Assessing Workforce Needs & Opportunities for School Based Health Centers in California

by Catherine Dower, Center for the Health Professions at UCSF, December 2010

ABSTRACT

School based health centers go beyond the traditional services of a school nurse to provide comprehensive care – including primary and mental health care – to students. The centers are seen as a way to reach populations that would otherwise not be receiving appropriate care. California has many such centers though policy makers and leaders in the field would significantly expand these programs if possible. Two of the biggest challenges have been insufficient funding and limited pools of qualified providers to work in the centers. Recent attention and funding available for school based health centers may provide the needed attention for more fully tapping into this delivery model. In addition, a set of research, planning and coordination elements are explored to help spread the model.

Introduction

Outrage over the declining health status of children evidenced by increases in violence, obesity, chronic disease, mental and behavior health issues and low immunization rates has led to sweeping policy changes at the federal, state and local level. Expansions in children's health insurance coverage, new public health efforts and service delivery redesigns are now underway. In recent years, policy makers in California and elsewhere have promoted school based health centers as vehicles to better child and adolescent health. Not only are school health centers promoted as efficient and affordable providers of health care but evidence is mounting that locating health services at schools can improve attendance and performance at school.[i]

In 2006, Governor Schwarzenegger placed a strategy of adding 500 centers as a cornerstone to his plan to make health care more accessible, efficient and affordable to everyone in the state.[ii] The state Healthy Start Program, funded between 1991 and 2007, grew to $39 million per year in planning and operational funding for coordinated school health programs, but was defunded despite positive evaluation results.[iii]

While new California state funding has yet to materialize for school based health centers, federal funds appropriated in the American Recovery Act and Patient Protection and Affordable Health Care Act ("Affordable Care Act" or ACA) offer opportunities to further their expansion.

At the same time, the state faces shortages in appropriate preventive and primary care providers. A recent study of the supply of physicians in the state found that only 16 of California's 58 counties meet the need for primary care physicians and in eight counties the supply is less than half what is recommended.[iv] School based clinics are needed most in communities where children, youth and families do not have a regular source of care. These communities will need to recruit providers – including physicians, nurse practitioners (NPs) and physician assistants (PAs) – to work in their new clinics. Preferably these providers will mirror the racial and ethnic composition of the community. This will not be easy since minorities are dramatically under-represented in California medical schools when compared to the state's population.[v]

This issue brief will describe what is known about the workforce needs of California School Based Health Clinics (SBHCs), what the funding opportunities are for the clinics and what steps are needed to formulate a strategy to prepare a school clinic workforce that can improve the health and school performance of children and youth in California.

What is School Based Health?

The U.S. Centers for Disease Control states that schools can provide a critical facility in which many agencies might work together to maintain the well-being of young people. They promote a comprehensive model of school based health that includes eight components provided by qualified staff and community members:[vi]

- Health Education (trained health educators)
- Physical Education (trained physical activity teachers)
- Nutrition Services (child nutrition professionals)
- Healthy School Environment (facilities and grounds personnel)
- Health Services (physicians, nurses, dentists, health educators, and other allied health personnel provide these services)
- Counseling, Psychological & Social Services (certified school counselors, psychologists, and social workers provide these services)
- Health Promotion for Staff (trained health educators)
- Family/Community Involvement (parent/ community advisory councils)

What is School Based Health in California?

Current Scale – To better meet the demands on schools for health related services, in the 1990s, with private foundation funding as a catalyst, California began to develop school based health care beyond the provision of school nurses. Today, as seen in Table 1, the student to health center ratio is still large compared to other states and far from what the Governor proposed in 2006. Currently, 800 of 10,233 California schools can readily access a health center.[vii]

Table 1. K-12 Students and School Based Health Centers by State 2009

	# Students	#Centers	1 Center:Students	Proposed*
CA	6,322,528	160	39,516	9,580
FL	2,631,021	245	10,739	
IL	2,119,707	62	34,189	
MA	958,910	59	16,253	
MI	1,659,921	90	18,444	
NY	2,740,805	206	13,305	
OR	575,393	51	11,282	
TN	971,950	21	46,283	
TX	4,752,148	70	67,888	

Sources: National Center for Education Statistics, 2009 and National Assembly on School Based Health Care, Census Data, 2009
* Ratio of students to clinic if the additional 500 were added as suggested by Governor Schwarzenegger, 07/24/2006.

