

# **Sustaining the Future: School-Based Health Center Reform in Washington State**

Claire Johnson, Kate McMurchie, Joshua Rubenstein  
The State of the State for Washington Latinos  
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## **I. Introduction**

In the United States today, universal health care is a topic of national interest and controversy, especially with the recent passage of the Affordable Care Act. With the help of the federal and state governments, many individuals throughout the nation are now able to get health insurance for the first time. Yet in this moment of upheaval in our country's health care system, those who remain unable to access care often find themselves left out of the discussion. While "universal health care" is an exciting buzzword, it does not actually convey the situation facing many Americans, for whom health insurance does not necessarily translate to health care. For instance, though almost every child in Washington State has health insurance, many still struggle to access consistent health care.

Who are these youth? Imagine you are a fifteen-year old student living in poverty in the small town of Walla Walla, Washington. Though you have Medicaid insurance, you have not seen a primary care doctor since you were seven because your parents are unsupportive or busy working and thus do not have time to take you. When you do get sick, you are forced to either ignore it or go to the emergency room for basic care.

It is youth like this that need School-Based Health Centers (SBHCs). SBHCs operate as fully functioning clinics in or near schools, where students can go to receive primary,

preventative and mental health care just as they would at any doctor's office. SBHCs are easily accessible, provide a confidential and safe space away from parents or families, and provide care to any student regardless of their ability to pay. However, SBHCs often struggle financially and have not caught on as a mainstream part of the health care system in most states. For example, Washington does not address SBHCs in law and policy, leaving these clinics without any state support.

In this report we seek to answer the question: What further evidence is there that Washington State should support SBHCs, and what is the best way to fund them sustainably? To answer this question, we worked in partnership with Holly Howard and Katherine Boehm, the executive director and clinic director at The Health Center (THC) at Lincoln High School, a nationally recognized SBHC at an alternative high school in Walla Walla. We started our study in response to THC's inability to bill Medicaid or other insurance providers for the students they see, hoping to find a solution to this problem and a steady source of funding for the clinic. Using THC as a case study, we evaluate the SBHC model's effectiveness in reaching underserved youth as well as the specific financial difficulties these clinics face. We then analyze Washington health care policy and policies regarding SBHCs in seven other states to determine what policy options exist for fortifying these clinics in Washington. We also explore prior scholarship in order to frame our study, including research that addresses disparities in health care for youth, the barriers youth face when accessing health care, the role and success of SBHCs in providing care to such youth, and the best ways to finance SBHCs. Our research both confirms scholarship that indicates the success of SBHCs and elaborates on research of SBHC funding by specifically examining policy in Washington State.

Washington has an important stake in securing the financial viability of SBHCs. We find that these clinics meet the unique needs of underserved youth and thus can help the state keep its promise to provide health care to all children. Based on our research, we recommend that Washington define SBHCs in law and policy, thus recognizing them as an important part of the health care system. Further, we suggest that Washington integrate SBHCs into Medicaid billing structures to provide these clinics with a steady source of revenue.

If Washington puts these recommendations into action, it would secure more sustainable funding for THC in Walla Walla and encourage the development of SBHCs across the state. SBHCs provide low-income, minority and other underserved children with the opportunity to access vital care on their own terms. Increased state support will help encourage the growth of SBHCs in Washington while ensuring the continued success of existing clinics, bringing accessible health care to students statewide.

## **II. Student Health and SBHCs in Scholarly Literature**

Prior scholarship shows that minority, low-income, and uninsured children are underserved by our health care system. To explain this scholars point to the specific factors that prevent people from accessing health care, defined as “barriers to care.” Research shows that children (particularly low-income, racial minority and uninsured children) have specific health care needs that result in barriers to care different than those faced by adults. Scholars further show how SBHCs overcome these barriers and thus agree that these clinics are particularly effective at providing care to underserved children. In the process, scholars show that SBHCs positively impact students’ academics, reproductive and mental health concerns. Even though they are

widely proven as an effective and innovative way of reaching underserved youth, SBHCs nationwide struggle with funding and financial sustainability. Nineteen states do support their SBHCs, and studies from these states show that while state support is not everything, clinics in these areas are more stable and better integrated into the health care network. However, scholars do not agree on the best method for states to support these clinics. Exploring and evaluating these debates will frame our understanding of how Washington State can better support its SBHCs.

## Health Care Disparities Among Children

In the United States, low-income, uninsured, and racial minority children receive less primary and preventative health care than other populations.<sup>1</sup> In a study of the effects of community health centers (CHCs) on eliminating racial health care disparities, Hadley et al. report that Hispanics and other minorities are more likely to be uninsured and less likely to have access to care.<sup>2</sup> Similarly, according to Kataoka et al.'s study on mental health care use among children, "most children and adolescents who need a mental health evaluation do not get any

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<sup>1</sup> Robert M. Politzer et al, "Inequality in America: The Contribution of Health Centers in Reducing and Eliminating Disparities in Access to Care," *Medical Care Research and Review* 58, no. 2 (June 1, 2001); Jack Hadley, Peter Cunningham, and J. Lee Hargraves, "Would Safety-Net Expansions Offset Reduced Access Resulting From Lost Insurance Coverage? Race/Ethnicity Differences," *Health Affairs* 25, no. 6 (December 11, 2006); Ann F. Garland et al., "Racial and Ethnic Differences in Utilization of Mental Health Services Among High-Risk Youths," *American Journal of Psychiatry* 162, no. 7 (July 1, 2005); Leiyu Shi and Gregory D. Stevens, "Disparities in Access to Care and Satisfaction among U.S. Children: The Roles of Race/ethnicity and Poverty Status," *Public Health Reports* 120, no. 4 (2005); Salam Abdus and Thomas M. Selden, "Adherence With Recommended Well-Child Visits Has Grown, But Large Gaps Persist Among Various Socioeconomic Groups," *Health Affairs* 32, no. 3 (March 1, 2013); Sheryl H. Kataoka, Lily Zhang, and Kenneth B. Wells, "Unmet Need for Mental Health Care Among U.S. Children: Variation by Ethnicity and Insurance Status," *American Journal of Psychiatry* 159, no. 9 (September 1, 2002); Glenn Flores and Sandra C. Tomany-Kormam, "Racial and Ethnic Disparities in Medical and Dental Health, Access to Care, and Use of Services in US Children," *Pediatrics* 121, no. 2 (February 1, 2008); Neal Halfon, Moira Inkelas and David Wood, "Nonfinancial Barriers to Care for Children and Youth," *Annual Review of Public Health* 16, no. 1 (1995).

<sup>2</sup> Hadley et al, "Safety-Net Expansions Offset Reduced Access," 1679, 1682.

mental health care in a year, and this [is] more pronounced for Latinos and the uninsured.”<sup>3</sup>

Research agrees that the health care system does not adequately serve these populations.

Scholars frame disparities in health care access in terms of barriers to care. We define this term based on the definition from Sobo et al., who state “barriers to care are conceptualized as processes related to, but distinct from, sociodemographic vulnerability characteristics....

Disparities in care and outcomes arise, in part, because barriers to care moderate each... journey through the health care services system.”<sup>4</sup> The concept of barriers to care allows researchers to point to specific factors, both within and external to the health care system, that impact the amount and quality of care a person actually receives.

While the most obvious barrier to care is a lack of insurance, scholarship points to a number of other key factors that limit children’s ability to get the health care they need. In their study of children’s mental health care use nationally, Kataoka et al. find that “uninsured children [have] higher rates of unmet need [for mental health care] than publicly insured children.”<sup>5</sup> In particular, minority and low-income children are more likely to lack insurance, and thus receive less care.<sup>6</sup> However, Hadley et al. point out that “although eliminating un-insurance would have a sizeable impact on minorities’ access levels, it would not eliminate access gaps.”<sup>7</sup> Kenney et al. show that in Medicaid and Children’s Health Insurance Programs, “thirty percent of enrolled children

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<sup>3</sup> Kataoka et al, “Unmet Need for Mental Health Care,” 1552.

<sup>4</sup> Elisa J. Sobo, Michael Seid, and Laticia Reyes Gelhard, “Parent-Identified Barriers to Pediatric Health Care: A Process-Oriented Model” *Health Services Research* 41 (2006): 150.

<sup>5</sup> Kataoka et al., “Unmet Need for Mental Health Care,” 1553.

<sup>6</sup> Hadley et al., “Safety-Net Expansions Offset Reduced Access,” 1680.

<sup>7</sup> Hadley et al., “Safety-Net Expansions Offset Reduced Access,” 1685.

receive little or no care.”<sup>8</sup> These children have insurance, yet barriers still prevent them from getting care. In short, although insurance improves a child’s access to care, a significant percentage of *insured* youth also do not receive the primary and mental health care they need.

Currently, the health care system does not cater to the “unique characteristics of children” – such as vulnerability due to their developmental needs, dependency on adults, and health needs that differ from those of adults – and thus creates barriers to care specific to youth.<sup>9</sup> In a study of these barriers, Zuckerman et al. find common barriers to care that come from either the health care system or family and community factors. On the health care system side, providers often have inconvenient office hours and make getting appointments, communicating with offices and locating clinics difficult for families and children. As well, the family and community factors that make it difficult for children to receive care include transportation limitations, parents having trouble leaving work and a lack of health insurance.<sup>10</sup> In a survey of youth regarding barriers to care, Samargia et al. categorize barriers as stemming from either “difficulties encountered gaining entry” or “ambivalence about seeking care,” which they name “structural” or “nonstructural” barriers.<sup>11</sup> These structural barriers include “couldn’t pay,” “parent or guardian would not go,” “had no transportation,” and “I am not treated with respect there,” while nonstructural barriers include “didn’t want parents to know” and “afraid of what the counselor

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<sup>8</sup> Kenney, Ruhter, and Selden, “Containing Costs And Improving Care” w1025.

<sup>9</sup> Halfon, et al., “Nonfinancial Barriers to Care for Children and Youth.” 450-451.

<sup>10</sup> Katharine Zuckerman, et al., “Barriers to Specialty Care and Specialty Referral Completion in the Community Health Center Setting,” *The Journal Of Pediatrics* 162, no. 2 (February 2013): 410.

<sup>11</sup> Luzette A. Samargia, Elizabeth M. Saewyc, and Barbara A. Elliott, “Foregone Mental Health Care and Self-Reported Access Barriers Among Adolescents,” *The Journal of School Nursing* 22, no. 1 (February 1, 2006): 22.

would say or do.”<sup>12</sup> Samargia et al.’s decision to survey youth and not parents allows them to identify parental involvement as potential barriers to care, suggesting that sometimes youth need to be able to access health care without direct parental involvement. For example, scholars note that the act of accessing reproductive care can magnify barriers to care for adolescents because reproductive health can be such a sensitive and awkward topic to discuss with parents and peers. In Lindberg et al.’s study focusing on black adolescent males from an urban area, “participants felt that seeking sexual health services was a stressful enterprise.” The participants feared embarrassment, shame, and damage to their reputation if others found out about their need for sexual health services.<sup>13</sup> The different barriers to care these scholars identify all significantly impact the ability of youth to access health care.

Research shows that Federally Qualified Health Centers (FQHC) and other CHCs play an important role in the nation’s health care safety net and reduce barriers to care for medically underserved communities.<sup>14</sup> However, Zuckerman et al., Samargia et al., and Lindberg et al., demonstrate that our health care system needs to address more barriers to care particular to youth. The implication of the FQHC model’s success is that the health care system can and should continue to implement structural and systematic change to eliminate barriers to care for underserved populations. One way to do this is through a health care model designed to meet the

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<sup>12</sup> Samargia, Saewyc, and Elliott, “Foregone Mental Health Care and Self-Reported Access Barriers Among Adolescents,” 22.

