

**City of Seattle
School-Based Health Center Project**

February 2004

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Executive Summary

Seattle was one of the first communities in the country to develop school-based health centers to serve its adolescent population. The centers have been providing primary and preventive care services to teens in a safe, accessible, teen-friendly setting for the past fifteen years. The clinics were developed through a partnership of the City of Seattle, Public Health – Seattle & King County, Seattle Public Schools, and a number of community health care organizations. Over the years, the centers have become highly regarded by principals, teachers, students, and parents as valued resources to address teen health problems and help students overcome some of their barriers to learning. The program is also recognized as a unique resource that teaches students about prevention and positive health behaviors.

While the clinics have been successful, there are a number of changes that could strengthen the overall program. It is critical that the program develop other revenue sources, in addition to its primary funding source – the City of Seattle. All of the clinics need to introduce billing so that they can generate patient revenues from third party payers and publicly funded programs. The program also needs to introduce more effective business practices at the clinics and increase operational efficiencies. There is wide variation from clinic to clinic in the number of students served, visits per day, billing, documentation, and patient flow.

The program should reduce the number of sponsoring organizations to reduce administrative duplication and create more economies of scale. The program also needs to continue to promote integration with Seattle Public Schools' health resources to maximize care coordination and to minimize duplication of services. Finally, the program needs strong leadership to help articulate a vision for the future, implement change, and build a stronger, more diversified financial and political base of support.

Seattle's Teen Health and Wellness Centers should be a high priority for the next Families & Education Levy. Levy funding provides a critical core financing mechanism for a unique and valuable program. At the same time, the program's management, school administrators, and clinic sponsors must work together to make operational changes that will help make the program more efficient, effective, and sustainable. While there are economic pressures on the program, it is not in a state of crisis; and now is an opportune time for the partners to make a good program even better and to help secure its future.

Project - Objectives

In June 2003, the City of Seattle's Office of Policy & Management hired a team of consultants from Washington Park Consulting to conduct an in-depth study of the City-funded Teen Health and Wellness Centers. The City initiated the project in preparation for planning the renewal of the Families & Education Levy, which expires in 2004 and which is the principal funding source for the centers. The purpose of the study was to review the funding and operations of the Seattle school-based health centers, and to develop strategies that would strengthen the program and make it more sustainable in the future.

The City asked the consultants to -

- identify and evaluate alternative funding and delivery models for the centers;
- recommend organizational and operational changes that could improve the program's performance, and
- recommend an approach to on-going program evaluation and improvement.

Project - Process

The consultants began working on the project in June 2003, under the guidance of a sponsor group that included: Jen Chan, Office of Policy & Management, City of Seattle; Cheryl Swab, Department of Finance, City of Seattle; Rebecca Salinas and Sid Sidorowicz, Office of Education, City of Seattle, Dorothy Teeter, Public Health – Seattle/King County, and Lin Carlson, Seattle Public Schools. The consultants conducted initial meetings and interviews with key administrators and leaders in the program. They also made site visits to most of the clinics in the system. They reviewed program service, staffing, and financial information and evaluation reports. They also conducted a literature search and discussed financial and operational issues with national leaders, programs in other parts of the country, and State Medicaid officials.

The consultants issued preliminary findings in July and August, and developed pilot projects at Sealth and Franklin high schools and Denny Middle School to test the effectiveness of new documentation and billing practices. The consultants conducted additional on-site reviews of operating procedures and patient activity at the pilot sites, and reviewed billing information from September to November of 2003. During the fall, the consultants met frequently with Public Health staff to discuss operational improvements and on-going data needs. They also met with key sponsors and School District officials to talk about their findings and offer suggestions for improving the program. The results of their work over the past six months are presented in the following findings and recommendations.

Overall Assessment

Teen Health and Wellness Centers are an important part of Seattle's health care system, and provide needed medical and mental health services to one of the community's most under served populations – adolescents. School-based health centers are designed to provide preventive and primary physical and mental health services to teens in an accessible, safe environment. Many of the students who use the service have limited access to the mainstream medical system.