To get a more complete picture of health services in the schools however, one should look at the number of students per school nurse as well. These ratios are shown in Table 2. This ratio is much better than the ratio of students to clinic but is far above the American Academy of Pediatrics recommendation of 750 students to 1 school nurse. The AAP recommends an even lower ratio for schools with more students with special health care needs.

School based health centers in California are intended to serve students in underperforming schools by filling the gaps in health and social services that support student achievement. To get a true estimate of the need for school based health centers, one would need to compare the number of target communities to actual school

based centers. Officials from the California Department of Education state that when expansion of centers has been proposed, it has been based on estimates of potential funding, not estimates of unmet need.[viii]

Table 2. Ratio of California Students to 1FTE School Nurse from 1997 to 2008

	1997-1998	2002-2003	2007-2008
Nurses	2,397	2,292	2,218

Source: California Department of Education, Fact Book 2009 accessed 11/20/2010. <http://www.cde.ca.gov>

Type of Schools - As Table 3 shows California's school based clinics are most frequently found in high schools as is the case nationally but clinics at other types of schools are also well represented in California with another 27% found in schools with students in kindergarten to 8th grade. It is interesting to note that 15% of schools in California and 20% nationally are sharing school clinic resources between several campuses.

Table 3. California US School Based Health Clinics by School Level 2007

	CA		US
	#	%	%
K - 6th Grade	42	27	10
K - 8th Grade			7
7 - 8th Grade	14	10	8
7 - 12th Grade			5
9 - 12th Grade	58	38	33
K - 12th Grade	16	10	17
Multi School	23	15	20
Total:	156	100	100

Source: California Association of School Based Health Centers website, accessed 11/15/2010 and National Assembly on School Based Health, 2007 Census.

Geography – The majority (69%) of school based clinics in California are in urban areas and only 10% in rural areas. 21% are in suburban areas. This is similar to the national distribution of clinics (see Table 4).[ix]

Table 4. California US School Based Health Clinics by Community Type 2007-2008

	CA	US
Urban	69%	57%
Suburban	21%	16%
Rural	10%	27%
Total:	100%	100%

Sponsors - In California, school based health centers are primarily sponsored by the school systems and community health centers. Nationally, they are more evenly distributed among a larger number of sponsors including community health centers, school systems, local health departments, hospitals and other non-profit providers (see Table 5).

Table 5. Percent School Based Health Clinics in California US by Sponsor 2007

	CA	US
Community Health Center	35	28
School System	33	12
Private Non Profit	12	
Local Health Department	7	15
Hospital/Medical Center	5	25
Mental Health	3	
Other	5	
Other Non Profits, Universities, Mental Health Agencies		20
Total:	100	100

Source: National Assembly for School Based Health Care Centers, 2007 Census.

Services Provided - Schools have been increasingly recognized as logical locations to provide coordinated health and social services since all children over the age of five are required to attend school. In addition to having to deal with students becoming ill and medical emergencies at school, state and federal laws impose certain requirements for health services on schools. These requirements are described in *A Health Framework for California Schools* as follows:[x]

California law requires that schools:

- Provide health screenings for vision, hearing, scoliosis, and dental problems (Education Code sections 49452 and 49452.5)
- Assure that students are immunized against specific vaccine-preventable communicable diseases (Health and Safety Code Section 120335).
- Provide for routine health care needs of students such as administration of medications (Education Code Section 49423).

