disparities because they are often located in low-income schools with larger concentrations of diverse student populations. Still others highlighted a need for SBHCs to explicitly address the specific needs and challenges experienced by historically underserved communities and populations.

Lack of data alignment and interoperability

When discussing data collection among SBHCs, partners talked about the challenges posed by differing requirements and systems for tracking and reporting data. With no standardized requirements established at the state level, decisions about what data to track and how, when, and where to report it often vary by provider, although regional collaborations such as Growing Well are helping provide some degree of commonality. One partner explained that they have consistently expanded data collection over the years. Where they initially tracked the number of visits, users, and consent rates at each school, they now collect data on equity-related indicators, such as the percentage of students on Medicaid and race/ethnicity data. Aggregating and analyzing across multiple providers is further complicated by the fact that different partners utilize different electronic data management systems and platforms to track and report data, including electronic medical records (EMRs) such as EPIC and NextGen. Some partners talked about the challenges of complying with federal regulations, such as FERPA and HIPAA, while another stated that SBHCs should not be deterred as they "overcome those issues all the time."[6] While progress is being made, the lack of standardized measures and metrics continues to limit the ability to make claims and comparisons regarding improved access and outcomes over different time periods, locations, or providers.

6. See Joint Guidance on the Application of FEBA and HIPAA to Student Health Records and hipaa-ferpa-infographic-508.pdf.

Facilitating Factors

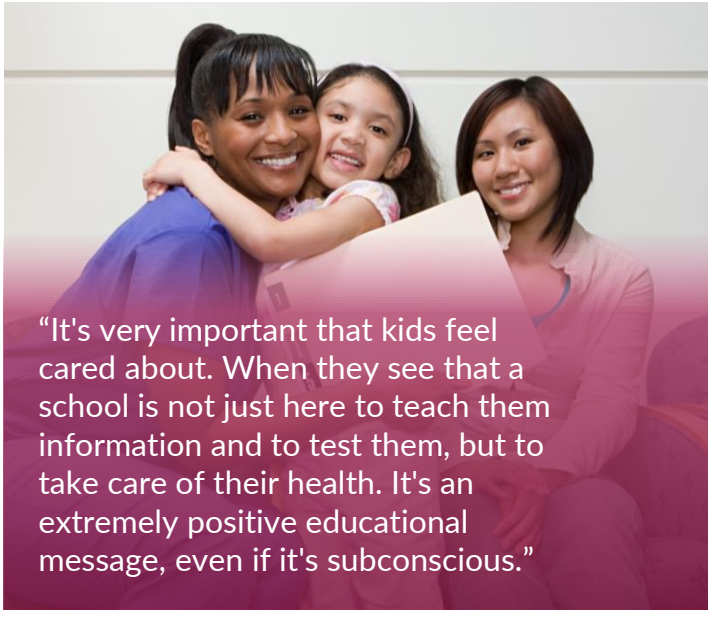
Despite the considerable array of challenges confronting them, SBHCs in the Greater Cincinnati region have succeeded in expanding access to care and improving health outcomes for students and the community by employing a range of strategies and approaches, as described in the following section.

Starting with trust

Students and families opt-in to receive services through SBHCs by completing consent to care forms. In order for them to do so, they must first feel safe and welcomed by both the school and medical staff. Rather than presuming that trust already exists, schools and providers can take proactive steps toward earning it by prioritizing relationship building, listening, and treating parents and students with respect.

In focus groups and interviews, students frequently commented upon how important they found it when SBHC staff "treat you as if you're one of their own," "make me feel like I can ask questions," and take time to "make sure I feel comfortable with the decision that they're making." Parents concurred, saying that "the staff is amazing. They are great. They listen, and I think that is one of the main things that helps families is when you have somebody who listens and cares." Another commented that SBHC providers respected them as experts on their own children, saying, "They listen to my concerns because nobody knows your child like you do." Another parent said, "These people work with my child and will listen to me as a parent." One parent described a situation in which her child was being bullied at school, and an SBHC staff member intervened on the family's behalf: "[The SBHC staff member] personally walked me and my son over to the school, went in, and was like: 'I need the principal or assistant principal.'" Another parent, who is also an educator at another school, said, "It's very important that kids feel cared about. When they see that a school is not just here to teach them information and to test them, but to take care of their health. It's an extremely positive educational message, even if it's subconscious."

While building trust and relationships is important for all students and families, it is critical with underserved and marginalized populations because of a historical legacy of discrimination and past experiences of feeling unseen, unheard, and unwelcomed. Research has shown that mistrust of medical providers [7] and healthcare systems results in worse outcomes for patients. It can negatively impact patient–clinician relationships and make it less likely for patients to share important



7. See Medical News Today. (n.d.) Medical distrust linked to race/ethnicity and discrimination. https://www.medicalnewstoday.com/articles/medical-mistrust-linked-to-race-ethnicity-and-discrimination#Mistrust-and-health-discrimination.

health-related information with their medical providers. When there is trust, patients are more willing to discuss potentially sensitive health problems with their medical providers, but that trust may be less prevalent for some racial and ethnic minority groups.[8] Mistrust in the U.S. healthcare system likely stems in part from a historical legacy of discriminating against and exploiting Black Americans. Studies have also shown that Black patients often feel unseen and unheard by medical providers.[9] Accordingly, one medical partner talked about prioritizing underserved and marginalized community members and working to eliminate or reduce barriers and build trust: "One of our priorities is focused on underserved population [and] marginalized community members. . . . We have a vested interest in ensuring there are no barriers or reduce as many barriers as we possibly can . . . and to build that trust factor."

Earning that trust comes in many shapes and forms. To **provide equitable and culturally responsive care**, many SBHCs offer translated materials and interpreters and make an effort to hire bi-lingual staff, especially for the front desk. Some seek to support health education and literacy so that students and families feel equipped to navigate the healthcare system and advocate for themselves. Some recognize that every interaction is an opportunity to either earn or undermine trust and thus make the effort to "prioritize the seemingly little things," such as bringing a "comfort bag" with toys and coloring books to make children feel cared for, even during the short drive when transporting them to or from medical appointments.

Because they require parent and community support in order to be successful, SBHCs "need to be deliberate and intentional about seeking engagement." For some, that process begins with the initial planning process for opening a new center through holding focus groups and establishing a community advisory council. Other models include creating student advisory councils such as the **Youth Health Hub,**[10] sponsored through the national School-Based Health Alliance. Local School Decision Making Committees (LSDMC) provide another forum for gathering community input and feedback on the services provided by SBHCs. Within the Cincinnati Public Schools, LSDMCs are composed of parents, community representatives, teachers, school leaders, and sometimes students and serve as the local governing body for each school while providing input into decisions that impact students' lives and educational experiences.[11]

In addition to building trust with students and families, the relationship between medical providers and educational partners is critical as well. Strong **buy-in by school and district leaders** is key for the sustainability and success of SBHCs. As one educational partner stated, "If the principal doesn't love the idea, then don't even try it because it's not going to work. If the principal doesn't find it valuable . . . then it's just

"One of our priorities is focused on underserved populations [and] marginalized community members. . . . We have a vested interest in ensuring there are no barriers or reduce as many barriers as we possibly can . . . and to build that trust factor."

9. See Wells, L. & Gowda, A. (2020). A legacy of mistrust: African Americans and the US healthcare system. *Proceedings of UCLA Health, 24*. https://proceedings.med.ucla.edu/wp-content/uploads/2020/06/Wells-A200421LW-rko-Wells-Lindsay-M.D.-BLM-formatted.pdf.
10. See School-Based Health Alliance. (n.d.). Youth Health Hub. SBHA website. https://www.youthhealthhub.org/
11. See Cincinnati Public School website. https://www.cps-k12.org/Page/183 for more information on LSDMCs

not going to be successful." A medical partner pointed out that "it starts with the superintendent because . . . if they're not sold on this making a difference for their youth, it's going to be very difficult to navigate within the district."

According to educational partners, SBHC staff need to be an "active part of the fabric of the community." One medical partner talked about setting expectations for SBHC staff to be fully engaged and immersed in the school community and culture:

> "I ensure that my team is fully immersed in the culture of that school district. I expect them to participate in events, whether that's a football game, a basketball game, or a choir concert, but they truly are embracing who they are as a part of the team of that school district. Because I feel wholeheartedly that that trust is imperative, and that the students need to see you as a part of their school system, not an external entity that has just plopped down a space inside of their building."

Similarly, another medical partner stated: "We really try our best to be present at different school activities . . . to just be kind of like a normal part of the school environment to normalize that [the SBHC] is here and available to everybody." An educational partner talked about how SBHC staff who participate in school luncheons and holiday parties are working toward "knocking down that wall of us and them . . . I think you have to make it a priority."

