Acknowledgements

The 1999-2000 SBHC services report was prepared by the staff of the state SBHC program office within the Center for Child and Family Health, Oregon Health Division, Oregon Department of Human Services. Staff include; Robert J. Nystrom, Adolescent Health Manager, Katie Zeal, SBHC Program Coordinator, Andy Osborn, SBHC Program Analyst, Wendy Shelden, SBHC Clinical Coordinator and Anne Bradley, Office Specialist. The report was designed by Kim Kelly, Web/Publications Specialist. The state program office extends its appreciation to all of the Oregon SBHCs and their professional staffs who provided information used in preparation of this report.

In compliance with the Americans with Disabilities Act (ADA), this information may be requested in an alternate format by contacting Anne Bradley, Center for Child and Family Health, Adolescent Health Section, (503) 731-4021.

School-Based Health Centers

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EXECUTIVE SUMMARY

The goal of Oregon's School-Based Health Center program is to improve access to primary health care, preventive services and mental health care services to school-aged youth through development of the comprehensive SBHC model. The 1999-2000 Annual SBHC Report details the most current information available regarding the services, client data and funding information.

The SBHCs serve all students within a school with parental consent, regardless of insurance status. Comprehensive services include general medical, acute and chronic conditions (such as asthma and diabetes), mental and emotional health, reproductive health services, and health promotion and disease prevention. Of particular importance in light of today's increased high risk behaviors such as drug use, gun violence, unprotected sex, eating disorders and attempted suicide is the SBHC focus on prevention. Prevention services are a vital component of every SBHC visit. The SBHC's policy on performing risk screenings, coupled with their ability to follow-up and make referrals make important contributions to improving the short and long-term health outcomes of Oregon youth. For further detail on health risks and outcomes, see pg. 8 of this report, The Case For Prevention.

School-Based Health Centers

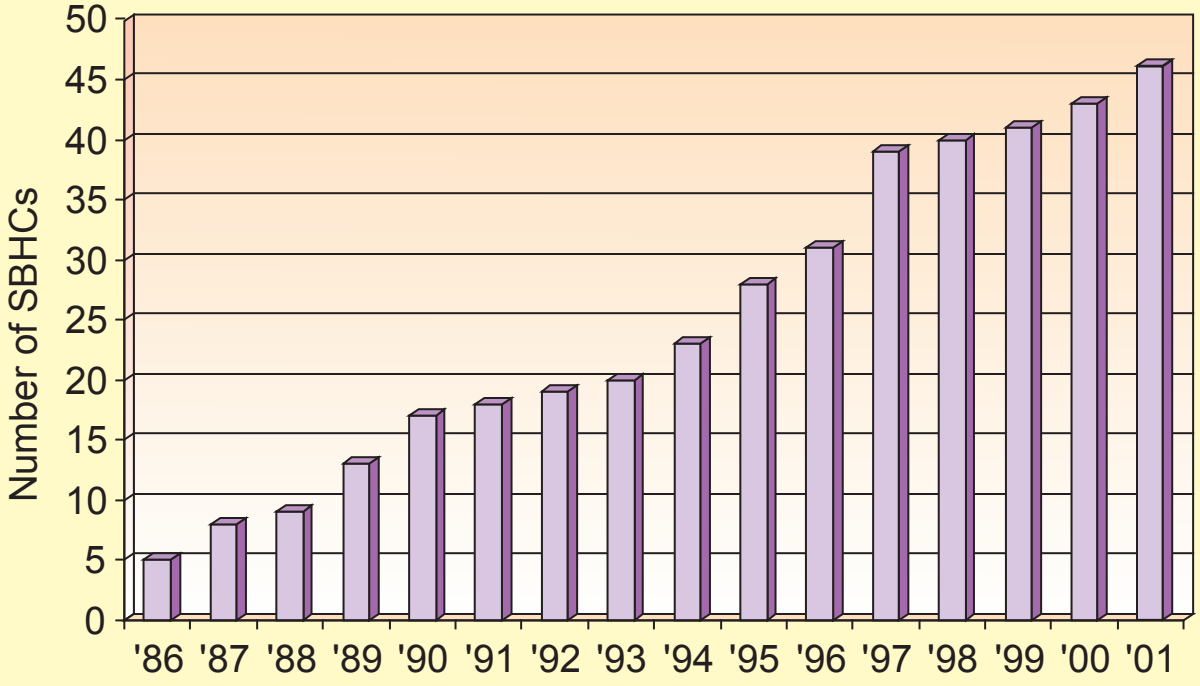
The state of Oregon currently provides core funding for 20 of the 46 SBHCs in operation (representing about 33% of a clinic's operating budget). Other monies come from counties, local school districts, reimbursement, private foundations and fundraising. A state program office staff of four persons provides technical assistance, training, quality assurance, standards development and data-base support. Standards for Certification were implemented in July, 2000, in an effort to focus on quality of care and legitimize SBHCs as a viable health care service delivery option.

Statewide during the last school year –

- 21,610 clients made 70,089 visits
- 95% of students reported a high rate of satisfaction
- 33% of SBHC clients reported having no insurance
- 14,576 immunizations were administered
- 1 in 6 SBHC diagnoses showed a mental health condition

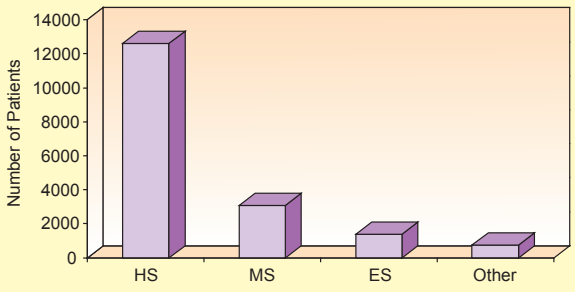
The 1999-2000 report holds implications for those interested in improving student learning, enhancing student mental and physical health, preventing high risk behaviors before they start, early intervention in identified health problems, and preserving significant numbers of health care dollars. All of these are impacted by the presence, the support and continued growth of Oregon's school-based health centers.

Growth of School-Based Health Centers in Oregon, 1986-2001

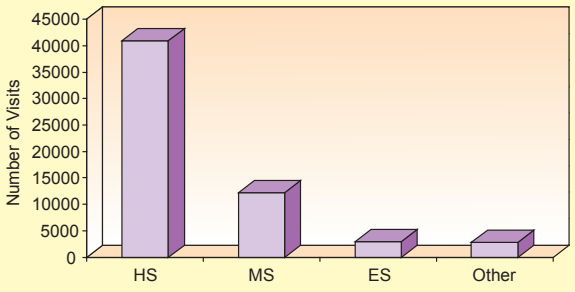


School-Based Health Centers

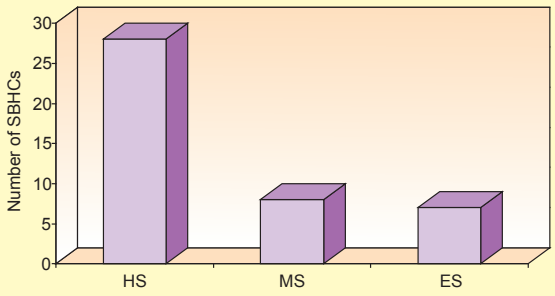
Number of Patients, SY 1999-2000



Number of Visits, SY 1999-2000



Number of SBHCs, SY 1999-2000



Introduction

Since 1986, when School-Based Health Centers (SBHCs) were first established in Oregon, the program has grown to its current size of 46 SBHCs, serving youth grades K-12. A primary reason for the success of the program is that SBHCs are located where the students are: in schools. SBHCs provide easy access to comprehensive, primary physical and mental health services. Services focus on preventive, developmentally appropriate care. The reasons for the continued growth of SBHCs are clear. Clinics are easy to access and available during school hours, services are free and confidential, staffs are knowledgeable and aware of student needs, and schools, parents and communities enthusiastically support them.

Why are these services so necessary? Studies show that school-aged children are at increasing risk of a variety of potentially dangerous health problems. According to results reported from The National Longitudinal Study of Adolescent Health, a third of students lack health insurance, 20% did not get the care they felt they needed, and neither students nor parents knew how to access appropriate health care. Furthermore, the students with the highest risk of negative health outcomes were the most likely not to get the health care services they needed. The reasons the students gave included: they did not know where to go; didn't want their parents to know; thought the problem would go away; they had no transportation; lacked resources; or had no one to go with them. These student responses clearly reflect why the SBHC program, an access model, works.

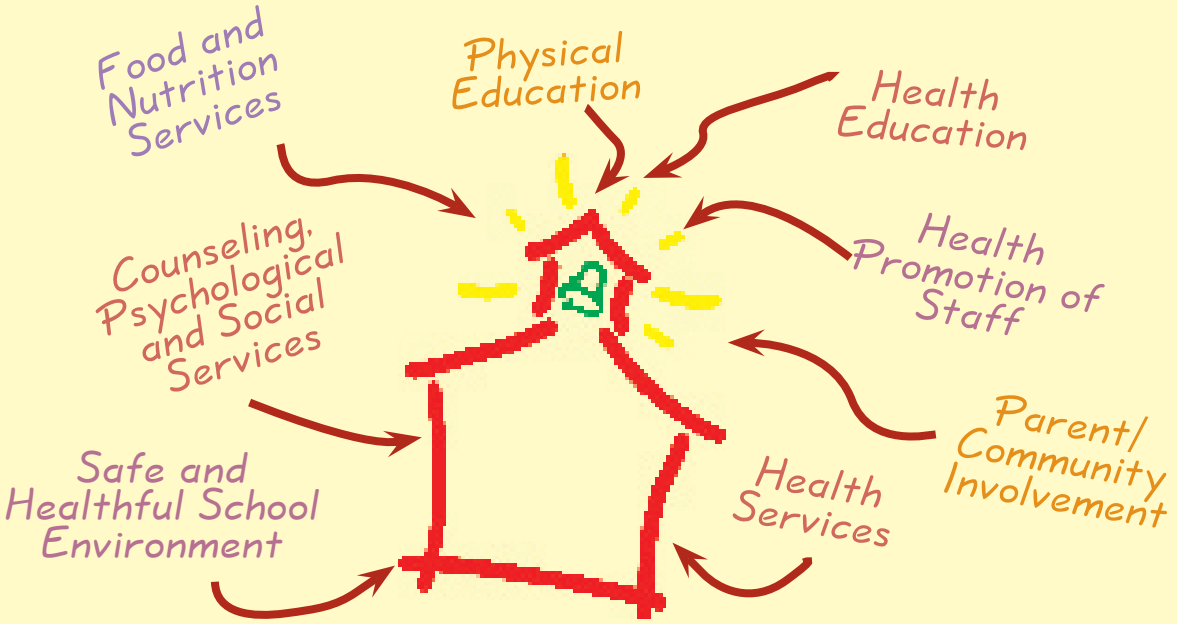
When we look at what is hurting our children the facts are alarming. According to an Oregon Health Division study "Weapons and Oregon Teens: What is the Risk?", more Oregon high school-aged students die of gunshot injuries than from all natural causes combined. Two studies looked closely at the risks confronting our youth - the ***1999 Youth Risk Behavior Survey and Suicidal Behavior; A Survey of Oregon High School Students, 1997*** - found that students involved in one risk-taking behavior are more likely to be involved in other forms of risky behavior. SBHCs have consistently served those youth with multiple risk behaviors.