Teen health problems are often behavioral - unwanted pregnancy, sexually transmitted diseases, substance abuse, eating disorders, obesity, depression, and suicide. The school-based health centers emphasize prevention, wellness, and early intervention and are uniquely positioned and staffed to address behavioral and other health problems. They teach students about self-care and how to access additional community resources; and by providing services on site, the clinics help reduce the time that students are away from school.

Over the past decade, there has been a dramatic growth in the number of school-based health centers around the country - from 200 in 1990 to nearly 1500 today in 43 different states. School-based health centers have demonstrated that they are an effective strategy to improve access to health care services. They also increase teens' health knowledge, and help students stay in school by addressing health barriers to learning. School-based health centers have wide professional support from the American Medical Association, the American Academy of Pediatrics, the Society for Adolescent Medicine, and a number of other educational, medical, and public health organizations.

Seattle's program is one of the older, successful school-based health programs in the country. The program is managed by Public Health – Seattle-King County, which also operates three of the centers. The other centers are operated by six prominent community health organizations - Children's Hospital/Odessa Brown Clinic, Group Health Cooperative, Harborview Medical Center, Puget Sound Neighborhood Health Centers, Swedish Medical Center, and the University of Washington.

The centers at 10 comprehensive high schools and 4 middle schools are open to all students, and provide general acute care, preventive health, reproductive health and mental health counseling services. The program offers services to nearly 16,000 adolescents in schools throughout the City. It serves 4,500 individual students, provides more than 21,000 office visits a year, and provides numerous other informal educational, counseling, and mentoring services to the wider school community.

All the centers are staffed with a core team of a nurse practitioner, a mental health counselor, and a coordinator/receptionist. The teams provide primary medical care, mental health and drug and alcohol assessment and referral, counseling, prevention, education, and case management. They also work with school nurses, school psychologists, and drug and alcohol interventionists, and with other community social and health resources. In some schools, sponsoring organizations have augmented the core staff with part-time physicians, psychiatrists, physician assistants, and health educators.

One of the critical ingredients of the program's success has been the partnership model that has been developed between the City, Public Health, Seattle Public Schools, and the community health care organizations. Each party has made important contributions to the program. The City has provided a stable funding base through Seattle general funds and special tax levies - the Families & Education levies of 1990 and 1997, and the Children and Youth Action Plan in 1992. Public Health has provided program coordination, direct services, public health expertise, and technical assistance to the clinics. The Seattle Public Schools have housed the centers and have worked to connect students and staff with these additional health resources. The health care sponsors have operated the clinics, providing health care services, health education, personnel, and administration. The sponsors have also financially supported the program through in-kind services, 17% of total expenses, and by absorbing operating losses when their costs have exceeded their revenues.

Planning for the renewal of the Families & Education Levy has raised questions about student needs and the program's outcomes. In a formal evaluation of the program by the Epidemiology, Planning and Evaluation Unit at Public Health in December 2002, 546 school employees, i.e. teachers, administrators, and support staff, at 12 schools responded to a questionnaire about the program. 99% of the staff respondents said that students' general health problems affected their school performance, and 86% of the staff said that the school-based health centers had a great deal or somewhat of an impact on improving school performance. 94% of the staff said that the SBHCs had a great deal or somewhat of an influence in improving students' health and 92% said that the SBHCs had an influence on improving self-esteem or mental health. In a survey of 2,248 student users, 87% said that they know how to take better care of their health as a result of contact with the SBHC staff, and 78% said their health has improved as a result of having a center at their school.

The consulting team consistently heard from school officials and health professionals that students' health problems, especially mental health issues, exceed available resources. They also spoke very positively about the value of having teen health centers available to students at the school facilities. In other formal evaluations by Public Health and the Teen Health Survey, the Seattle school-based health center program has consistently received very positive feedback from students, parents, and school staff.

Unfortunately, there is little health outcome data that specifically shows the impact of the clinics. However, it is interesting to note that the City of Seattle has experienced a dramatic decline (65%) in teen births over the past decade in which teen health centers have been operating. Seattle's improvement has exceeded reductions in teen births in the rest of King County and in Washington State. Also, there is evidence in the national health research literature that school-based health centers have a positive impact on students' health status, absenteeism, health knowledge, and appropriate use of health resources.