<sup>13</sup> Claire Lindberg, Carolyn Lewis-Spruill, and Rodney Crownover, “Barriers to Sexual and Reproductive Health Care: Urban Male Adolescents Speak Out,” *Issues in Comprehensive Pediatric Nursing* 29, no. 2 (June 2006): 80.

<sup>14</sup> To earn the FQHC designation a health center must specifically serve a health professional shortage area, medically underserved area, or medically underserved population and accept patients regardless of insurance status or ability to pay. Description draw from: Anthony T. Lo Sasso, and Gayle R. Byck. “Funding Growth Drives Community Health Center Services.” *Health Affairs* 29, no. 2 (February 1, 2010): 289–296.



unique needs of students. Scholarship shows that by accommodating the specific needs of underserved children and youth, school-based health centers provide a promising health care model specifically designed to meet the needs of students.

### **The Impact of School Based-Health Care on Underserved Youth**

School-based health centers (SBHCs) provide accessible and quality health care in an environment familiar and welcoming to the youth they serve. A long history of scholarship discusses the impact and successes of SBHCs in four main categories: overcoming barriers to care, providing mental health services, providing reproductive health services and impacting academic outcomes.

For youth with limited or no access to quality health care, SBHCs overcome common barriers to care in order to provide the services these individuals most need. In their study of emergency room use among SBHC users and non-users, Key et al. describe how in order to serve the needs of youth, clinics must address the specific challenges these individuals face in accessing care, as detailed above by Zuckerman et al., Samargia et al. and Lindburg et al.<sup>15</sup> Kisker and Brown show how SBHCs do just that. In their study on the effect of SBHCs, they demonstrate how these clinics eliminate transportation issues, financial barriers and reliance on parental support. Multiple studies reinforce Kisker and Brown's research through findings that

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<sup>15</sup> Janice D. E. Key, Camille Washington, and Thomas C. Hulsey, "Reduced Emergency Department Utilization Associated With School-Based Clinic Enrollment," *Journal of Adolescent Health* 30, no. 4 (April 2002): 273.

suggest the effectiveness of SBHCs in providing for uninsured students.<sup>16</sup> By providing students with the independence to access care on their own, these clinics reach underserved youth better than other community health models.

Scholars agree that the comfort created by the welcoming setting and staff of SBHCs directly impacts their success in providing care to children. In their comprehensive study of mental health services at a Chicago SBHC, Gampetro et al. interviewed students who suggested that the accessibility of care, as well as their relationship with clinic staff, gave them the “added courage to pursue and maintain counseling.”<sup>17</sup> Similarly, Wade et al. suggest the importance of the “positive relationships students form with clinic staff” in students use of services at SBHCs.<sup>18</sup> In creating an easily accessible and friendly environment, these clinics are able to reach populations that other community health programs cannot.<sup>19</sup> By overcoming the personal barriers to care children face, such as fear of the health care system, SBHCs encourage students to access the care they need.

Research emphasizes that SBHCs are particularly effective at providing care for low income

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<sup>16</sup> M. A. Allison et al., “School-Based Health Centers: Improving Access and Quality of Care for Low-Income Adolescents,” *PEDIATRICS* 120, no. 4 (October 1, 2007): e887–e894; Ellen E. Kisker and Randall S. Brown, “Do School-Based Health Centers Improve Adolescents’ Access to Health Care, Health Status and Risk-Taking Behavior?” *Journal of Adolescent Health* 18, no. 5 (May 1993): 339; Thomas L. Young, Sandra L. D’angelo, and James Davis, “Impact of a School-Based Health Center on Emergency Department Use by Elementary School Students,” *Journal of School Health* 71, no. 5 (May 2001): 196 – 198.

<sup>17</sup> Pam Gampetro, Elizabeth A. Wojciechowski, and Kim Siarkowski Amer, “Life Concerns and Perceptions of Care in Adolescents with Mental Health Care Needs: A Qualitative Study In a School-Based Health Clinic,” *Pediatric Nursing* 38, no. 1 (January/February 2012): 29.

<sup>18</sup> Terrance Wade et al., “Improvements in Health-Related Quality of Life Among School-Based Health Center Users in Elementary and Middle School,” *Ambulatory Pediatrics* 8, no. 4 (July/August 2008): 241-249.

<sup>19</sup> Gorette Amaral et al. 2011. “Mental Health Characteristics and Health-Seeking Behaviors of Adolescent School Based Health Center Users and Nonusers.” *Journal of School Health* 81, no. 3 (March 2011): 138–145. Jeff J Guo, Terrance J. Wade, and Kathryn N. Keller, “Impact of School-Based Health Centers on Students With Mental Health Problems,” *Public Health Reports* 123, no. 6 (November/December 2008): 768:780.

and minority students. Studies observe that SBHCs disproportionately serve black and Latino youth and students of lower socioeconomic status.<sup>20</sup> Anyon et al. argue that this disparity reflects “cultural and contextual factors” that affect racial minority and low-income students in their ability to gain access to health care.<sup>21</sup> Anyon et al. and others postulate that SBHCs serve these students at a higher rate because the staff make an effort to address their distinct needs by reaching out to students on a personal level rather than just dealing with their immediate health concerns.<sup>22</sup> Berti et al. provide one example of this in a study that shows how homeless youth particularly benefit from SBHC use because staff can help them with both their health needs and the additional struggles they face as homeless students.<sup>23</sup> This scholarship, in general, highlights how SBHCs better reach racial minority and low-income youth by recognizing the specific needs of these populations.

Scholars agree that SBHC users come to these clinics with a higher than average need for mental health care and little previous access to such care. In their study of SBHC users and non-users, Amara et al. find that the students who use SBHCs have “more frequent experiences of depression, anxiety and suicide ideation; higher rates of sexual activity, pregnancy, alcohol and drug use; poorer self-reported health status; greater exposure to violence; and poorer academic

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<sup>20</sup> Yolanda Anyon et al., “Health Risks, Race, and Adolescents’ Use of School-Based Health Centers: Policy and Service Recommendations,” *Journal of Behavioral Health Services & Research* 40, no. 4 (October 2013): 465.; Linda C. Berti, Susan Zylbert, and Linda Rolnitzky, “Comparison of Health Status of Children Using a School-Based Health Center for Comprehensive Care,” *Journal of Pediatric Health Care* 15, no. 5 (September/October 2001): 244-250.

<sup>21</sup> Anyon et al., “Health Risks, Race and Adolescents’ Use of School-Based Health Centers,” 466.

<sup>22</sup> Anyon et al., “Health Risks, Race and Adolescents’ Use of School-Based Health Centers,” 458.

<sup>23</sup> Berti et al., “Comparison of Health Status of Children,” 249.

outcomes.”<sup>24</sup> These students were more likely to visit these clinics than classmates with fewer mental health needs, which Amara et al. argue points to the effectiveness of providing these services through SBHCs.<sup>25</sup> Kisker and Brown reinforce this finding by showing that SBHC users have lower suicide ideation rates than non-users.<sup>26</sup> SBHCs are a vital mental health resource for youth because they feel safe and comfortable accessing the care they need.

Studies agree that SBHCs also successfully meet students’ reproductive health needs. It follows, as Ethier et al. find, that confidentiality is a key reason for this success, as students can get reproductive health services without parental involvement.<sup>27</sup> In a study of New York City SBHCs, Minquez et al. recorded evidence of increased condom and hormonal contraceptive use among students with access to a SBHC.<sup>28</sup> Ethier et al.’s findings complicate Minquez et al.’s work by showing that these clinics were best at providing STD and pregnancy prevention care to female students, but more inconsistent in providing other reproductive health services.<sup>29</sup> The difference in these two studies likely has to do with the fact that SBHCs are often limited in what forms of reproductive health they can and cannot serve due to the controversial nature of the

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<sup>24</sup> Amaral et al., “Mental Health Characteristics and Health-Seeking Behaviors of Adolescent School-Based Health Center Users and Nonusers,” 138–145.

<sup>25</sup> Amaral et al., “Mental Health Characteristics and Health-Seeking Behaviors of Adolescent School-Based Health Center Users and Nonusers,” 144.

<sup>26</sup> Kisker and Brown et al., “Do School-Based Health Centers Improve Adolescents’ Access to Health Care,” 335-243.

<sup>27</sup> Kathleen A. Ethier et al., “School-Based Health Center Access, Reproductive Health Care, and Contraceptive Use Among Sexually Experienced High School Students,” *Journal of Adolescent Health* 48, no. 6 (January 2011): 562-565.

<sup>28</sup> Mara Minquez et al., “Evaluation of a NYC School-Based Health Center Providing Comprehensive Reproductive Health Care,” *Journal of Adolescent Health* 48, no. 2 (February 2011): 119.

<sup>29</sup> Ethier et al., “School Based Health Center Access,” 562-565.

services.<sup>30</sup> Despite the disagreement over what reproductive health services SBHCs best provide, both studies agree that overall access to reproductive health increases among SBHC users.

Beyond addressing direct health concerns, SBHCs also have a positive impact on students' academic lives. Studies show that these clinics improve attendance rates, GPAs and loss of seat time for students because youth can meet their health needs without leaving school.<sup>31</sup> Further, in a study of schools with and without SBHCs, Strolin-Goltzman suggests that the role of these clinics in improving academic outcomes goes beyond attendance. When a SBHC engages with the students and school beyond simply providing health care services (such as by forming close relationships with students or directly working with staff in the school) it impacts "multiple aspects of the overall school learning environment."<sup>32</sup> Specifically, students report increased engagement in their education, an increased sense of school connectedness and improve overall happiness with their school life. Strolin-Goltzman argues that relationships students and parents form with SBHC staff lead to such effects.<sup>33</sup> As this finding suggests, despite the fact that SBHCs are unique because of students' ability to access them without parents, involving parents in the health care process can have a positive impact. Overall, SBHCs facilitate healthier habits and engage with students outside of their direct health concerns, positively influencing the outcome of their academic efforts.

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<sup>30</sup> Kate Fothergill and Ammie Feijoo, "Family Planning Services at School-Based Health Centers: Findings From a National Survey" *Journal of Adolescent Health* 27, no. 3 (September 2000): 167.

<sup>31</sup> Maureen Van Cura, "The Relationship Between School-Based Health Centers, Rates of Early Dismissal From School, and Loss of Seat Time," *Journal of School Health* 80, no. 8 (August 2010): 376.; Jessica Strolin-Goltzman, "The Relationship between School Based Health Centers and the Learning Environment," *Journal of School Health* 80, no. 3 (March 2010): 8.; Walker, Sarah et al., "Impact of School-Based Health Center Use on Academic Outcomes," *Journal of Adolescent Health* 46, no. 3 (July 2009): 6.

<sup>32</sup> Strolin-Goltzman, "The Relationship between School Based Health Centers and the Learning Environment," 3.

<sup>33</sup> Strolin-Goltzman, "The Relationship between School Based Health Centers and the Learning Environment," 3.

In summary, research on the impact of SBHCs generally agrees that they are particularly effective at providing care to low-income, racial minority, and uninsured youth by overcoming barriers to care these students face. Additionally, access to a SBHC can notably impact students' lives, such as by addressing their mental health concerns and improving their academics. Yet, despite the substantial research displaying the potential for SBHCs in reaching the needs of underserved youth, a limited number of these clinics exist throughout the country. The National Assembly on School-Based Health Care suggests that there needs to be 5,808 more SBHCs in order to address the needs of uninsured youth, not even counting state insured and other underserved students.<sup>34</sup> In part, this lack of SBHCs represents the difficulties they face in securing funding.

## **Funding SBHCs**

Even though scholars widely recognize SBHCs as an effective and innovative model for reaching underserved youth and improving adolescent health, these clinics often struggle financially. In the U.S. nineteen states have laws and policies that or support, fund, or regulate their SBHCs. Clinics in these states are able to become more sustainable and better integrated in to the fabric of the state's health care system.