Supporting systems of care

Establishing trusting relationships with students and families as well as with a range of educational and community partners equips SBHCs to function as an integral part of a broader system of care. Like spokes of a wheel radiating in many directions, SBHCs help connect students with a variety of services beyond their own scope of responsibility or capacity. One medical provider described the need for centers to have a "cross-sectional understanding of roles and responsibilities. . . . We're not the one-stop shop for all. We are a piece of this puzzle that we're trying to fit together." For example, SBHCs will make referrals to mental health agencies or specialists for medical and dental care if the care that is needed is beyond the scope of what the SBHC can provide. SBHCs can generally "handle the mild to moderate end of the spectrum," but referrals may be needed for more specialized or intensive services.

For educational partners, SBHCs serve as valued partners in their effort to educate and care for the whole child. For schools, that mission takes many forms, including serving as hubs for community services. Following a Community Learning Center (CLC) model, schools help convene and coordinate a system of integrated partnerships, which promote educational, social, health, civic, and cultural opportunities for students, families, and the surrounding community.[12] One principal described the approach in terms of anticipating "where the need is going to be" and taking steps to address it as part of an overall plan. The school provides services such as washing clothes so that all students would have clean clothes to wear, and it offers a food pantry where students can take whatever they needed for their families. The result has been a school with a strong support system that "feels like a family." In this environment, the SBHC, which addresses the health needs of the school community, is viewed as one part of a larger system of support.

12. See https://www.cps-k12.org/domain/152 for more information about Community Learning Centers in the Cincinnati Public Schools.

While SBHCs can contribute to this model of collective support, they can also benefit from it. Mustering support for integrated mental and behavioral health services, for example, medical providers and educational partners from one district issued a joint appeal to student health and safety goals already committed to within district-wide strategic plans. Framing advocacy efforts with direct reference to established goals and embedded frameworks, such as the Educating the Whole Child framework or Multi-Tiered System of Supports, provided a successful rationale not just for securing needed funding but also for follow-up support and accountability.

Of course, the larger and more varied the group of community partners, the greater the effort needed to coordinate their efforts. To support effective collaboration between all partners involved in providing integrated mental and behavioral health services, for example, required ongoing participation in regular meetings between SBHC and school staff, monthly behavioral health team meetings involving all medical providers, and quarterly district-wide Wellness Committee meetings. Although a significant outlay of time, one participant described the critical value derived from such meetings: "The ability to meet on a [regular] basis is really pretty powerful because it opens up conversations that may not always happen. You're meeting new people and you're learning about services."

Cross-sector collaboration and coordination

Beyond the advantages of coordinating efforts among the various educational and medical partners who operate or offer services through SBHCs, soliciting the involvement of additional cross-sector collaborators can help address pressing capacity gaps. Local institutions of higher education can be a particularly valuable source for both technical expertise and personnel support. Seeking to provide dental services at a newly opened center in rural Kentucky but unable to attract a dental provider, SBHC staff and advocates turned their attention to securing support from the University of Kentucky College of Dentistry. Viewing the request as an opportunity to help fulfil its mission to create a healthier Kentucky,[13] the college agreed to provide specialized staffing support and screening tools to help launch the effort. While direct staffing support may potentially prove to be a temporary stop-gap measure, the university and others like it are receptive partners to addressing gaps in the longer-term health care workforce development pipeline through an array of emerging programs, such as offering pathway programs for aspiring health care professionals from historically underserved and underrepresented ethnic and racial backgrounds, prioritizing clinical placements in underserved communities, and offering tuition reimbursement opportunities for currently employed health care workers seeking to grow and advance within their fields.

Though not wholly the result of unique partnerships such as with the University of Kentucky College of Dentistry, cross-sector partnerships have helped contribute to the rise in staffing capacity at SBHCs since 2017. As depicted in figure 20, non-SBHC-sponsored personnel account for over 20% of overall staffing.

In addition to supporting short- and long-term staffing needs, higher education partners can be sources of valuable technical assistance to

13. See UK Healthcare website at https://ukhealthcare.uky.edu/community-commitment/workforce-development

Figure 20: Staffing FTE at SBHCs, 2016–2022

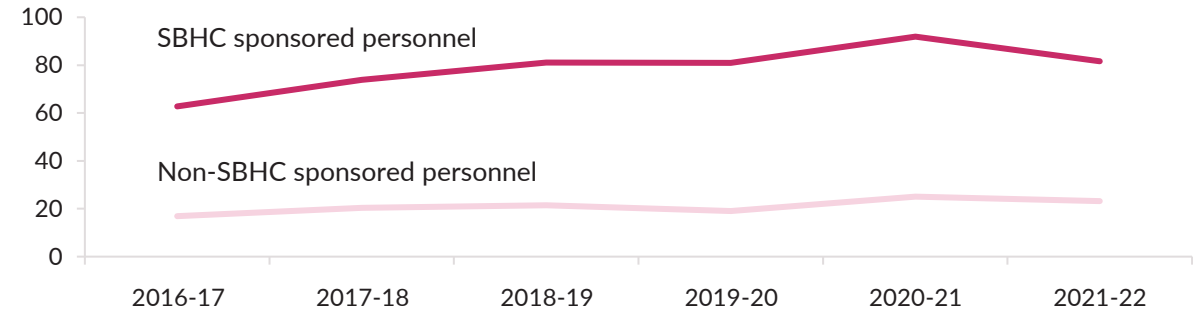
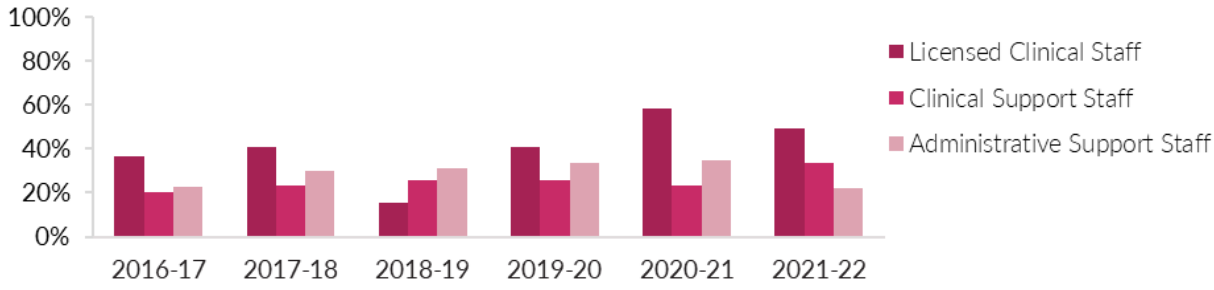


Figure 21: FTE by Staffing Type, 2016–2022



support the operational needs of SBHCs. Graduating students from Xavier University, for example, designed a data dashboard as part of their senior capstone project to assist a local school district track measures and depict outcomes associated with SBHC services.

Collaborations involving philanthropic partners can also provide benefits that extend beyond direct financing. Interact for Health, for example, utilized a pay-for-performance funding model that specifies key targets associated with improved access, outcomes, and equity. Sites meeting or exceeding three or more targets receive additional funding to help cover administrative and operational costs. In addition to the funding support, a secondary benefit of the pay-for-performance model is the ability to collect data and prioritize metrics through the associated reporting requirements. In this case, quarterly utilization reports served as the primary data source for measuring access and outcomes related to primary, dental, and vision care for 38 SBHC sites throughout the Greater Cincinnati region. Looking ahead, potential refinements to the structure and content of utilization reports provide a powerful tool for influencing the selection of future reporting metrics as proposed within the upcoming recommendations. And looking back as well as forward, partners involved in the Growing Well collaborative network marvel at the "amazing journey" and accomplishments of "having the health centers themselves" continue to come together and work together based upon the shared vision and commitment of a "group of people that have gotten together for 20 years."

Spotlight Case Study

The following case study paints a picture of how one set of committed partners navigated the multitude of challenges encountered during their journey to offer integrated mental and behavioral health care services for all students. While far from a definitive or comprehensive examination of the facilitating factors discussed previously, it is offered to provide insight into the decision-making processes and considerations through which they successfully mobilized support, leveraged resources, and secured the follow-through and accountability needed to launch and sustain their efforts.

The Viking School-Based Health Center and Integrated Mental and Behavioral Health in Princeton City Schools

The Viking School-Based Health Center opened in 2013 and has been serving students in the Princeton City School District ever since. Between 2013 and 2018, the center provided primary care services for students Grades 6 through 12, offering services such as treatments for common illnesses and injuries, management of chronic conditions, physicals, and vaccinations. Beginning in 2019, services were expanded to all students K–12 and included dental and mental health screenings. There are no eligibility, income, or insurance coverage requirements, and no student is denied services due to the inability to pay. Operating in partnership with the HealthCare Connection as its primary health provider, the expansion of services and staffing have facilitated an over three-fold increase in users and total visits within a 5-year period.

