



Making the Grade: State and Local Partnerships to Establish School-Based Health Centers

An RWJF national program

SUMMARY

Making the Grade: State and Local Partnerships to Establish School-Based Health Centers was a national program of the Robert Wood Johnson Foundation (RWJF) that supported state-local collaborations designed to expand comprehensive school-based health services for children and adolescents.

First authorized by the Board of Trustees in 1992, the program, which operated from 1994 to 2001, helped states and their local partners establish new school-based health centers (SBHCs) and promote policies to sustain the centers over the long term.

Although SBHCs vary from place to place, their basic mission is to provide children and adolescents with comprehensive primary, acute and preventive care for physical and mental health conditions in school settings. The centers, which have interdisciplinary staffs, not only deliver routine primary health care—physical exams, screening and treatment for physical and mental health problems—but also teach students how to manage their own health.

Key Results

According to the national program office at George Washington University in Washington, *Making the Grade*:

- Helped expand the total number of school-based health centers in the nine states from 278 in 1994 to 442 in 2000, an increase of 59 percent.
- Brought about more stable state financing, primarily from state general funds.
- Stimulated more favorable state policies, including expanding centers' eligibility to participate in Medicaid and managed care programs.
- Strengthened quality improvement practices in SBHCs and created a specialized continuous quality improvement (CQI) tool.

- Established the comprehensive SBHC model as the gold standard for school-based health care. (See [Appendix 1](#) for features of the model.)
- Helped launch the [National Assembly on School-Based Health Care](#), with state chapters in eight *Making the Grade* states and many others.

Evaluation Findings

The Barents Group of KPMG Consulting in Washington conducted an evaluation of the program. Among its key findings:

- School-based health centers have become an established, permanent and respected part of the publicly supported health system infrastructure.
- Although school-based health centers have not achieved widespread penetration through the public school systems of this country, there is continued momentum toward program growth, even in states nurturing new and fragile programs.
- School-based health centers need mixed financing strategies involving federal, state and local sources in both the private and public sectors.
- The political environment and political support for school-based health centers are of fundamental importance to the long-run sustainability of SBHCs.

THE PROBLEM

Among the 41 million people without health insurance in the United States are millions of school-age children, and multiple barriers keep many additional children who are insured from getting the care and preventive health services they need.

The difficulty children and adolescents have in getting needed care is a significant public health concern. This is true, not only because of the large number affected, but also because of the severity of the health problems and risks they face, including violence, substance abuse, serious mental health conditions, pregnancy and sexually transmitted diseases.

To carry out vital prevention strategies, the health system needs access to children and adolescents, but the most vulnerable young people are often the hardest to reach.

CONTEXT

Contemporary experiments with bringing health care services directly to children in schools, where they spend much of their time, began in the early 1970s. RWJF funded its first large initiative in this area in 1977—the seven-year *School Health Services Program*, which brought nurse practitioners into elementary schools in four states. Between 1986 and the end of 1993, RWJF supported a national program, the *School-*

Based Adolescent Health Care Program, designed to explore the feasibility of school-based health centers (SBHCs) as a means of improving adolescent access to appropriate services. The comprehensive SBHC model, which was developed and validated during the *School-Based Adolescent Health Care Program*, calls for biennial comprehensive physicals and annual risk assessments for all enrollees. (See [Appendix 1](#) for key features of comprehensive SBHCs. For a composite sketch of what an SBHC is like, and some vignettes of how their care has affected students' lives, see [Appendix 2](#); for case examples of three SBHCs in the program, see [Appendix 3](#).)

Helping students to identify risks and change unhealthy behaviors are major objectives of the model. Routine services cover such things as mental health conditions, substance abuse problems, acute illness, respiratory conditions, sports injuries, age-appropriate reproductive health guidance and counseling about diet and other health practices. Many centers also include parent health education among their activities. Communities determine the services to be offered in conformity with state laws, integrating them with existing health services in the community and school.

Most school-based health centers staffs are headed by a nurse-practitioner and include individuals with expertise in mental as well as physical health, and in some centers, dental health as well. Referrals are made to specialists as needed. The centers generally operate during school hours and offer backup when school is not in session. School districts, working with a sponsoring health provider organization, decide where to locate centers—typically in schools with a high percentage of low-income students. Some centers serve only students in that school, while others are open to any child or adolescent in the service area. According to the Center for Health and Health Care in Schools that grew out of the national program office for this program, of the 1,380 SBHCs operating in 2000, 38 percent were in elementary schools, 17 percent in middle schools and 34 percent in high schools.

During its work with some 23 SBHCs, the *School-Based Adolescent Health Care Program* demonstrated that providing access to care for adolescents in schools could be an effective public health strategy. Students sought care from SBHCs far more often than their contemporaries in other health care delivery systems. (On average, SBHC enrollees used health services four times a year, while other children sought care less than once every two years at other health facilities.) The centers also won the approval of most parents; 70 percent of students in schools with SBHCs had written permission to use the centers.

Although the *School-Based Adolescent Health Care* national program validated the comprehensive model, it also drew attention to the absence of conditions for sustaining centers or establishing new ones. In many states, for example, state policy prevented the centers from participating in Medicaid or managed care networks. In most states, there

was no state office or infrastructure to provide support to the centers or set policy on the scope and content of care offered.

THE PROGRAM

Making the Grade was a national program that supported state-local collaborations designed to expand comprehensive school-based health services for children and adolescents. The overall goal was to help states and their local partners establish new SBHCs and promote policies to sustain the centers over the long term. RWJF originally authorized \$23.2 million for the program, which was to include planning grants for 12 states, implementation grants for up to 10 states and the creation of SBHCs in at least two communities in each state. (For a list of states receiving grants under this national program, see [Appendix 3](#).)

The program had two phases. In the first, 12 states received \$100,000 planning grants designed to support a 12-to-18-month planning period. States were expected during that time to: (1) establish a state *Making the Grade* office and coordinating committee, (2) form partnerships with local providers and community groups, (3) assess and set objectives for state policy, (4) develop strategies for reducing financing barriers, and (5) plan ways to increase the supply of qualified nurse practitioners, clinical social workers and other [mid-level providers](#). Only three states met their planning objectives in one year (Colorado, Connecticut and New York), largely because of external challenges detailed below (see [A Changing Environment](#)); these states received implementation grants of \$1.5 to \$2.5 million.