Patient satisfaction surveys demonstrate that SBHC staff frequently become the trusted adults to whom students can turn for support. Risk assessments of alcohol, drug, tobacco use, suicide, sexuality, and nutrition are performed as a part of ongoing care. Students, parents, school personnel and community members are included in planning and implementation. It is at the school-based health center that the student can get the necessary health care and preventive services easily, safely and with a focus on individual concerns.

> Students involved in one risk-taking behavior are more likely to be involved in other forms of risky behavior. The SBHCs have consistently served those youth with multiple health risk behaviors.

COORDINATED SCHOOL HEALTH PROGRAMS

The School-Based Health Centers are one integral part of a much larger prevention effort, known as a Coordinated School Health Program (CSHP). Such programs provide local schools and communities with a proven effective framework for addressing the physical, social and emotional health needs of children and youth, thus addressing non-academic barriers to learning in a systematic way. In addition, they allow communities to maximize local resources for youth, determine and address locally important priorities, tailor efforts to reflect local community norms, and eliminate duplicate efforts. The program model utilizes community and school resources to improve overall health for students and school employees. The eight components of a Coordinated School Health Program include:



As joint recipients of a renewable CDC grant designed to build infrastructure of Coordinated School Health Programs, the Oregon Health Division and the Oregon Department of Education are partners in the Oregon effort. The funding and personnel provided by the grant will allow new capacity to provide school districts with assistance on the development of comprehensive school health education (CSHE) programs, and increase capacity to provide state, regional, and site-based teacher trainings on research-based, effective CSHE curricula. Through the grant, coordinated school health demonstration projects will occur at three schools in Oregon, each in a high-poverty area.

The scope of work on the infrastructure project will include: development of a coordinated school health services manual to help local schools and communities build their programs; development of a Coordinated School Health Program (CSHP) Blueprint for Action; and the development of a social marketing campaign to reach school administrators. Because SBHCs are a key piece of a coordinated school health program, Oregon's school-based health center program office will actively participate in all of these planning efforts.

The Case for Prevention

We have the facts; Oregon adolescents are at risk for a wide variety of conditions and behaviors that may seriously harm their health. The best way to ensure these health risks don't occur is by working to prevent them. Health risk reduction efforts have a history of success in areas such as child maltreatment, smoking, alcohol and other drug use, and pregnancy and STD/HIV transmission. Prevention programs have even been known to work in the treatment of physiological conditions such as schizophrenia. However, most pediatricians and other private-sector health care professionals who treat adolescents don't commonly screen adolescents for risk behaviors, test them for signs of risky behaviors (such as STD testing for all sexually active adolescents) nor deliver prevention services. Also, adolescents are known to use traditional medical services at lower rates than any other age group. The trust relationship between patient and health care provider that is essential to successful delivery of prevention services is often lacking.

School-Based Health Centers

Successful prevention programs often call for cooperation among a broad range of community partners including schools, the community in general, families, and health care providers. Those private-sector medical professionals who do deliver prevention services to adolescents enjoy less success if their efforts are isolated from those of other community partners. The risk behaviors of adolescents usually occur in clusters: smoking, use of alcohol or other drugs, sexual activity and nutritional risks usually occur together. Additionally, underlying conditions such as poverty are often present. Prevention programs that attempt to address one risk factor to the exclusion of others or underlying conditions will be less successful.

No institutions are better positioned or equipped to implement general prevention services to adolescents than school-based health centers. SBHCs are located in schools where most kids spend a great deal of their formative life and also where reside the teachers, school administrators and counselors who deliver additional adolescent prevention services. Teachers routinely depend upon SBHC staff to deliver classroom-based prevention messages. SBHCs are also connected to broader community and public health organizations dedicated to prevention.

Prevention services are provided in SBHCs routinely. Additionally, SBHC staff form close relationships with the students they see and through these relationships can provide direct prevention services. The time SBHC health care providers are able to spend with individual students allows them the opportunity to address a broad range of risk behaviors, including some socio-economic conditions. SBHCs routinely collaborate with adolescents' primary care providers to ensure continuity of care. SBHCs often form relationships with patients' parents and other family members, placing them in an ideal position to provide family-level prevention services.

Listed below are some areas of health concerns for adolescents. Each section contains data about the health area, quotes from students who took the 1999 Oregon High School Youth Risk Behavior Survey (YRBS) and anecdotes about how health centers fit into addressing these issues.

Access to Health Care

Adolescents have the lowest health care service use of any age group and they are the least likely to seek care through traditional office-based settings. One in six of the 1999 Oregon YRBS survey respondents reported not seeing a doctor in the previous year. One-in-three students did not see either a doctor or a dentist, or neither, in the previous year. Inadequate insurance coverage and the lack of a consistent relationship between health care provider and adolescent patient may contribute to infrequent use. Adolescents are also more likely than other age groups to be uninsured and often undergo changes in diagnosis, provider and presenting problems as they mature. Those adolescents who forgo health care that is needed are at greater risk of physical and mental health problems.

School-based health centers benefit adolescents in large part by improving health care access for students. Access to health care is easier and more convenient, relationships with providers are more consistent, services are provided regardless of the students' ability to pay, and SBHC providers are intimately familiar with adolescent health issues. In addition, SBHCs have traditionally provided services to adolescents with greater health risks. Analysis of the 1999 Oregon YRBS survey results are consistent with this tradition; of those students whose school has a SBHC, those who use the health center are more likely to report risk factors to their health including contemplation of suicide, smoking, alcohol and marijuana use, and sexual activity.

"I don't have money to go to the doctor."

"I have a medical condition but I never go to the doctor."

"We have a really helpful health clinic."

"The school-based health center helps me out a lot."

Real Life:

An elementary school-aged girl with no health insurance was seen at an SBHC for a routine physical. The nurse practitioner noticed an unusual skin deformity on the girl's leg and referred her to a dermatologist for evaluation and treatment. The girl was diagnosed with scleroderma, a potentially serious condition, which had been present but undiagnosed for almost a year. Appropriate treatment and physcial therapy (to prevent permanent deformity and physical limitations) were undertaken immediately.

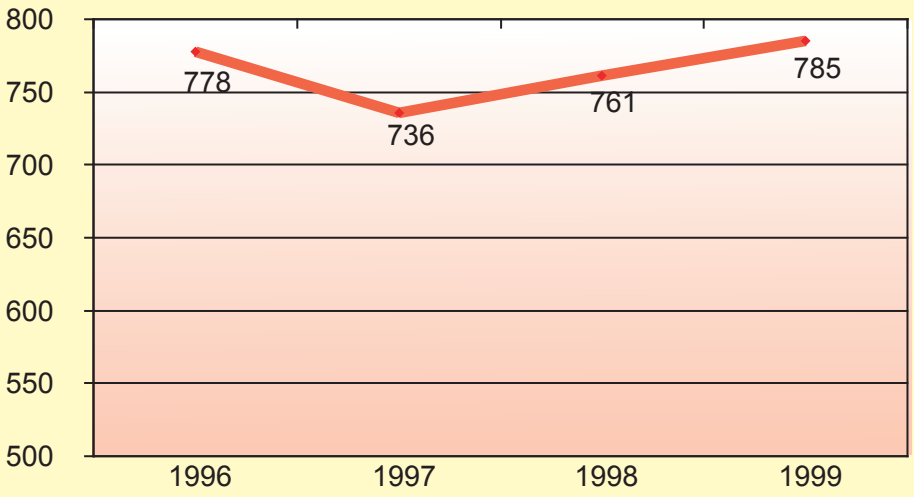
A young man came into a SBHC complaining of a headache. The nurse practitioner, suspecting deeper problems began asking questions. Eventually, the patient was diagnosed with uncontrolled hypertension, obesity, grief (from the recent loss of his mother), and adult onset diabetes. Soon after these diagnoses, the patient was denied insurance coverage and is now considered uninsurable. The SBHC practitioner is currently coordinating with social workers to find another provider. In the meantime, the SBHC is the young man's primary care facility.

A student's mother called the Health Center requesting that her child be seen that day. The child had a sore throat and they could not get in to see her primary care physician. Because the family lived in a rural area, the mother and child would have had to travel 1 1/2 hours to see another physician were it not for the SBHC. The student was evaluated by the Health Center physician that same day, was able to get medication and return to class in a very short period of time.

"It's reassuring to know someone cares."

Violence/Suicide

Oregon adolescent suicide attempts:



From 1995-1997, Oregon ranked 17th among all states for suicides among 15-19 year-olds. During this time period, Oregon's rate of suicide for this age group was 29% higher than the national average.

In 1998, suicide was the second leading cause of death among Oregonians aged 15-19 y/o.

In 1998 1 death in eight among 15-19 year-old Oregonians was by gunshot. Gunshots ranked second only to motor vehicle accidents as the leading external cause of death for Oregonians under 20.

One in six 1999 YRBS respondents reported seriously considering suicide.

Nearly one in seven respondents to the 1999 Oregon YRBS reported carrying a weapon (such as a gun, knife, or club) in the previous thirty days.

"It's hard for a depressed person to ask for help."

"We need (someone) to talk to us about suicide and not just a 5 minute speech."

"A lot of students are very upset and walking around like zombies with all their stress.."

"I should try to have a higher self-esteem."

"My unhealthy behavior is keeping my feelings to myself, stressing out way too much and not talking to someone about it."

