



EXECUTIVE SUMMARY

The Colorado Health Foundation's School-Based Health Care Initiative: A Mid-Term Evaluation Report

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OVERVIEW: STEPS, PROCESSES AND TOOLS

Recognizing the important role school-based health programs play in the health and wellness of Colorado's children, the Colorado Health Foundation launched a \$10.8 million, four-year initiative in June 2009 to support school-based health care in communities throughout the state. This report shares preliminary findings from the evaluation of the School-Based Health Care initiative.

Under the initiative, the Foundation set out to support the planning and implementation of more than 20 new school-based health programs. Based on the numbers of students already served by school-based health centers (SBHCs) in Colorado, it is estimated these new programs will provide services for an additional 15,000 students each year. Funding from the initiative may be used to support the development of new SBHCs or the integration of mental or dental health services into existing school-based programs.

Eligible organizations include schools, school districts, community health centers, community hospitals, health care providers, parent or family groups, social service agencies, business groups, and youth-serving and faith-based organizations.

To qualify for funding from the School-Based Health Care initiative, prospective grantees are required to complete the following three-step process designed to ensure readiness, effectiveness and long-term sustainability:

Step 1: Complete a readiness assessment/Apply for planning grant – Applicants complete a readiness assessment to identify community needs, resources and partners. Once completed, applicants fill out an application for a planning grant. The Colorado Association for School-Based Health Care (CASBHC) provides technical assistance in completing the readiness assessments.

Step 2: Prepare a business plan and financial template – To help ensure long-term sustainability while identifying a program's needs, the development of a business plan is a critical component of the application process.

Grantees may receive one of two types of planning grants:

- **Planning grant:** Sites that completed the readiness assessment can receive a planning grant of up to \$20,000 to develop a multi-year business plan. The funding may be used to hire a consultant to develop a business plan, convene community partners and assess necessary school-based health care services. CASBHC compiled a list of consultants to assist grantees with their business plans. Grantees also can opt to recruit their own consultants.
- **Operational planning grant:** Established clinic sites that lack formal business plans could be awarded one-year operational planning grants to develop a business plan and financial template. One-year operational planning grants of up to \$100,000 are available through the Foundation and can be renewed if necessary.

“These types of grant funded programs are critical and the process with the Foundation is exemplary. No matter whether we get funded or not, they walk the talk and are there to make us better organizations. Ultimately, through the process, we are a better organization.” — Planning Grantee

Step 3: Receive an implementation grant – Implementation grants are awarded based on the funding needs identified in the business plan. Grants of up to \$400,000 per program site are available to cover operating costs. The Foundation also considers modest requests to construct or renovate facilities.

EVALUATION GOALS AND METHODS

To make recent findings from the School-Based Health Care initiative available for other communities interested in building or enhancing school-based health care, the Foundation awarded a four-year evaluation grant to a team from the University of California, San Francisco and Philliber Research Associates. This mid-term evaluation report shares findings from the first half of the initiative.

Ultimately, the evaluation aims to determine if the initiative is effective in moving its grantees toward self-sustainability.

Evaluation Methods

During the first phase of the evaluation (spring 2010 to summer 2011), data collection methods included an analysis of readiness assessments and proposals.

To collect feedback on the initiative, political and social support for school-based health care and the challenges and successes of school-based health care in Colorado, the evaluation team also conducted interviews with grantees and key stakeholders.

During the second phase of evaluating the initiative (summer 2011 to summer 2012), the evaluation team used the following data collection methods:

Planning grantee interviews – The team conducted telephone interviews with eight grantees in June and July 2011. Five grantees were interviewed in January 2012. Interviewees (which included clinicians, clinic managers, school district staff and a grant writer) were asked about the challenges and successes they encountered. They were also asked to provide feedback on the initiative's tools.

