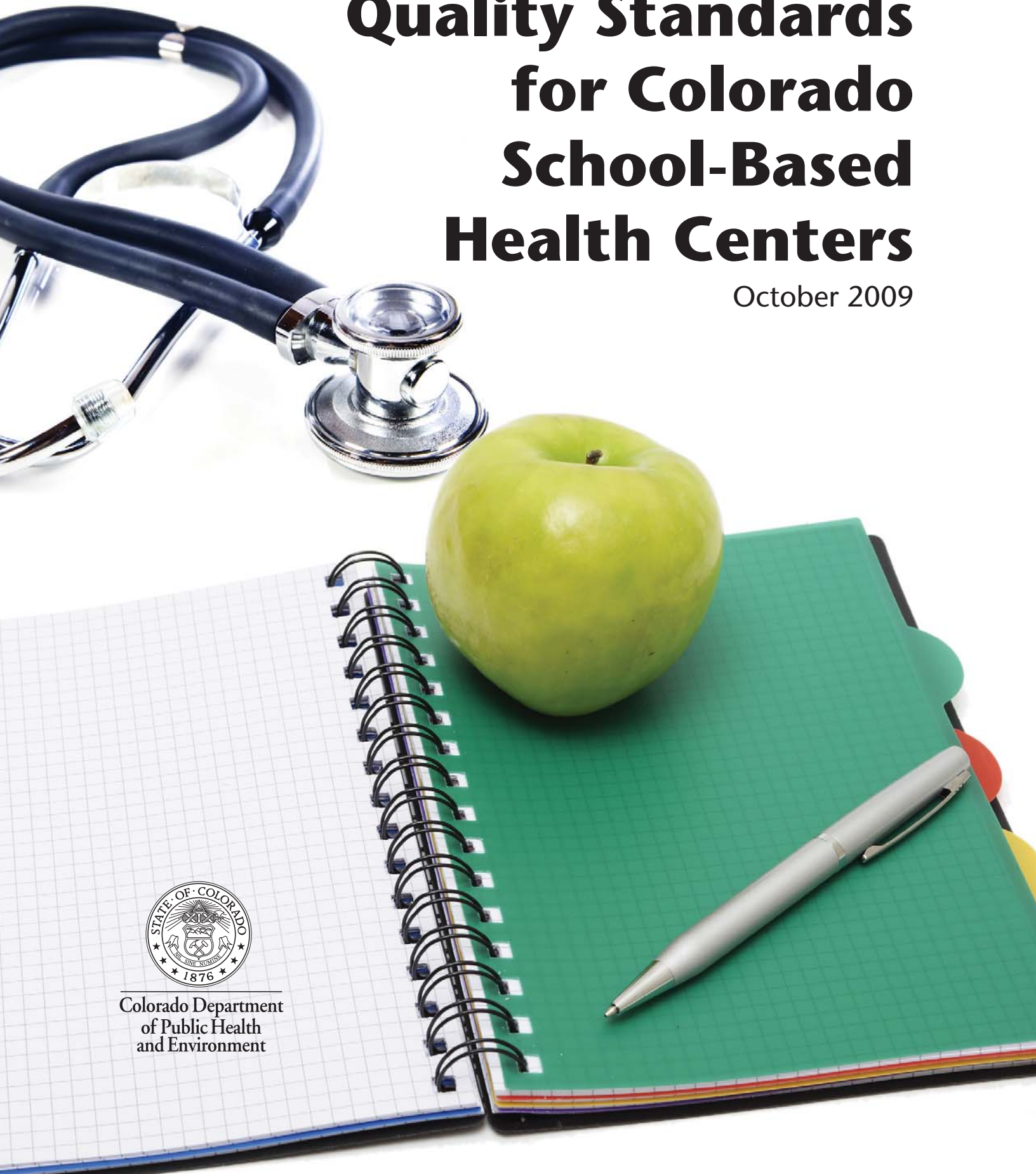
Quality Standards for Colorado School-Based Health Centers

October 2009



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Colorado Department
of Public Health
and Environment

October 2009

Dear Supporters of School-Based Health Care:

On behalf of the Colorado Department of Public Health and Environment, I am pleased to write this letter expressing my support for the *Quality Standards for Colorado School-Based Health Centers.* The *Standards* represent the effort of the key constituents who formed the School-Based Health Center Standards Leadership Commission and the Standards Workgroup to ensure the quality and sustainability of these programs.

For more than 20 years, the Colorado Department of Public Health and Environment has demonstrated its commitment to school-based health centers as a model for providing access to basic preventive and primary physical, behavioral and oral health services to children and youth in public schools who might not otherwise receive health care. Beginning in 2006, the Colorado General Assembly established a new school-based health center program in statute appropriating funding to support their implementation within the school setting.

In April 2009, the department convened a Leadership Commission of key stakeholders to oversee development of quality standards for school-based health centers. A workgroup of experts in the field of school-based health care were appointed to develop the attached *Quality Standards for Colorado School-Based Health Centers.* These standards are intended to define expectations for the delivery of services in school-based health centers, to provide benchmarks for improving quality, and to ensure continued growth of these programs as a vibrant, creative approach to delivering health care to students in public schools.

The development of these quality standards was completed in close collaboration with the Colorado Department of Health Care Policy and Financing, the Colorado Department of Education and numerous private partners. We are grateful for the contributions of these organizations and individuals that participated in the Leadership Commission and Standards Workgroup.