"I suffer from depression. Such a big desease yet so little knowledge about it. I hate it. I feel sad and angry most of the time."

Real Life:

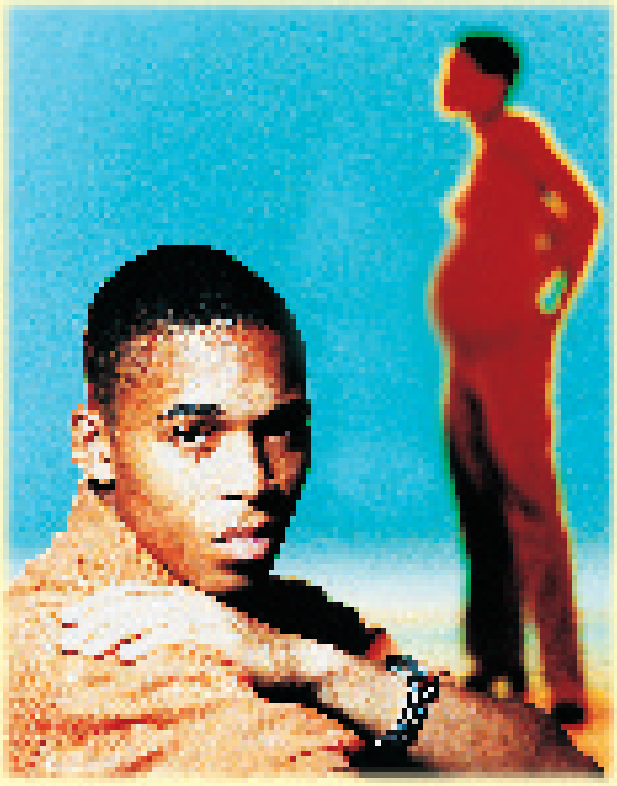
A high school student came in to have a cut finger treated, and inquired about HIV testing. After some discussion, he revealed numerous problems including poor self-esteem, depression, drug abuse, conflicts with a parent, and difficulty in school. He was referred to the clinic's mental health counselor who began regular counseling sessions. The student has kept his counseling appointments and has shown improvement emotionally and academically.

Sexually Transmitted Disease/ Pregnancy

In Oregon in 1999, 9% of all newly reported AIDS cases occurred in the 20-29 year old age group. Nationally, approximately 50% of all new AIDS cases occur in persons aged 25 or younger. Because of the long period of time from HIV infection to diagnosis of AIDS, it can be assumed that many of these AIDS patients contracted the HIV virus while teenagers.

In 1999, Oregonians aged 15-19 were responsible for 41% of all chlamydia infections, 27% of all gonnococcal infections and 28% of all reports of pelvic inflammatory disease.

"My parents warned me that if I had sex I would get pregnant, but I didn't listen and now I have a baby."



Thirteen percent of all births in Oregon in 1998 were to teenage mothers. One in fourteen 15-19 year old females became pregnant in 1998.

Real Life:

A young woman who lost her father to suicide became pregnant at 13 (after having sex only one time) and faced ostracism from her family by her new step-father. Her mother, while supportive, was unable to intervene. Through the SBHC, the teenager received emotional and nutritional counseling and is now the parent of a healthy, four-year old child. The teen has become a good mother, an exceptional student and contributing member of the community.

"I have to gain weight (because) I'm going to have a baby."

"My unhealthy behavior is having sex with someone who could possibly have an STD but I'm gonna quit that."

Disordered Eating

One in every five females who completed the 1999 high school YRBS reported taking diet pills or supplements (excluding products like Slim Fast), laxatives, or inducing vomiting in order to lose weight.

"My eating habits are not as good as they could be."

"When I get depressed I stop eating. Once (earlier this year) I stopped eating for six weeks and lost 25 pounds."

"I am way too lazy, and I need to get more exercise (don't we all)."

"I have been admitted to a hospital for anorexia."

"I think that I worry about my weight too much, and am always trying to lose weight."

"I need to lose 20 lbs then I will stop starving myself and making myself throw up."

"I'm fat and I need help...I'd work out but...I'm afraid people would laugh at me."

Real Life:

A young girl was brought into an SBHC by a friend, who told the staff that the girl had been vomiting after each meal for 3 weeks. The girl denied that the pattern was important but did admit that it had been over a year since she had eaten normally. The SBHC provider met with her frequently for about a month, calling her into the health center and following up, making sure she saw the counselor faithfully. During that time the girl did some reading on her own about eating disorders, and chose to stop vomiting. She is now in family counseling with her mother as well as working with the school counselor.

Tobacco, Alcohol and Drug Use

Nationally, cigarette smoking by adolescents is considered an epidemic.

Of those high school students who took the 1999 Oregon YRBS:

Nearly 1 in 4 smoked cigarettes in the 30 days prior to the survey.

Nearly 1 in 2 (44%) had at least one drink of alcohol in the 30 days prior to the survey.

Nearly 1 in 3 drank 5 or more alcoholic drinks in a row in the 30 days prior to the survey.

More than 1 in 5 smoked marijuana in the 30 days prior to the survey.

Nearly 1 in 75 students used a needle to inject illegal drugs in the 30 days prior to the survey.

"I smoke a lot...weed and cigarettes. If there were more programs to help kids like me...then we could probably stop."

"I think it's unhealthy that I smoke but I don't have the money to get help."

"I'm 16 and will do any drug."

"I suppose I drink too much but I'm not really worried about it."

Real Life:

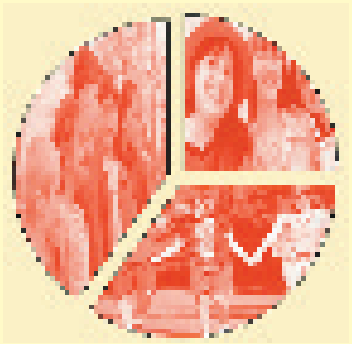
At one SBHC, the staff focus on delivering one-on-one interventions to teach students techniques to quit smoking or chewing tobacco. One student who referred himself to the clinic to learn about the dangers of chewing tobacco revealed that he had been chewing since he was six years old. An examination revealed he had a pre-cancerous area in his mouth. With the help of the SBHC, the student quit chewing tobacco, chewed an herbal substitute for a time, then quit altogether. Again with help from the SBHC he pursued enrollment in the Oregon Health Plan and was able to see a dentist.

Patient Satisfaction Survey

In Spring, 2000, 1,285 patients of school-based health centers filled out a satisfaction survey immediately following an encounter with a health center staff member. Breakdown of survey responses by grade level were as follows: HS - 1,039, MS - 190 and ES - 19. Sixty-six percent of respondents were female and 34% were male, which closely reflects the female/male proportion of total visits.

SBHC patients continue to report a high degree of satisfaction with the care they receive there. Ninety-five percent of respondents rated their care good or excellent, and 93% said they were likely or very likely to follow the advice they were given. Health care providers relate well to their patients; 91% of respondents said they understood the advice given them and 90% said they were comfortable asking more questions. The health centers continue to be easy to access; of those who made an appointment at the center, 95% said an appointment was easy to get.

Access to Care: One of the greatest values SBHCs have is the increased access to care for students. According to the Spring, 2000 student satisfaction survey, only 1/3 of respondents would have gotten care for the condition that brought them into the health center if they had to seek care elsewhere:



Not receiving health care could result in poorer short- and long-term health outcomes for those students who did not receive care. In addition, the health of the student body in general could decrease as communicable conditions remained unaddressed.

Support for Education: School-based health centers work because they are located in school, where the students are, and thus are able to shorten significantly the amount of school time a student must sacrifice because of health needs:

Students reported that seeking health care elsewhere (if they sought it at all) would have taken over 3 times more school time had it not been for the school-based health center ($p<.001$). These centers facilitate a quicker return to the classroom for the student. Once health care needs have been addressed, students who receive care are better able to focus on school work, likely resulting in improved scholastic performance.

Oregon School-Based Health Centers

	County	Grades Served	Enrollment 2000-2001	Year Opened	Certified Core/Expanded
Baker HS	Baker	9-12	710	1991	C
Lincoln ES	Benton	K-5	253	1997	E
Monroe MS	Benton	4-8	191	1994	C
Philomath ES	Benton	K-4	591	1994	
Lewis & Clark ES	Columbia	K-5	547	2000	
Oregon City HS	Clackamas	10-12	1421	1988	C
Roseburg HS	Douglas	10-12	1562	1990	C
Ashland HS	Jackson	9-12	1228	1989	C
Crater HS	Jackson	9-12	1498	1986	C
Crossroads HS	Jackson	9-12	200	1992	C
Jackson ES	Jackson	K-6	404	1997	C
Jewett ES	Jackson	K-5	461	1996	C
Scenic MS	Jackson	6-8	782	1996	C
Washington ES	Jackson	K-6	508	1997	C
Lorna Byrnes MS	Josephine	6-8	383	1999	C
Illinois Valley HS	Josephine	9-12	480	1993	C
Cottage Grove HS	Lane	9-12	806	1999	C
North Eugene HS	Lane	9-12	1095	1986	E
South Eugene HS	Lane	9-12	1771	1989	E
Springfield HS	Lane	9-12	1483	2000	
Willamette HS	Lane	9-12	1352	1997	C
W. Churchill HS	Lane	9-12	1262	1995	E
Sheldon HS	Lane	9-12	1585	1995	E
Newport HS	Lincoln	9-12	713	1998	C

HS = High School MS = Middle School ES = Elementary School

Data Source
OHD: Oregon Health Division
C: County
O: Other
* Not open 1998-1999

Funding Source
OHD: Oregon Health Division
C: County
O: Other
E: Education

Oregon School-Based Health Centers

Days Clinic Per/Wk/	# Visits	# Students Served	Funding	Data Code Source	Mental Health AOD Services Hr./Wk.
5	595	1813	OHD	OHD	0
5	468	1509	O	C	20
3	165	477	E	C	0
4	656	1151	E	C	0
5	971	1463	O	OHD	2
5	262	645	OHD	OHD	0
5	632	2734	OHD	OHD	4
5	656	1151	OHD	OHD	0
5	971	1463	OHD	OHD	0
4	199	667	E	OHD	0
3	158	481	O	OHD	0
5	485	1082	OHD	OHD	21
5	687	1165	OHD	OHD	14
3	152	421	O	OHD	0
5	505	2234	O	OHD	40
5	335	1034	OHD	OHD	0
5	393	1453	O	OHD	0
5	898	2941	OHD	OHD	10
5	984	2618	OHD	OHD	12
5	434	1500	O	OHD	0
5	589	792	E	OHD	0
5	1094	2643	E	OHD	0
5	897	3475	E	OHD	20
3	392	1543	O	OHD	12