Sustainability self-assessment tool and implementation grantee interviews – Nine grantees, representing 16 sites, were asked to complete the initiative's sustainability self-assessment tool in the fall of 2011, describing the 2010-11 school year. These nine

grantees also participated in telephone interviews in July and August 2012. The interviews were intended to understand grantees' experiences, the technical assistance they received and their use of planning-grant tools.

Analysis of grantee tools – The evaluation team looked at the readiness assessments and proposals completed by each grantee to develop a clearer picture of the grantees as well as their planning groups, medical sponsors, schools, school districts and communities.

Prior to receiving implementation funding, grantee administrators were required to submit a business plan and two financial templates that projected revenues and costs for the first several years of operation.

In the financial template, grantees submitted a "best-case scenario" and a more "conservative" forecast. The evaluation team reviewed and analyzed these documents, referencing the conservative projections as a point of comparison to actual data during each grantee's first full school year of implementation funding.

Evaluation Next Steps

In 2013, the evaluation team will launch into the next phase of data collection. This phase will include a continued analysis of grantee materials (including readiness assessments, proposals, business plans and financial templates); interviews with grantees on planning and implementation; and an assessment of the initiative's sustainability self-assessment tool.

The team also will conduct interviews with key stakeholders to obtain additional feedback. Finally, the team will develop a series of in-depth case studies highlighting promising school-based health care practices. A final evaluation report will be available in early 2014.



GRANTEE PROFILES

Planning Grantees

Through June 2012, a total of 13 organizations completed the planning grant process for the School-Based Health Care initiative. Characteristics of grantees included the following:

Planning grantees serve all grade levels – Of the 12 organizations that completed the readiness assessments, six planned to serve preschools, eight planned to serve elementary schools, five planned to serve middle schools and eight planned to serve high schools. Seven of these 12 grantees planned to serve only one school while four intended to serve two or three schools. Of the 13 organizations that completed the planning grant process, one was not required to complete the readiness assessment.

Planning grantees' medical sponsors provide a wide range of services – All of the medical sponsors for grantees who submitted readiness assessment information provide medical services. Other services provided by medical sponsors include preventative education (10 grantees), oral health (eight grantees), mental health (five grantees) and substance abuse services (two grantees). Eight of the grantees' medical sponsors had previous experience operating one or more SBHCs.

Eight grantees plan to open new SBHCs – Through June 2012, eight organizations with planning grants to start new clinics had completed their planning grant process (which took an average of eight months to complete). However, many extended their planning periods before officially applying for implementation funding. Six of the eight later received implementation grants; four of these had opened their clinic sites by June 2012. One organization received funding to open a new site and expand services for existing centers.

Six grantees planned to expand services – Through June 2012, six organizations with planning grants to expand services at existing SBHC sites had completed their planning grant process, which averaged eight months. Of these grantees:

- Two planned to add both mental health and oral health services
- One planned to add only mental health services while another planned to add only oral health services
- Two intended to improve clinic functioning

All who submitted business plans and financial templates received implementation grants.

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"I so appreciate the Foundation's fundamental grasp of the value of SBHCs and their dedication to financially and technically supporting the success of SBHCs in Colorado."

— Planning Grantee
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Implementation Grantees

Through June 2012, nine organizations that received implementation grants had participated in the first phase of the sustainability self-assessment process (including the baseline sustainability self-assessment and follow-up interview). Of those, three had opened new clinics by June 2011. Seven had received implementation funding to expand their existing programs. The majority of SBHCs receiving implementation grants had operated for at least three years, with an average of seven years of operation.

To assess the School-Based Health Care initiative's technical assistance and tools, the evaluation team asked grantees to rate the "helpfulness" and "difficulty" of these resources on a five-point scale. Based on the ratings from grantees, the team calculated an average rating.

GRANTEE FEEDBACK ON RESOURCES

Technical Assistance from CASBHC and Technical Assistance Consultants

Description: CASBHC helped nearly all of the initiative's 13 planning grantees with operational, policy and funding issues through its annual conference, emails, telephone calls, Web site resources and other technical assistance. Nine also hired technical assistance consultants during the planning grant. Most were recommended and trained by CASBHC on the initiative's tools.