Federal law related to students with special needs requires schools to provide to enable these students to attend school including:

- monitoring of vital signs,
- assistance with medical devices such as tracheostomy care and suctioning, dressing changes, catheterization, gastric tube feeding, and
- administration of oxygen.

Students are now attending school with chronic health conditions, such as diabetes, cancer, arthritis, and severe asthma. These students need school health personnel to provide:

- consultation with families and physicians to coordinate care, and
- assistance with medications, special treatments, and equipment use.

The actual services provided in each SBHC vary based on funding, other school district health programs offered and local health care resources available. The California Association of School Health Centers has published guidelines for services to be provided in SBHCs.

Table 6 shows the portion of California school based clinics providing selected services compared to all school based clinics in the US. Minor differences are apparent. Namely, California clinics are more likely to see patients who are not students at the schools where they are located and less likely to treat acute illnesses and provide mental health assessments.

Table 6. Percent School Based Health Centers Providing Selected Services in California and US 2007

	% CA SBHCs	% US SBHCs
Comprehensive Health Assessments	94	97
General Dental Care	10	10
Asthma Treatment	84	95
Immunizations	90	85
Conflict Resolution/Mediation	61	78
Mental Health Assessment	76	84
Nutrition/Fitness/Weight Management	90	86
On Site STD Dx & Treat for Adolescents	59	68
Scheduled After Hrs Care	57	67
Sees Non-School Patients	87	64
Prescriptions for Rx*	81	96
Treatment of Acute Illnesses*	79	96

Source: National Assembly of School Based Health Care, 2007 Census.
*National Assembly of School Based Health Care, 2004-2005 Census.

Staffing: School based health centers in California are staffed by a variety of health and mental health professionals. They are largely run by nurse practitioners and to a lesser extent, physician assistants. A slight majority of clinics have full time staff but almost half of them use part time staff.[xi]

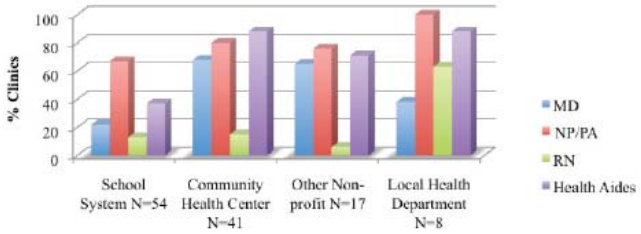
Staffing can vary based on the services offered and whether it is sponsored by the school district or a community health or mental health organization. Figures 1 and 2 begin to examine this. They show the variety of staff in health centers based on sponsoring agency. Officials add that school based centers sponsored by community health centers are usually larger with more staff including medical assistants and mental health workers. A school nurse and

school mental health workers may co-locate in the center but would not work for the center. School district sponsored health clinics are more likely to include school nurses and school mental health workers in health clinic budgets.[xii]

California requires that health and mental health providers – including nurses, psychologists, counselors and social workers -- employed by school districts obtain a credential as a school provider (in addition to their professional license or certification).[xiii] However, many school based health centers are run by community agencies, which do not require these credentials.[xiv]

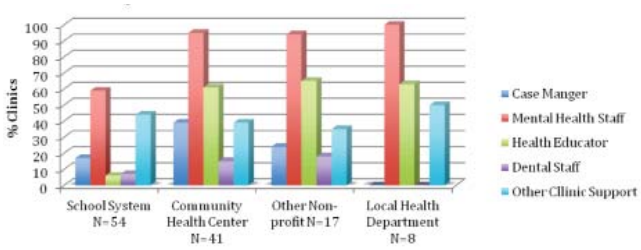
A 2003 study of pupil support personnel in schools found that approximately 74% of districts sampled utilize credentialed school nurses in their programs with a higher proportion found in elementary schools than high schools. Districts reported a higher proportion of credentialed mental health personnel at 85% working in schools. The major reason for using non-credentialed personnel is lack of adequate funding to hire credentialed personnel.[xv]