Six states were given a second planning grant of \$100,000 (Louisiana, Maryland, North Carolina, Oregon, Rhode Island and Vermont), and three state projects (Delaware, Hawaii and Tennessee) were terminated for a variety of reasons related to project design and local funding and support. After the second planning grants, the six states receiving a second planning grant joined the three states in receiving implementation grants. The implementation grants required states to:

- Partner with local health care providers and school districts to create new school-based health centers in at least two communities.
- Implement the comprehensive SBHC model.
- Collaborate with other agencies through a coordinating body.

Locally, the entities receiving RWJF implementation funding made commitments to:

- Form a formal advisory body.
- Select a medical provider to serve as the lead organization.

- Build local support.
- Create school-based health centers in two or more schools (including developing the space using separate funding).
- Develop plans for district-wide expansion.

Implementation grants, spread over four years, supported service delivery and state program management. Some states received no-cost extensions to complete the expenditure of funds.

Grants of an additional \$100,000 were available for state training programs for nurse practitioners and other mid-level professionals. According to National Program director Julia Lear, only Colorado made a sustained effort to promote training of nurse practitioners and other mid-level providers. Nationwide, the growth of managed care had increased demand for the services of nurse practitioners sufficiently to spur increased training through market forces.

Site Selection

Forty states and the District of Columbia applied for planning grants. Selection of the 12 planning grant recipients was based on recommendations from a National Advisory Committee, which included state and local community leaders, representatives of health care professions, educators and school health experts. (For a roster of National Advisory Committee members, see [Appendix 4](#).)

Evidence of a strong state-government commitment to the grant objectives was a major criterion in the selection process for planning grant recipients. In the selection of recipients for implementation grants, evidence of state government commitment was also critical; selection panel members looked for evidence of participation by the governor and legislature, public agency collaboration, progress in reshaping state policy and concrete steps toward implementing the comprehensive SBHC model.

National Program Office

A national program office at George Washington University administered *Making the Grade*. Julia Lear, Ph.D., an associate professor and former co-director of the RWJF *School-Based Adolescent Health Care Program*, served as program director. The national program office provided support and technical assistance to state project directors, who provided support and technical assistance to new and existing SBHCs in their states. According to the program director, the national program office's most important contribution was "to support state project directors as they learned to become players' in their state's health policy development arena."

Technical Assistance

The national program office used a battery of tools including site visits, meetings, media training and telephone consultations to support state programs. Communications vehicles included a newsletter, an award-winning website, special reports and articles. (See [Communications](#).)

One of these special reports, *Issues in Financing School-Based Health Centers: A Guide for State Officials*, by Stephen Rosenberg, a health care financing consultant from Oakland, Calif., was published in 1995 and addressed a top priority for *Making the Grade*. The national program office then contracted with Rosenberg to advise state project directors on strategies to position their programs in public policy and the health care marketplace. At a June 1998 meeting with the project directors, Rosenberg emphasized that SBHCs would need to become more business-like in their thinking and planning. "If you are taking a public dollar, you have to be publicly accountable. It is not sufficient to say that 'we're good people and we do good things,'" he said. Highlights of the meeting were summarized in proceedings titled, *Nine State Strategies to Support School-Based Health Centers*.

Site visits by national program office staff provided an opportunity to assess progress on policy objectives and implementation of the comprehensive model. They also served as an important strategy for drawing the attention of state elected officials and media to school-based health centers and for holding states accountable for the promises they made as a condition of the accepting the grants. One site visit was the genesis of a national effort to promote quality and consistency among SBHCs, and it evolved into a continuous quality improvement (CQI) initiative described below (see [Results](#)).

Interpreting and promoting implementation of the comprehensive SBHC model was another national program office priority. The national program office helped develop the literature on school-based health care by placing articles in respected journals (e.g. the *Journal of Adolescent Health* and the *Journal of School Health*); conducting surveys and media activities; and publishing reports such as *From the Margins to the Mainstream: Institutionalizing School-Based Health Centers* and *The New Child Health Insurance Expansions: How Will School-Based Health Centers Fit In?* State and local programs used these documents to build the credibility of SBHCs with potential supporters.

Other RWJF School-Based Health Center Grants

RWJF made a number of grants outside of this program that supported school-based health centers.

- **Information Systems.** Between 1991 and 2000, RWJF provided three grants (see [Program Results Report](#) on ID#s 018694, 021457 and 031122) to support development of a management information system that would allow SBHCs to track

care received by patients, bill for services provided and check outcomes as part of quality improvement efforts.

- **Coordinating Services.** Rosenberg & Associates received a grant (ID# 035008) to examine how eight school districts worked to coordinate school-based health services with other health services provided in the community.
- **Prevention Strategies.** The Urban Institute received a grant (ID# 035066) to identify interventions that SBHCs could use to reduce health risks and promote health and school success.

A CHANGING ENVIRONMENT

Soon after *Making the Grade* began in 1994, the political climate in the United States changed. The project had anticipated a big push from President Clinton's proposed [Health Security Act](#), which budgeted \$300 million for school-based health care. When that initiative was defeated, the effort to create and sustain SBHCs lost potential financial resources and momentum. At the same time, a number of states had enacted budget caps.

These challenges to anticipated financing forced SBHCs to begin to look to Medicaid and other [third-party payers](#) as potential revenue sources. Medicaid was the main third-party focus because it covers most school-based health center patients who have any coverage. Tapping this source was not possible in most states, however, without significant changes in state policy and a waiver from the federal government. For example, states would have to allow SBHCs to participate in managed care networks as primary care providers and to receive payments from Medicaid and the [Children's Health Insurance Program \(CHIP\)](#). SBHCs, with their emphasis on safety-net services, wide access and generally modest data collection capacities, were not a good match for managed care. See [Results](#) for more information on how states addressed these challenges.

Another challenge to the program was the vigorous opposition to school-based health centers that emerged early on, from groups objecting to the centers' provision of reproductive health services such as contraceptives for high school students. In some states, this opposition had the paradoxical effect of generating more support for SBHCs; in others, *Making the Grade* programs were forced to accept constraints on services or to focus on younger children for whom controversial services were moot. In all cases, opposition challenged state and local programs to be sensitive to local conditions and to cultivate local support.