Helpfulness rating: 4.78 (5 is most helpful)

Technical Assistance from the Foundation

Description: In addition to technical assistance from CASBHC and other consultants, planning grantees appreciated the Foundation's technical assistance via conference calls and webinars, as well as through one-on-one calls and emails.

Helpfulness rating: 4.75 (5 is most helpful)

Comments: "They really leave no stone unturned and make sure that you are really ready," said one grantee. Another reported the Foundation provided "answers and feedback in a quick, timely way."

Additional Technical Assistance Needs

Planning grantees who began work on implementation grants reported they would like additional help with billing, maximizing reimbursement revenue and handling challenging collaborative relationships and information on the initiative grant process for school and community partners (via a webinar or guidance documents).

Implementation grantees also expressed the need to learn about expanding and improving their services by maximizing billing (particularly for mental health services); identifying funding opportunities, deciphering health care reform changes; collaborating effectively with health, school and community partners; understanding health care business models; and predicting changes in client population and insurance coverage.

GRANTEE FEEDBACK: USE OF INITIATIVE TOOLS

Readiness Assessment

Description: Together with a brief online application, applicants identified their needs, resources and partners through a readiness assessment.

Helpfulness rating: 3.79 (5 is most helpful)

Comments: Most grantees appreciated the comprehensiveness of the assessment, saying it helped them organize their "thought process" and inform stakeholders about the need for an SBHC.

Difficulty rating: 3.17 (5 is most challenging)

Comments: Grantees reported the main challenge in completing the readiness assessment was finding the time

to compile and repackage the data. Looking back, grantees agreed the tool helped them establish the need for services and provided a vision and plan. However, only three of the nine grantees reported that they had used the readiness assessment during the implementation grant period.

Business Plan

Description: Planning grant applicants developed a required multi-year business plan, describing their project's purpose, the problem to be addressed, school and district information, organization and management structure, market analysis, marketing and communications plans, and financial and situational needs. Along with the financial template, the business plan is considered a critical component of the application for an implementation grant.

Helpfulness rating: 4.00 *(5 is most helpful)*

Comments: Grantees reported the business plan process brought diverse stakeholders together to clarify goals and outcomes, develop a feasible timeline, and create a unified vision.

Difficulty rating: 3.80 *(5 is most challenging)*

Comments: Grantees identified working with a narrative format as a challenge. Though grantees from Federally Qualified Health Centers (FQHCs) had little difficulty completing the business plan, other grantees struggled to make the document clear and concise. Grantees referred to their business plans during the implementation phase to ensure they were on track for meeting their goals and deliverables, and as a resource in producing new grant proposals.

Financial Templates

Description: In addition to the business plan, grantees produced financial templates for a “best-case scenario” and a “conservative” projection of revenues and costs for the next four years of the site’s operation. The approach required grantees to examine their funding sources and billing practices, providing a clear picture of their long-term sustainability. Preparing financial templates encouraged applicants to consider financial plans from a business perspective they would not have otherwise explored.

Helpfulness rating: 4.20 *(5 is most helpful)*

Comments: The process of completing the financial templates brought together different staff and providers to discuss a plan for the future as well as new proposed services.

Difficulty rating: 4.20 *(5 is most challenging)*

Comments: Several grantees needed assistance completing financial templates because it was time-consuming and, in some cases, because of a lack of

financial expertise. Many grantees were not confident in the accuracy of their projections, but tried to estimate as best as they could, given limited resources.

The task proved less challenging for grantees drawing their projections from existing clinics. Grantees with a medical sponsor or operating agency in place (such as an FQHC) also fared better in the process. Even then, grantees reported that the Foundation’s technical assistance greatly helped them successfully complete the financial templates. Five of the eight grantees that completed the financial template reported using it during the implementation grant to share with their partners and when writing grants.