Sincerely,

Ned Calonge, M.D., M.P.H.
Chief Medical Officer

Table of Contents

Quality Standards

Table of Contents *(continued)*

Quality Standards

A. Executive Summary

In April 2009, the Colorado Department of Public Health and Environment convened a Leadership Commission comprising key constituents to oversee development of quality standards for school-based health centers. The commission identified several goals for the standards, which highlighted their desire to advance the quality of school-based health centers and to ensure sustainable mechanisms for financing them.

The commission sanctioned a Standards Workgroup to ensure stakeholder involvement and assist in drafting and vetting the standards. This group dedicated many hours within a short time frame to achieve a product that urges school-based health centers to "aim high" as they strive for quality improvement and closer alignment with the health care mainstream.

A six-month process of writing and vetting the standards resulted in this current version. In September 2009, the Leadership Commission approved the *Quality Standards for Colorado School-Based Health Centers*, along with a plan for implementing and evaluating them.

B. Introduction

1. Process for Developing the Standards

Responsibilities of the state of Colorado include crafting policy to maximize the use of state resources for improving child and adolescent health. Experience shows that a collaborative approach to policy development yields the best results.

As the lead public health agency, the Colorado Department of Public Health and Environment convened a Leadership Commission in April 2009 to oversee development of standards for school-based health centers, and to ensure the solicitation and incorporation of broad stakeholder input into the process. Commission members included providers, payers, advocates, provider associations, foundations, higher education and state government. A sponsor and advocate for school-based health services chaired the Commission. (See ***Appendix 1: List of Contributors*** on page 20.)

The Leadership Commission sanctioned formation of a Standards Workgroup to involve local school-based health center providers and others with needed expertise in writing and vetting the standards. Included were representatives of local program sponsors, health care providers and associations, advocacy groups, foundations, higher education and government agencies. This group worked long hours to achieve a product that urges school-based health centers to "aim high" as they strive for quality improvement and closer alignment with the health care mainstream. (See ***Appendix 1: List of Contributors*** on page 20.)

2. Intended Purposes for the Quality Standards

The Leadership Commission identified several purposes and applications for the standards:

- To define school-based health centers as a unique provider and service delivery system
- To provide benchmarks for existing school-based health centers to advance the quality and comprehensiveness of their programs
- To guide interested communities in planning new centers
- To determine school-based health center eligibility for state-directed funding
- To qualify school-based health centers for optimal reimbursement from Medicaid, the Child Health Plan Plus (CHP+) and other third-party payers
- To inform private foundations developing school-based health center initiatives about state funding priorities

3. Background

This document defines the elements of a quality school-based health center. Those who participated in its development value the approach of locating the delivery of health care to children and adolescents in schools, and intend for these quality standards to foster a healthy, sustainable future for this approach.

From the perspective of their increasing numbers, the future of school-based health centers in Colorado looks promising. Between 1993 and 2008, the number of school-based health centers swelled from fewer than 10 sites to 45. In school year 2007–08, the centers provided preventive and primary, physical, behavioral, and oral health care to 26,650 students, generating more than 80,000 clinical visits.[i]

While a multitude of organizations and individuals played a part in the successful growth of school-based health centers, the contributions of three have been pivotal.

In 1993, after several years of funding a few school-based health center sites, the Colorado Department of Public Health and Environment launched the first statewide initiative with funds from a national foundation. The department now manages the School-Based Health Center Program, defined in a 2006 statute, which provides partial funding support to most of the state's school-based health centers and contributes policy, technical assistance and evaluation resources.

In 1996, school-based health center providers founded the Colorado Association for School-Based Health Care. Currently undergoing expansion, the organization serves as an important resource for its members, with benefits that include advocacy, continuing education and technical assistance.

Many Colorado-based foundations have supported school-based health centers over the years. Most recently, in 2007, The Colorado Trust announced $1 million for school-based health center support, and in 2009, the Colorado Health Foundation announced a four-year, $10.8 million initiative.

4. Accountability and Sustainability

Two interrelated concerns germinated the standards: accountability and financing. The commission hopes that the standards establish benchmarks for accountability, thereby paving the way for more and sustainable funding for school-based health centers.

An expression about school-based health centers contends: "If you've seen one school-based health center, you've seen one school-based health center." This statement captures the flexibility of the school-based health center model, which can be adapted to meet the varying needs of diverse communities. However, with increased investment in school-based health centers, policymakers and payers look for consistent quality and adoption of practices known to improve student health status.

Threats to their traditional revenue streams loom as an important consideration. As with all state-funded programs, school-based health centers face the constraints of Colorado's state budget. Over time, private foundations may shift to other investments. Continuing economic challenges may force local partners to reduce their in-kind support.

Successful pursuit of third-party reimbursement forms the missing piece of a diversified, long-term financing plan. The potential exists for school-based health centers to improve third-party revenues through supportive state policy, enhanced billing systems and enrolling more eligible students in Medicaid and Child Health Plan Plus (CHP+).

Lessons learned in other states could provide a starting point for Colorado's public health and Medicaid officials to explore policy solutions. In 2001, the National Assembly on School-Based Health Care examined state Medicaid policies that may contribute to the difficulties school-based health centers experience in capturing Medicaid revenues, and identified successful efforts by several states to ameliorate these difficulties.[ii] The study cited the development of a partnership between the state public health department and the state Medicaid agency as the foundation of the successes experienced in each of these states.

Leaders at the Colorado Department of Public Health and Environment and the Colorado Department of Health Care Policy and Financing have made a commitment to explore mechanisms that support quality improvements and good health outcomes achieved through school-based health centers. Program-level staff in both agencies were assigned to review the issue and propose recommendations, work that will continue during implementation and evaluation of the standards.