Oregon School-Based Health Centers

	County	Grades Served	Enrollment 2000-2001	Year Opened	Certified Core/Expanded
Taft HS+	Lincoln	9-12	634	1989	C
Toledo HS+	Lincoln	9-12	465	1986	C
Waldport ES/MS/HS	Lincoln	9-12	915	1999	C
Binnsmead MS	Multnomah	6-8	647	2000	E
Cleveland HS	Multnomah	9-12	1242	1987	E
George MS	Multnomah	6-8	555	1995	E
Grant HS	Multnomah	9-12	1912	1990	E
Jefferson HS	Multnomah	9-12	842	1987	E
Lane MS	Multnomah	6-8	657	1996	E
Lincoln Park ES	Multnomah	K-6	679	1995	E
Madison HS	Multnomah	9-12	1236	1990	E
Marshall HS	Multnomah	9-12	1332	1987	E
Parkrose HS	Multnomah	9-12	1106	1990	E
Portsmouth MS	Multnomah	6-8	403	1995	E
Roosevelt HS	Multnomah	9-12	1155	1986	E
Whitaker MS	Multnomah	6-8	703	1997	E
Pendleton HS	Umatilla	9-12	1120	1997	C
Sunridge MS	Umatilla	6-8	874	1997	C
Health Network	Union	K-8	~1205	1997	
LaGrande HS	Union	9-12	838	1986	C
Merlo Station HS	Washington	9-12	446	1994	C
Willamina HS	Yamhill	9-12	282	1989	C

HS = High School MS = Middle School ES = Elementary School

Data Source
OHD: Oregon Health Division
C: County
O: Other
* Not open 1998-1999

Funding Source
OHD: Oregon Health Division
C: County
O: Other
E: Education

Oregon School-Based Health Centers

Days Clinic Per/Wk/	# Visits	# Students Served	Funding	Data Code Source	Mental Health AOD Services Hr./Wk.
5+	207	999	OHD	OHD	12
5+	237	1020	OHD	OHD	12
5	434	1500	O	OHD	18
5	199	667	C	C	40
5	918	3775	C	C	40
5	230	1333	C	C	48
5	836	2948	C,OHD	C	40
5	516	3053	C,OHD	C	36
5	244	1443	C,OHD	C	40
5	402	1442	O	C	28
5	681	2976	C	C	56
5	742	3750	C	C	56
5	588	1987	C	C	38
5	194	1007	C	C	48
5	660	2751	C	C	52
5	278	1116	C,OHD	C	53
5	616	1342	OHD	OHD	20
5	506	1656	OHD	OHD	20
5	~260	865	O	O	18
5	404	739	OHD	OHD	0
4	522	1365	E	OHD	20
3	222	640	OHD	OHD	0

Students` Use of SBHCs:
Combined Data File: Reporting Change

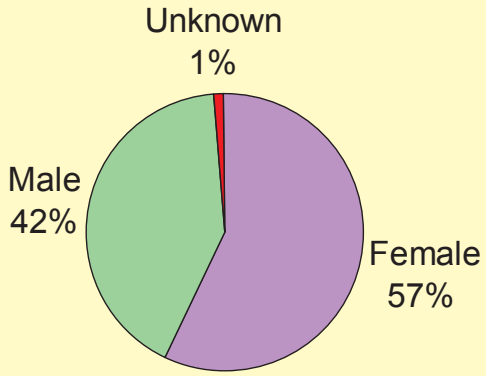
This report takes an additional step forward in reporting patient and visit information for Oregon SBHCs with the inclusion of clinical information from the State Data Network, the Multnomah County SBHC system and Lincoln and Monroe SBHCs from Benton County. For the first time, reporting is based on all SBHC patient and visit information in Oregon, making the report a more accurate and complete picture. The program office gratefully acknowledges the efforts of Multnomah and Benton County staff members for assisting in the creation of the combined data file.

Changes in reporting makes comparing figures over time more difficult. However, a principle function of this report is to present as complete a picture as possible of SBHC use in Oregon. To this end, the inclusion of all possible data is consistent and essential. Requests for SBHC figures for the 1999-2000 school year comparable to previous reports may be made to the state program office.

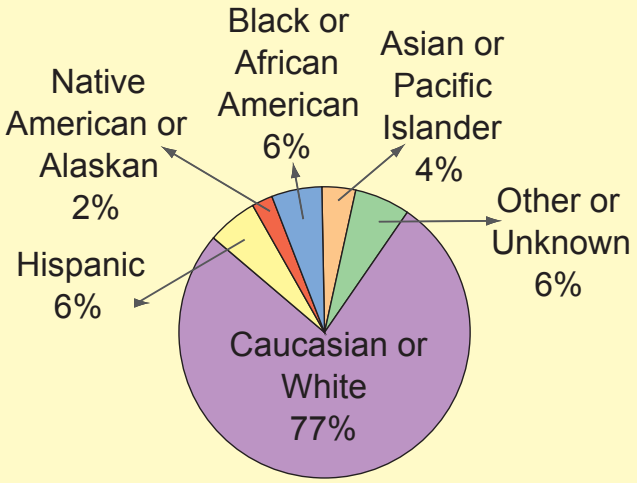
Registrants

In service year 99-00, there were 21,610 registered users of School-Based Health Centers (SBHCs).

Gender (%)



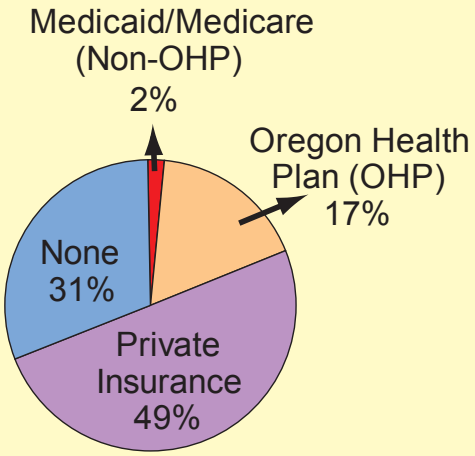
Race (%)*



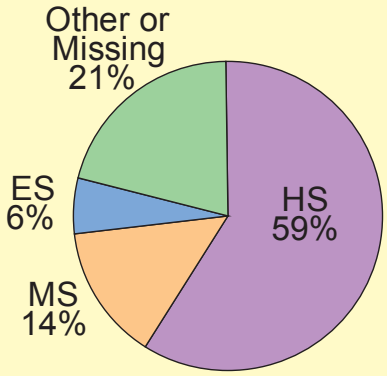
* Exceeds 100% due to rounding.

Reflecting statewide demographics, the vast majority of SBHC clients were white.

Insurance Coverage (%)*



Grade Level: %

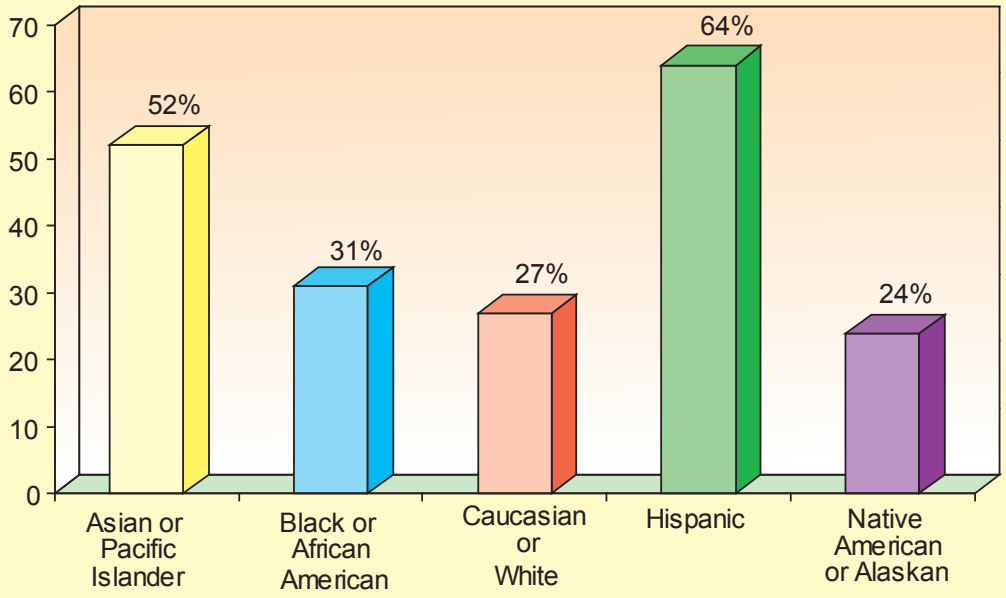


*Note: Insurance information was not gathered on 34% of clients.

Note: HS, MS and ES students averaged 5 visits per patient.

Insurance status for each client was reported on the first visit to the clinic. The above figures do not reflect any changes over time.

Clients with No Health Insurance by Race (%)



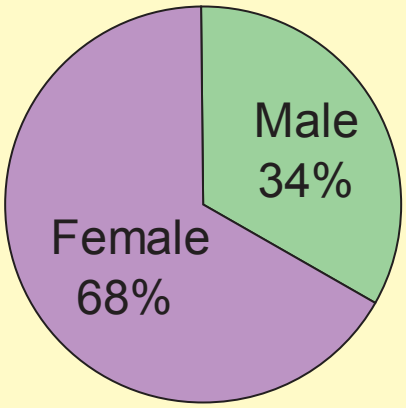
Asian or Pacific Islander, Black or African American, and Hispanic were more likely to report being without insurance while Caucasian/White and Native American/Alaskan clients were less likely to report being without insurance.