Sustainability Self-Assessment Tool

Description: This tool was developed to leverage data already collected in the “School-Based Health Centers Survey” and reported to CASBHC every year. Additionally, many items on the assessment tool were borrowed from the “Quality Standards for Colorado School-Based Health Centers: Self-Assessment Checklist,” developed by the Colorado Department of Public Health and Environment.

Helpfulness rating: 4.14 *(5 is most helpful)*

Comments: Most grantees reported that seeing all of the data organized in one place helped them assess their current status and identify gaps and priority areas to focus on to increase sustainability.

Difficulty rating: 2.43 *(5 is most challenging)*

Comments: Some grantees appreciated that data was pre-populated in the self-assessment tool, and that the interviews allowed them to provide more context to their responses. Others mentioned that the tool would be easier to complete a second time since they were now more familiar with the process.

SUSTAINABILITY FACTORS: GRANTEE SELF-ASSESSMENTS AND INTERVIEWS

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This section presents baseline data from the initiative’s sustainability self-assessment tool (or survey) from nine implementation grantees. Findings from implementation grantee telephone interviews conducted in the summer of 2012 are also cited. To gauge the programs’ implementation status, administrators for each site were asked to rate specific indicators on a four-point scale, with the top score representing a program that’s “fully implemented.” This survey measures eight areas considered by the field to be key factors and indicators of sustainability. In order to understand if grantees move toward self-sustainability, these factors will be assessed again at the completion of the SBHC initiative.

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Sustainability Factor No. 1: STAFFING

Interaction with clients, school staff and administration promotes the positive perception of SBHCs within the community. Also, the quality of care the staff members deliver impacts client outcomes and satisfaction.

On average, the SBHC sites had a two-third full-time equivalent (FTE) staff member in primary care, and a three-quarter FTE staff member providing mental health care and/or clinical support staff.

Staffing indicators – Administrators assessed their clinics on four items pertaining to staffing. The average indicator score was 3.61 (*4 equals fully implemented*).

Staffing strengths – Most sites had already fully implemented written job descriptions, had hiring strategies to meet the cultural and language needs of their students, and provided needed staff training. Half had fully implemented organizational charts (the other half had partially implemented them). In addition, very few sites reported staff turnover during the previous year.

Staffing challenges – Given the small sizes of the SBHC teams, any turnover can have a significant (and sometimes negative) impact. Two grantees described staff turnover as a major problem for their sites. Another staffing challenge is delivering clinical services when providers are also required to “wear multiple hats” and perform

vital administrative functions (front desk support, billing, coding, etc.). Time spent on administrative tasks, while crucial for functions such as electronic health records and billing, takes time away from direct patient care.

However, funding administrative staff is difficult for many, particularly since that staff time cannot be billed.

Sustainability Factor No. 2: PROVISION OF SERVICES

Successful SBHCs have designed and tailored services to best meet their school community’s needs. The grantees described the advantages of their integrated care model in which primary care, mental health and even oral health services are coordinated.

Provision of services indicators: Administrators assessed their clinics on 11 items pertaining to service delivery. The nine items received an average indicator score of 3.71.

Provision of services strengths: The highest scores were for extending eligibility to students, creating welcoming and respectful services, conducting outreach, complying with regulations, and administration.

Provision of services challenges: The lowest scores (under 3.5) were for conducting periodic comprehensive needs assessments, and for having 24-hour, 7-day-a-week coverage.

Mix of services: The actual mix of services was higher than projected for behavioral health services (30 percent vs. 19 percent), and lower than projected for immunization and primary care services (58 percent vs. 72 percent).