5. Implementation and Evaluation

In September 2009, the Leadership Commission approved the *Quality Standards for Colorado School-Based Health Centers*. For the standards to fulfill their intended purposes, the commission realized that implementation of the standards would require a process for changing the standards to keep pace with evolving local school and community needs, and advancements in health care as a whole. To facilitate this, the commission approved a plan for implementation and evaluation of the standards, designed as a feedback loop to create opportunities for continuous improvement of the standards themselves. In this way, the standards remain a reflection of the best school-based health centers have to offer as a vibrant, creative system for delivering health care

C. Colorado School-Based Health Centers: Program Overview

The Leadership Commission and the Standards Workgroup ratified the vision, mission, intended results, goals and guiding principles for Colorado school-based health centers, outlined below. As they developed the quality standards for school-based health centers, the two groups strived to be true to these principles and statements.

1. Vision

Colorado's youth* will have quality, integrated school health services* to improve health status, optimize academic achievement and enhance well-being.[iii]

2. Mission

The school-based health center mission is to keep youth healthy, in school and ready to learn.[iv]

3. Results

The process and health status results listed below originated from published literature and research.[v]

a. Process results:

1) Increased access to preventive and primary, physical, behavioral and oral health care services*
2) Improved quality of services provided
3) Improved coordination of health care services
4) Improved Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program screening rates
5) Increased enrollment of eligible students in Medicaid and the Child Health Plan Plus (CHP+)

b. Health status results:

1) Reduced health-related absenteeism
2) Reduced tobacco use and exposure to secondhand smoke
3) Reduced use of alcohol and other drugs
4) Improved nutrition and physical activity, and appropriate weight management
5) Decreased unintended pregnancies
6) Improved chronic disease management
7) Improved social, emotional and behavioral well-being
8) Improved oral health status
9) Reduced disparities in quality of health and health care among youth, across racial, ethnic, sexual orientation and socioeconomic groups
10) Reduced emergency room use

4. Goals for Operation[vi]

a. The school-based health center supports the school, building upon mutual respect and collaboration with the school to promote the health and educational success of school-aged youth.

b. The school-based health center responds to the community, developing and operating services that are rooted in continual assessment of local assets and needs.

c. The school-based health center involves students as responsible participants in their health care, encourages an active role for parents/guardians and other family members and provides accessible, confidential, culturally responsive* and developmentally appropriate services.

*Denotes that a definition of a term is included in Section **H. Glossary**, on page 19.*

d. Through an integrated interprofessional team, the school-based health center provides access to high-quality, comprehensive physical, behavioral and oral health services, emphasizing prevention and early intervention.

e. The school-based health center advances wellness/health promotion* activities, utilizing its location to advance effective wellness/health promotion activities with students and community.

f. The school-based health center implements administrative and clinical systems that support effective delivery of health services and pursues process and outcome measures by using performance-improvement practices.

g. The school-based health center provides leadership to increase community knowledge and understanding of youth and to inform and influence community policy and practice related to child and adolescent health.

5. Guiding Principles

a. solicit broad input from community stakeholders in planning and implementation to ensure that services respond to the needs of students;

b. participate in an integrated system for delivering health care to youth through collaborative relationships with key school and community stakeholders;

c. serve as a safety net provider to reduce health disparities by ensuring access to health care for all youth regardless of ability to pay, insurance status or insurance carrier, and physical and behavioral health challenges;

d. serve as the primary care provider, the student's medical home, and/or complement services provided by an outside provider or health plan;

e. provide services in a culturally responsive*, compassionate, youth- and family-centered manner;

f. coordinate services with community-based providers;

g. actively work to link youth and their families to community-based providers to ensure comprehensive and continuous care;

h. align and integrate with the school's health-related efforts and resources: health education, nutrition services, physical education, school nursing, school counseling and psychological services, and efforts to promote faculty wellness and a healthy school environment;

i. work in concert with the school nurse, who serves as the leader of school health services and provides health care services to all students in the school, not replacing the school nurse, but working to integrate the school-based health center and school nursing services;

j. emphasize preventive services, including outreach to all students and population-based wellness and health promotion* activities that encourage healthy behavior;

k. continuously monitor and improve health care services, ensuring consistent delivery of evidence-based practices;

l. develop, improve and maintain administrative processes and systems that keep pace with the changing demands of health care, which may include information technology systems.

*Denotes that a definition of a term is included in Section **H. Glossary**, on page 19.*

D. Core Requirements[vii, viii]

1. Administrative

School-based health centers in Colorado provide:

a. an organizational chart with clear lines of authority and supervision;

b. an administrator responsible for overall program management, quality of care and coordination with school and collaborating partner agency personnel, with program management duties outlined in the position's job description;

c. an identified coordinator for each school-based health center site, with duties outlined in the position's job description (an onsite health care provider may serve as the coordinator; the coordinator also may serve as the administrator in D.1.b, above);

d. written job descriptions for all staff providing care or involved in school-based health center operations;

e. a written policy delineating roles and responsibilities of the school-based health center and the school nurse;

f. a written policy addressing the exchange of information between the school-based health center provider staff and school health staff, in accordance with the Health Insurance Portability and Accountability Act and the Family Education Rights and Privacy Act;

g. periodic performance evaluation of staff;

h. a written process for appropriate credentialing and re-credentialing of all clinical providers, per the National Commission for Quality Assurance Standards and Guidelines (see http://www.ncqa.org/tabid/378/Default.aspx);

i. annual assessment of staff training needs and provision of training for staff, as indicated;

j. a written policy outlining registration procedures that provide for effective collection of demographic, parent/guardian contact, third-party billing and primary care provider* information;

k. a written policy for managing medical and psychiatric emergencies;

l. a written policy regarding school-based health center staff responsibilities in case of a school emergency or disaster.