State support of SBHCs varies widely and involves much more than just funding. In terms of actual dollars, the majority of state money directed toward SBHCs comes from state general

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<sup>34</sup> "Location of Existing Programs & Number of SBHCs Needed to Serve Children Living in Designated Health Professional Shortage Areas (Total = 9,816)," *National Assembly of School Based Health Centers*, November 19, 2013,

funds, followed by the Maternal and Child Health block grants and tobacco settlement money.<sup>35</sup> However, as Schlitt et al. emphasize in their survey of school-based health in all fifty states, even this support is usually not enough to sustain a SBHC. Of the nineteen states that fund these clinics to any extent, only two of them provide over 75% of the budget for the average SBHC.<sup>36</sup> Schlitt et al. note additional ways that states encourage the proliferation and sustainability of SBHCs, such as creating state program offices dedicated to these clinics and establishing standards for reimbursement between SBHCs and Medicaid.<sup>37</sup> In a similar study, Lear assesses what features California should include in its SBHC legislation. She describes many of these same findings but also emphasizes the role of the state in defining SBHCs, noting: “if school health centers are to solidify themselves within the health care mainstream, [states] must provide clarity in defining their purpose, location, population served, and detailed service description.”<sup>38</sup> States that fund SBHCs and recognize them in policy increase the sustainability and security of these clinics.

Scholars agree that, since state funding is often not sufficient, all SBHCs should strive to create diverse sources of income from wherever possible, including from various levels of government. This includes federal, state, county and local agencies as well as private grants and donations, support from community organizations, and billing revenues from Medicaid and other insurance companies. Despite this, Schlitt et al. still consider state programs and funding

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<sup>35</sup> John J. Schlitt, Linda J. Juszcak, and Nancy Haby Eichner, “Current Status of State Policies That Support School-Based Health Centers,” *Public Health Reports (1974-)* 123, no. 6 (November 1, 2008): 735.

<sup>36</sup> Schlitt et al., “Current Status of State Policies That Support School-Based Health Centers,” 735.

<sup>37</sup> Schlitt et al., “Current Status of State Policies That Support School-Based Health Centers,” 733.

<sup>38</sup> Julia Graham Lear, “It’s Elementary: Expanding the Use of School-Based Clinics,” *Center For Health And Health Care In Schools* (October 1, 2007): 11.

opportunities the primary concern for SBHCs. In comparison, Swider and Valukas argue that a SBHC's support from the state matters less than its status as a FQHC or its ability to partner with a FQHC as its medical oversight.<sup>39</sup> Swider and Valukas recognize that FQHC certification requirements may be outside the means of some SBHCs, and also that partnership with one might restrict the SBHC's independence in a community.<sup>40</sup> However, the study sees the most sustainability in FQHCs because they are eligible for federal grants and receive much greater revenue from billing for services. Nystrom and Prata's study of SBHCs in Oregon supports this point with the finding that FQHC-affiliated clinics in the state earn much more of their revenue from billing than independent centers.<sup>41</sup> For some SBHCs, these alternative funding sources are completely sufficient to round out their budget, but without the added security of state funding many still struggle.

Researchers pay special attention to SBHCs' relationship with Medicaid and managed care organizations (MCOs). Nystrom and Prata note that in Oregon, Medicaid billing revenues range from 5% of annual funding to 43%, and such a variation seems relatively standard across states.<sup>42</sup> While often a major hurdle, establishing a steady relationship with Medicaid is nevertheless an important goal for all SBHCs because doing so secures a sustainable income source through billing, and helps integrate them into the mainstream health care network. Harvey et al. note in their survey of SBHCs nationwide for the U.S. Department of Health and Human

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<sup>39</sup> Susan M. Swider and Amy Valukas, "Options for Sustaining School-Based Health Centers," *Journal Of School Health* 74, no. 4 (April 2004): 116.

<sup>40</sup> Swider and Valukas, "Options for Sustaining School-Based Health Centers," 116.

<sup>41</sup> Robert J. Nystrom and Adriana Prata, "Planning and Sustaining a School-based Health Center: Cost and Revenue Findings from Oregon," *Public Health Reports (1974-)* 123, no. 6 (November 1, 2008): 755.

<sup>42</sup> Nystrom and Prata, "Planning and Sustaining a School-based Health Center," 755.



Services' Health Resources and Services Administration that developing a clear relationship between SBHCs and MCOs is important because without one duplicative payment can occur.<sup>43</sup> This situation does not maximize the opportunities for state savings or successfully coordinated care for children that could exist if SBHCs and MCOs find a way to collaborate.

Zimmerman and Santelli, and Ambruster et al. identify the barriers to SBHC-MCO collaboration. Both note that communication is a key issue, from a lack of information at MCOs about what SBHCs actually do, to inconsistent data collection at SBHCs that deter MCOs from getting involved with them.<sup>44</sup> Further, it can be difficult for SBHCs to meet the credentialing standards at MCOs, for SBHCs would “need to provide or contract for all primary care services, have extensive management information services, capacity to track utilization, and provide 24-hour coverage, similar to any typical primary care clinic.”<sup>45</sup> Ambruster et al. also add that the administrative burden involved with maintaining an MCO contract can be prohibitive for small, understaffed SBHCs.<sup>46</sup> Finally, Ambruster et al. suggest that these struggles are the result of “philosophical differences” between MCOs and SBHCs.<sup>47</sup> The MCO perspective is that of a business, which tries to keep expenses down and serve only people on their service plan, while

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<sup>43</sup> Jennel Harvey et al., “School-Based Health Centers And Managed Care Arrangements: A Review Of State Models And Implementation Issues,” *George Washington University Medical Center, Center for Health Services, Research, and Policy*.( July 2002): 17.

<sup>44</sup> Paula Ambruster et al., “Collision or Collaboration? School-based Health Services Meet Managed Care,” *Clinical Psychology Review* 19, no. 2 (March 1999): 224.

<sup>45</sup> J.D. Zimmerman and J.S. Santelli, "School and Adolescent Health and Managed Care," *American Journal of Preventive Medicine* 14, no. 3 (April 1998): 64.; Ambruster et al., “Collision or Collaboration? School-based Health Services Meet Managed Care,” 224.

<sup>46</sup> Ambruster et al., “Collision or Collaboration? School-based Health Services Meet Managed Care,” 227.

<sup>47</sup> Ambruster et al., “Collision or Collaboration? School-based Health Services Meet Managed Care,” 224.

SBHCs work to address the needs of all students regardless of insurance.<sup>48</sup> This fundamental difference in purpose must be recognized and reconciled in order to establish a relationship that serves the interest of both parties.

These two studies also pinpoint places where MCOs and SBHCs can find common ground. The most important area they identify is a mutual interest in preventative health care. Zimmerman and Santelli, and Ambruster et al. argue that preventative care serves the goals of both types of organizations because it keeps kids healthy as well as drives down future costs associated with illness, which MCOs might later incur.<sup>49</sup> In their interviews, Harvey et al. also observe that “MCOs cited as the principal advantages of including SBHCs in their network improved immunization levels and fewer emergency room visits,” highlighting SBHCs’ value to MCOs as a site of preventative care.<sup>50</sup> Focusing on preventative care provides a concrete reason for both types of organizations to form these partnerships.

Despite research that shows that “it is well within the capacity of state government” to ensure a working relationship between SBHCs and MCOs, scholars remain divided about what method of doing so is best.<sup>51</sup> Zimmerman and Santelli suggest that SBHCs and MCOs should negotiate these relationships on a case-by-case basis because this provides for more creative possibilities.<sup>52</sup> On the other hand, Ambruster et al. posit that states should take an active role in

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<sup>48</sup> Ambruster et al., “Collision or Collaboration? School-based Health Services Meet Managed Care,” 224.

<sup>49</sup> Ambruster et al., “Collision or Collaboration? School-based Health Services Meet Managed Care,” 225.; Zimmerman and Santelli, “School and adolescent health and managed care,” 62.

<sup>50</sup> Harvey et al., “School-Based Health Centers And Managed Care Arrangements: A Review Of State Models And Implementation Issues,” 12.

<sup>51</sup> Schlitt et al., “Current Status of State Policies That Support School-Based Health Centers,” 737-738.

<sup>52</sup> Zimmerman and Santelli, “School and Adolescent Health and Managed Care,” 65.

encouraging and regulating relationships between MCOs and SBHCs.<sup>53</sup> They use the example of Connecticut, where the state requires MCOs to contract with SBHCs, as a model for how the rest of the country might establish these links. Harvey et al. offer examples of other models that are viable depending on the individual state regulation of Medicaid and definition of SBHCs. These other models include the “carve-out” which allows SBHCs to bypass MCOs and bill the state directly.<sup>54</sup> This study agrees with Ambruster et al. that solidifying these relationships is pivotal to the continued success of SBHCs.<sup>55</sup> State regulations or mandates offer the encouragement and structure that SBHCs and MCOs need. However it is done, facilitating a partnership between its MCOs and its SBHCs is one of the most important roles a state can play in securing the stability of SBHCs.

## **Conclusion**

As studies show, many groups of youth remain underserved by the United States’s health care system. Calling on these youth to identify their own barriers to care brings to light the specific difficulties that prevent underserved children from receiving comprehensive care. As shown above, scholars agree that SBHCs are uniquely equipped to address these needs but lack enough support to do so. While some states have taken notice of the possibility of school-based health playing a greater role in the health care network, for the most part state policy remains

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<sup>53</sup> Ambruster et al., “Collision or Collaboration? School-based Health Services Meet Managed Care,” 229.

<sup>54</sup> Harvey et al., “School-Based Health Centers And Managed Care Arrangements: A Review Of State Models And Implementation Issues,” 24.

<sup>55</sup> Harvey et al., “School-Based Health Centers And Managed Care Arrangements: A Review Of State Models And Implementation Issues,” 36.

unfriendly towards the needs of SBHCs. Additionally, scholars reach no consensus on the best way for states to ensure SBHC sustainability and success. Our research attempts to fill this gap by providing a detailed analysis of the best way for Washington State to support its SBHCs and thus contribute to the health and wellness of underserved children across the state. In addition, we aim to further test the claims of research on the benefits of providing care through SBHCs to make a complete case for reforming school-based health care in our state.

### **III. Discussion of Research Methods**

Given that research shows SBHCs effectively provide care to underserved youth by overcoming common barriers to care, we seek to answer the following question: what further evidence is there that Washington State should support school-based health centers and what is the best way to fund them sustainably? We began our investigation due to The Health Center's (THC) struggle with sustainable funding and their inability to bill public insurance providers. Upon further investigation, we found that scholars do not agree on the best way for states to support these clinics, nor do they address the specific conditions for SBHCs in Washington State. Therefore, our research attempts to fill this gap while further expanding on research about the success of SBHCs.

In order to make the case for why Washington should support SBHCs, we conducted a detailed case study of The Health Center at Lincoln High School. To begin, we collected interviews from nine students and five teachers at Lincoln to better understand how students use and view THC. We asked both groups how and why the students used the clinic and how it impacted students both in and outside of school. We conducted these interviews throughout the

fall of 2013. THC staff suggested the participants, whom we interviewed on school or clinic property for between fifteen to thirty minutes. We obtained written consent from all participants to inform them of how we planned to use their testimony in our report. All Lincoln students, staff and teachers were given pseudonyms in our report to provide anonymity to those we interviewed. To analyze this information we transcribed all interviews verbatim and then ran a coding system to identify themes throughout. We compared and contrasted these themes in an outline detailing the major information gained from all interviews.