- **Primary care services:** Fifty-eight percent of visits provided at the initiative-funded SBHCs were for primary care services. Most services are performed on-site and include screenings, health assessments, treatment of chronic illnesses, and prescriptions.
- **Reproductive health services:** The majority of sites provide pregnancy testing (81 percent), sexual risk assessment and counseling (81 percent) and on-site

“Administrative support is not a billable commodity, and we don’t have a way to build it in clearly in the business plan, or space for more staff in our outdated and crumbling facility even if we did. At present, the clinic coordinator and the primary nurse practitioner perform the bulk of the administrative duties.” — Planning Grantee

birth control counseling (69 percent). Some obtain funding for these services through Title X grant funds, which provide a set amount per client. Other grantees described challenges of gaining school permission to provide these services.

- **Mental health services:** Among the grantees, 30 percent of visits were for behavioral health services, with many grantees reporting they expected it to expand to meet the growing needs. Nearly all of the sites provide on-site behavioral risk (94 percent) and mental health assessments (94 percent), as well as mental health treatment (81 percent).

- **Dental health services:** Only 12 percent of visits included dental services — although some grantees described future plans to increase their focus in this area. The majority of sites provide on-site dental hygiene education (75 percent) and dental screening/risk assessment (63 percent).

Sustainability Factor No. 3: FACILITY

A sufficiently large and well-equipped facility is important to a SBHC’s success. This section describes sustainability indicators related to facilities, as well as facility challenges and expansion plans.

Facility indicators: SBHC administrators assessed their clinics on six items pertaining to their SBHC facility. The average indicator score was 3.91.

Facility strengths: All SBHCs occupy a dedicated space and have an exam room, access to computers and telecommunications equipment.

Facility challenges: Some grantees reported that they have only partially implemented functional areas to facilitate privacy and confidentiality. Clinic sizes range from 90 to 2,500 square feet (with an average of 801 square feet). Many identified limited space as a challenge. Others noted that their SBHCs lacked a door directly from the outside, imposing a barrier for non-students.

Expansion plans: Clinics experiencing increased grant and billing revenue seemed poised to expand the hours of services and/or the clinical space; some received federal funding for capital expansion. Others were not ready to expand and wanted to work on improving their existing scope. Noting that flexibility and creativity are necessary to plan for and sustain a SBHC, one interviewee commented, “A SBHC isn’t a franchise; you can’t drop into a school and make it work with the same model for everyone.”

Sustainability Factor No. 4:

SCHOOL INTEGRATION

Another important determinant for sustainability is how well the SBHC integrates within the school environment and how it coordinates with other school health services.

School integration indicators: Program administrators assessed their clinics on 10 items pertaining to their SBHC facility, on the same four-point scale with the top score representing “fully implemented.” In addition, mean scores for stakeholder support, engagement and collaboration were converted to a four-point scale. The average indicator score on these 13 items was 2.92.

School integration strengths: School integration indicators that were most fully implemented (above 3.5) included stakeholder support, strong communication and coordination with school/district health staff and services for school staff. Students, school boards, other school staff, teachers and school administration were all rated as “very supportive” of the SBHCs.

“The capacity of clinical providers is limited. We can’t just increase services because it comes at a huge cost. People are always asking when is the next clinic opening up, but why would you want to expand when we aren’t even financial sustainable? We need to get this machine finely tuned. In order to not be so dependent on foundations – we need to really focus on revenue and get sustainable.”

— Implementation Grantee

School integration challenges: SBHC-school integration indicators that scored the lowest (less than 3.0) included co-locating SBHC personnel with school health staff, partnering in school-wide programs, SBHC advocacy for district-wide health programs and policies, student and teacher engagement and SBHC involvement in school health programs and policy decisions.

In-kind support from school district: All of the sites receive in-kind janitorial services, while the vast majority (94 percent) receives clinic space, maintenance, security, telephone and utilities as in-kind donations from the school district. The estimated value of support ranged from \$2,288 to \$92,312. Grantees reported that guesswork was required in making these estimates because such financial data is not always available from school districts.

Sustainability Factor No. 5:

COMMUNITY PARTNERSHIPS

Securing strong community partners and obtaining their support and engagement is a huge part of sustainability for school-based health care programs.