2. Population to be Served

a. School-based health centers target services to students and other youth* with documented needs, such as low-income status, lack of access to primary care and evidence of poor health status.

b. School-based health centers conduct comprehensive needs assessment of student health before school-based health center implementation and at least every three years thereafter, which includes a description of student demographic makeup; insurance status; perceptions of health needs by students, parents, faculty, community members and provider agencies; an assessment of local resources and barriers to care; and, for existing school-based health centers, a historical analysis of services provided.

3. Staffing

a. At a minimum, the school-based health center staff includes the following positions:

1) onsite support staff
2) onsite primary care provider*
3) onsite behavioral health provider*
4) a designated health care provider* available to clinical staff to discuss clinical issues as needed

Denotes that a definition of a term is included in Section **H. Glossary, on page 19.*

b. School-based health centers are staffed with providers who are trained and experienced in serving youth, and licensed and/or supervised in accordance with discipline-specific requirements published by the Colorado Department of Regulatory Agencies.

c. Clinical providers maintain current skills through ongoing continuing education and professional development, per discipline-specific licensing requirements.

d. School-based health centers ensure that all clinical providers hold current certification in cardiopulmonary resuscitation and training in mandated reporting requirements.

4. Facility

a. Location

The Colorado Revised Statutes define a *"school-based health center"* as *"a clinic established and operated within a public school building, including charter schools and state sanctioned GED programs associated with a school district, or on public school property by the school district."* C.R.S. § 25-20.5-502, (2006).

1) The General Assembly's express intent in supporting school-based health centers was to make health services easily accessible so students are more available for classroom instruction. C.R.S. § 25-20.5-501, (2006).

2) When located within a public school building or on the school campus, school-based health centers occupy a dedicated space used exclusively for the purpose of providing school-based health center services.

3) A school-based health center also may be operated in a facility owned by the school district but not located in a school building. In this circumstance, an applicant for school-based health center funding would need to provide information demonstrating that the off-site location facilitates student access to health care and student availability for classroom instruction. All other standards for school-based health centers apply.

b. Access and program integration:

1) In the locations described above, and in collaboration with staff from the school(s) served, the school-based health center addresses potential barriers to student access, including proximity, safety, transportation and hours.

2) The school-based health center gives consideration to co-locating its personnel with the school health staff, such as the school nurse.

c. Regulations:

1) The facility meets Americans with Disabilities Act requirements for accommodation of individuals with disabilities.

2) The facility meets local building codes (including lights, exit signs, ventilation, etc.); Occupational Safety and Health Administration requirements; and any other local, state or federal requirements for occupancy and use of the space allocated for the school-based health center.

d. Physical space:

1) Although some rooms/areas may serve more than one purpose in delivering school-based health services, the center includes at least the following functional elements:

   a) A designated waiting/reception room

   b) One exam room

   c) One accessible sink with hot and cold water

   d) A counseling room/private area

   e) An accessible toilet facility with a sink with hot and cold water

   f) Office/clerical area

   g) A secure storage area for supplies (e.g. medications, lab supplies)

   h) A designated lab space with clean and dirty areas

   i) A secure and confidential records storage area

*Denotes that a definition of a term is included in Section **H. Glossary**, on page 19.

j) A phone line exclusively dedicated to the center

k) One data connection

2) Walls extend from floor to ceiling, with doors in appropriate locations to facilitate privacy and confidentiality.

3) Each room/area includes adequate lighting.

4) Optimally (but not required), a dedicated entrance permits services before and after school hours.

5) The functional spaces are designed to facilitate privacy; confidentiality; safety; and secure storage of records, supplies and medications.

6) The school's central office intercom system connects to the school-based health center.

7) Available parking (including handicapped) accommodates the youth and families served, as well as school-based health center staff.

e. Equipment and supplies

The school-based health center includes:

1) equipment and supplies necessary to provide all services;

2) equipment checked regularly to ensure good working order, and maintained and calibrated as recommended by the manufacturer;

3) processes for inspecting emergency medical equipment monthly for items that need to be replaced or replenished;

4) an electrical circuit for refrigerator and/or freezer that remains active 24 hours per day, and is compliant with the Vaccines for Children Program for vaccines/medications that must be stored in the refrigerator or freezer;

5) procedures for checking medications and supplies monthly for outdated materials, and for processing them accordingly.

Denotes that a definition of a term is included in Section* ***H. Glossary**, on page 19.*

E. Sponsorship Requirements

The Colorado Revised Statutes include the following language with regard to sponsorship: *"School-based health centers are operated by school districts in cooperation with hospitals, public or private health care organizations, licensed medical providers, public health nurses, community health centers and community mental health centers."* C.R.S. § 25-20.5-502 (2006).