To better understand the financial situation of THC, the demographics of its users, and the services it provides, we performed billing analysis on all the medical procedures conducted by THC in the 2009-2010, 2010-2011 and 2011-2012 school years. This included carefully recording the procedure code, patient name, level of care and date from all individual procedure sheets. We then cross-referenced this information with The Health Center and Lincoln databases to gain demographic information on the patients, including race, gender, insurance provider, native language, and nationality. We handled this sensitive data from both THC and the school district confidentially and ensured that it was not released to any other party. Next, we ran statistical analysis on this information to find any correlations. This included mean distribution tests to discover the specific demographics of who used THC and correlation tests to see if there were correlations between demographic information and number of visits or procedures. Unfortunately, due to inconsistencies in THC and school databases, our data was skewed and thus we were unable to run tests on race or insurance provider. We also used our recording of procedures to calculate THC's potential revenue for the past three years. We first tallied all the procedures and their correlating levels of care performed by THC for the last three years. We

then cross-referenced this data with dollar amounts provided by the Washington State Health Center fee schedule to come up with the potential revenue.

By examining Washington policy we explored how the state acknowledges and regulates SBHCs, as well as how state policy dictates SBHC interactions with other health institutions. We looked at different branches and agencies of Washington State government to see how they currently impact SBHCs and their further potential to do so. We analyzed past Washington State legislative action regarding children's health, as well the authority and regulations of the Health Care Authority, Department of Health, and the Office of the Insurance Commissioner. We conducted this research primarily through the online versions of the Revised Code of Washington and the Washington Administrative Code. In addition, we obtained public government documents via the Access Washington database. We also conducted nine informational interviews over the phone with legislators, lobbyists, SBHC program administrators, and agency employees that ranged in length from five minutes to one and a half hours. We then synthesized this information to gain an understanding of the role of SBHCs in Washington State.

Finally, we collected information about law and policy concerning SBHCs in other states around the U.S. that already do fund and support these clinics in order to evaluate what combination of these models Washington State could most effectively implement. We specifically researched Oregon, New Mexico, Colorado, Illinois, New York, Maryland, and California. This data included legislation, state department policy or regulations, government documents, and facts and opinions collected from informational interviews with leaders in state SBHC advocacy. We accomplished most of this research online, gathering all available text from state websites and organizing it into a comparative chart. We conducted the informational

interviews either over email or brief discussions on the phone lasting no more than fifteen minutes. This process allowed us to understand the differences and similarities between these states' approaches, which ones are working better than others, and how we might apply them to Washington to serve the needs of The Health Center in Walla Walla as well as the state as a whole.

Taken together, this information allows us to make recommendations for how Washington State should move forward with SBHC reform.

## **IV. Analysis of Primary Research**

### **Making the Case for SBHCs: Promoting the Success of Youth at The Health Center**

The Health Center (THC) sits in a small brick building just next to Lincoln High School in Walla Walla, Washington. Students at Lincoln typically experience high rates of financial stress, homelessness, addiction, abuse and other traumatic events; these factors greatly impact their lives both within the classroom and at home.<sup>56</sup> In interviews, students and teachers confirmed that problems at home have a direct effect on students' ability to do well at school. It is in this environment that THC provides care to students. Established by Dr. Allison Kirby and Holly Howard, THC opened its doors in 2009 to Lincoln students, becoming the first school-based health center (SBHC) in Eastern Washington. Today, the clinic's mission is "to promote the success of children by providing for their physical, emotional and social well-being."<sup>57</sup> The clinic

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<sup>56</sup> Katherine Boehm and Holly Howard, interview with Rubenstein, November 19, 2013.

<sup>57</sup> The Health Center Walla Walla, last accessed March 6, 2014, [thehealthcenterww.org/](http://thehealthcenterww.org/).

employs nurses and counselors and receives the support of volunteer doctors and counselors who together provide medical and behavioral health services to the students. THC's board members are Walla Walla community members involved in health and education. The clinic runs on an annual budget of 234,500 dollars, which is compiled largely from private donations and grants. As a SBHC, THC serves only the students and teachers of Lincoln. Demographic analysis shows that the gender makeup of the clinic's patients is about half female and half male. Lincoln students are about thirty percent Latino and seventy percent white, and thus the clinic serves a similar ratio of Latino to white students. Finally, the majority of patients are born in the US but at least ten percent speak Spanish instead of English at home. Open every school day from nine to one, the clinic consistently serves the need of these students free of charge throughout the school year.

Through interviews and billing analysis of THC, we evaluate why Washington should support SBHCs. Our billing analysis of the students at Lincoln reveals that ninety two percent visited the clinic in the 2012-2013 school year, with a mean of seven visits per year per student. Our analysis does not find a significant correlation between students' birth country or native language and the number of times they visited the clinic or for what types of procedures. Unfortunately, we are unable to make any conclusions about correlations of race or type of insurance due to inconsistent data. Students report that they used the clinic largely for counseling, reproductive health, and other general medical needs. While these services contribute to the majority of official health center visits, students also describe the ways in which THC supports them outside of their direct mental and medical health needs. Whether handing out granola bars to hungry students, purchasing athletic equipment for varsity athletes, or simply



-serving as a place for youth to come talk during the day, the clinic plays a crucial role in many students' day-to-day lives.

The services THC provides are particularly valuable because they reach a population otherwise underserved by the health care system. While a few interviewed students had doctors outside of The Health Center, for the most part students had not seen a primary care doctor since childhood. In their study of twenty-four SBHCs throughout the country, Kisker and Brown suggest that these clinics are particularly successful at reaching the needs of underserved students because they overcome barriers youth face when trying to access health care.<sup>58</sup> In our interviews, Lincoln students confirmed Kisker and Brown's findings. Many express the importance of the free services at the clinic, suggesting that they cannot afford care otherwise. Additionally THC's accessibility, both in its location and hours of operation, is also a major motivator for students. As one student states, "The fact that I can come here while I'm at school...that really helps."<sup>59</sup> Finally, multiple students comment on the importance of accessing care in a confidential setting away from their parents. Students do not have to rely on inconsistent parental support to get to appointments and they can access services they would not be comfortable sharing with their parents, such as counseling or birth control. In overcoming these common barriers, THC provides services to students who would otherwise slip through the cracks of the health care system.

Almost unanimously, students agree that THC is so effective because of the ways it differs from other health centers in Walla Walla. Ben Isker, a Lincoln senior, describes the

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<sup>58</sup> Kisker and Brown, "Do School-Based Health Centers Improve Adolescents' Access," 339.

<sup>59</sup> Julia Conner, interviewed by Kate McMurchie, October 22, 2013.

difference, stating, “in other clinics around, I’m just like another number, you know – like great, get out of here, you look fine. But here they just nurture you, mother you, so its super comfortable.”<sup>60</sup> Ben noticed this after THC was able to diagnose a problem with his knee in one day, when he had been unable to get help from his community doctor for months. In general, students are more comfortable visiting THC than community clinics because they feel THC’s nurses and doctors genuinely care for them and understand what is going on in their lives. In part, this difference has to do with the relationships students form with THC staff. In a similar study of SBHCs, Gampetro et al. find that students’ relationships with staff members provide them with the additional courage they need to access health care services.<sup>61</sup> Each of our interviewees mentions how much they appreciate the staff, describing them with words such as “smiley” “friendly” and “understanding.” Teachers acknowledge a similar difference between THC and other community care. Gretchen Phillips, a Lincoln teacher, notices that “we have a lot of kids who would never go to The Health Center but they’ve built a relationship...that makes it easier.”<sup>62</sup> Both students and teachers suggest that the personal relationships students’ form with the THC staff contribute to the success of the clinic in reaching student’s health needs compared to other clinics in the community.

Furthermore, students and teachers see THC’s success as a result of the clinic’s complete integration into school life. Students all recalled a time when a teacher encouraged them or a peer to visit the clinic; whether proposing counseling support when a student was dealing with

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<sup>60</sup> Ben Isker, interviewed by Kate McMurchie, November 6, 2013.

<sup>61</sup> Gampetro et al., “Life Concerns and Perceptions of Care in Adolescents,” 23-30.

<sup>62</sup> Gretchen Phillips, interviewed by Kate McMurchie, November 11, 2013.

something at home, suggesting a student get birth control after entering a new relationship, or sending them to the clinic when they looked sick during class. Students appreciate the fact that school staff can remind them of appointments and that they can access the clinic quickly if something comes up during the day. Similarly, teachers speak highly of the relationship between the clinic and the school, describing the way clinic staff makes an effort to come to Lincoln campus to engage with students in the classrooms. Overall, they saw THC as a key component of what makes Lincoln a successful school.

THC directly provides care that students would not otherwise get. Ana Martinez, a Lincoln staff member, explains that without THC, students “would not be getting the [same] care.”<sup>63</sup> This is particularly true of reproductive health needs. As Jackie Hernandez, a student, bluntly put it, “I could be pregnant right now...because I’m pretty sure if I didn’t come here I wouldn’t go anywhere else to get birth control.”<sup>64</sup> Multiple female students suggested they would not have access to birth control without the clinic because they are not comfortable asking their parents, demonstrating the importance of providing reproductive care through school health centers.<sup>65</sup>

Multiple students describe the transformative effect counseling and emotional support from the clinic had on their lives. Indeed, secondary research suggests particular benefits to providing students with mental health care through SBHCs (Amarallo et al). At Lincoln, support from THC helps students lead more productive and happy lives by providing them with tools to

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<sup>63</sup> Ana Martinez, interviewed by Kate McMurchie, November 18, 2013.

<sup>64</sup> Jackie Hernandez, interviewed by Kate McMurchie, November SOMEHTING, 2013

<sup>65</sup> Jenna Ames, interviewed by Kate McMurchie, November 19, 2013.

deal with issues going on in the rest of their life outside of school. As Lincoln student Julia Conner so astutely reflects, “the students actually have a place they can go to talk to and just some people don’t have that at home. Like I didn’t have that for so many years growing up. I had no one to talk to and had all these problems that went unresolved.”<sup>66</sup> Teachers echo Julia’s remarks, as they frequently witness students change after beginning to use the clinic. For example, staff member Ana Martinez described one student who entered high school so emotionally distressed and angry so much so that he frequently acted out in class. But, after consistently using The Health Center, he is now stabilized and on track to graduate. The mental health services and emotional support THC offers can dramatically improve students’ lives both in and out of school.

The transformative services THC provides also specifically impact students’ academic success. Stronlin-Goltzman suggests that SBHCs can lead to overall increased satisfaction with school life among students.<sup>67</sup> Lincoln students and teachers reinforced this finding. Students and teachers believe THC improves attendance rates because students come to school for care rather than staying home when they feel sick or upset. Jenna Ames, a Lincoln English teacher, shared an example of a girl who continued showing up at school after the death of her parents because she could visit THC multiple times throughout the day for support.<sup>68</sup> Students also attribute THC with helping them stay focused in school. Ben Isker comments, “I remember before they got me back in here I was just losing it school, leaving school ‘cause I get super irritated. And then they

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<sup>66</sup> Julia Conner, interviewed by Kate McMurchie, October 22, 2013.

<sup>67</sup> Jessica Strolin-Goltzman, “School Based Health Centers and the Learning Environment,” 8.

<sup>68</sup> Jenna Ames, interviewed by Kate McMurchie, November 19, 2013.

got me back on the counseling and oh man – it’s just been so good.”<sup>69</sup> Another student credits THC with helping him stay clean, which he believes helped him get back on track to graduate.<sup>70</sup> Tellingly, since THC was established at Lincoln, graduation rates have steadily improved. Students and teachers consistently emphasize ways that the support students receive from THC helps them succeed academically.

It should be noted that one teacher disagreed with the sentiments outlined by teachers and students above. When asked if the clinic positively impacted students, Kent Rogers states, “I would have to say no...I haven’t noticed much of a difference at all.”<sup>71</sup> While it is important to acknowledge this opinion, the majority of statements in Kent’s interview suggest a broader frustration with alternative high school and Lincoln students and teachers rather than specifically with THC. Further, his opinion so greatly differ from the other interview data that we can safely assume his statements do not impact our overall findings.