Visits

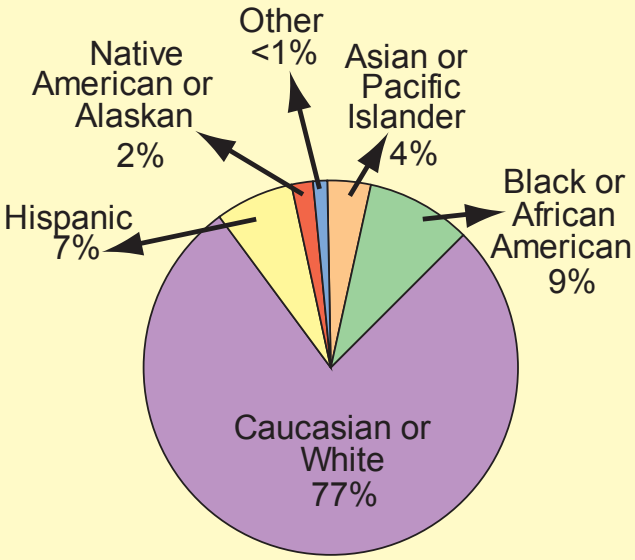
SBHC clients made 70,089 visits for an average of 3.2 visits per user. Fifty-two percent of patients used the clinic two times or fewer. Visits to the health center were made predominantly by Caucasian (78%) and female clients (66%). Ninety-five percent of visits were made by school-aged users (i.e., 5-19 years old). There were 76 visits (1.3%) made by transitional (inactive or dropout) students, and 404 visits (0.7%) made by the children of students.

Visits to SBHCs

Visits By Gender



Visits By Race



Gender was missing on 20 visit records

Reflecting national trends, females used SBHC services more often.

Race was missing on 3,732 visit records

Generally speaking, visits to the health centers reflected the racial demographics of registrants. For example, African-American students accounted for 8% of all registered patients and made 6% of the visits.

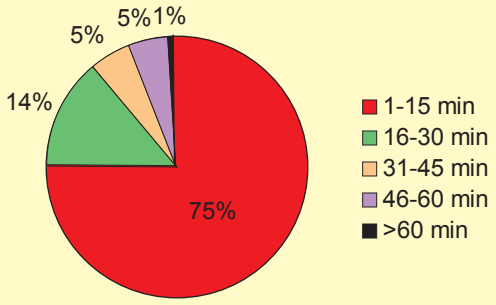
Visits By Grade Level*

Grade Status	Visits	%	#of SBHCs	%	Average Provider Time per Visit**
HS	40953	69	28	65	19
MS	12262	21	8	19	20
ES	2966	5	7	16	24
Other	2791	5	*	*	20
Total	58,972	100	43	100	

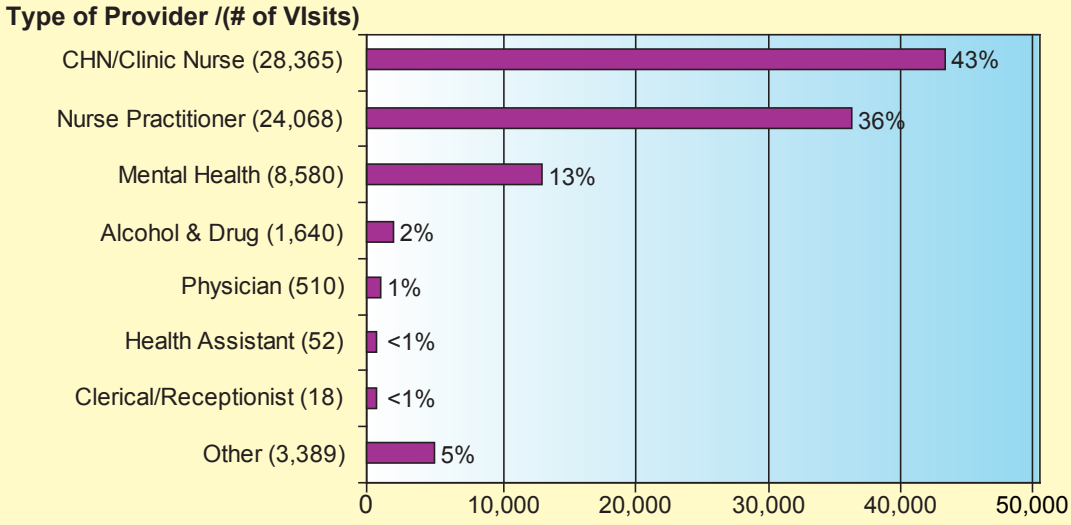
* 11,117 visits were missing grade status. ** In Minutes

Provider Time: Sixty-eight percent of visits lasted fifteen minutes or less.

Time Group



Type of Provider*



Total: 66,622 visits

Type of provider was missing for 3,467 visits

Frequency of Procedure by Grade Level

Counseling/MH	HS	%	MS	%	ES	%**	Average Provider Time per Visit
Regular Clinic Visit	30,316	74	8,002	65	2,206	74	14
Preventive Service	5,198	13	1,056	9	134	5	33
Immunization	1,564	4	1,348	11	226	8	7
Counseling/MH	3,524	9	1,786	15	398	13	46
Lab/Screening	176	<1	32	<1	2	<1	8
	40,778	100	12,224	100	2,966	100	

* Based on first Current Procedural Terminology (CPT) code listed for the visit
** Percentages may not equal 100 due to rounding

Diagnostic Category by Grade Level*

	HS	%	MS	%	ES	%
Health Supervision	26,781	46	5,618	34	1,005	24
Symptoms	8,746	15	2,077	13	345	8
Mental Disorders	5,170	9	1,821	11	683	16
Injuries/Poisonings	3,677	6	1,729	10	362	9
Respiratory	3,450	6	1,496	9	496	12
Genitourinary System	2,119	4	245	1	35	1
IMM	1,924	3	959	6	196	5
Muscoloskeletal	1,834	3	686	4	87	2
Skin	1,138	2	537	3	168	4
Nervous System	1,011	2	658	4	399	10
Infections	846	1	349	2	224	5
Gastrointestinal	467	1	258	2	97	2
Endocrine	330	1	102	1	29	1
Hemotology	109	<1	8	<1	1	<1
Cardiovascular	45	<1	16	<1	11	<1
Neoplasm	20	<1	13	<1	1	<1
Pregnancy Contraception	19	<1				
Congenital Anomaly	12	<1	3	<1	2	<1
Perinatal Period	7	<1	4	<1		
Total	57,705	100	16,579	100	4,141	100

* Number of diagnoses exceed total number of visits due to multiple diagnoses

Diagnoses are reported based on the categories from the International Classification of Disease (ICD).

Immunizations:

Efforts to protect Oregon youth from preventable disease continue by ensuring they are fully immunized. Current requirements to enter Oregon schools include a number of immunization standards. New school immunization requirements are summarized below:

Oregon Revised Immunization Requirements

If any child will be attending:	Beginning School Year	Additional Shots Required
Child Care	2000-01	Varicella
Kindergarten	2000-01	Varicella
7th Grade	2000-01	Hepatitis B, 2nd Dose Measles, Varicella

By the year 2006, all children from Kindergarten thru 12th grade will be required to have the following immunizations: Immunization, Varicella, Diptheria/Tetanus, Polio, Measles/Mumps/Rubella, Hepatitis B.

Immunizations were administered during 8,108 visits (12%), during which a total of 14,511 immunizations were administered. In addition, many health centers conduct immunization clinics that are not recorded here because the clinics do not include them as a visit to a health center.

Types of Immunization by Grade Level

	HS	%	MS	%	ES	%
Varicella			27	1	1	<1
Diptheria/Tetanus	742	12	253	7	85	11
MMR	552	9	367	10	103	14
Polio	62	1	21	1	38	5
Hep B	2728	44	1622	43	230	31
Flu Shot	205	3	22	1	3	<1
OPV	48	1	10	<1	10	1
Other/Not Specified	1682	27	1458	38	251	33
PPD	206	3	28	1	31	4
Total	6225	100	3808	100	752	100

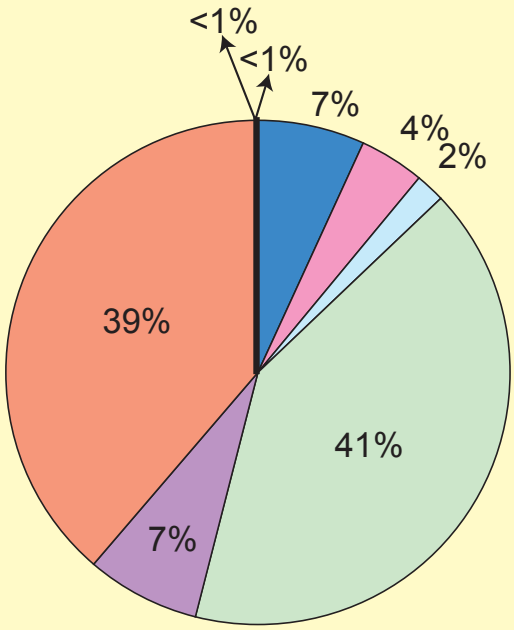
Reproductive Health:

The reproductive health of Oregon's students is important for many reasons. Adolescents and young adults account for a large percentage of STD infections in the state. Teen pregnancy in Oregon, while declining, still occurs in 1 of 58 female teens in the state. Sexual behaviors, including disease transmission and unintended pregnancies, are listed by the national Center of Disease Control as one of the six major threats to the health of youth. Reproductive health visits are defined as any visit that contained any reproductive diagnosis, regardless of whether or not the primary reason for the visit was reproductive health-related. Not all health centers provide reproductive health services in the same way or at the same level. In particular, with regard to prescribing and/or distributing contraceptive devices to students, each health center or health center network works with the school district and local communities to form its policy. The Oregon Standards for Certification require health centers to make referrals for family planning, but do not require a health center to prescribe or dispense contraceptives.

A total of 17,070 (24%) of visits to health centers contained a reproductive health (RH) component. Female patients accounted for 83% of RH visits, and males 17%. RH visits by different race/ethnic categories were made in the same proportion as were total visits with two exceptions: African American patients accounted for 9% of total visits and 15% of all RH visits, and white patients accounted for 78% of total visits and 72% of all RH visits. High school students accounted for 90%, middle school students 9%, and elementary students 1% of all RH visits.

Reproductive health visits were broken down into seven categories: breast condition, menstrual condition, sexually transmitted disease (STD), contraception, pregnancy, RH maintenance, other gynecological condition and other male reproductive condition.