Community partnerships indicators: Administrators assessed their clinics on two items pertaining to community partnerships, on the same four-point scale with the top score representing “fully implemented.” Additionally, three mean scores for stakeholder support, stakeholder engagement and level of collaboration were all converted to a four-point scale. The average indicators score on these five items was 3.26.

Community partnerships strengths: The highest scores were for soliciting participation from key community stakeholders, support from parents and other community members, and coordinating care with primary care providers.

Community partnerships challenges: Parents and local community members reported to be supportive of and aware of the programs. However, many only took small steps to become engaged, perhaps because of economic limitations and lack of time.

In-kind community support: At the majority of sites, the lead medical agency provides, on an in-kind basis, billing and collection services, financial services, a medical director, administrative staff, and legal services. The most common in-kind support received from another community agency is mental health staff (44 percent) and medical director support (31 percent). Although some grantees reported challenges in accurately estimating these contributions, most felt that they were more accurate than the school in-kind contributions.

There is clear interest from the surrounding school districts in what we are doing. Our hope is that our SBHC can provide the model, and that our medical sponsor and other organizations in the health care community will take the initiative to work with the larger school district on a broader vision of SBHC support throughout the county.” — Implementation Grantee

The role of the medical sponsor: Relationships with the program sponsors vary and often evolve over time, but the central importance of that role was emphasized by all of the grantees. Nearly all of the grantees spoke of how key that relationships and support systems are to the success of their programs. In fact, collaboration with lead medical agencies was rated as fairly high. One of the best practices reported by grantees regarding financial sustainability includes a medical sponsorship from a Federally Qualified Health Center, which can provide billing and administrative support, a higher reimbursement rate and easier access to federal grant opportunities.

Sustainability Factor No. 6: MANAGEMENT PRACTICES

Management also is vital to a program’s success. This section describes sustainability indicators related to management, as well as management challenges.

Management practices indicators: Administrators rated 13 items related to their management practices. The average indicators score was 3.45.

“The electronic medical record is standard in medical practice and with meaningful use and health care reform, it was something we felt we had to accomplish.”

— Implementation Grantee

Management strengths: Sites reported they were closest to full implementation in obtaining consent for SBHC records, working with community advisory councils, developing annual budgeting, developing and updating business plans, collecting and reporting financial data, including providers in clinical policies and procedures, and developing a continual quality improvement plan.

Management challenges: The implementation of electronic health records (EHR) proved challenging to sites because of the expense, time and labor involved in converting to these new systems. But those who implemented EHRs noted that the new system improved their ability to bill Medicaid and Child Health Plan Plus (CHP+) while giving them access to more thorough and accurate patient records which could be charted in real time. Though most grantees appear to have a good understanding of their client demographics, fewer have the ability to track student health and academic outcomes. Most sites had started with the practice management aspects of EHRs (such as scheduling, billing, etc.), but plan to learn how to get more data out of the system, document client outcomes and integrate the EHR between providers. Most grantees reported that the schools are happy that sites are there, and are not requesting academic impact data.

Sustainability Factor No. 7: MARKETING AND OUTREACH

Marketing and outreach also was identified as a key element in the sustainability of SBHCs.

Marketing and outreach: Administrators were asked to rate their status on five items. The average indicators score was 3.36.

Marketing and outreach strengths: The vast majority of sites use a variety of marketing and outreach strategies (e.g., open houses, advertising that engages, and peer-to-peer outreach) and have crafted messages on school health services for different audiences (e.g., students, parents, school staff and the general public).

Marketing and outreach challenges: Few grantees fully implemented a written marketing plan, used data to promote school health services or developed a clear strategy for addressing potential opposition to their site. A number of respondents commented they lack the expertise or resources to move forward in those areas.