Table 3: Viking SBHC Expansion of Services

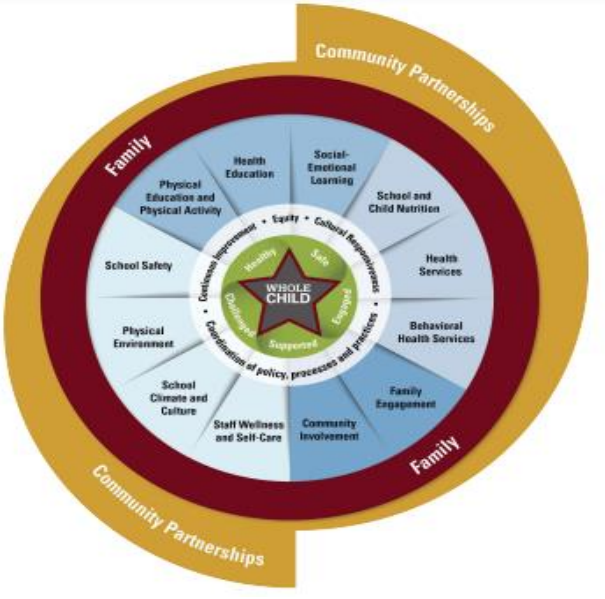
AY	2017–2018	2018–2019	2019–2020	2020–2021	2021–2022
Scope of services	Primary care	Primary care	Primary care, dental and mental health screenings	Primary care, dental and mental health screenings	Primary care, dental and mental health screenings
Staff FTE	1.1	1.8	2.0	2.0	3.0
Grades served	6–12	6–12	K–12	K–12	K–12
Total visits	358	244	498	740	1308
Total users	277	200	346	505	896

Launched prior to the onset of the COVID-19 pandemic, the expansion of services reflected a growing recognition and commitment on behalf of the district regarding the critical importance of meeting the mental and behavioral health needs of its students:

> "As a district, we have to continually assess where mental health access gaps exist and how we can partner to fill these gaps so that we have a school-based, comprehensive framework that can adjust to the needs of our students. Over the past few years, we have been expanding our partnerships with community and health providers to assemble an array of services and supports to address students' social-emotional and behavioral health needs in order to maximize academic achievement. Then when the pandemic hit, the need for increased services just became even that much more apparent."
>
> —former director of Student Services

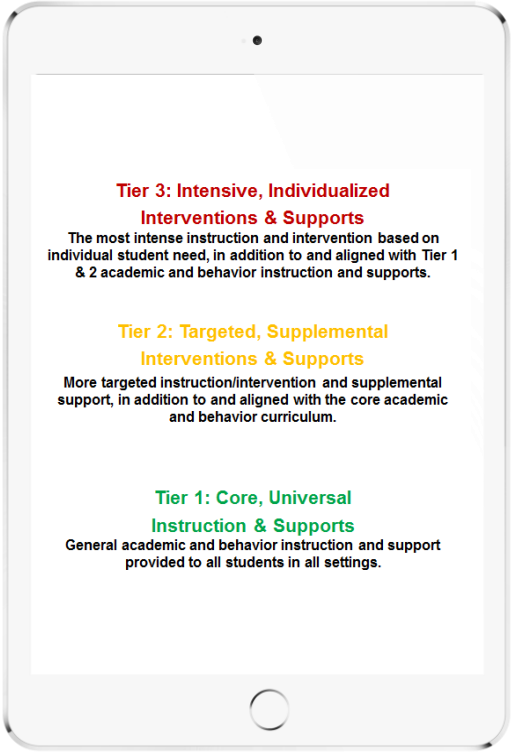
In advocating for the expansion, explicitly tying the request to strategic goals to which the district had already committed proved critical, not just in securing the required funding but also for ensuring follow-up support and accountability. In this case, the connection was made to the student health and safety goal included with the district's strategic plan, academic achievement plan, and equity plan, while also connecting to the Ohio's Whole Child Framework (Figure 22) included within the statewide Ohio Department of Education's "Each Child, Our Future" strategic plan.

Figure 22: Ohio's Whole Child Framework



School-based mental health services were also strategically situated within the district's multi-tiered system of supports framework which distinguishes between universal services available to all students and more intensive services available to smaller, more targeted populations of students. Tier 1 services embedded within the general academic instruction and behavioral support system for all students included social-emotional learning curricula, suicide prevention and anti-bullying programing, and screening for risk and resiliency factors. Targeted Tier 2 and Tier 3 interventions include alcohol and drug awareness and prevention programing, bi-lingual counseling programs, mental health screenings, short-term counseling, completion of the Adverse Childhood Experiences (ACES) survey, and referrals to Princeton mental health partners.

Figure 23: Multi-Tiered System of Supports



While already working in close collaboration with the HealthCare Connection as the primary care provider at the Viking SBHC, the district-initiated outreach to a wide array of additional community partners and providers with **the capacity and expertise needed to provide specialized services**. The National Youth Advocate Program and Catholic Charities were brought on board to provide bilingual school-based counseling programs. A collection of community-based mental health agencies (Talbert House School Based Counseling, Lighthouse Youth & Family Services School Based Counseling, Camelot Community Care Day Treatment, and the Children's Home of Cincinnati School-Based Day Treatment) contributed to the provision of Tier 2 alcohol and drug awareness and prevention programs as well as more targeted Tier 3 interventions in mental health counseling. Moving beyond provision of direct services, the Cincinnati Children's Hospital Medical Center sponsored Trauma-Informed Educator professional development trainings focused on equipping teachers to better support students' mental, emotional, and behavioral needs within the classroom setting by understanding brain health science, the challenges associated with trauma, self-care strategies, and mechanisms for managing trauma in school environments. Yet another community health provider was brought in to support the district Employee Assistance Program and support the mental and emotional health needs of teachers and staff.

The resulting array of expanded services and providers dramatically increased access to the range of mental health services available for students while simultaneously supporting schools' instructional and behavioral goals. It also presented a **complex set of challenges to navigate**.

First, each new set of services introduces a new set of funding streams, reporting requirements, and eligibility criteria for district, school, and health center personnel to wade through. To exemplify the maze of differing eligibility requirements:

- Access to Tier 3 student mental health services requires counselor referral, parent/guardian consent, a diagnostic assessment, and Ohio Medicaid eligibility.
- Access to bi-lingual counseling services requires a counselor referral, parent/guardian consent, and a diagnostic assessment.
- Access to risk and resiliency programing is available district wide and can be orchestrated at the school level, for targeted grade levels, or for students with Tier 2 or Tier 3 behavioral health concerns.
- Alcohol and drug prevention and short-term counseling services can be accessed through school counselor referral and does not require a diagnostic assessment or Medicaid eligibility.
- Counseling for district staff members and their families through the Employee Assistance Program can be accessed through self-referral.

In addition to the differing eligibility requirements for specific services, the referral process is complicated yet further by the varied circumstances, income, insurance, and immigration status of students and families in an increasingly diverse district. Ohio Medicaid is a major funding stream for community mental health partners but requires students to qualify subject to family income guidelines. While other students may rely on their family's private medical insurance coverage, still others have no health coverage due to immigrant status or other factors. As a result, matching students to needed services is an ongoing and constantly evolving process that requires both educational partners and medical providers to reach and maintain shared understanding around a series of critical issues, including but not limited to the following:

1. How various funding sources are utilized to pay for the cost of school-based mental health service delivery
2. How Medicaid eligibility drives the level and scope of school-based mental health services students receive
3. How school-based mental health supports are organized into a multi-tiered system of supports
4. How school-based mental health supports and services are delineated across different schools

To support their ability to communicate around these issues and navigate a host of other organizational and emergent challenges, the district and its various partners committed to a series of regular venues for ongoing coordination and collaboration.

> "We were coming across so many different issues and working so hard trying to stay abreast of what was going on that we decided we needed more of a chance to connect and learn from each other. Once we were partnering so heavily with so many different partners, we really began expanding who we were bringing to the table to participate in our regular meetings."

School-based health center meetings, monthly behavioral health team meetings, quarterly district wellness committee meetings, and even monthly community and parent education meetings all brought together staff from the district and

schools, the HealthCare Connection and school-based health center, county health departments, and community mental health providers. Sharing data, solving mutual problems, and learning each other's system requirements and constraints helped build trust and provided a platform for further connections.

> "Because of that increased communication we ended up moving forward with such stronger partnerships and collaborations around how to navigate not just the pandemic but everything that was going on. We ended up feeling like we had more hands on deck, better focus on what was really going on with our students and in our schools, and better systems for sharing information and tracking our student health acuity data."