Opportunities for Improvement

Although Seattle's school-based health program is providing significant value to the community, there are opportunities to strengthen the program and make it more sustainable in the future. There are five vital issues that must be addressed to secure the success of the program's future: funding, business practices, sponsorship, clinic-school integration, and leadership.

Funding - One of the most critical issues is the program's high dependence on City and levy funding. Given continuing budget pressures at the City and greater competition for levy funds, there is considerable risk that the program could lose some of its funding base or not receive sufficient funds to cover rising costs. Broadening the program's funding support would be a sensible strategy under most circumstances, but is especially important in the current economic environment.

While there are no easy solutions to the financial challenges facing the program, the consultants believe that there are good opportunities to diversify funding, especially by collecting additional patient revenues. Currently, only 6% of the program's revenues come from billing for services, even though a number of students have third party insurance and some of the services are reimbursable. Patient revenues will not provide a financial windfall to the program, but they can complement other funding sources.

Business Practices - Another important need is to strengthen the business practices of the centers and operate the program more efficiently. There is considerable variation among the clinics in billing practices, documentation of services, procedures to identify students with insurance, staff deployment, patient flow, and integration into the school. While some variation is unavoidable and may even be appropriate, it can also be costly and lead to inconsistent outcomes. The program also funds a core staffing pattern at all Teen Health Centers and a modified version at all Wellness Centers. However, there is significant variation in the number of students at each school, clinic users, visits, and staff productivity. The mismatch of staffing to student use of services contributes to further inefficiencies in the program.

The program needs to establish clearer performance expectations, better evaluation and improvement processes, and greater technical assistance with administrative matters such as billing and documentation. The program's administrators also need to establish productivity goals, work with the clinics to reach targets, and adjust staffing where necessary. Over the past year, Public Health and the sponsors have been working to document services, create standards for medical and mental health practice, and encourage adopting best practices. The consultants support these efforts and believe that there are further opportunities to improve the operations of the clinics.

Sponsorship - The current program model is built around the concept of partnering with multiple health care organizations. The advantages of this approach are that it helps broaden community support, brings diverse skills to the schools, creates linkages to community health resources, and reduces the financial burden on any one organization. However, the disadvantages of the model are that it makes it more difficult to implement

operational improvements because each change must be coordinated and adapted to the unique needs of the different sponsors. It also makes it more difficult to centralize functions or gain economies of scale, and it generates administrative inefficiencies, as each organization must provide its own administrative and supervisory structure.

In designing the program's future, the consultants believe there is an important role for each of the current sponsors to play in the program, but that fewer organizations should operate clinics. This recommendation is predicated on the adoption of this report's proposed funding strategies, which are intended to not place too large a financial burden on the sponsors. In addition, plans to change sponsorship should consider the financial impact of organizations that are designated as Federally Qualified Health Centers (FQHC), which enables them to receive enhanced Medicaid reimbursement. Efforts should be made, when appropriate, to align FQHC-sponsorship with schools that have a high Medicaid-eligible student population to increase patient revenues.

Clinic-School Integration – Each school that is a site for a school-based health center also is home to health personnel who are employed by Seattle Public Schools. The school-based health clinics are open to all students, but require students to obtain parental permission to access many of their services. The school nurses and counselors who work for the Seattle Public Schools may serve students without special parental permission.

The presence of two separate health staff, who are employed by and report to different organizations, can create duplication of efforts, discontinuity of care, and confusion for students and staff. Further complicating the coordination among the different health personnel are concerns about regulatory restrictions governing patient and student confidentiality, and issues of professional liability. Nonetheless, in some schools there is effective coordination among the SBHC and school health personnel, but in other schools the staffs are isolated from one another.

The consultants believe that there is a need for better coordination and integration of services for the overall program and at each site. Leaders from the Seattle Public Schools, Public Health, the City, and the sponsors should take a comprehensive approach to school health services, rather than focusing exclusively on their own separate programs. At each school, the school administrators, SBHC staff, and District health staff should meet routinely to discuss student health needs, review current operations and programs, and coordinate services. The program managers should also identify and implement best practices for SBHC-school integration from local and national experience.