1. Lead Sponsoring Agency

a. More than one agency may sponsor a school-based health center, but only one serves as the lead sponsoring agency.

b. Types of eligible entities include the following:

1) school districts, charter schools, and state sanctioned GED programs
2) local public health agencies
3) community health centers
4) rural health centers
5) hospitals
6) private medical practices
7) nurse practitioner practices
8) university medical centers
9) community mental health centers
10) managed care organizations
11) independent nonprofit medical practices

c. Requirements and responsibilities

The lead sponsoring agency:

1) provides one or more of the following: funding, staffing, medical oversight, and/or medical liability coverage;
2) negotiates and maintains a current agreement between the medical sponsoring agency and the school district, reviewed at least every five years or as changes warrant;
3) maintains current agreements with any other organizations that provide services to youth in the school-based health center;
4) ensures that interagency agreements specify priorities, responsibilities and a process for resolving differences;
5) ensures buy-in and support for the school-based health center by the superintendent and school principal;
6) develops mechanisms for coordination of all school-based health center and school health services;
7) ensures electronic collection and storage of services data.

d. Community advisory council

In collaboration with the local school district, the lead sponsoring agency:

1) establishes or works with an existing community advisory council to assist in planning and implementation, ensuring that the services meet the health needs of the youth to be served;
2) solicits involvement of youth through membership on the advisory council, a youth advisory committee, and/or another formalized mechanism for youth involvement and input;
3) solicits participation from other key community stakeholders including parents/guardian, school administration, school health providers, community health providers and public health organizations, as well as appropriate specialty care providers and insurers;
4) holds a minimum of two community advisory council meetings per year;
5) ensures a role for the community advisory council that includes reviewing and advising on student needs; program planning; implementation and evaluation; and decisions about governance, management, services and funding.

*Denotes that a definition of a term is included in Section **H. Glossary**, on page 19.

2. Lead Medical Sponsoring Agency

a. More than one agency may offer health care services in the school-based health center, but only one may serve as the lead medical sponsoring agency.

b. Types of eligible entities include the following:

1) local public health agencies
2) community health centers
3) rural health centers
4) hospitals
5) private medical practices
6) nurse practitioner practices
7) university medical centers
8) community mental health centers that include primary care practice
9) managed care organizations
10) independent nonprofit medical practices

c. The requirements and responsibilities of the medical sponsor are to:

1) ensure available consultation and oversight for health care services provided in the school-based health center through a designated health care provider;*
2) provide evidence of ongoing involvement of the designated health care provider, as necessary, in clinical policy and procedures development, records review and clinical oversight;
3) provide a primary care provider;*
4) arrange for 24-hour, seven-days-per-week coverage for services needed by users of the school-based health center;
5) provide evidence of adequate medical liability and malpractice coverage;
6) maintain ownership of medical records;
7) maintain a Certificate of Waiver to provide "waived" laboratory tests, per the Clinical Laboratory Improvement Amendments.

Denotes that a definition of a term is included in Section* ***H. Glossary**, on page 19.*

F. Program Operations

1. Eligibility, Enrollment, and Consent

a. The school-based health center develops and maintains a written policy on consent for treatment, within the scope of the law.

b. At a minimum, the school-based health center extends eligibility for all services to all students attending the school that hosts the school-based health center. The school-based health center may choose to extend eligibility to other youth in the community and/or students attending other schools.

c. The school-based health center ensures students' access to services regardless of their race, color, national origin, religion, immigration status, sexual orientation, handicap, gender, or insurance status.

d. In cooperation with the participating school, the school-based health center provides written information about the center to parents/guardians and youth, which includes the scope of services offered, the ability of the center to serve as the youth's primary care provider or to provide services in collaboration with the primary care provider, the staffing pattern and how to access 24-hour, seven-days-per-week health services for school-based health center users during non-school hours and vacation periods.

2. Records and Confidentiality

a. Optimally (but not required), a single, integrated electronic health record facilitates the provision of care for the youth who use the school-based health center.

b. At a minimum, the required health record or records include the following:

1) signed consent form
2) personal information
3) individual and family medical history
4) problem list
5) medication list
6) immunization record
7) screening and diagnostic tests, including laboratory findings
8) health and behavioral health progress notes or encounter forms
9) treatment plan
10) referral system*

c. Requirements regarding records management:

1) Maintain and store records in a manner that restricts access to records to school-based health center staff, in accordance with the Health Insurance Portability and Accountability Act.
2) Keep records separate from any part of student's educational record.
3) Release information only with a signed consent by the parent/guardian, a youth* 18 years of age or older, or a youth receiving services under the minor consent law.

d. Requirements regarding confidentiality and sharing of health information:

1) Inform parents/guardians in advance when school-based health center staff members plan to attend a school meeting on their child's behalf.
2) Communicate among school-based health center providers, regardless of their sponsoring organization, and with school nurses regarding treatment plan without parent/guardian consent.
3) Share immunization information with school personnel, parent/guardian and other health providers without written consent.
4) Obtain signed parent/guardian consent (or student permission, as appropriate) to obtain school health services records or to share school-based health center records

*Denotes that a definition of a term is included in Section **H. Glossary**, on page 19.*

(other than immunizations) with school health staff.

5) Utilize release of information forms specific to behavioral health services.

6) With appropriate signed release of information, communicate with the primary care provider, as indicated, to avoid duplication and to improve coordination of care.

3. Quality Improvement and Program Evaluation

Quality improvement processes and measures for school-based health centers emanate from the outcomes identified in published literature and research, as summarized in section C.3, on page 6.[ix]

a. Continuous quality improvement plan includes:

1) a designated staff member to serve as the quality improvement coordinator;

2) a mechanism for monitoring clinical services and evaluating program goals;

3) at least two clinical or practice management measures per year to be monitored and evaluated for improvement, including one to be selected from 3.b., below;

4) a plan for improvement;

5) a written record of progress toward improving selected measures.

b. The school-based health center selects at least one clinical or practice management measure from the following:

1) percent of school-based health center users with up-to-date immunizations for age, with immunizations documented in the Colorado Immunization Registry

2) percent of school-based health center users who have received a complete well child/ well adolescent exam, per G.1., on page 16.