Beyond the complexity of eligibility requirements, the labyrinth of **differing data requirements** and systems has been a second important hurdle to negotiate. Depending upon their specific set of services provided, funding sources, and accrediting bodies, some mental health providers track outcomes for therapeutic services using the Ohio Scales for Youth, reporting problem severity scores and functioning scores every 90 days. Others utilize the GAD-7 Assessment to screen for generalized anxiety and/or the PHQ-2 or 9 Questionnaire to screen for depression. Still others employ symmetric diagnostics for dental screening, or Terrace Metrics life skills assessment for social-emotional wellness.

Establishing regular and collective meeting spaces helped both district staff and medical providers build familiarity with and understanding of not just the data and measures themselves but

Figure 24: A Village of Partners

of what each other was doing, the results they were seeing and aspiring to, and the conditions and constraints under which each was operating. It also afforded an opportunity to systematize and streamline the maze of data where possible as well as make fuller use of the data being collected.

> "We were coming across so many different issues and working so hard trying to stay abreast of what was going on that we decided we needed more of a chance to connect and learn from each other. Once we were partnering so heavily with so many different partners, we really began expanding who we were bringing to the table to participate in our regular meetings."

Bringing new partners to the table has also afforded opportunities to tap additional funding streams and build capacity to meet a broader range of student needs. Noting the lack of bi-lingual clinicians among their current mental health staff, the district went in search of new potential partners capable of filling that gap. Identifying two, they contracted with National

Youth Advocates and Catholic Charities to provide bi-lingual counseling services to their growing community of Spanish-speaking students. And due to the population being served, they were able to pay those contracts out of Title III funding for English language learners and leverage funding previously unavailable to support mental health services.

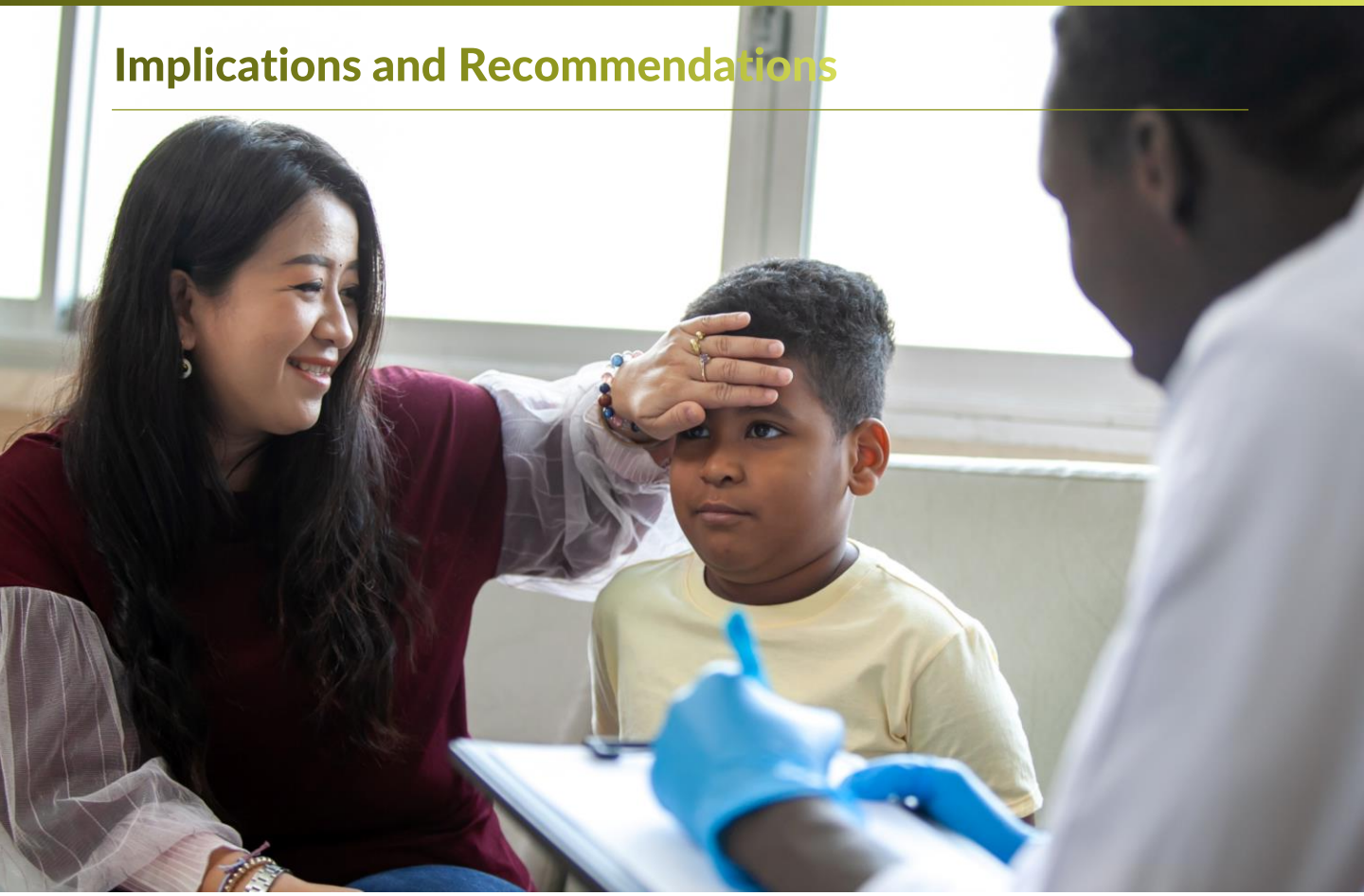
Building trust and relationships with multiple partners at the table has also enhanced their collective ability to think creatively about how to maximize the impact of the dollars spent on services. Among the resulting changes has been a shift away from fee-for-services contracting and toward an FTE model. Providing a more consistent funding stream for contracting agencies to budget, the shift also benefits schools and students:

"Moving to an FTE model allows us to have a provider here on site for a given amount of their time knowing that we can make full use of their time to serve as many kids as we can send their way."

In the case of the Princeton City School District, the Viking School-Based Health Center has and continues to serve as a critical catalyst for a series of cascading benefits, partnerships, and learnings. While not all services are solely located in the health center, bringing multiple providers to the table in and around the center and devoting time and space for ongoing collaboration and coordination helps establish a win-win-win situation. The district, schools, and providers benefit through their enhanced ability to access funding, systematize and share data, simplify referrals, and navigate the complexity of eligibility requirements. Most significantly of all, students benefit by virtue of having direct access to the services they need, setting them up for success in school and in life.

"Just as it takes a village to raise a child, it takes a village of partners to run a school-based health center."

Implications and Recommendations



School-based health centers can make significant contributions to expanding access to health care services, improving health outcomes, and narrowing health disparities for students and communities. In conversations with educational partners, medical providers, and system partners directly involved in planning, supporting, and operating SBHCs within the Greater Cincinnati region and in community comparators elsewhere around the country, five recurring themes emerged as key factors in shaping the nature and extent of that impact:

1. Health Equity and Access
2. Student and Family Engagement
3. Coordination, Collaboration, and Integration
4. Staffing and Capacity
5. Assessment and Reporting

In this section, we describe those themes and offer insights and recommendations to consider when making decisions about the design, operation, support, and evaluation of SBHCs.

Throughout the section, we employ the term **creative tensions** to highlight competing priorities surfaced through interviews and review of data. Unlike dichotomies, in which one priority is valued or pursued at the expense of the other, creative tensions recognize the validity of competing priorities while acknowledging the potential challenges and tradeoffs involved in pursuing both. The recommendations we offer in the following sections are informed by innovative approaches we observed being employed by SBHC providers and partners both within and beyond the Greater Cincinnati region.

Health Equity and Access:
Improving Outcomes and Reducing Disparities

Health equity means everyone has a fair and just opportunity to be as healthy as possible.[1] While health outcomes experienced by individuals are partially shaped by their personal choices, behaviors, and heredity, the opportunity to be healthy is also influenced by a range of social determinants and system-level factors, such as economic stability, educational access and quality, social and community context, and the neighborhood and built environment in which people live.[2] Included among these external factors, access to affordable and quality health care services plays a critical role.

Barriers to access can prevent individuals from receiving needed health care services and lead to worsening conditions, greater risk of chronic disease, greater expense and preventable hospitalizations when care is finally received, and disparities in both opportunity and outcomes for disadvantaged populations. Common barriers include limited availability of services within certain communities; lack of transportation to reach services; inability to pay for services that are available; the complexity of navigating the medical and insurance systems; and feeling unsafe, unwelcomed, or stigmatized due to past negative experiences with the health care system or providers.