Leadership - The fifth important issue that needs to be addressed is the question of program leadership. Managing the program requires working effectively with a number of different stakeholders with unique perspectives and interests. The partnership model requires leadership skills that foster collaborative problem-solving that is both participative and respectful but also decisive and action-oriented. There is a need to articulate a vision for the program's future, establish clear performance expectations, and build greater authority and accountability into the program. Given the challenges confronting the program, there is clearly a need for strong leadership.

RECOMMENDATIONS

The consulting team believes that Seattle's school-based health program is fundamentally sound and that the partnership model is appropriate for organizing and operating the teen health centers. The consultants also believe that on-going City funding is critical to the sustainability of the program. However, there are a number of recommended actions that can strengthen the program, improve its performance, and enhance its long-term survival. It is important that modifications to the program be thoughtfully implemented given the upcoming levy. Changes in sponsorship need to be planned carefully to not disrupt services or weaken the overall system. Key partners must make decisions, reaffirm their commitment to the clinics, and initiate improvements that will strengthen the program.

1. The School-Based Health Center program should diversify its funding sources, initially focusing on billing for patient revenues.

The program needs to broaden its financial base to enhance sustainability. All the school-based health centers should bill for services. Special funding arrangements may need to be negotiated with Medicaid managed care plans and local commercial health insurers. Based on national experience, it is reasonable to expect the clinics to generate 12-15% of their revenues from patient billing. The program should also seek State and private foundation funding so that the burden of rising costs does not fall on the sponsoring organizations. The contribution of the health care sponsors is significant, 17% of total revenues, and needs to be acknowledged and maintained.

2. The City should continue to finance the program at existing dollar levels with funds from the Families & Education levy.

The Teen Health and Wellness Centers are providing valuable services that improve the health of an underserved population in the community and that remove barriers to learning. Ongoing funding will enable the program to remain stable as it implements new business practices and diversifies its revenue base. Recognizing that the City is under financial pressures, the program should remain a top priority for levy support.

3. The program should reduce the number of organizations operating centers from seven to three or four.

Retaining the current number of sponsors contributes to system inefficiencies and makes it difficult to simplify administration and gain economies of scale. Contracting with one or two providers makes it easier to gain operating efficiencies, but increases the sponsors' financial risk and weakens the program's contracting leverage. Contracting with 3 or 4 providers creates a balance between gaining operational efficiencies and retaining broad community and financial support.

Planning for changes in sponsorship should include consideration, among other factors, of aligning FQHC sponsors with schools that have larger numbers of Medicaid-eligible students. The timing for implementing changes in sponsorship needs to be coordinated with efforts to secure the program's funding base and strengthen overall program leadership.

4. The Seattle Public Schools should foster integration of the SBHCs with school health services to avoid duplication of efforts, maximize care coordination and create staffing economies.

The Seattle Public Schools, Public Health, the City of Seattle, and the SBHC sponsors should adopt a comprehensive approach to planning and improving school health services. The Seattle Public Schools and its partners should commit to addressing issues of confidentiality and service integration. The District should work with school and health service administrators to ensure that the SBHCs are supported in each school. District health personnel should be deployed to schools with school-based health centers, and the two staffs should operate as a cohesive team, providing appropriate cross coverage and care coordination. The Seattle School District should not charge the centers rent.

5. The Program Manager needs to provide strong leadership in developing effective business practices and implementing system improvements.

The Program Manager should take the lead in developing the necessary business systems to build new revenue streams. They need to provide technical assistance to sponsors to ensure effective documentation and efficient billing practices, and to help sponsors enroll more eligible students on Medicaid. They should provide leadership in negotiating financial arrangements with public agencies and private insurers. They should establish productivity standards, and work with centers to maximize resources, staffing and investments. They also need to ensure that sponsors provide adequate supervision on-site to improve performance and operational effectiveness.

6. The Program Manager and the sponsors should develop a strong, ongoing evaluation and improvement program.

The SBHC program should have a strong evaluation component that assesses student health needs, service efficiency and effectiveness, customer satisfaction, and health and school-related outcomes. The Program Manager and the other partners should work to secure external funding for assessment tools, such as the Teen Health Surveys. The Program Manager and the sponsors should commit to staff training in quality assessment and improvement techniques, and should develop an ongoing quality improvement program.