Other Changes

In February 1995, overall funding for the program was reduced from \$23.2 million to \$16.6 million, as part of a general reassessment and consolidation of RWJF grant programs conducted by the Board of Trustees. According to Terrance Keenan, a former

RWJF program officer (currently a consultant), the Board's decision to reduce funding had nothing to do with the merits of *Making the Grade*, "a program in which the Board takes very considerable pride." As a result of the reduction, however, some *Making the Grade* states received lower implementation grants than did others.

RESULTS

The national program office identified these accomplishments as among the chief results of the *Making the Grade* program overall:

- The number of SBHCs in *Making the Grade* states grew 59 percent between 1994 and 2000.** All *Making the Grade* states except Vermont met the *Making the Grade* goal of creating at least two new SBHCs each in two communities. A total of 43 new centers were created with *Making the Grade* funds. In addition, the state programs created conditions that led to the development of additional SBHCs. In all, the number of SBHCs in *Making the Grade* states grew from 278 to 442 between 1994 and 2000, with large variations among states:

Growth in Numbers of SBHCs in <i>Making the Grade</i> States			
	1994	2000	% change
Colorado	26	33	26.9%
Connecticut	32	56	75%
Louisiana	9	40	340%
Maryland	23	59	156%
New York	146	159	8.9%
North Carolina	20	41	105%
Oregon	19	44	131.6%
Rhode Island	2	7	250%
Vermont	1	3	200%
TOTAL	278	442	59%

- Both national and state organizers had hoped that more school-based health centers would be started as a result of *Making the Grade*.** SBHCs actually multiplied more slowly in *Making the Grade* states than they did in states that were not part of the program. (Over the same period, non-*Making the Grade* states saw SBHCs increase by 177 percent, from 339 to 938.) Program director Julia Lear said, "*Making the Grade* states committed to fitting the school-based health centers into a third-party reimbursement model." This meant that *Making the Grade* states had to "play by the new, managed care rules," while other states took other approaches to financing, including not requiring centers to bill for services. She believes this accounts for the difference in growth in numbers—since the commitment to get third-party reimbursement for services complicated the growth of SBHCs in *Making the Grade* states.

- Funding for school-based health centers became more stable.** *Making the Grade* programs gradually replaced their initial RWJF grant funds with a shifting patchwork of local, state and federal sources. Today, most funding comes from state general funds, supplemented by federal block grants and special sources such as funds from the recent multi-state settlement of a suit against tobacco companies. *Making the Grade* programs worked hard to secure Medicaid financing, an early *Making the Grade* policy objective, and a few states had some success. (See the New York State [Program Results Report](#) on ID# 031658 for example.) Centers have had very limited success billing private third-party payers, which generally impose the same constraints as Medicaid and whose policies are not under state control. At the end of *Making the Grade*, the Children's Health Insurance Program (CHIP) remained a relatively insignificant source of funds but one with growing promise in many states.
- States enacted finance policies more favorable to school-based health centers.** State finance policies were essential in helping SBHCs secure third-party reimbursement. The following table from the national program office summarizes financing-related policies in the nine *Making the Grade* states, and the number of states with each one:

State Policies to Support Third-Party Payments for SBHC Services					
SBHCs can receive Medicaid payments	SBHCs can receive CHIP payments	State has taken specific measures to help SBHCs participate in managed care	State has taken specific measures to help SBHC participate in CHIP	SBHCs may participate in managed care organization as primary care providers	SBHCs or their sponsors have contracts with managed care plans
9	8	9	9	6	5

- States enacted other policies more favorable to school-based health centers.** *Making the Grade* states enacted policies concerning the content and delivery of care, aimed at standardizing and assuring quality and elevating the status of school-based health care in the managed care environment. All *Making the Grade* states passed laws permitting nurse practitioners (NPs) to participate in managed care as "primary community providers (PCPs)", thus qualifying their SBHCs for Medicaid and sometimes Children's Health Insurance Program reimbursement. The following table from the national program office summarizes nonfinancial policies in the *Making the Grade* states and the number that has adopted each one:

Nonfinancial State Policies to Support SBHCs						
State has a gov't office explicitly charged to develop SBHCs	State laws permit NPs to participate in managed care networks as PCPs	State has targeting guidelines for SBHCs	State has operating standards for SBHCs	State has recommended standards	State has required standards	SBHCs are licensed by state health licensing authority
9	9	8	9	5	4	3

- **School-Based Health Centers gained a political foothold in state government and politics.** During *Making the Grade*, states expanded and consolidated their infrastructures for managing school-based health care and coordinating child health and welfare programs. Governors created Children's Cabinets or in other ways strengthened the place of child/adolescent health and school health in their administrations. In addition, through the efforts of *Making the Grade* Project Directors and local school-based health center supporters, SBHCs built a strong base of support among both high-level allies and grassroots constituents.
- **The comprehensive SBHC model was established as the national gold standard for school-based health care.** *Making the Grade's* rigorous comprehensive model held states to the highest standard in the range and quality of services being provided. The national program office determined midway through the program that state project directors needed additional support in helping school-based health centers implement the comprehensive model. Besides producing publications on the comprehensive model, including a series of articles in its newsletter, ACCESS, the national program office worked with state project directors to assist SBHCs with implementation. By the end of *Making the Grade*, the school-based health center field at large had accepted the validity of the comprehensive model and the importance of having interdisciplinary staffs able to address the full gamut of students' health needs.
- ***Making the Grade* developed and tested a continuous quality improvement (CQI) tool for school-based health centers.** Late in *Making the Grade*, the national program office engaged three national experts with school-based health center experience to develop a CQI tool that SBHCs could use to keep standardized records and carry out quality improvement activities. The national program office tested the CQI tool in 19 SBHCs, with funding from the federal Bureau of Primary Health Care. It was completed in 2001 and turned over to the [National Assembly on School-Based Health Care \(www.nasbhc.org\)](#) for administration (see *Afterward*). The CQI tool is tailored to elementary, middle and high school centers and provides a way to track practices around seven essential clinical activities or commonly treated ("sentinel") conditions, including at least one mental health condition, a comprehensive annual health risk assessment and a biannual physical exam. It is consistent with HEDIS (the Health Plan Employer Data and Information Set, a quality measurement instrument for managed care created by the National Committee for Quality Assurance) and with professional society clinical practice guidelines.
- **The national program office helped launch the [National Assembly on School-Based Health Care](#).** Created in 1995, the national assembly has become an important forum for disseminating best practices and sharing innovations among school-based health centers. The executive director, John Schlitt, is a former *Making the Grade* deputy director. All *Making the Grade* states except Vermont helped launch state networks that eventually formalized into assemblies or associations and became National Assembly on School-Based Health Care chapters. The state and national

associations play key roles in mobilizing and sustaining support for school-based health centers.