Reproductive Health Diagnosis Categories



Reproductive Health Diagnosis Categories*	Frequency
Breast Condition	(87)
Menstrual Condition	(1,542)
STD	(922)
Other GYN	(500)
Contraception	(9,123)
Pregnancy	(1,482)
Reproductive Maintenance	(8,807)
Other Male RH Condition	(10)
Total	(22,473)

* Gender was unknown for two visits

Reproductive Health Categories by Gender

	Female	%	Male	%	Total*	%
Contraception	8,391	44	732	22	9,123	41
Reproductive Maintenance	6,487	34	2,320	70	8,807	39
Menstrual Condition	1,531	8	11	<1	1,542	7
Pregnancy	1,475	8	7	<1	1,482	7
STD	701	4	221	7	922	4
Other GYN	497	3	3	<1	500	2
Breast Condition	69	<1	18	1	87	<1
Other Male RH Condition		0	10	<1	10	<1
	19,151		3,322		22,473	

*Total exceeds number of RH visits due to multiple diagnoses

Sample Diagnoses (not inclusive or in order of frequency):

Breast Condition:
- Breast Mass
- Fibrocystic Breast
- Galactorrhea

Menstrual Condition:
- Ovulation Bleeding
- Dysmenorrhea
- Irregular Menses

Sexually Transmitted Disease (STD)
- Pubic Lice
- Chlamydial Infection
- Exposure to Venereal Disease

Contraception
- Contraception Counseling
- Oral Contraception Visit
- Contraceptive Surveillance

Pregnancy
- Pregnancy Counseling
- Post-Partum Care
- Pregnancy Complications

Reproductive Health Maintenance
- Health & Sexuality Counseling
- Annual Pap/Gyn Exam
- STD or HIV Counseling

Other Gyn (non-STD/STI))
- Infertility
- Abnormal Pap
- Ovarian Cyst

Other Male Reproductive Condition
- Inflamed Penis
- Male Genital Disorder
- Undescended Testes

Reproductive Health Categories by Grade Level

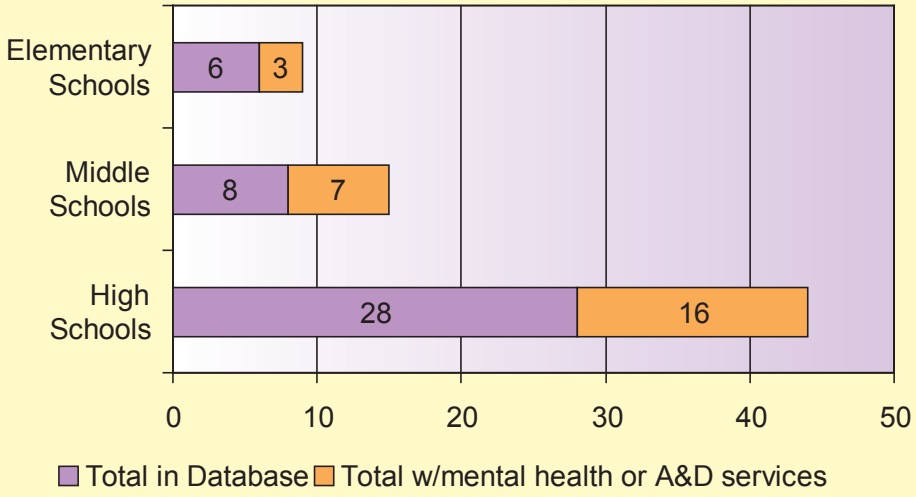
	HS		MS		ES		Total	
	N	%	N	%	N	%	N	%
Breast Condition	29	<1	3	<1	0	0	32	<1
Menstrual Condition	1,318	10	100	6	1	4	1,419	9
Sexually Transmitted Disease (STD)	727	5	47	3	1	4	775	5
Other Gyn (including infection or disease (non-STD/STI))	596	4	24	1	1	4	621	4
Contraception	6,500	47	741	44	0	0	7,241	47
Pregnancy	1,328	10	81	5	0	0	1,409	9
Reproductive Health Maintenance	3,308	24	702	41	20	88	4,030	26
Total*	13,806	100	1,698	100	23	100	15,527	100

* Total exceeds number of RH visits due to multiple diagnoses

Mental Health:

The mental health of Oregon adolescents is receiving increasing attention. Between 1995 and 1997, Oregon's adolescent suicide rate was 29% higher than the national average and in 1998 was the second leading cause of death in the 15-19 year old age range. Other factors such as adolescent violence, and drug and alcohol use highlight the need to address the emotional needs of adolescents as well as their physical health needs.

Mental Health Services in School-Based Health Centers



Health center data involving mental health are examined in two ways. There are visits made to see mental health professionals, expressly for the purpose of mental health and/or drug and alcohol issues. These are referred to as 'mental health visits.' There are also diagnoses made that relate to the mental health of the patient; diagnoses that can be made by any qualified health care professional. These are referred to as 'mental health diagnoses.'

In total, 15% (7,527) of all SBHC patient visits were mental health visits, and these visits comprised 20% of all time taken with patients in SBHCs. Mental health visits took, on average, 46 minutes per encounter, longer than any other type of visit. Mental health diagnoses were made (regardless of provider type) in 18% of all visits to SBHCs. Diagnoses in the mental health category included (but were not limited to):

Average Visit Time (in minutes)*

Major Depressive Disorder	45
Anxiety State	40
Panic Disorder	38
Self-Mutilation	36
Abuse of Alcohol	35
Tobacco Use Disorder	27
Cannabis Abuse	45
Eating Disorder	46
School Avoidance	20
Adjustment Reaction	45
Post-Traumatic Stress Disorder	45
Anger	91
Relationship Problems	23
Child Abuse	37

* This selection of mental health diagnoses is intended to demonstrate the wide variety of mental health issues encountered at school-based health centers, and to show the significant amount of clinic time often allocated to addressing such issues and their ramifications. The average visit time does not reflect additional time spent on an issue in the form of subsequent visits, referrals, multiple provider care, etc.

Mental health visits and diagnoses were made along the lines of the population served by the SBHCs. Uniform results were found across gender and race/ethnicity lines; individual categories of students made mental health visits or were diagnosed with mental health problems at the same rate as their total visits to health centers.

High school students accounted for 73% of all visits to health centers and for 72% of all mental health diagnoses. However, only 58% of all visits to mental health providers were made by high school students. Also, high school students accounted for 85% of all mental health diagnoses made outside of mental health visits. Many things might explain the data: high school students may be more reticent to seek mental health care despite their apparent need; they may be more open, aware of, or willing to reveal their mental health needs to non-mental health care providers, or the disparity may be an access-to-care issue. High schools with mental health services are only 57% of all high schools. However, even if all high school health centers were staffed with mental health care providers, the large size of a typical high school would still make the provider-to-student ratio the lowest of all grade levels.

Risk Factor Identification: Reporting Change (State Data Network)

In previous years' reports, all reports of risk factors were recorded and analyzed for this report. However, due to variation in reporting protocols by various sites, risk factors were vastly underreported. For SY 1999-2000 and forward, reporting will focus on full risk factor screens; i.e., visits which included a comprehensive evaluation of health risks to which patients may be exposed. Health centers that conducted full risk factor screens were asked to use a special procedural code so that these visits could be flagged. Analysis of only those visits which included a full risk factor screen will result in a more accurate presentation of the level of risk by SBHC users. Risk factor categories include extrinsic, instrinsic, negative health behaviors and preventive health behaviors. For a complete list of risk factors covered contact the state program office.

Approximately 1 in 6 SBHC patients received a full risk factor screen. Screens were conducted in proportion to the racial/ethnic, gender and grade level makeup of all visits. The number of risk factors reported was not influenced by gender, race/ethnicity or grade level.

Oregon's adolescent suicide rate is 29% higher than the national average from 1995 - 1997 and in 1998 was the second leading cause of death in the 15-19 year old age range.

Below is the percentage of times an individual risk factor subject area arose during a screen:

Percentage^ of risk reports by subject area by grade level*

	HS%	MS%	ES%
Sexual Activity	34	5	
School	24	22	48
Alcohol Use	22	6	5
Tobacco Use	21	3	3
Family Use of ATOD	20	18	47
Stress/Anxiety	20	14	36
Depression	18	10	14
Inadequate Nutritional Choices	17	16	33
Other Drug Use	16	3	9
Inadequate Safety Practices	16	24	38
Body Image	14	19	24
Physical/Sexual Abuse	12	6	26
Family/Home	12	8	17
Peers	12	8	17
No Risk Factors Identified	9	14	3
Inadequate Sleep/Rest	7	4	14
Disordered Eating	7	1	
Inadequate Physical Activity	7	9	14
Interpersonal Violence	6	5	14
Other Mental Health Problems	5	9	7
Inadequate Dental Care	4	17	57
Self-harm	4	2	7
Inadequate Skin Care	3	8	17
Gender Identity/Sexual Orientation	1	1	
Unable to Complete Risk Screen	>1		
Patient Refused to Complete Risk Screen	>1		

^ Percentages exceed 100% due to reporting of multiple risks.

* Of those visits that contained a full risk-factor screen.

These reports of risk factors by students more closely mirror the levels of risk reported elsewhere than has been true in the past. For example, 25% of students who took the 1999 HS YRBS reported smoking in the last 30 days, as compared to 21% of those patients who received a full risk factor screen in a SBHC in SY99-00.

Visits containing a full risk factor screen were more likely to include a mental health diagnosis and a larger number of mental health diagnoses ($p<.001$). This result demonstrates the contribution full risk factor screening can make to a more complete understanding of the health care needs of patients.

SBHC health care providers continue to pay special attention to those patients who report one or more risk factors. The presence of risk factors had a significant impact on the number and length of visits by a user. Analysis by linear regression revealed that users who reported a risk factor made, on average, 5 additional visits to the health center and the presence of a risk factor increased the average duration of a visit by 21 minutes.

Average Provider Time by Presence of Risk Factor*

	High School	Middle School	Elementary School
Risk Factor Present	36.9	39.5	34.9
Risk Factor Absent	15.3	16.5	23.7

* All differences statistically significant at $p < .001$

SBHC Program Office:

The SBHC Program Office provides leadership and guidance on a statewide level for all SBHCs

The Oregon Health Division (OHD) is charged with responsibility for the School-Based Health Center (SBHC) program. OHD's mission is to preserve, protect, and promote the health of all people in Oregon. The SBHC program works to fulfill this mission by working on the health care and prevention needs of school-aged youth and their families.