Funding - Findings

Diversifying Funding Sources

Seattle's program is financially vulnerable because it is so heavily dependent on City General Funds and levy funds, and local government funding is unable to keep up with rising costs. The Seattle SBHCs derive a much higher percentage (81%) of their funding from local government sources than do most other SBHCs around the country (20%). (Table 1) Many programs receive a portion of their funding from State (29%) and/or Federal sources (8%). Across the country, SBHCs report receiving 12% of their funding from patient fees compared to the Seattle area's 6%.

Table 1: Sources of Funding

NASBHC National Survey 1999-2000

Center Budgets	Total	Co/Cy	%	Other	%	Pat Rev	%	In-Kind	%	Fed	%	State	%
National Average	169,000	33,000	20%	24,000	14	21,000	12	28,000	17	14,000	8	49,000	29
Washington Ave.	185,000	161,000	87%	4,000	2	3,000	2	13,000	7	2,000	1	3,000	2

Seattle School-Based Health Centers 2003-2004

Center Budgets	Total	Co/Cy	%	Other	%	Pat Rev	%	Sponsor	%	Fed	%	State	%
Seattle Average	243,000	196,000	81	3,000	1	15,000	5	29,000	12	0	-	0	-
Ballard HS	242,000	202,000	84	10,000	4			30,000	12	0	-	0	-
Cleveland HS	242,000	202,000	83			22,000	9	18,000	7	0	-	0	-
Franklin HS	273,000	201,000	74	22,000	8			51,000	19	0	-	0	-
Garfield HS	267,000	201,000	75			2,000	1	64,000	24	0	-	0	-
Ingraham HS	262,000	203,000	77			40,000	15	19,000	7				
Nathan Hale HS	220,000	202,000	92					18,000	8	0	-	0	-
Rainier Beach	281,000	215,000	77			47,000	17	19,000	7	0	-	0	-
Roosevelt HS	292,000	202,000	69			24,000	8	65,000	22	0	-	0	-
Sealth HS	244,000	202,000	83			33,000	14	8,000	3	0	-	0	-
W. Seattle HS	248,000	202,000	82			33,000	13	13,000	5	0	-	0	-
Aki Kurose MS	210,000	178,000	85					31,000	15				
Denny MS	210,000	180,000	86	5,000	3	3,000	1	22,000	11	0	-	0	-
Madison MS	210,000	180,000	86	5,000	3	3,000	1	22,000	11	0	-	0	-
Washington MS	208,000	178,000	86	0	-	0	-	30,000	14	0	-	0	-
Grand Total	3,408,000	2,748,000	81	42,000	1	207,000	6	410,000	12	0		0	

Note 1: The Co/Cy category is county or city funding across the country, but refers to city funding in Seattle; the Other category includes financial contributions from foundations, fund raising, medical sponsors and corporate sponsors; Patient Revenues include Medicaid, third party, and self-pay patients; Federal funding comes from various programs such as block grants, funding for community health centers; State funding sources include block grants, program grants from Medicaid, and State general funds.

Note 2: Differences in clinic budgets in Seattle reflect variation in staffing, lab, pharmacy, and administrative costs, and differences in how the sponsors support the clinics. Ingraham's budget is an estimate based on a 6 months of operations in 2004.

Note 3: The following organizations sponsor clinics: Group Health - Franklin, Aki Kurose, Washington; Harborview - Nathan Hale/Summit; Odessa Brown/Childrens - Garfield/Nova; Public Health - Ingraham, Rainier Beach; Puget Sound Neighborhood Health Centers - Denny, Madison, Roosevelt, Sealth, West Seattle; Swedish Medical Center - Ballard

There is significant variation in funding sources for school-based health centers from state to state (Table 2). In California, Massachusetts, Minnesota, and New York, clinics report receiving 25% to 31% of their funding from patient revenues. Medicaid payments comprise 67% of the patient revenues with private insurance at 15% and self-pay at 5%. The largest share of private contributions is from sponsor agencies (49%), followed by state and local foundations (25%). School districts (40%) and medical sponsors (33%) provide the greatest percentage of in-kind services. Combining in-kind and cash contributions, sponsor organizations reported contributing an average of \$21,000 per center, which is 12% of the average center revenues.