- **The *Making the Grade* website established in 1996 became a vehicle for disseminating information on the program and school-based health centers generally.** The national program office facilitated media stories and produced a newsletter, a website, monographs and surveys to support state and local programs and promote the reputation and growth of school-based health care. The national program office conducted a biennial survey on school-based health centers that generated newspaper and radio coverage and broadened public awareness. The national program office also produced and commissioned multiple reports and information resources on school-based health care to assist state and local programs and widen public knowledge about this approach to health care delivery. See [Communications](#) for more information.

EVALUATION

An evaluation of the *Making the Grade* program was conducted by a team led by Kathryn Langwell, then of Barents Group, KPMG Consulting, LLC, and James Morone, of Brown University. According to the evaluation team's final report, the goal of the evaluation was to investigate the following questions:

- What will it take to bring SBHCs to scale across the nation?
- What are the critical ingredients for the survival and growth of this health care delivery method?
- What strategies have been successful?
- What barriers prevent growth, and how have these barriers been overcome?
- What barriers remain?
- How did the states adapt to environmental changes (described below) that forced them to "play by a different set of rules than those anticipated?"

The evaluators looked for answers to these questions in three areas: (1) gaining and maintaining political support; (2) securing financing; and (3) responding to the rapidly changing health delivery system. They used a structured, comparative case-study methodology, in which they gathered qualitative and quantitative information through site visits, interviews and document and budget review. Site visits took place in late 1998 and early 1999. The authors submitted the first volume of their report, addressing overall program objectives, *Evaluation of Making the Grade: State and Local Partnerships for School-Based Health Centers: Final Report*, in August 2000. A second volume, *Case Studies of the Nine Making the Grade States*, followed in April 2001.

Findings

The evaluation team noted these conclusions in *Evaluation of Making the Grade: State and Local Partnerships for School-Based Health Centers: Final Report*:

- **School-based health centers have become an established, permanent and respected part of the publicly supported health system infrastructure.** Although SBHCs have not achieved widespread penetration through the public school systems of this country, the evaluation team found a continued momentum toward program growth, even in states nurturing new and fragile programs. They noted that SBHCs must continue to evolve as the health care system changes.
- **School-based health centers have a "unique and critical role" in the contemporary health care environment.** For children without health insurance coverage, SBHCs can provide routine and preventive medical care that would not otherwise be available to them. For children in low- and middle-income working families, SBHCs offer working parents the opportunity to obtain routine and preventive medical services for their children without losing income, or potentially their jobs, for taking time off from work for medical visits. For middle or high school students, SBHCs offer services addressing sensitive problems, such as substance abuse, mental health or reproductive health, that they might not seek out from other primary care providers or from parents. In the absence of SBHC services, some children might not receive these services and, in the long run, could develop more serious long-term problems that could affect their future lives and livelihoods.
- **Medicaid is not a good match for school-based health care, especially when services are delivered through managed care.** The initial *Making the Grade* emphasis on putting third-party payment (mostly from Medicaid because of students' low-income status) at the center of states' finance strategies did not yield the intended results. After laboring in this arena, most *Making the Grade* states concluded that integrating SBHCs into third-party payer delivery systems would have modest financial returns (10–25 percent, according to the evaluation) and instead they should be part of a wider financing and political strategy.
- **School-based health centers need mixed financing strategies involving federal, state and local sources in both the private and public sectors.** SBHCs are most likely to rely on government funding for the major portion of their financial support, but mixed strategies are essential because government funding levels may be limited and variable.
- **The political environment and political support for school-based health centers are of fundamental importance to their long-term sustainability.** Financial stability begins with political stability, based on a strategy involving both state leadership and community support. A combination of targeted public education campaigns and grassroots political action, reinforced by high-level alliances, was successful in building and retaining legislative support and a place in state budgets for

SBHCs. The evaluators stress the interplay between "bureaucratic activists" and grassroots mobilization. In every case they studied, they say, "the innovating spark flew not up from the grassroots but down from state government"—and then back through the efforts of grassroots constituencies to affect state-level decision-making. Political viability came through a combination of local partnerships, statewide networks and high-level alliances, all pulled together by strong leaders. In most states, a key element was legislators who recognized that SBHCs are providing valuable services to families in their districts. National-level leadership is also needed, through bodies such as the national program office (now the Center for Health and Health Care in Schools) and the [National Assembly on School Based Health Care \(www.nasbhc.org\)](http://www.nasbhc.org).

- **School-based health center leaders must be flexible in adjusting to local social and cultural standards to reduce or avoid strong cultural opposition to school-based health care.** Schools and SBHCs are a potential stimulus for local opposition. Successful organizers recognize this and are able to offer compromise solutions to establish trust with potential adversaries. An important part of their approach is increasing community awareness of the high level of need among children and adolescents.

The [National Assembly on School-Based Health Care \(www.nasbhc.org\)](http://www.nasbhc.org) continues to provide leadership, support and a national forum for school-based health centers, working in close cooperation with the center. The assembly manages dissemination of the continuous quality improvement tool, and plans to further develop it and to encourage SBHCs to use it. A long-term goal is to use the tool to compare school-based health centers with other providers such as HMOs. States still have the option of using their own continuous quality improvement tools.

Communications

The national program office newsletter, *ACCESS to Comprehensive Services for Children and Youth*, was published three times a year and each issue was distributed to more than 5,500 people. The *Making the Grade* website, now expanded into the [website of the Center for Health and Health Care in Schools](http://www.nasbhc.org), provided SBHC clinicians, administrators and parents with resources including clinical and research reports, administrative information and policy updates. The website, which receives some 6,000 visits a week, won an award from the World Health Organization. In addition, the national program office managed a listserv for school-based health centers enabling person-to-person technical assistance within the field for some 600 participants. The national program office also produced a biennial national survey on state school-based health center initiatives, which generated periodic reports in local and national media.