3) percent of school-based health center users with a body mass index documented in the medical record

4) percent of school-based health center users with a diagnosis of asthma that have a treatment plan visible in the medical record

5) percent of school-based health center users who have been screened for mental health concerns

6) percent of school-based health center users who have been referred to an onsite mental health provider

4. Data Collection and Reporting

a. The school-based health center maintains an electronic data collection system that includes the following minimum data variables:

1) unique patient identifier

2) date of birth

3) gender

4) race

5) ethnicity

6) grade

7) insurance status

8) date of visit

9) location of visit

10) provider type

11) Current Procedural Terminology (CPT) visit code(s)

12) diagnostic code(s) (ICD-9 or ICD-10, and DSM IV)

b. Capacity exists for the school-based health center to report service data twice annually, including a final report within a month after the school year ends.

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5. Financing and Sustainability

a. Prior to implementation, new school-based health centers develop a business plan.

b. After two years of operation, school-based health centers create and periodically update a strategic plan.

c. School-based health centers develop an annual budget that describes all sources and uses of funding, including the estimated value of in-kind support.

d. School-based health centers collect financial data and are capable of reporting revenues and expenses by commonly accepted line item types.

e. Written billing policies for school-based health centers provide

1) processes for recording, charging, billing and collecting for services rendered;

2) sliding fee scale that facilitates care for users of the school-based health center, regardless of ability to pay;

3) assurances that services that are confidential by law are billed for in a manner that does not breach patient confidentiality;

4) outreach and application assistance to families with students eligible for Medicaid and the Child Health Plan Plus (CHP+), directly or through a partner agency.

6. Compliance with Applicable Federal and State Regulations

a. Americans with Disabilities Act of 1990 (referenced in D.4.c on page 9)

b. Clinical Laboratory Improvement Amendments (referenced in G.1.b.4 on page 16)

c. Family Education Rights and Privacy Act, published by the U.S. Department of Education (referenced in D.1.f on page 8)

d. Health Insurance Portability and Accountability Act (referenced in D.1.f on page 8)

e. Occupational Health and Safety Administration (referenced in D.4.c on page 9)

f. Colorado pharmacy licensing and health care provider licensing regulations promulgated by the Colorado Department of Regulatory Agencies (referenced in D.3.b on page 9 and G.5.c on page 18)

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G. Program Core Elements and Levels

The Leadership Commission intended these Quality Standards to support the inventive, flexible approaches that school-based health centers traditionally use to meet school, community and student needs. While they are encouraged to advance, local programs decide whether to progress from Level I to Level II and Level II to Level III. In concert with their constituents, school-based health centers are encouraged to select their site's hours and scope of services based on community needs and to strive for high levels of quality in all areas. (See ***Appendix 2: Scope of Services*** on page 23.)

School health programs unable to provide the "core elements" of school-based health centers, below, may consider approaching funders that are able to support alternative models for delivering school health care.

1. Core Elements Provided by All Programs in Levels I, II and III

a. Provide access to integrated, coordinated care through:

1) scheduled and same-day appointments available to school-based health center users for non-urgent, acute and chronic health problems;
2) 24-hour, seven-days-per-week access to health services for school-based health center users during non-school hours and vacation periods to ensure the continuity of care;
3) care continuation and continuity arrangements for students with ongoing, non-emergent health or behavioral health needs during school vacations;
4) interprofessional care management that includes coordination of care among all health care staff in the school-based health center;
5) outreach activities to enroll students and encourage use of the school-based health center;
6) outreach activities to enroll students in the Child Health Plan Plus or Medicaid;
7) approaches that respond to the cultural and language needs of students served;
8) care coordination, including communication with the youth's primary care provider*;
9) a referral system* for health services not available in the school-based health center.

b. Provide preventive and primary physical health care with an emphasis on prevention of serious health risks and chronic disease, including the following:

1) Annual preventive health exams
   a) history, screening, and physical assessment
   b) anticipatory guidance
   c) screening and administration of immunizations, and utilization of the Colorado Immunization Registry
   d) oral health assessment, including an inspection of the mouth, identification of observable problems, determining the timing of the last oral health visit and appropriate oral health education and referral
2) diagnosis and treatment of acute illness and injury with referral as necessary
3) prescriptions for medications used to treat the conditions commonly encountered in the school-based health center
4) "waiver" laboratory tests onsite, as included in Clinical Laboratory Improvement Amendments (see http://wwwn.cdc.gov/clia/regs/toc.aspx)

Denotes that a definition of a term is included in Section **H. Glossary, on page 19.*

c. Provide behavioral health services* including:

1) mental health assessment and treatment onsite;

2) substance abuse assessment onsite or through a referral system* established through a written agreement with an outside provider that defines the services and a process for sharing information between the provider and the school-based health center.

2. Requirements for Level I Programs

a. Level I programs meet or exceed all the Core Elements in section G.1, on page 16.

b. Level I programs offer onsite services a minimum of 15 hours per week, at least three days each week while school is in session, with the following staffing:

1) support staff onsite at least 15 hours per week

2) primary care provider* accessible onsite at least 15 hours per week, at least three days per week

3) behavioral health services* provider accessible onsite at least 10 hours per week, at least two days per week

3. Requirements for Level II Programs

a. Level II programs meet or exceed all the Core Elements in section G.1, on page 16.

b. Level II programs offer onsite services a minimum of 20 hours per week, three days each week while school is in session, with the following staffing:

1) support staff onsite at least 20 hours per week

2) primary care provider* accessible onsite at least 20 hours per week, at least three days per week

3) behavioral health services* provider accessible onsite at least 10 hours per week, at least two days per week

c. In addition, Level II programs plan and implement prevention services through:

1) population-based assessments that include input and involvement of youth and result in implementation of wellness/health promotion* services for students attending the target schools;

2) individual and small group education (for example, weight management, asthma management or tobacco cessation);

3) schoolwide wellness/health promotion activities;

4) classroom-based health education.