Overall, teachers and students greatly believe in the positive impact of THC. By fully engaging with students while providing medical and mental health care, THC influences all aspects of student lives. Further, THC is able to better provide for the unique needs of its students than other community clinics. Anyon et al. and Berti et al. both suggest that school-based health is particularly effective at reaching the needs of rural, racial minority, and low-income students due to their ability to reach out and address the specific needs of these

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<sup>69</sup> Ben Isker, interviewed by Kate McMurchie, November 6, 2013.

<sup>70</sup> Jake Fisher, interviewed by Kate McMurchie, October 24, 2013.

<sup>71</sup> Kent Rodgers, interviewed by Kate McMurchie, November 7, 2013

students.<sup>72</sup> Student and teacher interviews indicated that this was indeed the case at THC. Thus, we suggest that THC makes a compelling case for the effectiveness of SBHCs in Washington State.

### **What Needs to Change about SBHC Policy In Washington?**

Paradoxically, despite the demonstrated success of school-based health care, most schools throughout the country do not have an onsite clinic. In part, this has to do with state policies surrounding SBHCs. At the moment, THC receives no state funding and is also unable to bill insurance providers. SBHCs in Washington cannot always bill insurance companies because the centers are not defined by state policy and thus are not seen as a standardized type of health care provider. As a result, they are not easily integrated into the health insurance system. Thus, THC is forced to rely primarily on private grants and donations from community members. Clinic staff members agree that this is not sustainable.<sup>73</sup> Billing data from clinic operations over the past three years shows that THC had the potential to make at least \$35,636 on medical operations alone had they been able to bill. This would account for 5% of THC's yearly budget. Thus, if SBHCs were able to bill, they would have a more consistent source of funding. In order to better provide care to underserved youth throughout Washington State, we must find a better way to sustainably fund SBHCs.

In light of SBHCs' need for sustainable funding, and due to the extensive interaction between state policy and health care, we will analyze Washington State law and policy related to

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<sup>72</sup> Anyon et al., "Health Risks, Race, and Adolescents Use of School-Based Health Centers," 457:468; Berti, "Comparison of Health Status of Children," 244-250.

<sup>73</sup> Katherine Boehm and Holly Howard, interview with Joshua Rubenstein, November 19, 2013.

SBHCs. This analysis will encompass Washington’s health obligations and goals, current policy that affects SBHCs, and policies that would impact SBHCs if these centers were more cohesively integrated into the state’s health care system. By examining state administrative code and public documents, and interviewing knowledgeable persons, we look to identify ways to improve SBHC sustainability in order to make health care accessible to all students in Washington.

*Washington State’s Health Care Obligations: Underserved Children*

Currently, Washington State policy makes no formal mention of SBHCs. However, the Revised Code of Washington (RCW) includes several directives suggesting the State should take interest in supporting these clinics.<sup>74</sup> In RCW 74.09.402 the Legislature declares the importance of providing health care to children, acknowledging, “the health of children is critical to their success in school and throughout their lives.” The law goes on to say, “It is the intent of the Legislature that... All children in the state of Washington have health care coverage by 2010,” and emphasizes the importance of linking every child to a regular source of care.<sup>75</sup> The Census Bureau estimates that 94.2% of children in Washington currently have health insurance. Yet, secondary research and our interviews at Lincoln show that having insurance does not guarantee actual access to health care.<sup>76</sup> As our case study illustrates and prior research confirms, SBHCs seem to reach students more effectively than other forms of care.<sup>77</sup> Thus, Washington State has

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<sup>74</sup> “Revised Code of Washington (RCW),” Washington State Legislature, Last Modified November 25<sup>th</sup>, 2013.

<sup>75</sup> “RCW 74.09.402: Children’s Health Care — Findings — Intent,” Accessed October 20, 2013.

<sup>76</sup> Zuckerman et al, “Barriers to Specialty Care,” 413. Samargia, Saewyc, and Elliott, “Foregone Mental Health Care and Self-Reported Access Barriers Among Adolescents,” 22.

<sup>77</sup> Kisker and Brown, “Do School-Based Health Centers Improve Adolescents’ Access to Health Care,” 339.

incentive to support SBHCs in order to fulfill the goals outlined in the RCW.

In addition to children's health care, Washington commits to improving care for people of color and other underserved populations. RCW 41.05.220 states

The [Health Care Authority (HCA)], in consultation with the Department of Health, shall work with community and migrant health clinics and other providers of care to underserved populations, to ensure that the number of people of color and underserved people receiving access to managed care is expanded in proportion to need, based upon demographic data.<sup>78</sup>

Previous research reveals racial inequalities in health care nationally, including Ellis et al. who, in their study of mental health care in Washington, find "lower use of mental health care in areas with a higher proportion of Hispanic residents."<sup>79</sup> Research shows that SBHCs do indeed provide care to students from such populations. Our case study of THC confirmed this, illustrating how THC serves at-risk, minority, and underserved populations including Walla Walla's large Latino population. Therefore, by supporting SBHCs in schools with high percentages of underserved students, Washington can continue to fulfill its health care commitments.

In 2008, a legislative task force acknowledged the specific importance of SBHCs, and the need to solve SBHC funding issues, reporting that,

Schools have become de facto health care homes for many students and school-based health centers represent a promising structure to help schools fulfill that role... the Legislature should encourage the resolution of billing obstacles to promote the establishment of more school-based health centers.<sup>80</sup>

Clearly, Washington State already calls on itself to support SBHCs but has yet to take direct

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<sup>78</sup> "RCW 41.05.220 Community and migrant health centers — Maternity health care centers — People of color — Underserved populations," *Washington State Legislature*. Accessed October 22, 2013.

<sup>79</sup> Wendy R. Ellis, et al., "Washington State Exhibits Wide Regional Variation In Proportion Of Medicaid-Eligible Children Who Get Needed Mental Health Care," *Health Affairs* 31, no. 5 (May 1, 2012): 990-999.

<sup>80</sup> Rep. Glenn Andersen, Sen. Chris Marr, Rep. Eileen Cody, Rep. Lynn Schindler, Sen. Rosa Franklin, Rep. Shay Schual-Berke, "Final Report; December 2008," The Select Interim Legislative Task Force on Comprehensive School Health Reform – Washington State Legislature, December 2008.



action.

### *Current Policy Environment for SBHCs in Washington*

SBHCs in Washington State struggle with funding, in part because Washington health care policy does not include them. The state does not define these clinics as a category of health care provider, does not fund them, and has not structured them into Medicaid or private insurance billing systems. Currently there are thirty-one SBHCs in Washington State, twenty-two of which are located in Seattle.<sup>81</sup> Seattle has so many of the state's SBHCs because the city funds up to seventy percent of operating costs with its Families and Education Levy.<sup>82</sup> Most areas of the state do not have access to this kind of funding, and therefore have fewer SBHCs. In this report we will focus on structural changes, rather than direct funding, that would improve SBHC financial sustainability statewide. However, we strongly encourage the state to directly fund SBHCs, as this has proven successful in Seattle and in other states across the country.

To determine how Washington can improve SBHC sustainability we must first understand current policies that do not allow SBHCs to bill insurers, beginning with an examination of children's health insurance. In Washington, ninety four percent of youth have health insurance, with thirty six percent insured through Apple Health, which combines Medicaid and the State Children's Health Insurance Program.<sup>83</sup> Therefore, almost all students have

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<sup>81</sup> "School-Based Health Centers in Washington," *Washington Alliance for School Health Care*, Accessed December 17, 2013.

<sup>82</sup> Sara Rigel (Public Health Seattle & King County), interview with Rubenstein, October 30, 2013.

<sup>83</sup> "Health Insurance Coverage Status, Washington, 2012 American Community Survey 1-Year Estimates," *American Fact Finder – US Census Bureau*. Accessed December 17, 2013; "Health Insurance Coverage of Children 0-18." *Kaiser Family Foundation*. Accessed December 17, 2013.

insurance that SBHCs could theoretically bill. A child on Apple Health gets insurance through a managed care organization (MCO).<sup>84</sup> This MCO is a private company under state contract to provide Medicaid insurance. The MCO builds a network of health care providers, and then limits its clients to this network.<sup>85</sup> Every month Washington pays MCOs a set amount (capitated premium) for every child enrolled in their plans, regardless of how often the child receives care (Figure 1).<sup>86</sup> Whether or not children on public insurance access health care, Washington still pays the MCO.

<b>Figure 1: Apple Health Capitated Premiums December 2013</b>	
<b>Client Age/Gender</b>	<b>Statewide Mean Family Premium</b>
3-14	\$ 74.80
F15-18	\$ 151.62
M15-18	\$ 115.43

Table 1 displays the mean capitated premium amounts for December 2013. The HCA pays MCOs this amount of money each month for each child on the MCO's insurance plans.

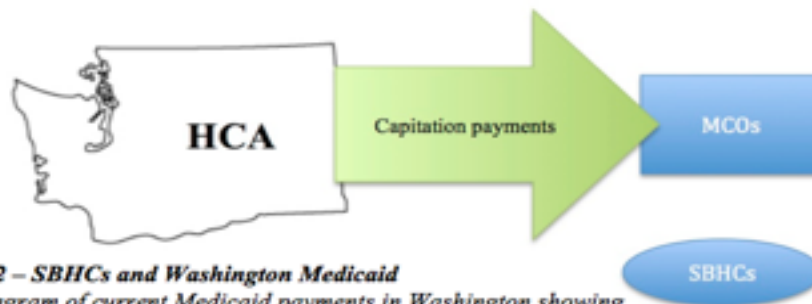
The lack of partnerships between MCOs and SBHCs limits billing possibilities. As the school health legislative task force recognized in 2008, “school-based health centers frequently provide free services that would be eligible for reimbursement had they been delivered at a

<sup>84</sup> “RCW 74.09.470: Children’s Affordable Health Coverage — Authority Duties,” *Washington State Legislature*. Accessed October 20, 2013.

<sup>85</sup> “RCW 74.09.522: Medical Assistance — Agreements with Managed Health Care Systems Required for Services to Recipients of Temporary Assistance for Needy Families — Principles to Be Applied in Purchasing Managed Health Care — Expiration of Subsections,” *Washington State Legislature*, Accessed October 20, 2013.

<sup>86</sup> Barbara Lantz, Manager, Quality and Care Management - [Washington State Health Care Authority](http://www.wa.gov/health), Email message to author, December 10, 2013

health care provider's office.”<sup>87</sup> Figure 2 (below) illustrates the current situation in Washington, where SBHCs provide care, but only MCOs receive reimbursement. No rules exist encouraging MCOs to reimburse SBHCs.<sup>88</sup> Therefore, improving access to care by integrating SBHCs into the Medicaid system would improve student health and enable Washington to get its money’s worth on insurance.



**Fig. 2 – SBHCs and Washington Medicaid**  
*A diagram of current Medicaid payments in Washington showing that SBHCs left out of the health insurance system have difficulty getting reimbursed for services they provide.*

The main state agencies in Washington involved in regulating health care and insurance providers include: the Department of Health (DOH), the Health Care Authority (HCA), and the Office of the Insurance Commissioner (OIC). The DOH has broad responsibilities regarding health in the state. These responsibilities include licensing various categories of health providers.<sup>89</sup> The DOH also does policy development in cooperation with health agencies.<sup>90</sup> The

<sup>87</sup> Rep. Glenn Andersen, et al., “Final Report; December 2008.” The Select Interim Legislative Task Force on Comprehensive School Health Reform – *Washington State Legislature*, December 2008.

<sup>88</sup> “WAC 182-538-063: Managed Care for Medical Care Services Clients,” Accessed October 21, 2013.

<sup>89</sup> “WAC 246-01-020: Functions,” *Washington State Department of Health*, Accessed December 10, 2013; Janis LaFlash (Health and Disability Manager, Office of the Insurance Commissioner) and Jennifer Kreidler (Senior Policy & Compliance Analyst, Office of the Insurance Commissioner), interview with Rubenstein, December 4, 2013.