Special reports by the national program office include:

- *School-Based Health Centers: Critical Caring on the Front Lines*, a double-pocket information folder developed with the [National Assembly on School-Based Health Care \(www.nasbhc.org\)](http://www.nasbhc.org) and distributed to some 5,000 people.
- *From the Margins to the Mainstream: Institutionalizing School-Based Health Centers*, and *The Picture of Health: State and Community Leaders on School-Based Health Care*.

National program office personnel made numerous presentations on the program at local, state and national conferences, including *Making the Grade* state conferences and national meetings sponsored by the U.S. Department of Health and Human Services Center for Mental Health Services, the National Child Health Leadership Conference, the National Summit on School-Based Outreach for the Children's Health Insurance Program and the National Conference of State Legislators. (See the [Bibliography](#).) Coverage of school-based health centers has appeared in the *New York Times*, the *Chronicle of Philanthropy* and *Time* magazine, among other major media.

At the end of *Making the Grade*, the evaluation team published an article on the evaluation in the journal *Health Affairs*, "Back to School: A Health Care Strategy for Youth" (January–February 2001).

LESSONS LEARNED

1. **Well-designed communications campaigns are a major tool in building awareness and support for school-based health centers.** Communications consultants and media training are useful to state programs and the national program office. Communications were a critical tool in building support for school-based health centers and knitting them into the fabric of communities and states. The most effective *Making the Grade* programs took a strategic approach to communications, using special events, site visits and media campaigns as well as print materials. Most project directors used consultants to help them reach the media and develop effective products and events. RWJF provided invaluable support, offering communications advice, website development and project director media training. (Program Director)
2. **School-based health centers need data and quality assurance practices to improve operations and performance and to show constituents and supporters the value of SBHC services.** During *Making the Grade*, data collection and quality assurance procedures became increasingly important and formalized. They provided a means for self-assessment and improvement of services, as well as a way to demonstrate value to political supporters and funders and to meet the requirements of third-party payers and managed care plans. (Deputy Program Director)
3. **Providing care to as many children and adolescents as possible—the public health mission of school-based health centers—is as important as assuring**

quality and comprehensiveness in SBHC services. The national program office worked in a host of ways to strengthen SBHCs' understanding of the SBHC comprehensive model and their ability to implement it. Equally important because of the extent of the need, says Lear, is the goal of using available resources to serve as many children as possible without compromising quality. (Program Director)

4. **The school-based health centers field flourishes through sharing what it learns and produces.** The SBHC community has "a real collectiveness," according to Lear. Because of this willingness to share, the national program office was able to serve as "the universal joint" among programs. Centers and state coordinators can continue to exchange useful experiences and products through their connections with the national resource center and national and state SBHC assemblies. (Program Director)
5. **Alliances with the education sector did not develop as expected, but they remain important.** Neither at the federal level nor in any state did a successful partnership emerge between education agencies and school-based health center initiatives. "At present there is limited interest within the education establishment to invest time, energy or money in the development of school-based health programs," the program director said. (A notable exception can be seen in the Connecticut [Program Results Report](#) on ID#s 023519, 027113, 032362). At the local level, collaborations between the education and health sectors are more often, though not always, positive, and it remains important to cultivate and optimize this partnership. (Program Director)

AFTERWARD

In February 2001, the *Making the Grade* national program office became the *Center for Health and Health Care in Schools* under a new RWJF grant program authorized by the Board of Trustees for up to \$6 million, which ran through 2006. (See the [Program Results Report](#) on the center.)

The center has served as a resource for school-based health care, to provide technical and communications assistance and funding to school-based health centers and school health programs to develop approaches to include mental and dental health care in the services they provide.

With RWJF funding, the center started a multi-site national program, *Caring for Kids: Expanding Dental and Mental Health Services through School-Based Health Centers*, which funds eight mental health and seven dental health demonstration SBHCs. The program is described on the center's [website](#).

The *Center for Health and Health Care in Schools* has begun working on the issue of childhood obesity, and has devoted a section of the [website](#) to this issue. The center has published a number of reports on the subject.

- *Keeping Kids Healthy: Obesity, Nutrition & Physical Exercise (a resource document).*
- *Nutrition, Physical Exercise and Obesity Survey.*
- *Childhood Obesity Fact Sheet.*
- *Parent Resource Center. Act Now: School Lunch and Nutrition.*
- *Parent Resource Center. School Lunch Parent Handout.*

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APPENDIX 1

The School-Based Health Center Model

(Current as of the time of the grant; provided by the grantee organization; not verified by RWJF.)

(Source: Making the Grade Call for Proposals)

Although comprehensive school-based health centers vary in staffing patterns and services provided, they share some common features:

- They are located in schools.
- Parents sign written consents for their children to enroll in the health center.
- An advisory board of community representatives, parents, youth and family agencies and other appropriate organizations participate in planning and oversight of the health center.
- The health center works cooperatively with school nurses, coaches, counselors, classroom teachers and school principals and their staff to ensure that the health center is an integral part of the life of the school.
- Clinical services are the responsibility of a qualified health provider (hospital, health center, health department or group medical practice.)
- A multidisciplinary team of nurse practitioners, clinical social workers, physicians and other health professionals care for students.
- The health center provides a comprehensive range of services that specifically meets the serious health problems of young people in the community as well as provides general medical care.

APPENDIX 2

The Look and Feel of a School-Based Health Center (SBHC)

(Current as of the time of the grant; provided by the grantee organization; not verified by RWJF.)

A Composite Sketch

Picturing a combination of a busy doctor's office and the main office of a school produces a rough idea of a typical SBHC, with its mixture of order and flexibility. Student enrollees have several options for visiting their SBHC caregivers (generally nurse practitioners, community health nurses, mental health professionals and sometimes dentists or hygienists). As in other primary care settings, physicals and other forms of

routine health management and screening are handled by appointment. Students also can drop in for help with unanticipated needs, and faculty or administrators may send them to the SBHC for emergency illnesses or injuries. Centers have differing arrangements for non-school hours, from access to an on-call nurse or community health center to a simple answering machine with next-day follow up. Some centers also are open during evening hours and have special summer programs.