School-based health centers increase health care access and improve health outcomes by reducing or removing many of the barriers experienced by the students, families, and communities they serve. Some system partners characterize SBHCs as "addressing equity by design" because they serve all students regardless of income and are often located in low-income schools with a larger percentage of marginalized and underserved populations. Other partners highlight the need to explicitly address persistent health disparities by attending to the unique needs and challenges experienced by historically underserved populations and communities. The specific framing of health equity—in particular the relative balance weight placed upon promoting universal access and providing targeted support for priority populations—holds significant implications for the design, operation, and evaluation of SBHCs.

Creative tension #1: Promoting universal access while also providing targeted support for prioritized populations

Most SBHCs **promote universal access** by ensuring that no students are denied services due to the inability to pay. The absence of eligibility, income, or insurance coverage requirements extends access to all students, normalizes the experience of receiving care through the SBHC, and reduces the likelihood that students may feel or be stigmatized when doing so. A second strategy for promoting universal access is to co-locate a range of services within the same site. Co-locating primary, dental, vision, and/or behavioral and mental health care improves access for all students by reducing the time and difficulty needed to access services and navigate referrals. As will be discussed in the sections that follow, additional approaches to enhancing staffing and capacity also offer potential for extending universal access by increasing the availability of services.

1. The Health Collaborative. (2021). Greater Cincinnati and Greater Dayton Regional Community Health Needs Assessment. Retrieved from https://healthcollab.org/chna-reveals-regions-priorities/
2. Centers for Disease Control and Prevention. (2022). Social determinants of health at CDC. Retrieved from https://www.cdc.gov/about/sdoh/index.html

Strategies for supporting priority populations center around understanding and responding to the specific challenges they confront. Transportation is a significant barrier frequently encountered by low-income populations and rural communities. The cost and challenge of taking time off work to transport children to appointments, along with the additional time and expense associated with taking public transportation, can be a significant burden for lower-income families. Transportation challenges are often compounded for families living in rural communities where the lower concentration of health care providers require traveling greater distances and investing more time and expense to do so. SBHCs can mitigate these challenges by offering transportation assistance, such as travel subsidies or providing a vehicle and driver to transport students directly. Telehealth and mobile vision and dental care services also increase access to health care for students, families, and communities for whom transportation is a barrier. Additional strategies for providing targeted support for priority populations that will be discussed in further detail in subsequent sections include adopting asset-based approaches for encouraging student and family engagement, cultivating a culturally responsive and representative SBHC work force, and applying an equity lens when assessing and reporting outcomes and quality of care.

Recommendation #1: Expand telehealth, mobile care, transportation services, and the scope of services co-located in SBHCs.

There is an opportunity and expressed desire for expanded services offered at SBHCs to meet the needs of students and families. In particular, partners, students, and families spoke to unmet needs for dental, vision, and mental and behavioral health care. Some partners pointed to expanding telehealth as a means for increasing access to behavioral and mental health services, particularly in rural areas. Others cited successful models for addressing transportation challenges through mobile units and direct travel services, including a dedicated van and driver to transport students to appointments. Additional opportunities mentioned for expanded preventative care include applying fluoride varnish and increasing suicide prevention efforts.

Recommendation #2: Explicitly align SBHC services with strategic goals and statewide frameworks to which districts have already committed.

While co-locating services is an important strategy for expanding access to primary, dental, vision, and behavioral and mental health care, it can be a costly and complex undertaking. In seeking to secure the necessary support and commitment of resources, framing the issue in direct reference to existing goals and frameworks already codified within district and statewide strategic and continuous improvement plans has proven to be a winning strategy. Specifically, aligning behavioral and mental health services with Educating the Whole Child frameworks, including the Community Learning Center Model, and Multi-Tiered System of Supports has proven to be a winning strategy for Princeton City Schools.

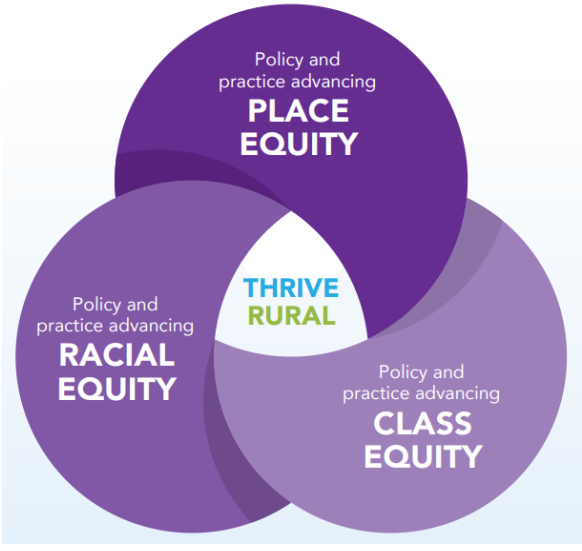
Recommendation #3: Employ the Thrive Rural Equity Framework to bridge the gap between universal access and targeted support for priority populations.

Efforts to promote both universal access and support for priority populations are rendered

more challenging when the two are viewed as being in opposition to or in conflict with one another. Particularly within today's highly charged and partisan political environment, efforts to acknowledge and address persistent disparities and pursue equity-related goals can frequently be perceived or portrayed as coming at the expense of universal access for all students. The concept of "creative tensions" is offered as one tool for avoiding or responding to such dichotomous framing. As previously stated, creative tensions overtly assert the validity of competing priorities while acknowledging the complexities and potential tradeoffs involved in pursuing both.

The Thrive Rural Framework[3] provides a second powerful tool for overcoming the tendency to frame equity in a dichotomous manner. Jointly produced by the Aspen Institute, Robert Wood Johnson Foundation, and University of Wisconsin Population Health Institute, the framework depicts and describes specific ways in which race, class, and place-based disparities manifest in rural contexts. Importantly, it also shines attention upon how the strengths and assets of rural places can be melded together to promote shared and widespread prosperity, health, and wellbeing. For SBHCs grappling with how to frame and advance health equity, the Thrive Rural Framework offers a widely recognized and politically agnostic vehicle for depicting race, class, and place-based equity as complementary and mutually reinforcing priorities. Particularly as SBHCs continue expansion into more rural communities while maintaining their presence within more racially diverse urban areas, referencing, endorsing, or formally adopting the Thrive Rural Framework may provide a helpful touchpoint for advancing a shared understanding of health equity.

Figure 25: Thrive Rural Equity Framework



3. Aspen Institute (2022), Thrive Rural Framework. Retrieved from https://www.aspeninstitute.org/publications/thrive-rural-framework-overview/

Student and Family Engagement:
Making the Leap from Access to Equitable Access

Beyond common barriers to access described previously, additional obstacles frequently confront members of historically underserved populations. Language barriers and cultural differences can make communication challenging for both patients and providers, potentially leading to confusion, misunderstandings, and/or negative perceptions and experiences. Particularly where patients or their family or community members have experienced a history of negative interactions, fear of judgement, condescension, or distrust can undermine the willingness to seek care or be forthcoming about symptoms or concerns. Each of these barriers can be compounded by a lack of proportionality between the racial, ethnic, and linguistic composition of health care providers and the communities they serve.

As previously discussed in the Findings section, building trusting relationships between medical providers, educational partners, students, families, and communities is critical for the success and impact of SBHCs. To facilitate trust building, SBHCs engage in a variety of community outreach events, proactive communications, incentives for participation, and forums to invite student, parent, and community input and voice such as advisory councils and local school decision-making committees (LSDMCs). As important as these efforts are, their success largely depends upon the extent to which students and family members feel welcomed, respected, and valued by both the school and medical providers. Particularly for families and communities who have been historically underserved by the education and/or medical systems, such trust must be earned rather than presumed.

Creative tension #2: Proactively inviting student and family involvement while acknowledging the legitimate basis for historical distrust

Evidence of trust within certain SBHCs rang clear in the community conversations reported in the Findings. Other indicators of trust can be found in the rate of students consenting to receive care and in the racial and ethnic mix of SBHC users relative to the population of the school as a whole. And particularly during and since the COVID-19 pandemic, the average rate of immunizations may serve as another potential proxy for trust and the success of community outreach and trust-building efforts. Where those numbers are less than desired, school and health center staff should view building or restoring trust as a responsibility that rests primarily upon their shoulders.

Recommendation #4: Apply asset-based, student-ready frameworks to facilitate equitable family engagement strategies.

Educators have long viewed student and family engagement as a critical ingredient for success in school. Whereas some commentators portray a lack of engagement as evidence of parental indifference, research indicates that engagement is primarily school initiated and school led. [4] While schools need parents to be involved and supportive of their children's learning, schools themselves need to be perceived as welcoming and supportive of parents acting as partners in setting and reinforcing goals for their children.