4. Requirements for Level III Programs

a. Level III programs meet or exceed all the Core Elements in section G.1, on page 16.

b. Level III programs offer services a minimum of 30 hours per week, five days each week while school is in session, with the following staffing:

1) support staff onsite at least 30 hours per week

2) primary care provider* accessible onsite at least 30 hours per week, five days per week

3) behavioral health services* provider accessible onsite at least 20 hours per week, at least three days per week

c. Level III programs plan and implement prevention services through:

1) population-based assessments that include input and involvement of youth and result in implementation of wellness/health promotion* services for students attending the target schools;

2) individual and small group education (for example, weight management, asthma management or tobacco cessation);

Denotes that a definition of a term is included in Section **H. Glossary, on page 19.*

3) schoolwide wellness/health promotion activities;

4) classroom-based health education.

d. In addition, Level III programs offer some service hours during periods when school is not in session to address the ongoing health needs of students.

5. Optional Services for Levels I, II and III

School-based health centers at all levels may offer the following:

a. expanded, preventive oral health care services, such as sealants, fluoride treatment and restorative care

b. onsite substance abuse treatment services

c. onsite pharmacy services appropriate to the conditions common to the population served, in compliance with the Colorado Department of Regulatory Agencies

d. psychiatric consultation

e. telemedicine, telepsychiatry

f. reproductive health care services

Denotes that a definition of a term is included in Section **H. Glossary, on page 19.*

H. Glossary

Behavioral health services/care—
The provision of outpatient services for the prevention, assessment, early intervention and treatment of mental health and substance abuse challenges, as well as the behavioral aspect of medical conditions by a trained, qualified behavioral health care professional.

Culturally responsive—
The ability to learn from and relate respectfully to people from one's own and other cultures, moving health care toward equity in the delivery of services and the achievement of outcomes. Entails active involvement in developing cultural self-awareness; discovering the primary cultural roles of students based upon differences in ethnicity, language, nationality or religion; building on students' cultural strengths; and incorporating cultural understanding into health care interventions.

Designated Health Care Provider—
A designated health care provider has obtained a license to practice independently with the population being served and prescriptive authority (e.g., a physician, a doctor of osteopathy or a nurse practitioner).

Integrated School Health Services—
A community-based collaborative approach to identifying the needs of youth, defined and agreed-upon goals and outcomes, identifying resources in the educational, health care, and social services sectors, and linking them for delivery in the school setting.

Oral Health Services/Care—
Oral health includes an accessible and affordable source of care. For school-based health center programs unable to perform as an oral health home, oral health services may include preventive modalities (fluoride and dental sealants), oral health screening and assessment and local referral systems when necessary for treatment.

Primary Care Provider—
Defined as a physician, a doctor of osteopathy, a nurse practitioner or a physician assistant with prescriptive authority and eligible for reimbursement from Medicaid and the Child Health Plan Plus, through independent practice or supervision by a physician.

Referral System—
A process of sending or directing clients to an identified provider for a particular service, made available to users of the school-based health center through a contract or agreement with that service provider, and operationalized by the school-based health center through protocol or policy.

Wellness/Health Promotion—
The science and art of guiding people in changing their lifestyle toward a state of optimal health, defined as a balance of physical, emotional, social, spiritual and intellectual health.

Youth—
A person or people with the condition or quality of being young; ages 0–21, in conformity with the definition used by the public education system.

I. Appendices

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Appendix 2: Scope of Services for Colorado School-Based Health Centers

KEY:
Required to be provided onsite = **Onsite all, Onsite Level II and III, or Onsite Level III**
Direct referral required with follow-up if not provided onsite = **Onsite or Referral**
Services optional either onsite or by referral but not required = **Optional**