School-based health centers with large-enough waiting rooms often serve as informal community centers for students—one of the reasons why RWJF program officer for *Making the Grade* and the Center for Health and Health Care in Schools, Judy Stavisky, calls them "islands of hope in the schools." Just as SBHC clinicians are experts in child/adolescent healthcare, office assistants (a strategic role in school-based health centers) are expert at creating safe, welcoming environments that complement the physical and mental health services. One waiting room, for example, provides a basket of laminated cards naming various ailments, to help shy patients identify and communicate the problem that brought them there.

Center staff members see themselves as supporting and supplementing parents' roles. Generally, parents give their consent when children are enrolled in school-based health centers. For young children, some centers ask a parent to be present for appointments, thus affording a health education opportunity for the family. For older children, even if permission for specific services is not required, center administrators stress the importance of communicating with parents—asking staff to keep records of their own parent contacts and to coach students on talking with parents about sensitive subjects, such as those related to sexuality. Filling in the gaps for sometimes-overstressed parents is another school-based health center role: "We do a lot of being Mom to these kids," says a middle-school SBHC community health nurse in Oregon.

A Web of Care

As noted in the [Problem](#) section, school-based health center services cover the gamut of physical and mental (and in some cases dental) health needs. One of the pillars of the comprehensive model of care that SBHCs provide is the interdisciplinary team of providers, working side by side and coordinating care.

Every visit is seen as an opportunity to gather a wide range of information on the child, and comprehensive treatment models and staffing make it possible to move back and forth between mind and body in treating patients. A member of Oregon's Multnomah County school-based health center's staff observes that, "The centers help kids sort out what's physical and what's not. In the process, they can destigmatize mental health work so kids can accept help for that component as well."

In addition to the biennial physical exam, which can identify issues before they become critical, the annual risk assessment helps providers look at the factors underlying health and illness. The [continuous quality improvement \(CQI\)](#) tool (see [Results](#)) for school-based health centers states that the risk assessment (with age-appropriate variations) is expected to cover injury, safety, violence, diet and exercise, dental health, substance use and passive exposure, abuse, family relationships, school, friends, mood and emotional health and sexuality. For the SBHCs' target population, poverty can exacerbate risks, as can immigrant status and the challenge of learning English.

Many SBHCs use therapeutic groups to help students collectively tackle issues ranging from puberty and the vicissitudes of adolescent friendship to sexual abuse, depression, anxiety disorders and parental substance abuse. While inevitably affecting the classroom, such challenges are often beyond teachers' capacity to handle. "So much affects kids' ability to learn, and we can pick up some of the pieces that teachers can't," says the director of a Colorado SBHC.

School-based health centers have a public health mission of reaching as many students in their jurisdiction as possible. Besides treating those who seek or are sent for care, staff members also provide health education through classroom presentations, interaction with families, information campaigns and special public events. One SBHC in the Denver area, for example, recently conducted special initiatives (with assessment, treatment plans, follow-up and family education) on childhood asthma, dental hygiene and immunizations, and it plans such a campaign on obesity. Ideally, efforts such as these are supported by community partnerships. For example, this Denver-area center partners with its school district, the University of Colorado School of Nursing, the local health department, the Breathe Better Foundation, the American Lung Association, the community mental health center, a local hospital and a large HMO.

Examples of Care

The *Making the Grade* evaluation (see [Evaluation](#)) illustrates the needs school-based health centers are meeting with these stories:

- In Brooklyn, an irate mother called the school, furious that her child had been asked to disrobe at the health clinic. It was clear neither she nor her children had ever had a full physical exam and did not know what to expect from one. Health center staff was able to educate her about the importance of annual physical exams.
- In Louisiana, a rural, largely African-American parish is home to 9,000 children. The entire parish has three physicians, none of them a pediatrician and only one younger than 65 and willing to accept Medicaid patients. For most of the children, the school-based health center is their first source of regular medical care.

The 2000 RWJF *Anthology, To Improve Health and Health Care* (Chapter One) describes *Making the Grade* and tells of children receiving life-altering help from their school-based health centers for behavioral and emotional problems:

- A third grader with a history of violence toward himself and others learns from a SBHC social worker how to recognize the emotionally charged incidents that trigger his violence and depression, and how to cope better with stressful situations.
- A SBHC therapist helps a suicidal 15-year-old girl reveal a long-hidden experience of sexual abuse and join a sexual-abuse therapy group at school, where she gains perspective on her trauma and builds self-respect.
- A home visit enables a SBHC social worker to help an adolescent patient deal with family members' alcohol and substance abuse as well as resolve her problems with teachers.

Finally, school-based health center staff members share these stories from their clinical experience:

- A high school girl from a strict immigrant family—described by her caregivers as "a charismatic child who believes in education"—is steered into prenatal care after SBHC staff members finally help her admit she could be pregnant, allaying concerns that she has a tumor.
- A high school boy's abnormal blood pressure, picked up in a routine SBHC sports physical, leads to discovery of a heart abnormality and corrective surgery that may have saved his life.
- An 8th grade boy confides in his nurse practitioner that he's concerned about his alcohol craving. With support from the entire SBHC staff, he undergoes the assessment (Personal Experience Screening Questionnaire) process, involves his father in counseling and eventually overcomes his budding alcohol addiction. Says the SBHC director, "This is raw prevention."

APPENDIX 3

Profiles of Three School-Based Health Centers (SBHCs) Created During *Making the Grade*.

(Current as of the time of the grant; provided by the grantee organization; not verified by RWJF.)

(Information derived from site visits and interviews conducted in 2002 by Susan Baird Kanaan.)

Eiber Wellness Center, Eiber Elementary School, Jefferson County, Colo. (a Denver suburb).

(See also [Program Results Report](#) on Colorado's *Making the Grade* project—ID#s 023518, 027112, 032293.)

Health and mental health services are "completely intermingled" with education at Eiber Elementary School, according to its principal. "We wouldn't have a complete school if the Wellness Center were not part of it. We don't just teach our kids reading, writing and math. We are teaching them how to take care of themselves and how to become human beings." Colorado's *Making the Grade* project director Bruce Guernsey says the principal's enthusiasm is so infectious that "we should take her on the road." She reports that many fellow principals with medically underserved students envy the health care resources in her school.