Figure 1. Clinical Use of Medical Personnel 2009



Data Source: National Assembly of School Based Health Centers Census Data 2009

Figure 2. Clinic Use of Non-Medical Personnel 2009



Data Source: National Assembly of School Based Health Centers Census Data 2009

Health Information Technology (HIT) in Use - California data was not available but the National Assembly of School Based Health Care reports that SBHCs are adopting HIT to enhance their work with more than half (56%) using electronic billing systems, and 53 percent with a management information system. A smaller number use an electronic medical record (32%) and electronic prescribing (22%) and 7 percent of SBHCs have a telemedicine system.[xvi]

Recruitment and Retention of School Based Health Clinic Personnel

Since there was little known about the recruitment and retention of personnel for School Based Health Centers in California, a study done by the California Department of Education sheds some light on the issues involved in hiring and retaining personnel who provide health services in the schools. The 2003 survey of school district administrators found that elementary school districts, high school districts and unified districts in California had different experiences when it came to recruiting and hiring personnel to support students.

Of the 161 school districts responding, the following were the top ranked difficulties in hiring support personnel (nurses, psychologists, counselors and Social workers):

- District cannot afford pupil support personnel
- Shortages of qualified applicants
- Competition with other school districts
- Inadequate salaries and benefits
- None (no difficulties)
- Lack of suitable or affordable housing in the community
- Inability to locate qualified candidates
- Other (specified)

- Applicants inadequately trained
- Job requirements (role and function)
- No suitable candidates

Elementary school districts were most likely to claim affordability most frequently whereas high school districts cited most often that there were no suitable candidates. In unified districts, respondents indicated that the fact that applicants were inadequately trained created the most difficulty for them to hire student support personnel.

The survey also asked administrators to identify the major causes for their difficulties in retaining student support staff. The top reasons were ranked in order as follows:

- District budget limitations
- No difficulties
- Burnout–high workload for pupil support personnel
- Competition with other school districts
- Geographical factors (location, climate, etc.)
- Isolation from higher education institutions
- Other (specified)
- Lack of suitable staff development

Elementary and unified districts cited budget limitations most frequently whereas high schools stated most frequently that they did not have any difficulty retaining student support personnel.

Report authors concluded that survey respondents felt the lack of defined funding for pupil services was the main cause of difficulties faced by districts in building and sustaining these activities. District limits on grants and categorical funding as well as lack of opportunities to blend these resources make it close to impossible to adequately fund and maintain pupil services.

Respondents strongly suggested mandating a dedicated funding stream and staffing ratios for student support services. Suggestions for improving retention of credentialed personnel stressed adequate funding, improved salaries and benefits, and support for optimum use of personnel by adequate staffing, appropriate role definition, and supportive professional development.[xvii]

The Colorado Association of School Based Health Centers recently published a report on the recruitment and retention of providers in school based health centers. The report was in response to members' difficulties in filling job openings for nurse practitioners and physician assistants in school based clinics.

The Association conducted interviews of current clinic staff, other qualified personnel not employed in school based health centers and current nurse practitioner and physician assistant students. They found that NPs and PAs in practice and those in training were largely unaware of the existence of school based health clinics. They also found that it is critical that new clinic hires be people who are interested in serving disadvantaged populations, like to spend more time with patients and seek to serve children and adolescents. While clinicians need to like to work with young people, some also find that school aged children are less challenging than newborns and infants clinically. Some see school based clinics more desirable than other settings because many operate part time and on the academic calendar.

Similar to health practitioners that practice in rural communities or in solo practice, Colorado SBHC clinicians state that the relative autonomy and isolation of the SBHC can be a barrier to recruiting new NPs and PAs. They also stated that they felt that greater opportunities for professional development could lead to greater job satisfaction. Training areas suggested included: inter-professional communication skill building, billing and revenue generation, confidentiality in the school environment, and managing parent concerns.