4. National Association for Family, School, and Community Engagement. Reframing the Conversation. Retrieved from https://nafsce.org/page/ReframingtheConversation

Doing so requires that teachers and school leaders set aside any preconceptions regarding the shortcomings and deficits of students and families in favor of an asset-based perspective that recognizes, affirms, and builds upon their strengths, capacities, and commitments. Rather than expecting all students to come to school fully equipped and "ready to learn" and then blaming students or parents if they fail to do so, schools (and by extension SBHCs) bear responsibility for becoming student-ready and "meeting them where they're at." From sending hungry children home with kitchen kits to bringing a comfort bag stocked with toys and coloring books when transporting students to and from appointments, SBHCs that were most successful remain mindful that little things matter and that every interaction with students and families presents an opportunity to build trust.

Recommendation #5: Employ proactive outreach and marketing strategies, including advertising in ethnic news media and local news outlets.

During the course of interviews and community conversations, students and community members flagged numerous opportunities for SBHCs to increase engagement and raise awareness through effective outreach. Students talked enthusiastically about putting up flyers and posters at school, and school partners discussed the value of having SBHC staff attend school events, assemblies, and community potlucks. Community members suggested setting up informational booths at community centers and churches, advertising in ethnic media, and getting the word out through local news outlets. Another promising suggestion was to include information on SBHCs and consent forms in electronic student data-gathering systems, such as FINAL FORMS.

Coordination, Collaboration, and Integration:
Operationalizing Partnerships to Close Care Gaps

Care gaps refer to the discrepancy between the health care patients need and the health care services they actually receive. Factors contributing to care gaps include a lack of availability of needed services, barriers to accessing services that are available, and a lack of follow-through on the part of patients in scheduling or keeping appointments.

Strategies to improve the availability of services at SBHCs will be discussed in the Staffing and Capacity section that follows. Strategies to improve patients' follow-through include proactive communications to remind them of upcoming appointments and incentives for arriving at appointments. Although these strategies can be time consuming and costly for providers, both have been employed and found to be effective by SBHCs. Strategies for lowering barriers to access include providing transportation assistance, telehealth and mobile care options, and co-locating multiple services at the same site.

While co-locating multiple services and providers at SBHCs is an effective means for reducing the challenges students face when trying to access care, educational partners and medical providers still confront significant challenges due to wide variations in eligibility requirements, funding streams, and reporting metrics associated with different types of services and populations of patients being served. The wider the range of services being provided, the greater the challenge of learning, navigating, and remaining up to date with the labyrinth of differing system requirements.

Creative tension #3: Providing access to complementary services while managing multiplying system constraints

Each referral or hand-off of patients between different providers is an opportunity for someone to fall through the cracks and encounter a gap in care. Coordinated care seeks to minimize those cracks and gaps by having providers take responsibility for sharing information, connecting the dots, and working together to help patients get all the different kinds of services they need.[5] Care integration, meanwhile, takes the additional step of restructuring the way services are delivered to create a more seamless experience for patients by bringing different services together and minimizing the need for transitions and hand-offs.[6] In the case of SBHCs, both models involve an additional layer of complexity in requiring communication and coordination not just between medical providers but also the school and district serving as their educational partner.

Recommendation #6: Create multiple and varied opportunities for medical providers and educational partners to exchange information, learn each other's systems, and engage in barrier busting.

While SBHCs can be an important piece of the puzzle in providing access to a range of services within a wider system of supports, doing so effectively and sustainably requires a substantial commitment on the part of all parties involved to

5. Agency for Healthcare Research and Quality. Retrieved from https://www.ahrq.gov/ncepcr/care/coordination.html
6. Poku, M. K., Kagan, C. M., & Yehia, B. (2019). Moving from care coordination to care integration. *Journal of General Internal Medicine* (34), 1906–1909.

build trust, learn about each other's systems, and engage in ongoing information sharing and troubleshooting. For this to occur, regular, frequent, and focused communication and collaboration between partnering organizations are critical. Growing Well is an example of the incredible things that can be accomplished when a committed group of individuals from different organizations meets regularly and develops trust and relationships that then serve as a foundation for their work together. In a similar fashion, regular participation in district wellness committees, behavioral health teams, school advisory councils, and/or local school decision-making committees provides an equally important opportunity for ongoing collaboration, information sharing, and trust-building between medical providers and their educational and community partners.

Recommendation #7: Allocate dedicated FTE to provide backbone support to facilitate regular convenings and information sharing among different partners.

Initiating consistent communications, convening regular meetings, and prompting follow-through on agreed-upon decisions require time, focus, and commitment. While launching new initiatives such as the establishment of SBHCs often results from the program of caring and committed individuals, the long-term effectiveness and sustainability of those efforts require an organizational- and system-level commitment rather than merely individual-level commitment. Particularly given the eventual likelihood of staff turnover and the emergence of other priorities competing for people's time and attention, allocating dedicated FTE for backbone support within an established position description is essential to ensure the continued viability and impact of inter-organizational, cross-sector undertakings such as SBHCs. Additionally, education of the systems providing care can accelerate the success of and reduce the pressure on staff to meet conflicting goals.

Staffing and Capacity:
Growing the Pie through Innovative Practices, Pathways, and Partnerships

Across the health care system, access is frequently constrained by the limited availability of services due to staffing and resource constraints. SBHCs are no exception. Days of operation and number of available appointments are directly related to the number and FTE of qualified clinical staff. Numbers of visits and users seen are further limited when licensed providers are engaged in administrative tasks in addition to providing direct patient care. Likewise, the range of dental, vision, and mental health services provided are dependent upon the availability of specialized providers in those areas. Meanwhile, the ability to recruit and hire additional staff is further constrained by the limited pipeline of qualified staff and by the temporary or restricted nature of available funding. The high number of posted positions that remain unfilled, extended length of time to hire, and limited diversity within applicant pools are all indicative of worrisome and persistent bottlenecks within the health care workforce development pipeline.

Thus, while expanding the number and range of SBHC services is a valuable step toward improving access and outcomes for students, the ability to do so requires that intentional and innovative attention be given to increasing staffing and resource capacity. Fortunately, a range of effective models are already in place within the Greater Cincinnati region and close proximity.

Creative tension #4: Leveraging innovative practices while maintaining professional standards

Integrated health care workforce development models involve cultivating cross-sector partnerships between local employers, regional workforce development boards, institutions of higher education, and public and philanthropic funders to develop, support, and incentivize career pathways for both licensed clinicians and paraprofessional support staff. With all parties having a vested interest in ensuring a diverse and high-quality workforce, each contributes to advancing shared priorities through supporting collaborative grant opportunities, job training and apprenticeship programs, clinical supervision, tuition assistance, and other forms of support for candidates seeking to enter or advance within the health care field.

Recommendation #8: Support Grow Your Own pathways for paraprofessional clinical and support staff.

While licensed providers such as MDs, DDSs, LNPs, RNs, and mental health counsellors are essential to the ability of SBHCs to provide clinical care, expanding the supply of qualified candidates is constrained by the high cost and lengthy duration of professional training, rigorous certification standards, and strong competition from a broad range of health care employers. Recognizing that the capacity of licensed practitioners to provide patient care is reduced when they are occupied by administrative tasks or non-specialized services, some providers and partnerships have focused on augmenting their clinical capacity by hiring and reallocating non-specialized duties to paraprofessional support staff, such as health care assistants and community health workers.

Due to their lower educational, training, and certification requirements, pathways to recruit and train paraprofessional staff are significantly quicker and cheaper than for licensed clinicians. As a result, they are also far more accessible for local community members, parents, and other adult learners seeking to enter or return to the workforce. Grow Your Own (GYO) programs involve schools, local employers, and other community partners proactively reaching out to identify, encourage, and incentivize candidates from within the local community to participate in the training and education necessary to prepare them to fill positions of need. Recent graduates, parents of students, and other community members already volunteering within schools are all prime candidates for GYO programs tailored to meet the staffing needs of SBHCs. And because they recruit from within the local community, GYO programs based within demographically diverse neighborhoods can make valuable contributions toward diversifying the health care workforce to be more closely representative of the students being served and enhance SBHCs ability to provide equitable access and culturally responsive care.

Recommendation #9: Cultivate partnerships with local postsecondary and higher education institutions to support an integrated workforce development model.

Beyond supplementing the capacity of SBHCs, paraprofessional positions can also serve as an attainable first step in a career ladder trajectory leading eventually to more advanced training and specialized roles. To support and accelerate that process, local community colleges and universities can partner with local medical providers in developing non-degree pathways, certificates, and micro-credentials in areas ranging from health care administration to dental, behavioral, or mental health assistants. SBHCs can both support and benefit from such programs through serving as practicum and internship sites for students pursuing such credentials as well as degree-seeking students in fields such as nursing, psychology, and premed. Graduate schools of medicine or dentistry can augment the staffing capacity of SBHCs by including them as approved sites for candidates to complete clinical requirements, having full-time or affiliated faculty serve as clinical supervisors, and/or providing direct service hours, screenings, or equipment as part of their commitment to community outreach. While several providers in the region have adopted a version of this model, universal adoption would likely lead to a more robust pipeline of future providers.