The SBHC Program Office provides leadership and guidance on a state level. Work this year has concentrated on implementing the Standards for Certification and the development of Planning, Implementation and Operations Manuals. Other tasks included quality improvement, advocacy, data collection and reporting, staff development, expansion and funding. In addition, the Program Office hosts a two-day Annual Meeting for School-Based Health Center staff and coordinators, and quarterly SBHC Coordinator meetings. To commemorate the close of the Robert Wood Johnson grant, "Making the Grade," the state program office hosted a one-day SBHC issues forum, "Beyond Making the Grade," which provided policymakers, business leaders and school officials the opportunity to discuss specific issues and challenges faced by SBHCs.

The Program Coordinator integrates financial, legislative, policy and grant requirements to sustain the SBHC program. Leadership on the implementation of certification requirements has become an essential part of this position. In addition, building community infrastructure, assisting in development and promotion of the SBHC model for state and national partners, program monitoring and evaluation are part of the Program Coordinator's role. The Program Coordinator also works with local health departments in the ongoing evaluation of community needs.

The Clinical Coordinator is a Nurse Practitioner who supports primary care activities for youth and adolescents in the clinics. This position provides leadership and guidance for SBHCs with an emphasis on clinical operations and quality assurance. This position provides leadership and guidance in further development/promotion of the SBHC clinical model for state and national partners. The Clinical Coordinator also works with local health departments in the ongoing development, implementation and evaluation of community needs.

The Program Analyst works on data collection, management and training for SBHCs and training and maintenance of Clinical Fusion, the data collection tool for SBHCs. As the SBHC model evolves, evaluation of outcomes is more critical. This position works on utilizing this information at local, state and national levels.

The SBHC Clinic Staff

School-based health centers are routinely staffed with a health assistant and a nurse or nurse practitioner (NP). Other health professionals such as mental health or alcohol-and-other-drug counselors may also have on-site office hours for patient assessment, education, primary care or prevention services.

The health assistant is responsible for scheduling appointments, maintaining supplies, data gathering, compiling health center statistics and providing general clerical support. In some health centers, the health assistant is also trained as a medical assistant and may assist the nurse or nurse practitioner by taking medical history information, weighing and measuring, and collecting lab specimens. Health assistants can also attend to student needs through triage encounters. As the first person students see when they enter the health center, the assistant also plays a vital role in helping make patients feel comfortable in the health center.

Integration of school nursing into the SBHC treatment team is important to offering coordinated health and preventive care to students. In conjunction with the SBHC, the school nurse provides basic health and prevention care services and acts as a liaison between the health center, the school, and the local health department. The SBHC nurse provides primary health care services to students, and works closely with parents, the advisory board and the community at large. In health centers without a nurse practitioner, the nurse refers students to outside sources for primary health care needs in accordance with practice definitions.

The NP (or physician assistant) provides primary health care for the students by: performing physical examinations; diagnosing, treating and/or writing prescriptions; and delivering prevention services in accordance with license practice definitions. The NP may refer students for specialized care or consult the students' private physicians. In health centers without a nurse, the NP also provides those functions normally filled by the nurse. Direct physician involvement in SBHCs occurs at a limited number of sites. Physician back-up is provided by the organization with management and oversight responsibilties.

Mental Health and/or Alcohol & Drug Counselors often work in the SBHCs as part of the direct services team by providing assessment, appropriate prevention service delivery, individual and family counseling and support group facilitation. They also provide essential coordination of extended community resources for more complex mental, emotional and social problems.

The true heros of the SBHC clinics are the dedicated staff.

The Services

General Medical Services Related to Acute and Chronic Conditions

The majority of visits to school-based health centers are for health supervision, the treatment of acute illnesses and injuries, or for the management of chronic conditions.

Students come to a health center with acute conditions including headaches, abdominal pain, coughs and colds, sprains and strains. They also utilize SBHC facilities for sports physicals, immunizations and the management of chronic conditions such as diabetes and asthma. When the care needed extends beyond the licensed professional scope of the practitioner, health center staff helps arrange for the necessary treatment. Staff make a concerted effort to coordinate care with students' primary care providers to avoid duplication of services and promote continuity of care.

Health Promotion/Prevention-Related Services

During every encounter with a student at a SBHC, health center staff incorporate prevention services and messages. The small signs of risk behaviors are well understood by SBHC staff and not overlooked. When a student comes in complaining of a cough, providers routinely ask about smoking behavior. When the complaint is a headache, providers probe about nutrition, stress in students' lives, and possible alcohol and/or drug use. Current SBHC prevention efforts are based largely on the Guidelines for Adolescent Preventive Services (GAPS) developed by the American Medical Association. The GAPS program addresses major youth health risks through identification of risk factors (e.g., sexual activity, substance use, violence, safety practices, depression), early recognition and management of problems. SBHC staff work to reinforce the positive messages and habits contained in GAPS and work with families so messages are heard in the home as well. Health centers have pamphlets, data and referral information about the health threats to students. Providers educate students so they take better care of themselves, become healthier and more independent, and better consumers of medical services. Students become aware of how their behavior affects their health as well as the role of personal responsibility in maintaining good health. SBHC staff work closely with families, school personnel and social services, referring students as needed to the appropriate professionals. Students rely on the SBHCs not only for professional medical care, but to help them cope with the constellation of conditions that affect health such as student behavior, social surroundings, economic conditions and scholastic achievement.

In addition to individual health education, SBHC staff provide classroom, school-wide and community presentations on the health of students. Staff also sponsor groups on topics such as smoking cessation and anger management. SBHC staff participation in health education and risk prevention in the health center, in schools and communities is a positive and beneficial strategy to improved long-term health for all students.

Reproductive Health Services

SBHCs offer a range of reproductive health services such as diagnosis and treatment of sexually transmitted diseases (STDs), help with menstrual problems, pregnancy tests, family planning information and referral. Abstinence education is an important component of risk management and anticipatory guidance at all SBHCs. Some health centers also provide comprehensive family planning services such as pelvic exams and prescriptions for contraception. SBHCs in Portland Public Schools may dispense condoms on an appointment basis as well as prescribe and dispense other contraceptives. Eugene SBHCs may dispense condoms for the treatment of sexually transmitted disease. No other state-supported health centers dispense any contraceptives on site at this time, although some are exploring this possibility with their communities.

The use of condoms as a tool to prevent STDs, apart from the benefits of preventing unwanted pregnancies, should be discussed at the community level. For sexually active students, condom distribution to prevent the spread of STDs (including HIV) is a factor to consider when developing potentially life-saving primary school-based health care. In health centers where family planning services are limited to information and referral, students are referred to the local health department or a private provider for service.

Mental and Emotional Health Services

Mental health needs are consistently identified in SBHCs. Research shows that teens at risk for multiple health-compromising behavior are more likely to seek services at a SBHC than with other providers. Each SBHC provides a range of mental and emotional health services that may include individual counseling, support groups or referrals to other community resources. Some health centers house a part- or full-time mental health counselor, generally funded by the school district or county.

Suicide prevention is a critical component of mental health services, particularly since Oregon has experienced high rates of suicide among adolescents. Part of a cooperative effort among all state programs with jurisdiction over youth-related programs to reduce youth suicides and attempted suicides includes SBHCs will play a vital part by educating health professionals about the issue of suicide, using gatekeeper training in recognizing and responding to youth in crisis, and implementing screening and referral services for youth at risk for a suicide attempt. The state SBHC program office provides training to SBHC staff in the Applied Suicide Intervention Skills (ASIST) model. By September, 2002, all SBHC staff members in Oregon will have had an chance to receive this training.

The Hours

Due to the acute nature of many student complaints, most visits to SBHCs are made on a walk in basis, in contrast to the appointment model followed by most primary care providers. The optimal model for SBHCs is to be open every school day for most of the day and staffing patterns should ensure that a health care provider is available at all times. Some centers remain open during the summer or evening hours, and some combine their efforts with other community-based services to expand health service delivery.

Community & Family Involvement

Community Involvement/Advisory Boards

Each school-based health center has a mechanism in place to obtain community input on SBHC services and operations. Most centers have an advisory board comprised of parents, teachers, students, health care providers, and community and religious leaders. Members represent a broad spectrum of community views and values.

The collaborative efforts of community partners serving on the Advisory boards strengthen the SBHCs by developing and reviewing policy, brainstorming program improvements, planning health center events, and serving other functions. Community participation ensures that the health center is designed and developed to meet the needs of the community.

Family Involvement

School-Based Health Centers

All school-based health centers strongly encourage teens to involve their parents in their health care. Each health center provides information about health center services to parents, and parents are welcome to call or visit the center. Past surveys have provided valuable parent feedback to both program planners and community members. It was found that communication between parents and SBHC users regarding both health concerns and health decisions is very high. Also, parents of SBHC users are supportive of centers in general, are very satisfied with the quality of care their children receive, and advocate for expansion of services. Parents of children who were non-users indicated it was generally due to having access to other providers and not due to their negative perceptions of the SBHCs. In fact, parents of non-users also supported the existence of centers and advocated for expansion of services (SBHC Program Evaluation, Multnomah County, 1995).

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By Oregon law, teens 15 and older may obtain health services without parental consent. Also by Oregon law, minors of any age may receive family planning and sexually transmitted disease services without parental consent. A minor 14 years or older may seek outpatient diagnosis and treatment of a mental or emotional disorder without parental consent.

Some health centers provide services without parental consent as allowed by these laws, though parental involvement is still strongly encouraged whenever possible. Other health centers will provide services only when the student has a parental consent form on file.

Implementation of SBHC Standards For Certification

After nearly two years of discussion and development, and in concert with a national trend towards SBHC certification, the Oregon SBHC standards for certification went into effect in July of 2000. The goals of standardization are to increase emphasis on best practices, decrease site-to-site variability, increase ability to study clinical outcomes and increase the potential for insurance reimbursement, the latter of which has remained a relatively untapped funding source to date. The standards are meant to represent reasonable but high expectations. Included in the standards are the following topics: requirements and recommendations for sponsoring agencies and medical sponsors, facilities, operations, staffing, laboratory services, clinical services, data collection and reporting, quality assurance activities and administrative procedures for certification.

The standards outline a voluntary certification process rather than a licensing process. The document highlights two different SBHC models that reflect differences in local needs and resources. The two models are defined as Core and Expanded centers. The differences in the two models pertain to facility requirements, hours of operation and staffing but not to quality of care provided. Though each site has the option of becoming certified by meeting the standards, all sites receiving state funding are required to be certified. All of them have completed this process.