Financial concerns also hinder some job applicants. Some feel that lower salaries due to fewer hours are less attractive as is the resource poor setting of many school clinics with older equipment fewer resources to order diagnostic tests and ancillary services, and the unwillingness of private practice physicians to consult on cases. Another concern of students and school based clinicians cite as a negative to the work environment is the lack of administrative support for back office functions, securing grants and aiding student enrollment in third party insurance plans and programs.

One finding that surprised researchers was that SBHC clinicians' difficulty forming and maintaining collaborative working relationships with school district health personnel was a factor in SBHC staff retention. The report states: "These inter-professional challenges that often resulted in a lack of sharing of information between providers were described as a source of job dissatisfaction among SBHC interviewees".[xviii]

It is unknown the extent to which these hiring and retention issues exist in California school based health centers. According to one leader in the field, the largest factors in hiring staff for California school based clinics currently appears to be funding for the positions and for many communities the availability of providers bilingual in Spanish and Asian languages.[xix]

Current Funding Sources for School Based Clinics

On its website, the California Association of School Health Centers outlines the following funding sources for school based health centers (partial listing):[xx]

Academically-Focused Sources

- Title I-A of the Elementary and Secondary Education Act
- 21st Century Community Learning Centers/ Title IV-B of the Elementary and Secondary Education Act
- After School Education and Safety Program
- High School Graduation Initiative
- McKinney-Vento Homeless Education Assistance Act
- Foster Youth Services

Broadly-Focused Sources

- Safe and Supportive Schools
- Safe and Drug Free Schools and Communities Program
- Promise Neighborhoods Initiative
- First 5

Health-/Mental Health-Focused Sources

- Local Educational Agency (LEA) Medi-Cal Billing
- Medi-Cal Administrative Activities (MAA)
- Elementary and Secondary School Counseling Program
- Grants for the Integration of Schools and Mental Health Systems

- Early Mental Health Initiative
- Grants to Reduce Alcohol Abuse

Safety-Focused Sources

- School Community Violence Prevention Program
- School Safety and Violence Prevention Act Grants

The Association also points out that the federal Health Resources and Services Administration (HRSA) recently released guidelines for "The Affordable Care Act Grants for the School-Based Health Centers Capital Program." Approximately $100 million will be awarded to 200 or more organizations in 2011. It supports expanded capacity of school based health centers to provide primary health care services to school aged children. These funds are available for construction, renovation or equipment expenses.[xxi]

A separate section of the Affordable Care Act creates a new federal grant program for the operation of school based health centers. To date, no appropriations have been made to the program.[xxii]

HRSA received $11 billion in funding in 2010 for more Federally Qualified Health Centers (FQHC). Many school based health clinics in California are operated by FQHCs and the California Association of School Based Centers is encouraging health center expansion into schools.[xxiii] Here are other key sections of the Affordable Care Act that could provide support for necessary efforts currently being undertaken by school based health clinics in California:[xxiv]

- In 2010, a grant program for states, public health departments, clinics, hospitals, federally qualified health centers and nonprofit organizations for the purpose of supporting community health workers to educate and provide outreach in community settings regarding health prevalent in medically underserved communities, particularly racial and ethnic minority populations; educating these communities regarding enrollment in health insurance; and providing home visitation services for maternal and child health.
- Starting in 2010 states can obtain grants for "personal responsibility education programs" to reduce teen pregnancies through 2014 (local organizations can submit a grant if states do not).
- In 2010, grants will be available to states for improving immunization coverage for children, adolescents and adults through the use of evidence-based interventions as recommended by the Community Preventive Services Task Force.
- In 2010, a three year demonstration program will begin for ten state-based non-profit public/private partnerships that provide access to comprehensive and affordable health services to the underserved.
- A childhood obesity demonstration project, established under the Children's Health Insurance Program, will begin with a wide range of eligible entities and a goal to develop an effective, community based model to reduce childhood obesity.
- In 2012 a demonstration project will begin for pediatric accountable care organizations to run through 2016.