Marketing and outreach ideas: Grantee ideas to improve marketing include demonstrating that student absences are prevented due to the presence of the SBHC — either through using attendance data or through anecdotal evidence. Another grantee hopes to gain permission from its school to host its own Web site, rather than posting a web page on the school district’s Web site. Another grantee sought permission to establish a Facebook presence to increase awareness.

Sustainability Factor No. 8: FUNDING STRATEGIES

Effective funding strategies are absolutely essential to ensuring that school-based health care programs have reliable sources of revenue.

Annual costs: In most cases, actual salaries and benefits and program costs exceeded conservative projections, with 13 of the 16 sites underestimating these expenses. Average actual administrative costs were lower than projected, however. Only five sites underestimated those costs (*see graph below*):

Clinic Expenses & Projections	Projected Range (Mean)	Actual Range (Mean)	Mean Difference
Salaries and Benefits	\$6,140 - \$453,461 (\$119,776)	\$66,136 - \$327,351 (\$130,872)	\$11,096
Program Costs	\$1,500 - \$60,561 (\$10,948)	\$0 - \$35,552 (\$16,538)	\$5,591
Administrative Costs	\$4,125 - \$34,883 (\$21,154)	\$0 - \$46,887 (\$15,766)	-\$5,388

Non-patient revenue: Actual non-patient government revenues (averaging \$55,844) were much higher than the projected average (\$23,447). Actual private source revenues (averaging \$74,836) also were much higher than the projected average (\$46,302) because of strong partnerships, primarily with local foundations. All grantees expressed concern, however, about maintaining this level of non-patient revenue.



Patient revenue: Average net patient revenues (\$40,183) were considerably higher than average conservative projections (\$25,996). Average Medicaid revenue was \$30,230–\$16,592 more than conservative projections. Revenue from the CHP+ program was lower than Medicaid, but still exceeded projections. Revenue from other government programs, private insurance and the uninsured was lower than projected (see graph below):

Clinic Revenue & Projections	Projected Range (Mean)	Actual Range (Mean)	Mean Difference
Medicaid	\$0 - \$49,505 (\$13,638)	\$0 - \$100,060 (\$30,230)	\$16,592
Uninsured	\$0 - \$30,714 (\$5,613)	\$0 - \$11,674 (\$3,394)	-\$2,219
CHP+	\$0 - \$11,424 (\$2,795)	\$0 - \$28,248 (\$4,753)	\$1,957
Private Insurance	\$0 - \$8,556 (\$2,496)	\$0 - \$6,772 (\$1,793)	-\$703
Other Government Program	\$0 - \$581 (\$65)	\$0 - \$98 (\$14)	-\$51
Total	\$0-\$90,335 (\$25,996)	\$0-\$134,513 (\$40,183)	\$14,187

Funding strategy indicators: Administrators rated five items related to their funding strategies. The average indicators score was 3.44.

Funding strengths: Nearly all sites provide outreach and application assistance for Medicaid and CHP+. Another strength, as indicated earlier, is the large increase in Medicaid revenue. Grantees are focused on increasing patient enrollment in government and private health insurance programs so that they can boost revenue from these sources. All strongly felt their enrollment from these programs would grow, especially given new federal, state and private efforts to expand enrollment.

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"We have been a grant-funded free clinic forever. We don't have billing oriented, revenue-generation mindset or language." — Implementation Grantee

Funding challenges: Many sites haven't yet developed written billing policies, a sliding-fee scale or a fully implemented billing system. Specific billing challenges include:

Improving billing systems: Most recognize the need to improve their billing systems to increase patient revenue. Developing or improving billing infrastructures through EHRs is a major priority.

- **Increasing patient enrollment:** Most sites employ enrollment staff to efficiently and quickly screen every client and determine their eligibility for coverage programs. Efforts also are being made to credential providers with private insurers and set up insurance contracts. However, grantees reported that this is a challenge.