<sup>90</sup> “WAC 246-01-020: Functions,” *Washington State Department of Health*, Accessed December 10, 2013.

HCA is the state agency that administers Washington’s Medicaid program, Apple Health.<sup>91</sup> Apple Health provides insurance through managed care to children in Washington younger than nineteen living below three hundred percent of the federal poverty level.<sup>92</sup> The OIC regulates private health insurance plans.<sup>93</sup> Acting together, these agencies can integrate SBHCs into the insurance system, strengthening SBHC sustainability, fulfilling Washington’s commitment to ensuring accessible health care, and improving student health and academic achievement.

### **State Policy and School-Based Health Centers Around the U.S.**

In order to better understand what Washington support of SBHCs should look like, we analyze and evaluate existing SBHC policies from other states around the nation. As of 2013, nineteen states fund SBHCs.<sup>94</sup> Most of this money comes from the states’ general fund or is allocated from federal Maternal and Child Health block grants and tobacco tax money.<sup>95</sup> However, granting money is the straightforward part. State policy influences SBHCs in a variety of ways. The most important aspects are the legal definition of SBHCs and regulation of the relationship between SBHCs and Medicaid. Since there is no general consensus among states or scholars on the “best” way to approach funding and regulating SBHCs, we seek first to describe

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<sup>91</sup> “Cooperative Agreement Between the Washington State Health Care Authority and the Washington State Department of Social and Health Services,” *Department of Social and Health Services*, November 1, 2012.

<sup>92</sup> “RCW 74.09.470: Children’s Affordable Health Coverage — Authority Duties,” *Washington State Legislature*, Accessed October 20, 2013.

<sup>93</sup> Janis LaFlash (Health and Disability Manager, Office of the Insurance Commissioner) and Jennifer Kreitler (Senior Policy & Compliance Analyst, Office of the Insurance Commissioner), interview with Rubenstein, December 4, 2013.

<sup>94</sup> National Assembly on School-Based Health Care, (NASBHC), “School-Based Health Care State Policy Survey. Executive Summary,” *National Assembly On School-Based Health Care* (August 1, 2012), 1.

<sup>95</sup> NASBHC, “School-Based Health Care State Policy Survey,” 2.

the differing models, and then evaluate the benefits and drawbacks of each. This information will allow us to assess the best way forward for Washington State.

### *Getting Their Priorities Straight: State Definitions*

All state policies depend on a clear legal definition of “school-based health center.” Important parts of this definition include: where in law or policy it is written, the requirements for partnerships between sponsoring agencies and SBHCs, and the types of services these health centers must provide. The definition is one of the places of widest variation between states.

Some states have their SBHC definitions written in detail into legislation, while others have much more vague legislative descriptions of SBHCs and leave the logistics to be determined by state health departments. Standards defined in legislation are more stable, while definitions located in department regulations have flexibility on their side. Illinois, for example, has a seventeen-part section of legislation, which lists all the requirements and specifics about services, facilities, providers, and billing at SBHCs. By contrast, Colorado legislation merely defines SBHCs as “a clinic established and operated within a public school building...SBHCs are operated by school districts in cooperation with hospitals, public or private health care organizations, licensed medical providers, public health centers, and community mental health centers.”<sup>96</sup> Colorado does have a long list of requirements similar to that of Illinois, but the Department of Public Health and Environment (DPHE) writes and regulates these. According to Debbie Costin, president of Colorado Association of School-Based Health Care, (CASBHC) this

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<sup>96</sup> Colorado Revised Statutes, Title 25 Article 20.5( HB 06-1396), (July 2006).

strategically vague legal definition “left the Colorado DPHE to develop state standards which could change over time without new legislation.”<sup>97</sup> New Mexico takes this strategy a step further — its definition and grant program is located entirely in the Department of Health, and legislation does not even earmark funding for SBHCs.<sup>98</sup> Both ends of this spectrum have advantages and disadvantages. Illinois’ standards are less vulnerable to budget cuts or changing political leadership, but they are also static and difficult to change. On the other hand, definitions located in department regulations are more flexible to accommodate a changing political and health care environment. This keeps states better poised to respond quickly to unexpected challenges SBHCs may face, but at the same time could allow easier negative changes or cuts. In addition, since the Illinois law passed only because it is a “solidly blue state,” more general regulations may be easier to pass through a divided legislature.<sup>99</sup> Given all this, Colorado’s model seems both the most feasible and the most advantageous due to a level of stability from the law coupled with lots of flexibility.

The sponsoring agency is the organization that provides medical oversight for a SBHC, and its role impacts everything from hours of operation to billing capabilities. Defining “sponsoring agency” presents a choice between prioritizing SBHCs’ financial stability or their institutional flexibility, a balance each state must decide how to strike. On one end of the spectrum, SBHCs in New York must meet requirements to be a “medical home” for any enrolled

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<sup>97</sup> Debbie Costin (President, Colorado Association of School-Based Health Centers), interviewed by Claire Johnson, October 2013.

<sup>98</sup> Nancy Rodriguez (President, New Mexico Association of School-Based Health Centers), interviewed by Claire Johnson, December 2013.

<sup>99</sup> Anna Burnham (Illinois Coalition of School-Based Health Care), interviewed by Claire Johnson, October 2013.

student who needs one.<sup>100</sup> New York requires its SBHCs to partner with a federally qualified health center (FQHC), community health center, or hospital that provides all medical oversight, facilitates all billing, and provides 24/7 backup-coverage for all of the enrolled students.<sup>101</sup> This tighter standard mean that New York SBHCs have an easier time earning federal funding and getting reimbursed by insurance companies because FQHCs get grants from the federal government as well as higher reimbursement rates when they bill Medicaid.<sup>102</sup> However, as Swider et al. note, the stability offered by FQHC status is not always necessary or worthwhile.<sup>103</sup> Although the FQHC requirements may be outside the means of some SBHCs, these SBHCs can still serve the community in valuable ways.

Additionally, a partnership with a FQHC might restrict the SBHC's independence in a community.<sup>104</sup> In our study of THC, Holly Howard explained that particularly in small or rural communities like Walla Walla where there are only a few hospitals and clinics, a partnership becomes "political" if one clinic feels that the SBHC could be "stealing their patients."<sup>105</sup> THC finds that operating independently gives them greater acceptance in a small town. Perhaps for this reason, some states such as Colorado and Illinois leave the definition of sponsoring agency

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<sup>100</sup> New York Department of Health, *Principles and Guidelines for School Based Health Centers in New York State (revised version)*, (Albany, NY: 2006): 3.

<sup>101</sup> New York Department of Health, *Principles and Guidelines for School Based Health Centers in New York State (revised version)*, 4.; NYC Department of Education, "Creating a new SBHC," School-Based Health Centers, accessed November 2013, <http://schools.nyc.gov/Offices/Health/SBHC/Principals.htm>.

<sup>102</sup>"What are Federally Qualified Health Centers (FQHCs)?" U.S. Department of Health and Human Services, accessed September 2013, <http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Introduction/qualified.html>

<sup>103</sup> Swider and Valukas, "Options for Sustaining School-Based Health Centers," 116.

<sup>104</sup> Swider and Valukas, "Options for Sustaining School-Based Health Centers," 116.

<sup>105</sup> Katherine Boehm and Holly Howard, interview with Rubenstein, November 2013.

open, allowing anything from a FQHC to a non-profit or school district to oversee the SBHC as long as it is capable of providing 24/hour coverage, at least by telephone, to the students enrolled at the SBHC.<sup>106</sup> Partnering with a FQHC, if it works out, is always financially advantageous for a SBHC. Yet despite the stability it offers, a policy like New York's could be too restrictive in some locations and could effectively shut down centers like THC, which despite its instability is a valuable community resource. However, some standards for a sponsoring agency should be in place in the state definition, since these partnerships are often what enable SBHCs to bill for their services.

One of the most contentious and thus most important parts of a SBHC definition is the list of services the SBHC is required to provide, especially when it comes to reproductive health services. As previously mentioned, students using THC report that reproductive health care is one of the most important services the center offers. However, it is also one of the most political and controversial. This tension is common to all SBHCs, as we found in prior scholarship and our own interviews with SBHC advocates around the country (Gadomski et al. 1998). SBHCs in rural communities struggle in particular with this issue because rural communities tend to be more conservative and thus a requirement for reproductive health care at a school often lacks support from parents, the school board or the local government. For example, the school board in Walla Walla was "very hesitant" and unwilling to talk about starting a health center at Lincoln at all until its supporters were able to show them that the SBHC would address other issues besides

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<sup>106</sup> Colorado Department of Public Health and Environment, *Quality Standards for Colorado School-Based Health Centers*, (Denver, CO: October 2009), 11.; Illinois Administrative Code, Title 77 Section 2200.80 (September 2000).



reproductive care.<sup>107</sup> This fear of a SBHC “flinging condoms from the walls”<sup>108</sup> persists across the country. Anna Burnham of the Illinois Coalition of School Health Care and Nancy Rodriguez of the New Mexico Association of School-Based Care both note that SBHCs looking to open in rural areas often struggle more than urban ones to meet the states’ requirements for reproductive care due to family and community opposition.<sup>109</sup> States again span a wide spectrum on how they deal with this issue. Maryland recommends that SBHCs provide pregnancy testing and STI testing and treatment, but does not actually require any type of reproductive care, and the standards do not even recommend referral to get condoms or birth control.<sup>110</sup> Colorado requires only “reproductive health education” onsite at its SBHCs, and all other reproductive care by referral.<sup>111</sup> New Mexico, Illinois, and Oregon attempt a compromise, requiring limited care onsite including pregnancy and STI tests and reproductive health exams, and more inclusive care on referral.<sup>112</sup> Finally, New York mandates all “age-appropriate reproductive care,” including birth control, as part of primary care onsite at SBHCs.<sup>113</sup>

Once again, there are costs and benefits to all of these policies. While New York’s SBHCs

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<sup>107</sup>Katherine Boehm and Holly Howard, interview with Rubenstein, November 2013.

<sup>108</sup>Katherine Boehm and Holly Howard, interview with Rubenstein, November 2013.

<sup>109</sup>Anna Burnham, interviewed by Johnson, October 2013; Rodriguez, interviewed by Johnson, December 2013.

<sup>110</sup> Maryland State Department of Education: Maryland School-Based Health Center Policy Advisory Council, *Maryland School-Based Health Center Standards*, (Annapolis, MD: 2006): 24.

<sup>111</sup> Colorado Department of Public Health and Environment, *Quality Standards*, 24.

New Mexico Office of School and Adolescent Health, *OSAH Standards and Benchmarks*, (Santa Fe, NM: 2012). Illinois Administrative Code, Title 77 Section 2200.60 (September 2000).

<sup>112</sup>Oregon Department of Human Services: Public Health Division, *School-Based Health Centers: Standards for Certification*, (Salem, OR: 2010), 15.

<sup>113</sup> New York Department of Health, *Principles and Guidelines*, 6.

are obviously able to serve the needs of adolescents in a more comprehensive way, Colorado and Maryland's rules (or lack thereof) allow SBHCs to provide important primary care in communities that may oppose a health center that offers reproductive care. In New Mexico, the state prioritizes reproductive care and highlights decreasing teen pregnancy as a goal on the state SBHC website, but the large percentage of rural SBHCs in the state probably limits the services, especially in terms of birth control, that it can realistically require.<sup>114</sup> Reproductive health requirements are one part of the definition that seem to belong solidly in department regulations rather than legislation, since they are a politicized issue that could hold back both the passage of a SBHC law in a state legislature and the success of SBHCs in more conservative rural areas where they are often needed. If it is feasible, SBHCs can be a valuable resource of reproductive care for adolescents, but these health centers can also do so much more. Therefore, treating the question of reproductive care delicately is vital.