The process used to implement standards has been extremely positive. In many SBHCs, the standards for certification were already being met. In all others, the response to the needs of certification by schools and communities has been very supportive. In two cases, entire new facilities were constructed, prompted by the certification process. These new facilities will join existing SBHCs in making lasting contributions to the health of Oregon students for years to come. Oregon's SBHCs are clearly committed to providing exceptional health and preventive care for Oregon's kids.

SCHOOL-BASED HEALTH CENTERS AND CORE PUBLIC HEALTH FUNCTIONS

Core Public Health Functions are a commonly accepted framework intended to provide guidance to public health programs. It is through these broad functions of assessment, policy development and assurance that public health has found an effective approach to addressing diverse and dynamic population-based health issues in today's world.

ASSESSMENT

The SBHC program participates in ongoing statewide data collection efforts to better assess and understand adolescent health status and health care needs. Via tools such as the Youth Risk Behavior Survey (a collaborative effort between the Departments of Education, Human Services and school districts throughout Oregon), client demographic and clinical encounter information provided the SBHC program office, and special surveys and studies regarding operation and policies, these assessments allow the SBHC program to evaluate the relationship between program activities, impacts and on-going health care needs of youth.

POLICY DEVELOPMENT

The SBHC office has made important progress over the past several years regarding the standardization of SBHC operations and services. A policy decision which resulted in the recent implementation of State Standards for SBHC Certification was based on the following principles: how to best meet the needs and provide optimal impact on the health care needs of youth through standardizing the delivery model; maximizing potential for financial sustainability; and improving accountability of outcomes in use of local, state and private resources. The SBHC office works closely with communities to address policy changes and develops guidance to help SBHCs interpret and meet both state and federal requirements.

ASSURANCES

The SBHC program office attempts to maximize available state and local SBHC resources and technical assistance efforts. Priorities include improving the clinical environment, developing new capacity and maintaining "adolescent friendly," developmentally appropriate care for Oregon youth. Frequently updated Quality Assurance tools are provided to centers, and technical assistance focuses on improved clinical care, operations, and meeting data requirements. Annual patient satisfaction surveys are conducted to keep the SBHCs on track with meeting patient needs. The Standards for Certification assure that all SBHCs meet minimum criteria for staffing, operations and services, and operate within state and federal laws governing health care facilities.

Funding

In the 1999-00 service year a total of twenty Oregon school-based health centers received some form of state support. Thirteen SBHCs received state general funds from the Oregon Health Division. Four others received final payments from the Oregon Making the Grade: Partnership for School-Based Health Centers grant distributed through the Oregon Department of Human Resources from the Robert Wood Johnson Foundation. Base funding of the state-supported centers varied slightly depending on the source.

The majority of all general funds for the SBHC program are distributed directly to communities through their local health department authority. The communities in which the base-funded SBHCs operate typically match state dollars ($2 for every $1 in general funds) with other local public and private resources. State general funds may be supplemented with county government or school district funds. For example, in 1999 Multnomah County provided $3,389,656 for their SBHC program to administer and run 12 centers. Special grants, fund-raising events, medical providers, hospitals, universities and other community partners also help cover expenses. Medicaid and third party insurance reimbursement normally account for less than 10% of operational costs due to a variety of systemic barriers.

The 1999 Legislative Session brought new and vital stability to the Oregon school-based health center program. Contained within the Governor's recommended budget for 1999-2001 was a policy package for SBHCs requesting $1,000,000 dollars in replacement funding. These general fund dollars were sought primarily to provide base funding to seven centers that were operating on expiring federal and private (Robert Wood Johnson Foundation Making the Grade) grant funds.

Significantly, the legislated funds have provided essential stability for SBHC program coordination, clinical coordination and research analyst capacity that had been building through grant funds over the past six years to support Oregon's rapidly growing SBHC program. The state program office provides SBHC Certification, technical assistance, quality assurance and support not only to state base-funded sites (N=20), but also to the remaining 26 existing Oregon SBHCs as well as any community operating or interested in developing a SBHC regardless of their primary funding source.

State funding for the current operational year (2000-2001) is shown below.

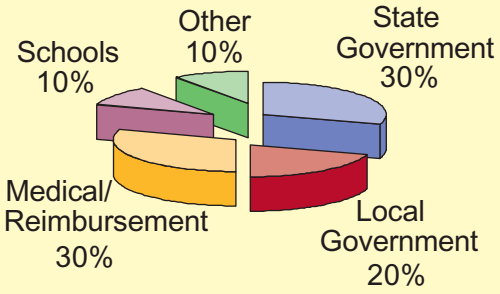
County	SBHC	Funding	Source 2000-01
Baker	Baker HS	$ 53,915	State General Funds
Clackamas	Oregon City HS	$ 53,915	State General Funds
Douglas	Roseburg HS	$ 53,915	State General Funds
Jackson (4)	Ashland & Crater HS Jewett ES & Scenic MS	$215,660	State General Funds
Josephine	Illinois Valley HS	$ 53,915	State General Funds
Lane (2)	North & South Eugene HS	$107,830	State General Funds
Lincoln (2)	Taft & Toledo HS	$107,830	State General Funds
Multnomah (4)	Grant & Jefferson HS Lane & Whitaker MS	$215,660	State General Funds
Umatilla (2)	Sunridge MS & Pendleton HS	$107,830	State General Funds
Union	LaGrande HS	$ 53,915	State General Funds
Yamhill	Willamina HS	$ 53,915	State General Funds
Total Centers with State Core Funding (N=20)		$1,078,400	State General Funds

Stable sources of ongoing revenue and operational funds remain a significant concern for most centers. The Oregon Making the Grade project (1994-2000) examined long-term financing issues and strategies to help stabilize school-based health center funding within the public and private health care delivery systems. Surveys or case analysis of selected centers have provided important information on operations and the financial status of SBHCs:

A typical SBHC offering core services includes an NP, RN, mental health provider and health assistant for staff, costs approximately 160K per year to operate and is open during the school year on most days when students are present in school. Actual budgets for centers are more variable depending on staffing patterns, hours of operation, services provided and degree of local support. Approximately 80% of a SBHC's budget is for staff, 11% for facilities and supplies, and 9% for administrative services.

Funding sources for SBHCs are variable and differ according to availability of local resources, medical sponsorship, and number and strength of partnerships. This model is an idealized representation showing a state, local and medical community shared responsibility for SBHC funding. In reality, many centers currently receive no state general funds and others are funded nearly exclusively by county government.

SBHC Model Funding



In this model:

State government =	base funding from general fund dollars
Local government =	local general funds or leveraged county services
Medical / reimbursement =	billable services, fees, other state or local mainstream medical dollars
Schools =	local school district funds and leveraged services
Other =	local business, grants, fundraising

The certification process implemented in SBHCs in July, 2000 will help strengthen the SBHC model throughout Oregon from the perspectives of service delivery, accountability and quality of care. These efforts also translate into the future viability of SBHCs as unique providers of preventive primary care and mental health care that successfully meet the developmental needs and access issues of youth. Finally, financial stability for centers will grow as a consequence of ongoing community commitment, maturing operational budgets under certification and as new dollars become justified and available.

Priorities for SBHC funding in the future will require continual review and careful management. In order to maintain the current high standard of care and address the growing health care and prevention needs of Oregon's adolescents, funding must at minimum include: preserving base dollars for certified Core centers; identifying supplemental dollars for certified Expanded centers; base funding of additional certified centers; and development funds for those communities which are currently planning SBHCs.

What conclusions can we reach regarding long-term financial sustainability for school-based health centers?

- First, where the state is a financial partner of a community's SBHC(s), the state general fund contribution typically represents no more than 35% of operations, considerably less in better-developed models. Regardless, this is a vital contribution to those communities who are maintaining improved access, primary care, preventive health and mental health services for children and youth. Future maintenance and enhanced state support is both desirable and essential to SBHC success.

- Second, a very meaningful portion of SBHC services falls within the health education, prevention, wellness and emotional health domains. Communities need to help prioritize and create better access to funding streams for school-based health centers where the short-term and long-term health of youth share outcomes with other programs, including education, welfare, social services, juvenile justice and vocational preparation. And, as prevention services steadily increase, they represent a growing and significant savings in health care dollars. The positive impact these services will have on the future of our adolescents translates to greater opportunities for Oregon as a whole.

- Finally, SBHCs are providing a significant amount of health care and prevention services, often to insured youth without the benefit of reimbursement. Financial analysis reveals it is not unreasonable to expect that 30% of operations be reimbursed by responsible parties. In order for that to occur, efforts to constantly improve SBHC standards of care, remove barriers, recognize and reimburse SBHCs as a safety net provider, develop billing capacity and model contracts, and to more effectively partner with public and private health care payors must continue.

The Health Network for Rural Schools

Since 1997, the Health Network for Rural Schools (HNRS), sponsored by the School of Nursing at the Eastern Oregon University, began operating in the elementary schools of Cove, Elgin, Imbler, North Powder and Union in Union County. The HNRS is a health services model that does not meet the current criteria for a comprehensive School-Based Health Center (SBHC) but it typifies what is often referred to as a School-Linked Health Center (SLHC) model. In this case of a school-linked model, a health team moves around to each of the school sites bringing a constellation of targeted services to each school for usually no more than 1-2 days per week, providing less on-site clinical and lab services and working within a more limited space.

The Oregon Health Division School-Based Health Center Program has been following this SLHC model in order to understand better the differences and challenges in operations, staffing, service delivery and financing between the two models. The model may be particularly well suited to rural or isolated settings or where school populations are too small to justify the greater expense of operating a certified SBHC.

In SY 1999-2000, there were a total of 1,645 services provided through the HNRS to students, school staff and community members including clinical visits, mental health counseling visits, immunizations, a weekly flouride rinse program, health screenings and education, and referrals to other providers.

Total Number of Services:	1,645
Clinical Visits:	865
Hepatitis B Immunizations:	480
Flu Shots	200
Cholesterol Screenings	100
Additional School-wide Screenings	67
Total Referrals to Other Providers:	116
Dental	53
Hearing	20
Other	43
Total Health Education Projects:	112
Head Lice Education	62
Other Education Projects	50

Mental Health Services	
Total Persons Served	113
Family Units	56
Students	74
Family Members	60
Most Frequent Problems Assessed:	
Behavior	50
Family	43
Depression	35
Relationships	25
Psychological	22

School-Based Health Centers

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