Payment for Services at School Based Clinics

In addition to all the funding sources mentioned above that schools use to establish and operate health centers, many clinics try to recover some operating costs by billing third party health care payers. The California Association of School Based Health Centers reports that the majority of centers recover less than 50% of their operating costs from all billing sources. In California,

important sources of third party reimbursement are the Child Health and Disability Program (CHDP), Medi-Cal, Family PACT and Healthy Families. Those school based centers that partner with community health providers such as FQHCs provide services at little or no cost to the school and take care of billing third parties.

The following are key provisions of the Patient Protection and Affordable Care Act that could make government program payment a more viable source of funds for school based health clinics:[xxv]

- In 2013 and 2014, primary care practitioners in Medi-Cal will be paid at 100% of Medicare rates for primary care services, fully funded by the federal government.

- By 2014 the state must expand Medi-Cal coverage to all those up to 133% of poverty.

Funding Opportunities for Training School Based Clinic Personnel

State and federal efforts are expanding to train workers for the health care jobs of the future. Seemingly intractable issues in getting poor communities access to necessary care are now being addressed by funding for programs in the federal economic stimulus legislation of 2009 and the Affordable Care Act of 2010. Four programs that are especially relevant to the workforce needs of school based health clinics in California are the Workforce Planning Grant, Public Health Workers Training, Primary Care Workers Training and Health Information Technology (IT) Training Programs. These are outlined below. To provide the public health and primary health care services needed by California's children in the most efficient way possible, interested stakeholders could assist communities in leveraging these many funding opportunities for obtaining the workforce needed for the school based health care of the future.

- **Workforce Planning Grant** – The deliverables of a $150,000 planning grant to California's Department of Employment Development will lead to a California plan that expands the primary care full-time equivalent health care workforce by 10 to 25 percent over 10 years.[xxvi]

  It will be important that the efforts associated with this grant and the new work of the Health Workforce Development Council have information on the ability of the school based health centers' to meet the needs of California's school aged children so that the centers are included in plans for workforce development.

- **Public Health Training Centers** – Three California universities collectively received nearly two million dollars as part of the Public Health Training Centers Program (PHTC), administered by HRSA's Bureau of Health Professions, to help improve the public health system by enhancing skills of the current and future public health workforce. These organizations (1) plan, develop, operate and evaluate projects that support goals in preventive medicine, health promotion and disease prevention; or (2) improve access to and quality of health services in medically underserved communities.

  As California seeks to rebuild its public health infrastructure it is important that these training centers help to coordinate all the local actors relating to community health efforts including schools. Such efforts need to recognize that many California schools are providing health and dental care, food, physical education, health education, and safety programs to the state's children, youth and families. All are vital components to healthy communities.

- **Primary Care Workers Training Programs** – As of November, 2010, California had received over $27 million in federal grants for primary care workforce training.[xxvii] Additional funding for other health professions' career ladders and training programs – including oral health, nurse practitioners, and professionals serving in rural and underserved areas – and may be available in coming years.

  Advocates of school health centers recognize that greater participation in training programs could be beneficial to the centers but few schools have the staff time required to make affiliations with training programs.[xxviii] While medical students and some residents rotate through some school based health centers in California, few centers participate in nurse practitioner training programs. Affiliations could mean that all types of workers that school clinics use could train in clinics. Current clinic staff could also upgrade their skills in these programs and graduates from local training programs could be recruited by the clinics.

- **Health Information Technology Personnel for School Based Health** – With improved technology and the reduction in equipment and transmission costs, public health and primary care providers have been extending their reach beyond traditional practice locations. These developments have opened up greater opportunities to meet the needs of school-aged children more efficiently. In California, the expansion of the California Telehealth Network and Department of Education efforts to link schools to community resources have put in place systems available for use in school health programs.

  Such systems enable schools to increase training and service delivery opportunities with distant sites. Health care providers at schools can receive training at a distance and can also obtain supervision and consultation from afar. When the goal is to keep children in school, the ability to bring resources to the student is extremely desirable.