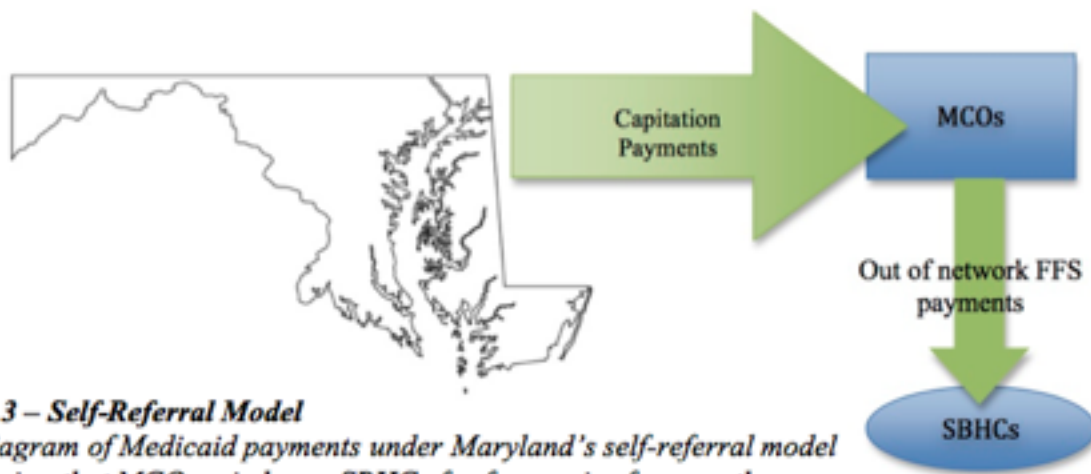
### *Medicaid and School-Based Health Centers*

A key step for SBHCs on the way to financial sustainability is becoming an established part of the health care network. Many students who use SBHCs qualify for Medicaid, and so it is important for SBHCs to be in communication with providers of Medicaid and be able to bill them for services. However, as Ambruster et al. note, SBHCs often struggle to create relationships with managed care organizations (MCOs) that administer Medicaid due to mutual distrust, prohibitively extensive or complex contracts, or philosophical differences between the two types of organizations. States can step in to streamline, facilitate, and regulate these

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<sup>114</sup> "School-Based Health Centers," New Mexico Department of Health Office of School and Adolescent Health, accessed October 2013, [www.nmschoolhealth.org/sb\\_centers.shtml](http://www.nmschoolhealth.org/sb_centers.shtml)New.

partnerships.<sup>115</sup> All of the states we surveyed mandate communication in some way between SBHCs, primary care providers, and MCOs, to ensure coordination of care and prevent duplication of services or payments. But communication is not enough to solidify billing relationships. In their report for the U.S. Department of Health Resources and Services Administration, Harvey et al. (2002) note three basic models for how states deal with the issue of SBHCs and Medicaid or managed care: self-referral, carve-out, and mandated contract.<sup>116</sup>



**Fig.3 – Self-Referral Model**

*A diagram of Medicaid payments under Maryland's self-referral model showing that MCOs reimburse SBHCs fee-for-service for care they provide.*

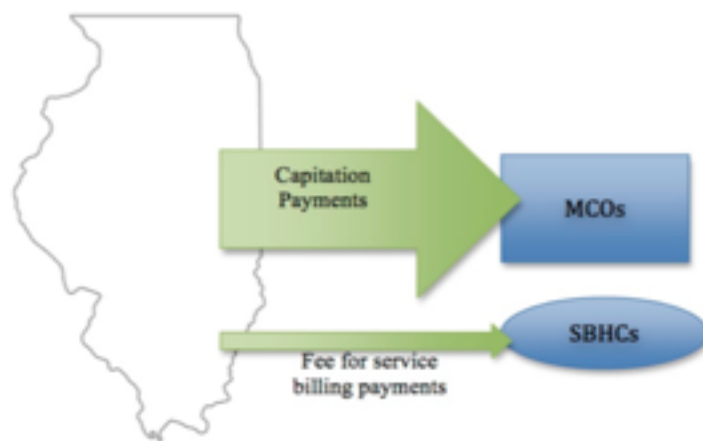
The first model is the “self-referral” model, which requires MCOs to pay SBHCs fee-for-service (FFS) for four visits a year and certain procedures if the student chooses to use the SBHC (Figure 3). This model is unique to Maryland, where SBHCs are understood as more of an acute

<sup>115</sup> Ambruster et al., “Collision or Collaboration? School-based Health Services Meet Managed Care,” 222-224.

<sup>116</sup> Harvey et al., “School-Based Health Centers And Managed Care Arrangements: A Review Of State Models And Implementation Issues.”

care provider than a public health resource. In this scenario, SBHCs are not part of the Medicaid network and their goal is always to get students back to their MCO and primary care provider as quickly as possible.<sup>117</sup> Such a system evades many of the conflicts between SBHCs and MCOs and avoids complicated contracts. However, it severely limits the potential of SBHCs to meet the needs of students in other health areas, such as mental and reproductive health, since they cannot bill for these services and are not even required to offer them.

**Fig. 4 – Carve-Out Model**  
A diagram of Medicaid payments under Illinois’s carve-out model. The state reimburses SBHCs fee-for-service for care they provide.

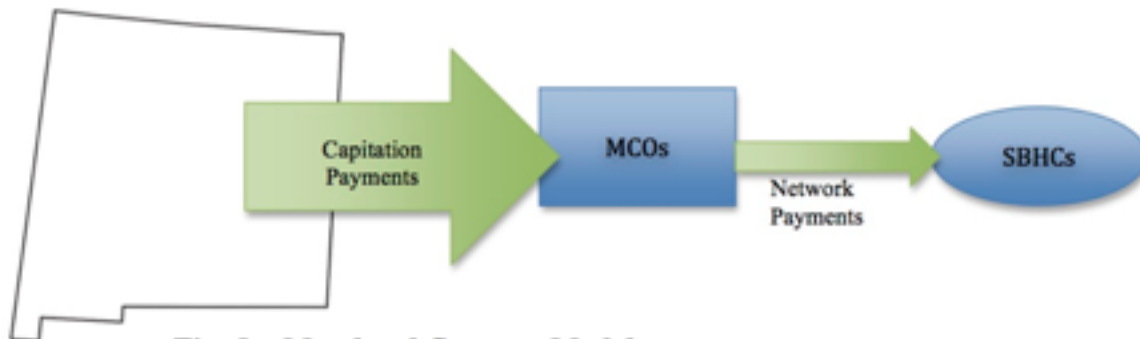


The second option is the “carve-out” from managed care (Figure 4). Illinois is an example of this. SBHCs that meet certain requirements get certified with the state, which defines them as a special type of provider (“Type 56”).<sup>118</sup> SBHCs are then able to bill the state FFS directly for certain procedures, no matter what type of Medicaid coverage the students have. The carve-out model also avoids complicated contracts, and unlike the self-referral system it includes SBHCs in the mainstream health care network of the state and embraces their role as providers of

<sup>117</sup> Code of Maryland Regulations (COMAR), 10.09.68.03, (1997).

<sup>118</sup> Illinois Department of Health care and Family Services, *Handbook for Providers of School Based/Linked Health Services, Chapter S-200*, (Springfield, IL: 2002), 2.

comprehensive care, including preventative medicine, mental health, and reproductive services. On the other hand, it does not integrate SBHCs with MCOs, which could still result in duplicative payments, and is not forward-looking since Medicaid in Illinois as well as Washington and the country as a whole is moving more and more towards MCOs and abandoning all forms of FFS billing.<sup>119</sup>



**Fig. 5 – Mandated Contract Model**

*A diagram of Medicaid payments under New Mexico's mandated contract model. MCOs must include qualified SBHCs in their provider networks. SBHCs bill MCOs just like any other primary care provider.*

The third model is the “mandated contract” (Figure 5). In New Mexico, for example, MCOs are required to contract with SBHCs who meet certain regulations and choose to join the Medicaid network as licensed providers. They can then bill the MCO like any other care provider.<sup>120</sup> Individual contracts with MCOs can be complicated and difficult for SBHCs, but this system puts most of the burden on MCOs, and in New Mexico there are only four MCOs to contend with. The administrative burden of this system may be worth the stable integration of

<sup>119</sup>Anna Burnham, interview with Johnson, October 2013.

<sup>120</sup>New Mexico Human Services Department, *SBHC Process for Becoming a Credentialed Medicaid Provider*, (Santa Fe: NM: 2012).

SBHCs into a changing health care landscape.

Despite research showing that billing Medicaid is not enough to fully fund a SBHC, especially one not connected to a FQHC, two points highlight the vital importance of a stable Medicaid billing system to the well-being and effectiveness of SBHCs.<sup>121</sup> First, in California, there are 226 SBHCs, even though the state does not offer grant money and defines them only very loosely in a law that was never funded.<sup>122</sup> However, California has set up its Medicaid (called Medi-Cal) insurance in such a way that “most, if not all” SBHCs that meet certain requirements can bill.<sup>123</sup> This source of funding is one reason why SBHCs have become so successful in California despite the lack of other types of state support. Second, the majority of students SBHCs serve are usually on public insurance.<sup>124</sup> For example THC has 70% of their students on Medicaid insurance.<sup>125</sup> If Medicaid billing is stable, SBHCs in low-income schools (that have more students on Medicaid) serve most effectively as a safety net and actually become more financially sustainable by doing so, because they can bill for a higher percentage of the students they see. As these examples highlight, linking SBHCs with Medicaid is an important aspect of state involvement, since integration into the Medicaid and health care system benefits both SBHCs and those they seek to serve.

States that support SBHCs and recognize their unique and vital role as providers of health

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<sup>121</sup> See for example: Swider and Valukas, “Collision or Collaboration,” 116.

<sup>122</sup> NASBHC “School-Based Health Care State Policy Survey,” 2; California Health and Safety Code, *Assembly Bill No. 2650* (passed September 19, 2006).

<sup>123</sup> Lisa White (Seinor Policy Analyst, California School Health Centers Association), interviewed by Claire Johnson, October 2013.

<sup>124</sup> Nystrom and Prata, “Planning and Sustaining a School-based Health Center,” 123.

<sup>125</sup> Katherine Boehm and Holly Howard, interview with Rubenstein, November 2013.

care for youth have all navigated these options, and determined what type of definition and policy is best suited to the needs of each state. As Washington State moves forward towards embracing school-based care, drawing on these examples of success, struggle, and compromise will be valuable and informative.

### **Primary Research Conclusion**

SBHCs such as THC directly address the barriers to care facing youth and meet the needs of underserved groups such as low-income children, students of color, or other “at-risk” youth. As kids and teachers at Lincoln describe, access to health care through THC has transformed the lives of Lincoln’s students. Like Gretchen Phillips, a Lincoln teacher, describes, “it just made us stronger as a school because we had something else to offer, something I really think is really beneficial to the kids.”<sup>126</sup> Students and teachers agree that because of THC youth are more engaged academically, are more supported and stable emotionally, and are physically healthier as a whole. Our research at THC supports claims by secondary research about the particular benefits of providing care to at-risk youth through SBHCs. Yet, THC also highlights the funding difficulties facing SBHCs, particularly due to their inability to bill insurance providers.

Our research also reveals that Washington State makes a strong commitment to serving the health needs of children, people of color, and low-income and other underserved populations, precisely the groups SBHCs reach best. However, Washington does not currently address SBHCs in state policy or provide them any direct funding. This lack of support combined with Washington’s current practice of paying MCOs whether or not youth actually access care results

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<sup>126</sup> Gretchen Phillips, interviewed by Kate McMurchie, November 11, 2013

in less support for kids who need it, inefficient use of state funds, and financial struggles for those SBHCs that do manage to reach kids.