Recommendation #10: Employ a braided-funds approach by leveraging funding streams with differing eligibility requirements.

Beyond staffing considerations, securing stable and sufficient sources of funding is a second significant capacity constraint for many SBHCs. The ability to offer and bill for services is the product of a complex interplay of factors, such as whether those services are grant funded, billed to Medicaid or private insurance, or paid for through statewide educational allocations; the extent to which funding sources are restricted or temporary in nature; and particular characteristics of the students or community being served, including their income, insurance, and immigration status. A braided-funds approach seeks to make virtue out of necessity by weaving together multiple funding streams to serve an overall population of students and pool of services beyond the scope made possible by any single source. Princeton City Schools' use of Title III English language learner funding to contract for bi-lingual counselling services stands as a successful example of a braided-funds approach from within the Greater Cincinnati region.

Assessment and Reporting:
Working Smarter Rather Than Harder When It Comes to Data

SBHCs expend considerable time and effort on collecting and reporting data. Across the Greater Cincinnati region, quarterly utilization reports track and aggregate over 90 discrete metrics from across 38 different sites. The information gleaned from these efforts is used to measure access and outcomes for the students being served, identify promising practices, and provide pay-for-performance support to local providers.

As valuable as these contributions are, the utility of the data being collected is constrained by two key factors. First, inconsistency in reporting limits the scope and precision with which comparisons over time can be drawn. Second, a lack of alignment with large-scale state and national datasets reduces the range and confidence of claims that can be made regarding relative impact across different communities and populations. While a degree of local autonomy in choosing metrics helps ensure that the process is reflective of and responsive to local contexts and priorities, greater and more selective standardization could enhance opportunities for shared learning and iterative improvement.

Creative tension #5: Honoring local autonomy while acknowledging the benefits of accountability, alignment, and shared learning

Because demonstrating impact and communicating progress serves a critical role in securing ongoing support for SBHCs from local communities, educational partners, and public and philanthropic funders, three approaches for maximizing the utility of reporting metrics should be considered.

Recommendation #11: Redesign utilization reports to allow for deeper outcomes analysis and provide training to ensure consistent reporting across sites.

By creating, collecting, and synthesizing quarterly utilization reports from SBHCs throughout the region, Growing Well makes it possible to collect data on a regional level, share best practices, and design quality improvement programs that address both operational and clinical outcomes. While current utilization reports reflect a host of locally identified priorities, they can be cumbersome and confusing for providers to compile, and the value of the information gleaned from them is not uniformly assumed to be commensurate with the time and effort needed to do so.

Redesigning and streamlining utilization reports to focus on a narrower but more selective range of metrics can help increase the value of the information being collected while simultaneously reducing the administrative burden required of providers. And while the data required by external funders and accrediting bodies certainly has a bearing upon the content to be included, redesigning utilization reports holds the advantage of falling within the locus of control of regional decision makers rather than requiring statewide action that may prove elusive or a long time coming. And rather than working to create a more extensive or robust assessment system, streamlined utilization reports should strive to be more strategic and selective. To that end, Growing Well and its local partners should focus shared deliberations around questions such as the following:

- What story/stories are we trying to tell and to whom through the data we collect?
- What currently collected data are we not using, and can we stop collecting them?
- Where are the gaps in utilization report data?
- Is our collection/reporting system right-sized?
    - Are the data granular enough for disaggregation?
    - Are the data too granular for sustainable collection?
- What is our approach to data equity?
    - Who gets access to data, and why?
    - What are we doing to reduce the extractive nature of data collection?
    - How and where do we close the feedback loop with stakeholders, and how do they benefit from the data being collected and reported?

Recommendation #12: Align local metrics with regional, statewide, and national datasets.

While currently collected data provide a thorough and nuanced window into students' access to health care services, data related to the health outcomes they experience is considerably less detailed. Metrics for reporting additional health outcomes of high relevance for children and adolescents can be drawn from existing regional, statewide, and national datasets. As a potential starting point, the Greater Cincinnati Children's Wellbeing Survey, Annie E. Casey Foundation's Kids Count Data Book, and National Survey of Children's Health include the following outcome indicators not currently reported within regional utilization reports:

- Children with asthma
- Children with diabetes
- Children whose teeth are in excellent and/or very good condition
- Children or teens with anxiety or depression

To ensure the highest quality data, this alignment, along with the application of an equity lens (Recommendation #13) should be applied at the regional, state, and national levels as well. This alignment across all levels would provide local SBHCs, and those across the nation, with multiple levels of comparison.

Recommendation #13: Apply an equity lens to defining and assessing quality of care and reinstitute the Kentucky Parent Survey culturally responsive care module.

Finally, in selecting key performance metrics to track and report, particular attention should be given to including indicators of student and family member's perception of receiving equitable and culturally appropriate care. Questions included in the 2012 Kentucky Parent Survey[7] provide a potential model for doing so:

- How often did health providers show respect for your family's values, customs, and how you prefer to raise your child?
- How often did health providers respect you as an expert about your child?
- How often did health providers explain things in a way you can understand?
- How often did health providers encourage you to ask questions?
- How often did health providers take time to understand the specific health needs of the child?

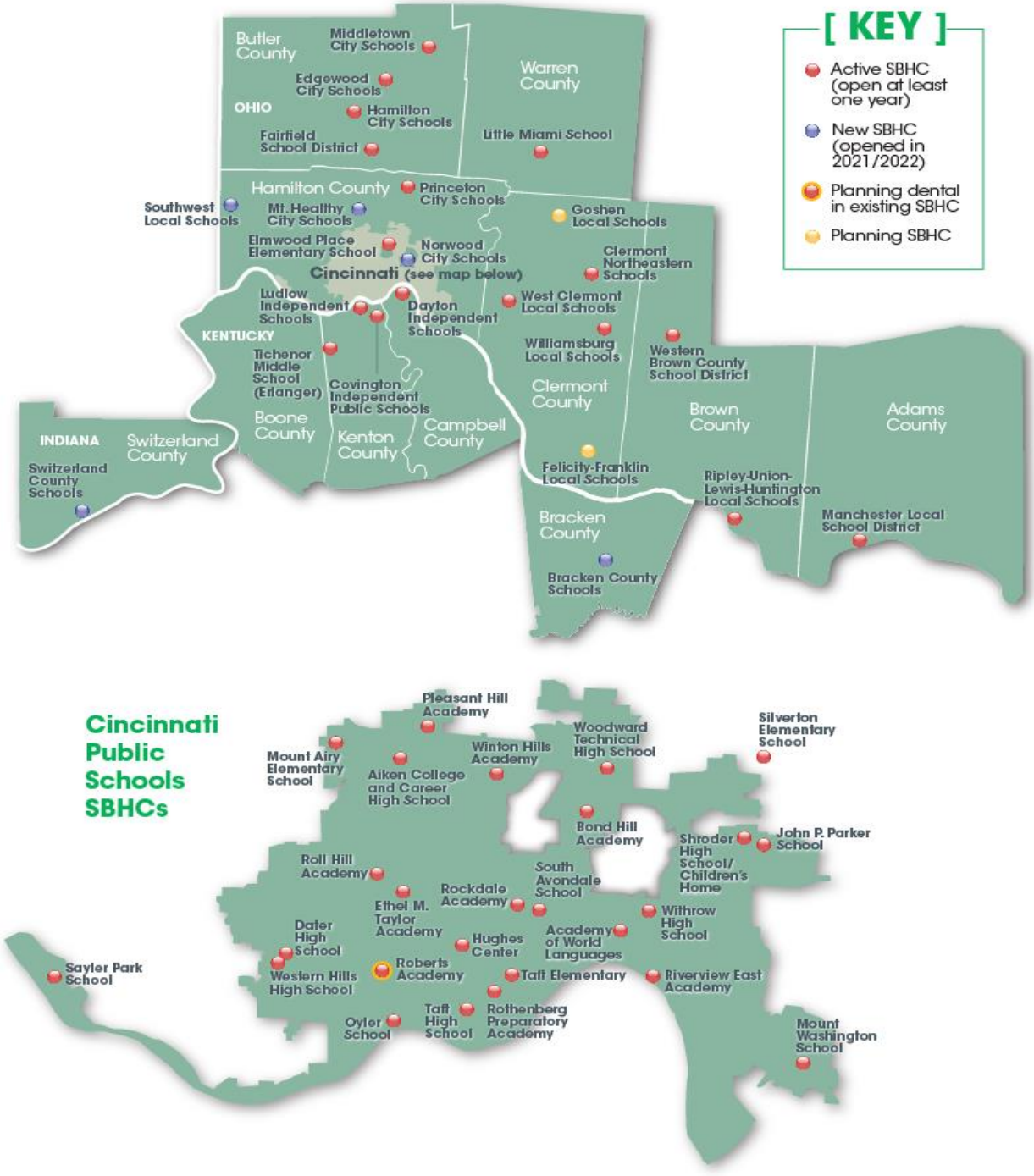
7. Retrieved from http://stats.oasisdataarchive.org/OASIS_CODE/Templates/Home.cfm