  California has received significant funding from the federal government through the Health Information Technology for Economic and Clinical Health (HITECH) sections of the American Recovery and Reinvestment Act (ARRA) of 2009 to train health information technology workers. Schools would be wise to participate in these programs as training sites and/or obtain training for employees to enable the school to utilize the capabilities of health IT to benefit students and their families. As vital players in pediatric and adolescent health care, schools need to be included in state efforts in Health Information Exchange, electronic emergency response networks, meaningful use of electronic medical records, telehealth networks and health education learning networks.

What is Necessary to Set A Statewide Strategy for A School Based Health Workforce to Improve Children and Adolescents' Health in California?

California's largest obstacles to expanding the workforce for school based health clinics have been limited funding and insufficient numbers of appropriately trained personnel. With the new federal funds in public health, community based primary care, health information technology and children's health insurance, the time may be right for school based health clinics to scale up to meet the unmet needs of children, youth and families. Key elements needed in order to scale up are presented below.

Need for More Descriptive Data on California SBHCs – California must first understand who is being served in SBHCs and what services are being provided. Officials point out that California does not have an accurate count of the number of students served by school based health

services and how many students are under the clinics' care compared to how many receive intermittent services. Such descriptive statistics are necessary to support planning efforts for future workforce needs.

Research Effectiveness of SBHC Models – Research is needed on what is known about the organizational models for school based health and their comparative effectiveness. More research on existing SBHC models and their outcomes relative to student health and performance is necessary. This is a complicated issue because currently school based health clinics are seen as filling in gaps in health care services for school aged children and adolescents. SBHC resources often follow the greatest medical need and education and prevention services are underemphasized. School centers can serve as key access points for children and adolescents to a continuum of services based on the scale of the school population underserved by community medical resources. All school sites could do more to emphasize health education, prevention and screening services. Understanding the different organizational models in use in the state and their effects on students will be important to forecasting future workforce needs.

Coordinated Planning at the Local, District and State Levels - Communities need planning support to formulate priorities in the area of child and adolescent health utilizing some of the most successful planning models from the Healthy Start Programs. Communities need tools and support in assessing local needs and available resources (in personnel and technology) to formulate the most effective and efficient combination of services to offer on-site at schools. They will also need support on how to coordinate funding streams if a dedicated funding source is not identified or created.

State and district coordinators could affiliate with training programs to formalize training tracks for school based health clinic providers. In addition, state Department of Education and School District leaders could coordinate program oversight with the Departments of Health and Mental Health to insure that local coordination of the most appropriate approaches for children and youth in schools will be supported at the highest levels.

High level coordination bodies could be encouraged to undertake a review of department and district laws, regulations and policies that impede students from getting the best health education and health services possible to support their learning.

Research on the Recruitment and Retention of SBHC Personnel in California – Building on the work done by other states including Colorado, California would benefit from identifying the key elements used to build successful staff at school based health clinics in California.

Assess Need for Specialized Curriculum for SBHC – Currently, most training for school based health center positions is received on the job unless personnel received their training in the few SBHCs that participate in training programs. Policy makers' decisions would be well-informed by an assessment of whether specialized training curriculum needs to be developed for clinicians based on evidence-based research on health and academic outcomes.

Coordinate Youth Development Efforts - Youth development programs could be coordinated with SBHC training programs. Youth from communities where more clinics are needed could be encouraged to enter professions needed to improve the learning readiness of students in their communities.

All Efforts Would Benefit from Appropriate Information Technologies - The efforts discussed above could incorporate available technologies such as electronic health records and telehealth where efficient to do so. Training programs could prepare personnel to operate such systems.

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Authors: Bonnie Preston, MSPH and Catherine Dower, JD

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Center for the Health Professions
University of California, San Francisco
3333 California Street, Suite 410
San Francisco, CA 94118
(415) 476-8181
http://futurehealth.ucsf.edu

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