The policies and practices of other states that have integrated SBHCs into their health care systems provide a place for us to start as we look ahead to reforming school-based health care in Washington State. By funding and defining SBHCs and offering them ways to become part of the Medicaid network, other states encourage the growth and sustainability of school-based care. Many models of doing so exist around the country and involve a matter of balance and tailoring policy to the specific conditions of each state. Based on our analysis, a vague legislative definition of SBHCs coupled with detailed departmental regulations seems to best serve SBHCs in Washington. These regulations should allow a variety of sponsoring agencies and be cognizant to the politically charged nature of reproductive care requirements in order to offer SBHCs the possibility of serving the broadest sector of the population. Similarly, a state-mandated contract between MCOs and SBHCs appears to offer the SBHC the most sustainability and futurity.

In order to better provide for our children through the development of organizations like THC, we suggest that Washington State makes a dedicated effort to support SBHCs. In the following pages, we will lay out how exactly the state can best tailor its policy to support school-based health.

## **V. Conclusion and Recommendations for Washington State SBHC Reform**

Our case study of THC and our policy analysis of Washington and other states provide



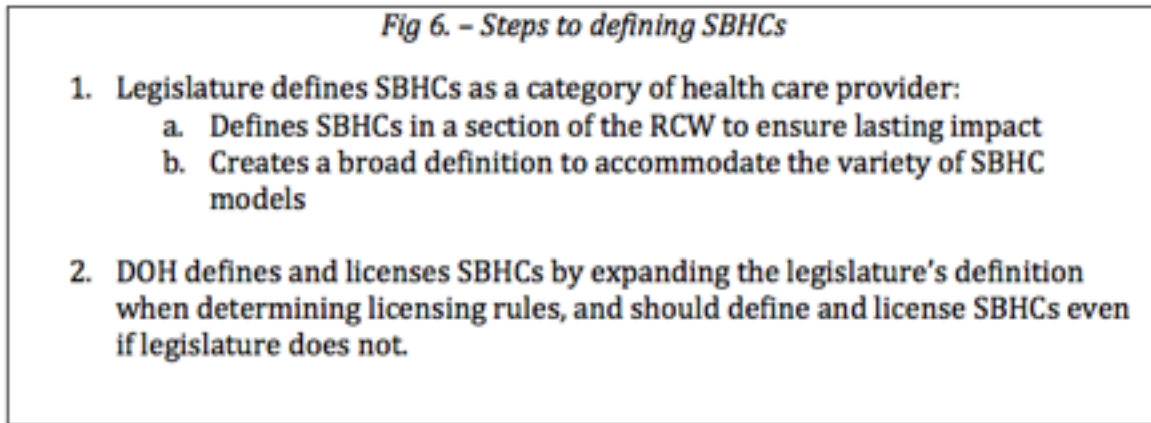
the basis for the following recommendations. Our research shows that Washington State support of SBHCs would improve youth health and academics, increase Washington State's spending efficiency, and increase SBHC financial sustainability. Thus, adopting our recommendations will bring Washington one-step closer to keeping its promise to provide health care to all children throughout the state.

### **Recommendations for Washington State Government Action**

We recommend that the Washington State legislature and Department of Health (DOH) formulate an official definition of SBHCs in public law and policy. Based on Colorado's successful model, the legislative definition should be broad so as not to define current or future SBHCs out of existence. The DOH should be responsible for licensing SBHCs and defining them as a provider type.<sup>127</sup> Making the DOH responsible for fine-tuning SBHC requirements will offer flexibility to accommodate different models of SBHCs. In order to accommodate the various situations facing SBHCs around the state, we recommend that the legislature and DOH have open-ended requirements regarding SBHC sponsoring agencies, and treat requirements about reproductive care with special sensitivity. Other state agencies, especially those regulating insurance, will then be able to put this official definition to use (Figure 6).

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<sup>127</sup> Washington State Department of Health staff, interview with Rubenstein, December 6<sup>th</sup> 2013.



We further recommend that Washington implement a mandated contract model based on the method New Mexico uses in order to integrate SBHCs into the Medicaid billing system (Figure 7).



*Fig. 7 – A diagram showing Medicaid payments if Washington implements a mandated contract model. SBHCs will be included in MCO networks, and would be reimbursed by MCOs for services they provide.*

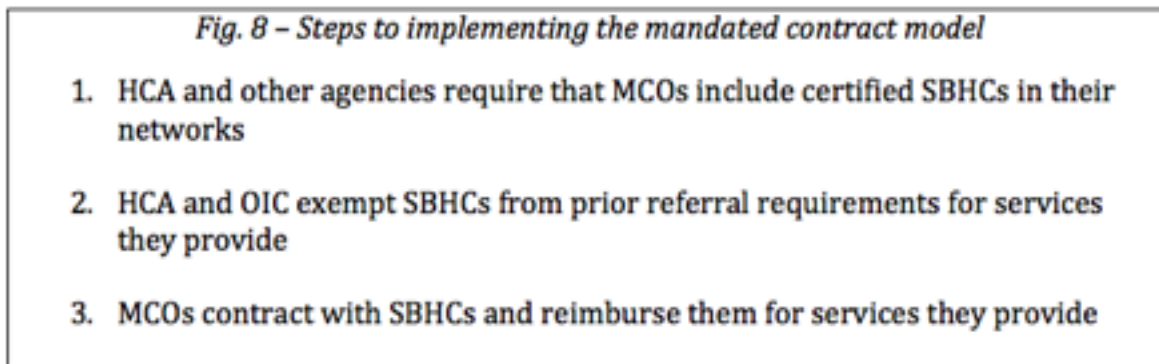
In comparison with the other models we researched, we argue that the mandated contract model will work best for Washington because the state is already moving towards a managed care system and has only five MCOs providing Medicaid insurance.<sup>128</sup> Therefore, just like in New Mexico, the mandated contract model will work within the state’s insurance system while the

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<sup>128</sup> Katherine Latet (Office of Health Innovation and Reform, Health Care Authority), interview with Rubenstein, December 13, 2013.

small number of MCO contracts will not create prohibitive administrative burdens for SBHCs. Such a model will provide SBHCs with a reliable funding source and save public funds by improving spending efficiency.

To implement a mandated contract system in Washington, the Health Care Authority (HCA) and other agencies with authority over health insurance should require MCOs to contract with all DOH-licensed SBHCs and include them in their networks. Additionally, these MCOs must ensure that students do not need prior referral to access services at SBHCs. Washington's regulation of women's health providers follows a similar model in which lawmakers give women the right to go to any provider in their insurer network without prior referral.<sup>129</sup> With this system in place, SBHCs will receive money from MCOs for the services they provide to students on Medicaid. (Figure 8).



Implementing the mandated contract model will also save the state money and improve health care efficiency. Washington State pays MCOs each month for every child on public insurance whether or not the child accesses this health care. When students receive care at a

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<sup>129</sup> “RCW 48.42.100: Women’s Health Care Services — Duties of Health Care Carriers.” *Washington State Legislature*. Accessed October 1, 2013. <http://apps.leg.wa.gov/RCW/default.aspx?cite=48.42.100>.

SBHC that cannot bill, the MCO keeps this money instead of passing it on to the SBHC.

Therefore, with a mandated contract in place, the state's money will reach the SBHCs actually providing care.

## **Recommendations for SBHCs, Health Organizations, and Washington**

### **Citizens**

In order to meet the needs of underserved children, communities also need to encourage the growth and sustainability of SBHCs. Therefore, local communities, health organizations, and SBHCs should do the following:

- Lobby Washington policymakers throughout the state to include SBHC reform on their agenda. Encourage the state to define SBHCs, set up a mandated contract model, and provide direct funding to centers throughout the state.
- Push local government to support SBHCs through funding provided by the county or city, such as the Families and Education Levy in Seattle
- Listen to students who need these health centers. SBHCs exist for them, and their voices should influence future action and policy. Encourage students like those at Lincoln to express their struggles accessing health care and the transformative impact of SBHCs on their academic and personal lives.
- Create partnerships between medical organizations (including Federally Qualified Health Centers) and SBHCs whenever possible to ensure increased financial sustainability.
- Support the centers in the community. Billing is only one of many sources of funding needed for SBHCs to thrive. Donate, volunteer, or support local SBHCs in whatever way possible.

While our research makes a case for school-based health center reform in Washington State, additional questions must be answered in future research to continue the conversation.

First, there needs to be a clear quantitative study on the financial impact of SBHCs (including

their effect on emergency room rates and the state Medicaid system). Additionally, to further inform our work, researchers should continue to conduct detailed analyses of the various state policies across the country to determine which models work best and why. Finally, research that addresses ways to allow SBHCs to bill non-Medicaid health insurance providers could be used to help further improve SBHC sustainability.

Our research shows that SBHCs already make an invaluable contribution to Washington State and its goals of providing health care to all youth. In turn, the state should make an effort to contribute to the sustainability and future of these vital sources of care for the state's neediest populations.

## **Appendix A - Interviews\***

\* All Lincoln High School student, staff, and teacher names are pseudonyms to protect each individual's identity

Anna Burnham (Illinois Coalition of School-Based Health Care), interviewed with Claire Johnson, Walla Walla, Wa, October 15, 2013.

Julia Conner (Lincoln High School Student), interviewed by Kate McMurchie, Walla Walla, WA, October 22, 2013

Debbie Costin (president, Colorado Association of School-Based Health Centers), interviewed by Claire Johnson, Walla Walla, WA, October 23, 2013.

Jake Fisher (Lincoln High School Student), interviewed by Kate McMurchie, Walla Walla, WA, October 24, 2013.

Sara Riegal (Public Health Seattle & King County), interview with Rubenstein, Walla Walla, WA, October 30, 2013.

John Founders (Lincoln High School Student), interviewed by Kate McMurchie, Walla Walla, WA, November 5, 2013

Kyle Smith (Lincoln High School Student), interviewed by Kate McMurchie, Walla Walla, WA, November 5, 2013

Ben Isker (Lincoln High School Student), interviewed by Kate McMurchie, Walla Walla, Wa, November 6, 2013.

Rosa Martinez (Lincoln High School Student), interviewed by Kate McMurchie, Walla Walla, WA, November 6, 2013

Kent Rodgers (Lincoln High School History Teacher), interviewed by Kate McMurchie, Walla Walla, WA, November 7, 2013

Gretchen Phillips (Lincoln High School English Teacher), interviewed by Kate McMurchie, Walla Walla, WA, November 11, 2013.

Ana Martinez (Lincoln High School Secretary), interviewed by Kate McMurchie, Walla Walla, WA November 18, 2013.

Jenna Ames (Lincoln High School English Teacher), interviewed by Kate McMurchie, Walla Walla, WA, November 19, 2013

Katherine Boehm (Clinic Director, The Health Center) and Holly Howard (Executive Director, The Health Center), interviewed by Joshua Rubenstein, Walla Walla, WA, November 19, 2013.

Jannis LaFlash (Health and Disability Manager, Office of the Insurance Commissioner) and Jennifer Kreidler (Senior Policy & Compliance Analyst, Office of the Insurance Commissioner), interview with Rubenstein, Walla Walla, WA December 4, 2013.

Nancy Rodriguez (president, New Mexico Association of School-Based Health Centers), interviewed by Claire Johnson, Walla Walla, WA, December 5, 2013.

Washington State Department of Health staff, interview with Rubenstein, Walla Walla, WA, December 6, 2013.

Barbara Lantz (Manager, Quality and Care Management - [Washington State Health Care Authority](#)), Email message to author, December 10, 2013.

Katherine Latet (Office of Health Innovation and Reform, Health Care Authority), interview with Rubenstein, Walla Walla, WA, December 13, 2013.

## **Appendix B - Acronyms**

CHC - Community Health Clinic

DOH - Department of Health

DPHE - Department of Health and Environment

FFS - Fee For Service

FQHC - Federally Qualified Health Center

HCA - Health Care Authority

MCOs - Managed Care Organization

OIC - Office of the Insurance Commissioner

RCW - Revised Code of Washington

SBHCs - School Based Health Center

THC - The Health Center

WAC - Washington Administrative Code

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