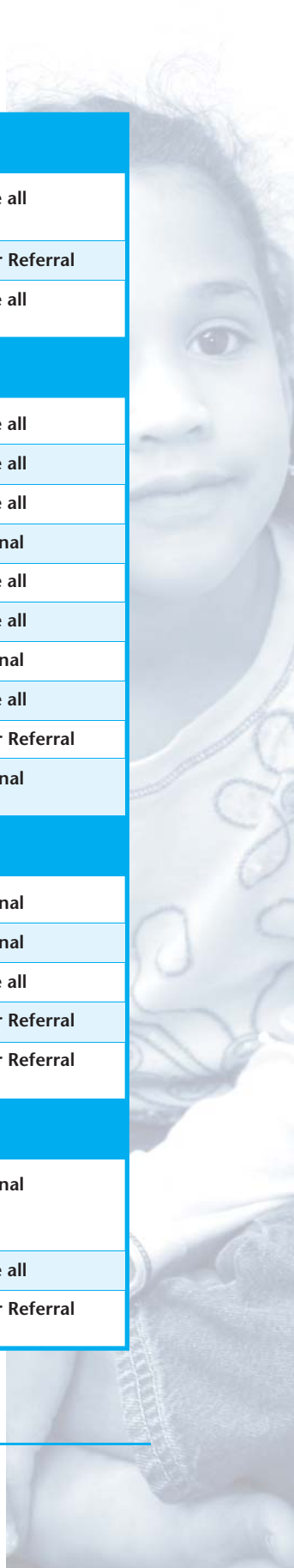
MEDICAL SERVICES	
Comprehensive health assessments/well child-adolescent exams (per EPSDT): Medical/oral health/psychosocial history; nutritional assessment; developmental/behavioral assessment; review of systems; physical exam, including height, weight, and body mass index (BMI); vision screening; age appropriate anticipatory guidance/health education	**Onsite all**
Sports Physicals	**Onsite all**
Standardized, age appropriate risk assessments (Guidelines for Adolescent Preventive Services (GAPS), those recommended by Bright Futures, and/or other nationally recognized tools)	**Onsite all**
Immunizations and use of CO Immunization Registry	**Onsite all**
Triage of medical emergencies	**Onsite all**
Initial management of emergencies (emergency kit)—Basic Life Support (BLS) certified provider onsite	**Onsite all**
Diagnosis (evaluation)/treatment of: • non-urgent problems • acute illness/problems • minor injuries • chronic problems	**Onsite all**
Medical case management of chronic conditions in conjunction with the specialist and/or primary care physician (PCP)	**Onsite all**
Well-child care of students' children and/or siblings	**Optional**
Referral and coordination of outside services, including offsite laboratory, X-rays and other services not available at the SBHC	**Onsite all or Referral**
Referral to medical specialty services and follow-up	**Onsite all or Referral**
Telemedicine (enables SBHC practitioners to consult with off-site medical specialists via closed-circuit television or phone)	**Optional**
Care coordination between SBHC staff, including communication with primary care provider (PCP)	**Onsite all**
Arrange 24 hour per day/7 day a week coverage (coverage does not necessarily have to be provided entirely by SBHC providers)	**Onsite all**
Physical/sexual abuse identification (ID) and reporting	**Onsite all**
Consultation/coordination with school staff, parent/guardian, teachers and students	**Onsite all**

KEY:
Required to be provided onsite = **Onsite all, Onsite Level II and III, or Onsite Level III**
Direct referral required with follow-up if not provided onsite = **Onsite or Referral**
Services optional either onsite or by referral but not required = **Optional**

REPRODUCTIVE HEALTH SERVICES	
Reproductive health exam, if indicated	**Onsite all or Referral**
Reproductive health education	**Onsite all**
Family planning services, including prescription or dispensing of contraceptives, condom availability/distribution	**Onsite all or Referral**
Pregnancy counseling/options	**Onsite all or Referral**
STI testing, diagnosis and treatment	**Onsite all or Referral**
HIV testing and counseling	**Onsite all or Referral**
HIV/AIDS treatment	**Onsite all or Referral**
Prenatal care	**Onsite all or Referral**
HEALTH EDUCATION	
Individual and small group targeted education (e.g., weight management, nutrition education and counseling, asthma management, smoking cessation, etc.)	**Onsite Level II, III Optional Level I**
School-wide wellness, health promotion services based on population-based assessments	**Onsite Level II, III Optional Level I**
Family and community health education	**Optional**
Classroom-based health education	**Optional**
Resource support for comprehensive health education	**Onsite all**
ORAL HEALTH/DENTAL SERVICES	
Oral health assessment: visual inspection of teeth and gums, identification of observable problems, dental health education/oral hygiene instructions, referral as indicated	**Onsite all**
Preventive oral health: Teeth cleaning, dental sealants, fluoride treatment, prescription for fluoride supplements	**Onsite all or Referral**
Oral health restorative care	**Onsite all or Referral**
PHARMACY	
Capacity to write prescriptions for: non-urgent problems, acute illness and injury, and chronic problems	**Onsite all**
Administer over-the-counter (OTC) medications	**Onsite all**
Administer prescription medications	**Optional**
Dispense medications	**Optional**

KEY:
Required to be provided onsite = **Onsite all, Onsite Level II and III, or Onsite Level III**
Direct referral required with follow-up if not provided onsite = **Onsite or Referral**
Services optional either onsite or by referral but not required = **Optional**

LABORATORY	
CLIA waived Laboratory testing, including rapid strep, Hgb/HCT, urine dipstick/reagent, glucose, pregnancy testing	**Onsite all**
Provider Performed Microscopy Procedures (PPMP)	**Onsite all or Referral**
Specimen collection and mechanism to transport to CLIA lab	**Onsite all**
MENTAL HEALTH SERVICES	
Mental health screening (for depression, anxiety, mood disorder, etc.)	**Onsite all**
Comprehensive assessment	**Onsite all**
Individual, family, and group counseling; case management; crisis intervention	**Onsite all**
Classroom-based suicide prevention education	**Optional**
Physical/sexual abuse ID and reporting	**Onsite all**
Consultation/coordination with school staff, parent/guardian, teachers and students	**Onsite all**
Psychiatric consultation (provider to provider)	**Optional**
Coordinate community behavioral health referral	**Onsite all**
Psychiatric evaluation and treatment of student	**Onsite all or Referral**
Telepsychiatry	**Optional**
SUBSTANCE ABUSE SERVICES	
Substance abuse prevention	**Optional**
Violence prevention (conflict resolution, anger management)	**Optional**
Substance abuse screening	**Onsite all**
Substance abuse assessment	**Onsite all or Referral**
Substance abuse counseling/treatment services	**Onsite all or Referral**
SOCIAL SERVICES	
Social service assessment, referral, and follow-up for needs such as basic needs, legal services, public assistance, child-care services, case management and transportation arrangements	**Optional**
Medicaid/CHP+ outreach and application assistance	**Onsite all**
Medicaid/CHP+ enrollment	**Onsite all or Referral**



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