At Eiber, where students speak 19 languages, the Wellness Center is housed in a small building a few steps from the school. The staff includes the director, office assistant, mental health therapist, health educator and dental hygienist. The director says the lack of space is their major challenge. The dental hygiene program is a welcome recent addition to services, even though it preempts one exam room for dental care, with the large chair occupying much of the room. Other clinicians and teachers identify kids in special need of dental care, and the hygienist pulls them out of class for treatment.

Students are enrolled in the center when they enroll in school, and staff members also publicize their services through newspaper ads and brochures. They and school administrators work closely with the district Medicaid office to enroll students in Medicaid and the [Children's Health Insurance Program \(CHIP\)](#), but they say they would prefer having a benefits specialist on site, as in some school-based health centers, to help link patients to reimbursement sources.

Besides providing routine clinical and preventive services to students, Eiber Wellness Center collaborates with the school on an array of family-oriented health outreach and education activities for their largely low-income community. Examples are a quarterly family night, an annual family health fair and special campaigns such as the annual helmet education campaign, complete with free helmet distribution to third-graders.

Among other things, the annual health fair offers parents screening and education about their weight and blood pressure. In school, the health educator works with faculty to identify subjects to include in their classroom curricula.

Besides serving Eiber's elementary-age students, the SBHC is open to area adolescents, who come for such services as sports physicals.

Lane Middle School School-Based Health Center, Multnomah County, Ore.

(See also [Program Results Report](#) on Oregon's *Making the Grade* project—ID#s 023526, 027117, and 029836.)

This SBHC sits between a middle school and a community center in a modest Portland neighborhood. A community health nurse, a nurse practitioner, a therapist and an office assistant staff the center. All but the office assistant have worked together since the center opened in 1997.

Typical of SBHCs, Lane has a friendly waiting area presided over by the office assistant, plus a couple of examining rooms, staff areas and simple lab facilities. Space is limited: the therapist describes shoehorning the six lively members of her Boys Group into her tiny office for their weekly sessions. The school took back some of the space originally promised for the center when its enrollment swelled, but with money tight in every agency, the director says this is not a good time to push for expansion.

The center's staff deals with everything from sore throats to depression to age-appropriate reproductive health guidance (such as puberty and abstinence education) with their young patients. They also collaborate with the school on an annual tobacco cessation/prevention campaign. Besides being a context for health education, center staff members see routine physical care as a potential setting for exploring any mental health issues students may be unwilling to bring to them initially. This is the first time most students are seeking health care on their own, and staff members also seize the opportunity to teach them how to be health consumers—"to see us as a resource, not an authority," says the community health nurse.

The community health nurse adds that middle school students are good at referring their friends to the SBHC. Knowing the merits of peer influence as a health promotion tool, she encourages students to bring a friend along to their nutrition and weight-loss counseling sessions. Friends know and will point out unhealthful behaviors, and this enables her to educate more children about food and fitness. Lane's staff members are using what they know about this age group to help develop a specialized middle school SBHC model as part of the county's Middle School Summit. Some of the factors being explored with respect to middle school students' developmental needs are appropriate

parental involvement and the best ways to prevent risky behaviors before children move on to high school.

Madison High School and Vocational High School School-Based Health Center (SBHC), Multnomah County, Ore.

(See also [Program Results Report](#) on Oregon's *Making the Grade* project—ID#s 023526, 027117, and 029836.)

Located inside Madison High School, this SBHC fits easily into the life of the large urban school. It serves teens in the nearby Vocational High School, as well. Staff members include a community health nurse, a nurse practitioner, a therapist and an office assistant. Students also had access to alcohol and drug counselors until the fall of 2002, when this county service was withdrawn for lack of funds.

Someone has worked to create an attractive, teen-friendly decor, though a poster on an exam room ceiling doesn't quite cover the missing acoustical tiles. The nurse practitioner has moved her desk into a nook in the common area to free up a small room for clinical purposes. The staff meets in the waiting room under a "whimsy board"—a bulletin board on which fragments of favorite song lyrics are written on CDs affixed to patches of colored paper. Earlier whimsy boards have featured students' poems and a world map where they could mark their families' countries of origin.

Ninety percent of Madison's 1,200 students qualify for the free or reduced-price lunch program, and English is the second language for a third of them. Just over half are enrolled in the school-based health center. Staff members' stories illustrate the interplay of economic, cultural, family and health issues confronting their diverse patient population, and the tailored interventions the SBHC is able to employ in this setting. For example, staff members told of getting a phone call from the 11-year-old sister of one of their patients, telling them, "My brother is sick in the eyes and you've got to help him"—which they did, of course. Spanish Day happens every two weeks for Hispanic clients, and interpreters are provided as needed for all languages. The office assistant says, "Kids come in here because they want to; we see them as individuals."

Asked to name the most common challenges they help clients with, staff members offer a wide-ranging list: lack of insurance, mental health problems, contraception, general primary care and not knowing how to use the health care system. They point out that simply having health insurance does not translate into getting care. Many young people will not seek out services from other providers—not just for sensitive matters but even for routine primary care—while they are willing to do so in the school-based health center setting. For example, they may be embarrassed, standard providers may not have settings that feel as safe as SBHCs do, they may be afraid their parents will find out or

they may feel that too much is involved in seeking other care compared with just stopping by the SBHC.

Like other school-based health centers, this one actively pursues health promotion opportunities in the school. In one such activity, staff members use "Noon Outreach" to informally survey students around the school on a given topic—"Name something you like about yourself," for example, or "What's your favorite food?" The written responses are posted on a colorful bulletin board located in a well-traveled school hallway. In this way, knowing that kids learn best from their peer group, the SBHC uses kids' messages to teach about topics such as nutrition and self-esteem.

APPENDIX 4

Making the Grade National Advisory Committee

(Current as of the time of the grant; provided by the grantee organization; not verified by RWJF.)

Mary E. Baca
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Connie Hubbel, President
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Ruth I. Katz
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Committee on Energy and Commerce
U.S. House of Representatives
Washington, D.C.

Betty King
Associate Director
The Annie E. Casey Foundation
Greenwich, Conn.

Governor Ray Mabus (first Chair)
Jackson, Miss.
(resigned when appointed Ambassador to
Saudi Arabia by President Clinton)

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State Senator
Albany, N.Y.

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Robert S. Peterkin, Ed.D.
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APPENDIX 5

Glossary

Children's Health Insurance Program (CHIP): A 1997 federal program that provides funds to states for expanding health care coverage for low-income children. Many states give their state CHIP programs unique names (e.g., ChildHealth Plus in New York; HUSKY Part B in Connecticut).