Appendix 1: Annotated Data Inventory

PUBLICLY AVAILABLE STATE AND NATIONAL DATASETS				
Resource	**What It Is**	**Example Indicators**	**Notes**	**Lift**
National Survey of Children's Health	Provides rich data on multiple intersecting aspects of children's lives, including physical and mental health; access to quality health care; and the child's family, neighborhood, school, and social context.	→ Doctor's visits (medical, dental, vision) → Rate of disordered eating behaviors → Ease of access to specialist care → Degree of guardian frustration in accessing care for child → Screen time → Parent/guardian health (medical and mental)	Easy query tool that filters by year, state/region, and topic. No search functionality but content map and topic tree are intuitive.	●●○
National Immunization Surveys	Provides current, population-based state and local area estimates of vaccination coverage among children.	→ Rates of vaccination among youth and teens → Reasons for noncompliance → Degree of vaccine hesitancy → Utilization of assistance programs	Questionnaires, codebooks, datasets, and guidance for use with SAS and R make this source quite technical. The information is free and easily available but require data analysis skills to parse.	●●●
KidsCount Data Book	Annual report that presents national and state data across four domains—economic wellbeing, education, health and family, and community—and ranks states in overall child wellbeing.	→ Eighth graders not proficient in math → Children in poverty → Teen births per 1,000 → Children without health insurance → Children and teens (ages 10 to 17) who are overweight or obese	Excellent interactive map & query tool for simple data exploration. Ready-made graphics, summaries, and state profiles. No access to raw data so time series analyses require data scraping.	●●○
Data Catalog | Data Ohio	Rich data library with hundreds of sets that can be filtered by topic or population.	→ Varies by dataset	This resource requires digging and exploration to identify relevant data. The data are presented in various formats.	●●●

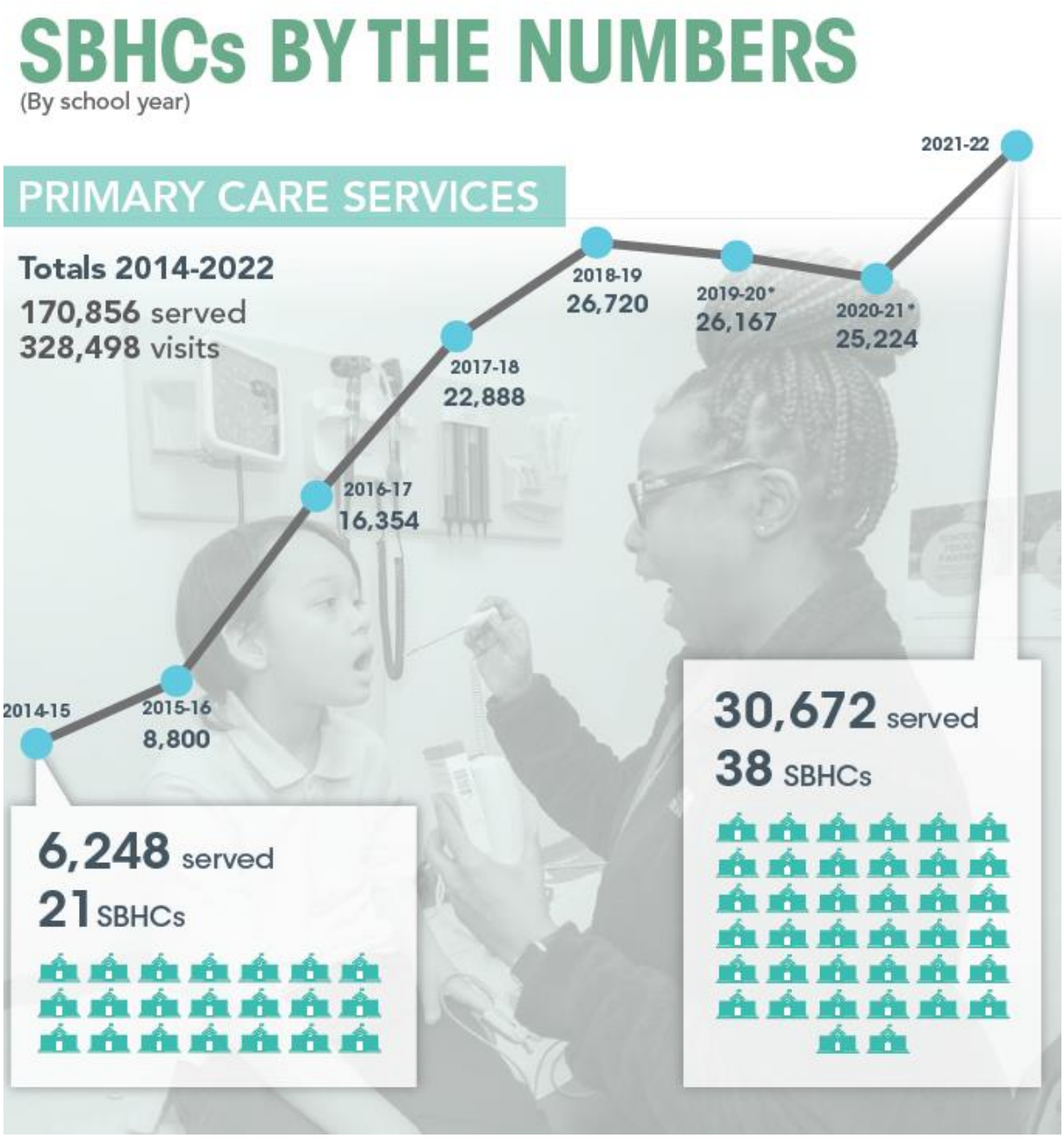
PUBLICLY AVAILABLE REGIONAL DATA				
Resource	**What It Is**	**Example Indicators**	**Notes**	**Lift**
Prevention First Survey	Tool to help understand the scope of substance use, attitudes about substance use, and other safety/health outcomes. Biannual: 2016–2022.	→ Frequency of thoughts of suicide → # of days absent → Ease of getting marijuana	Dense, rich dataset saved in technical file format. Best analyzed by someone experienced in SPSS or other statistics software. Contact Prevention First for 2016 data.	●●●
2017 Greater Cincinnati Child Well Being Survey	Anonymous survey data about the health of children in the Greater Cincinnati and Northern Kentucky area. Approximately 3,000 respondents.	→ Rate of health conditions → Insurance types	Free, accessible, granular data tables available on website. PDF format isn't flexible but there are rich, readily available data.	●●○
2022 Cincinnati Children's Community Health Needs Assessment Report	As a tax-exempt hospital, Cincinnati Children's is required to conduct an assessment of community health needs. This report outlines the needs identified.	→ Prioritized health issues impacting children in the community → Socioeconomic or environmental factors contributing to poor child health → Overall trust of medical research	Lengthy PDF report with substantial amount of data. No public access to raw dataset.	●●○
PROPRIETARY REGIONAL DATA: contact Growing Well to request access to these resources				
Resource	**What it is**	**Example Indicators**	**Notes**	**Lift**
Primary Care Utilization Reports	Number of health care access and outcome indicators as well as staffing across participating sites. Years 2016–2022.	→ BMI screening → Depression screening → User demographic data → Personnel FTE by role → Total users → % Well Child Check	Data in annual reports will need to be cleaned and aggregated.	●●○
Dental Utilization Reports	High level dental care access data. Years 2017–2022.	→ # served → # of visits	Data formatted in annual reports—will need to be cleaned, aggregated.	●○○
Vision Utilization Reports	High level vision care access data. Years 2016–2022.	→ # of users → # needing glasses → % needing glasses	Data formatted in annual reports—will need to be aggregated.	●○○

Appendix 2: School-Based Health Centers funded by Interact for Health, January 2023[1]



1. Interact for Health. (2022). Years in review 2018–2022: What happened, results and lessons learned.

Appendix 3: Interact for Health Progress Map[2]



2. Interact for Health. (2022). Years in review 2018–2022: What happened, results and lessons learned.