- **Colorado indigent care providers:** Only five sites are eligible for the Colorado Indigent Care Providers program (CICP), which provides funding to clinics and hospitals so that medical services can be provided at a discount to Colorado residents who meet eligibility requirements.
- **Funding services for uninsured clients:** Of the clinics' clients, 24 percent were uninsured or paid for services out of pocket. Many grantees serve populations, including the undocumented, that are not enrolled in government or private health insurance programs. Clinics generally charge a flat fee or a sliding scale fee for the uninsured. However, the sliding scale goes down to zero for clients who are unable to pay anything.
- **Funding for mental health services:** Securing funds for mental health services was identified by grantees as a particular challenge. Mental health services, in both Medicaid and most commercial health plans, are separate or "carved out" from physical health and paid under a different arrangement. SBHCs that bill Medicaid for mental health services need to maintain mental health staff as separate, credentialed providers under a behavioral health organization (BHO). Such arrangements present administrative challenges related to maintaining separate health and billing records and sharing health information.

- **Policy Advocacy to Improve Financial Sustainability:** Nearly all grantees described appreciation for CASBHC's role in sharing policy information and updates. Most are on CASBHC list-services, attend the CASBHC conference, and refer to tools and information on the organization's Web site.

Other sources of policy updates include the National Assembly on School Based Health Care (NASBHC), national advocacy organizations for FQHCs, private funders such as

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"Our biggest challenge is meeting the needs of the growing population of uninsured and underinsured on a shoe-string budget." — Implementation Grantee

the Colorado Health Foundation and The Colorado Trust, and other professional organizations. Nearly all grantees are focused on national health care reform legislation, and in particular how SBHCs fit into Accountable Care Organizations. Many expressed hopes for state policy change around mental health services reimbursement.



PRELIMINARY FINDINGS

While the Foundation's School-Based Health Care initiative is still ongoing and incomplete, at the mid-point here is a roundup of preliminary findings from the project:

- As of September 2012, the Colorado Health Foundation's School-Based Health Care initiative has supported 33 planning and implementation grants at new or expanded school-based health care sites in Colorado.
- These centers are engaging their school and community partners in thoughtful strategic work to provide health services for students.
- Grantees reported the tools required for the initiative (including the readiness assessment, the business plan and the financial template) were, for the most part, very helpful. During the planning processes, the grantees appreciated valuable technical assistance from both CASBHC and the Foundation's staff.
- Results from the baseline SBHC Self-Assessment Tool and follow-up telephone interviews demonstrated key strengths of the sites including their facilities, provisions of services and staffing. Most sites have fully implemented written job descriptions, hiring strategies to meet the cultural and language needs of students, and staff training.
- Grantees also report strong management of their sites, as demonstrated by their success in working with community advisory councils, developing annual budgets and business plans, collecting financial data, and involving providers in clinical policies and procedures.
- Management challenges for grantees include the need to implement or improve electronic health records and to improve client outcome data collection.
- Regarding funding strategies, grantee strengths include receiving a substantial increase in Medicaid funds, providing outreach and application assistance for Medicaid and CHP+, and developing processes for obtaining Medicaid and third-party billing. Challenges include developing written billing policies, sliding fee scales and effective and efficient billing systems. In addition, actual salaries and benefits and program costs exceeded conservative projections for most sites. Although many sites reported lack of marketing expertise and resources, most grantees use marketing and outreach strategies and have tailored messages on school health services for different target groups.
- Finally, grantees reported strengths with community partnerships, including soliciting participation from community stakeholders, support from parents and local community, communicating with primary care providers, and collaborating with lead medical agencies. The biggest challenge in building community partnerships was engaging parents and the local community. Despite strong stakeholder support, good communication and coordination with school/district health staff, and in-services for school staff, many SBHCs encounter challenges in integrating with other school school-wide programs, co-locating with school-health staff, advocacy for district-wide health programs and policies, engaging teachers and students engagement and involvement in school health programs and policy decisions.

A final evaluation report will be available at the completion of the initiative in early 2014.

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