Comprehensive school-based health center (SBHC) model: The approach to SBHC staffing and services that was validated by the School-Based Adolescent Health Care Program and extended by *Making the Grade*. The model requires an interdisciplinary staff with professionals trained in treating both mental and physical health issues (and in some centers, dental health as well). SBHCs have demonstrated that even when students initially seek treatment for a physical ailment, they often want help with emotional or mental health issues as well.

Health Security Act: President Clinton's legislative vehicle for attempted national health care reform, which was defeated by Congress in 1994.

Healthy Schools Healthy Communities: A program of the Bureau of Primary Health Care (BPHC) of the federal Health Resources and Services Administration, established in 1994 to encourage the development of new, comprehensive, full-time, school-based primary care programs that serve high-risk children. It was the first federal program to support the creation of school-based health centers.

Maternal and Child Health Block Grant Program: A federal program, established under Title V and administered by the Department of Health and Human Services, that provides funds to states for services that include special programs to prevent and treat birth-related disabilities, well-baby immunizations, and school health services for uninsured low-income children.

Mid-level providers: Health professionals with special training beyond the entry levels in their professions, e.g., nurse practitioners, licensed clinical social workers, and physician's assistants. Many SBHCs are supervised by nurse practitioners, with medical doctors serving in consultative roles.

National Assembly on School-Based Health Care (NASBHC): A membership organization created in 1995. It has become an important forum for disseminating best practices and sharing innovations among school based health centers. The executive director, John Schlitt, is a former *Making the Grade* (MTG) deputy director. All MTG states except Vermont helped launch state networks that eventually formalized into assemblies or associations that became NASBHC chapters. The state and national

associations play key roles in mobilizing and sustaining support for SBHCs. See the [NASBHC's website](#).

School-Based Adolescent Health Care (SBAHC) Program: A national program supported by RWJF from 1986 through 1991, designed to explore the feasibility of SBHCs as a means of improving adolescent access to appropriate services by working directly with some 23 SBHCs around the U.S.

School-Based Health Centers (SBHCs): Health care centers, located in school settings, that provide children and adolescents with comprehensive primary, acute, and preventive care for physical and mental health conditions. As developed particularly in two RWJF national programs (The School-Based Adolescent Health Care Program and *Making the Grade*), the centers, which have interdisciplinary staffs, not only deliver routine primary health care—physical exams, screening, and treatment for physical and mental health problems—but also teach students how to manage their own health.

Third-party payers: Entities providing partial or complete coverage for health care expenses, including publicly funded payers (such as Medicaid and Medicare) and private insurance companies.

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Grantee Websites

www.healthinschools.org provides information on a broad range of topics and materials, including information on state initiatives in school-based health centers, examples of state guidelines, funding initiatives, reports and technical assistance materials for individual school-based health centers on getting started, relevant research, communications issues and program publications. Washington: Center for Health and Health Care In Schools, George Washington University. In 1999, the site averaged about 200 visits per week. By the end of 2002, the site averaged 8,000–10,000 visits per week.

Sponsored Conferences

Making the Grade National Program Annual Conference, November 10, 1994, Baltimore. Attended by 50 grantee representatives and representatives of The Robert Wood Johnson Foundation and the Program evaluation team of KPG Peat-Marwick.

"Medicaid, Managed Care and School-Based Health Centers." June 26, 1995, Washington. Attended by 35 state and federal policy-makers as well as representatives of *Making the Grade* grantees.

Making the Grade National Program Annual Conference, September 21–23, 1995, Denver. Attended by 40 grantee representatives.

Making the Grade National Program Annual Conference, June 26–27, 1996, Baltimore. Attended by 40 grantee representatives.

"Toward Financing School-Based Health Care: Expanding Covered Lives, Funding Uncovered Services," June 27–28, 1997, Boston. Attended by 60 grantee representatives and invited guests from health policy field.

"Nine State Strategies to Support School-Based Health Centers," June 24–25, 1998, Los Angeles. Attended by 40 grantee representatives.

"The New Child Health Insurance Expansions: How Will School-Based Health Centers Fit In?" June 25, 1998, Los Angeles. Attended by 60 representatives from school-based health centers, *Making the Grade* grantees and health plans.

"From the Margins to the Mainstream: Institutionalizing School-Based Health Centers," June 23–24, 1999, Washington. Attended by 75 grantee representatives and leaders from the National Assembly on School-Based Health Care.

"Strategic Marketing of School-Based Health Centers: Taking the Model to Scale," June 23–24, 2000, Dearborn, Mich. Attended by 50 grantee representatives and leaders from the National Assembly on School-Based Health Care.

PROJECT LIST

Reports on the projects managed under this National Program are listed below. Click on a project's title to see the complete report, which typically includes a summary, description of the project's objectives, its results or findings, post grant activities and a list of key products.

Implementation Projects

- [Colorado Expands School-Based Health Care](#) (Grant ID# 32293, etc., November 2003)
- [Connecticut Expands School-Based Health Centers](#) (Grant ID# 32362, etc., November 2003)
- [High Marks for School-Based Health Centers in Louisiana](#) (Grant ID# 29321, etc., November 2003)
- [Making the Grade—Expanding and Improving School-Based Health Centers in New York](#) (Grant ID# 31658, etc., November 2003)
- [Maryland Locks in Financial Security for School-Based Health Centers](#) (Grant ID# 29322, etc., November 2003)
- [North Carolina's School-Based Health Centers Bring Comprehensive Primary Care Services to Underserved Adolescents](#) (Grant ID# 30189, etc., November 2003)
- [School-Based Health Centers Gain Ground in Rhode Island](#) (Grant ID# 38766, etc., November 2003)
- [School-Based Health Centers Go to the Head of the Class in Oregon](#) (Grant ID# 29836, etc., November 2003)
- [School-Based Health Centers Take Root in Vermont, but on Rocky Ground](#) (Grant ID# 29437, etc., November 2003)

Planning Grants

The following projects are not described in separate reports:

Delaware Making the Grade, State of Delaware Department of Health and Social Services

Hawaii Making the Grade, State of Hawaii Department of Health

Tennessee Making the Grade, State of Tennessee Department of Health