Table 2: Revenue by Source by State, NASBHC Survey 1999-2000

State	#	Total	Fed	%	State	%	Co/Cy	%	Pvt.	%	Pat Rev	%	In-Kind	%
NY	18	374,000	23,000	6%	125,000	34%	28,000	7%	3,000	1%	93,000	25%	102,000	27%
California	20	339,000	41,000	12%	44,000	13%	68,000	20%	45,000	13%	104,000	31%	37,000	27%
Mass	15	271,000	7,000	3%	67,000	25%	102,000	38%	0	0%	78,000	29%	17,000	6%
Illinois	14	242,000	15,000	6%	127,000	52%	2,500	1%	56,000	23%	29,000	12%	15,000	6%
Conn	19	198,000	20,000	10%	102,000	52%	9,000	5%	32,000	16%	7,000	4%	27,000	13%
Wash	5	185,000	2,000	1%	3,000	2%	161,000	87%	4,000	2%	3,000	2%	13,000	7%
Nat. Ave	412	169,000	14,000	8%	49,000	29%	33,000	20%	24,000	14%	21,000	12%	28,000	17%

Patient Billing

The Seattle clinics have not pursued patient billing for a number of reasons, including concerns about patient confidentiality, the relatively high cost of billing for services and the relatively small number of billable services provided to insured students. Although a number of students are eligible for Medicaid coverage, Medicaid reimbursement is challenging because of the complexity of managed care contracts and the low reimbursement rates for non-Federally Qualified Health Center (FQHC) sponsors. Puget Sound Neighborhood Health Centers (PSNHC) and Public Health bill Medicaid and the Take Charge program for services, and they receive substantially higher reimbursement for Medicaid fee-for-service visits because they are FQHC providers (\$120-\$190 per visit compared to an average of \$60 per visit). However, only a limited number of visits can be billed at higher FQHC rates. PSNHC is also billing commercial insurers such as Premera and Regence, but derives very limited revenues from them.

In the pilot study at Franklin, Sealth, and Denny, from September to November 2003, the percentage of total visits that were determined to be billable to publicly funded programs ranged from 10% to 21% of the total number of visits. Based on regular Medicaid reimbursement rates, these schools would generate approximately \$40,000 in patient revenues over the school year. Sealth and Denny budgeted \$36,000 in patient revenues for the 2003-2004 school year.

Assuming all the schools billed for publicly funded services, the clinics should be able to recover \$250,000 to \$300,000 in patient revenues. Assuming that billing costs are 25% of revenues, the net income from billing would be \$188,000 to \$225,000. If the clinics could reach the national average of 12% of their revenues from patient fees, they would be bringing in approximately \$400,000 a year, or an estimated \$300,000 in net revenues.

The consultants have developed patient revenue projections based on school enrollment, numbers of potential Medicaid-eligible students, and assumptions about reimbursement rates. They have also used revenues at schools that bill as a benchmark for assessing revenue potential at schools that do not bill. Revenue forecasts have also been adjusted to reflect if a sponsor is eligible for FQHC reimbursement. Mock billing information was developed by billing staff at Public Health and is based on the experience reported by the pilot site schools for the first third of the school year 2003-2004.

Table 3: Patient Revenue Projections Based on 2003-2004 Budgets & Mock Billing

School	Students	# Lunch Subsidy	Patient Revenues Budget 2003-2004	Patient Revenues Sep-Dec 2003-2004	Projected Patient Revenues
Franklin	1,593	617		\$ 6,406	\$ 25,000
Sealth	978	497	\$ 33,169	\$ 5,213	\$ 35,000
Ingraham	992	453	\$ 40,000		\$ 40,000
Cleveland	736	403	\$ 22,144		\$ 25,000
Rainier Beach	710	400	\$ 47,064	\$ 5,645	\$ 50,000
Garfield/Nova	1,948	407	\$ 2,400		\$ 18,000
Ballard	1,610	371			\$ 13,000
West Seattle	1,053	353	\$ 32,442		\$ 35,000
Roosevelt	1,670	314	\$ 24,413		\$ 25,000
Nathan Hale	1,081	175			\$ 13,000
Denny	814	520	\$ 2,739	\$ 1,320	\$ 6,000
Aki Kurose	670	425			\$ 5,000
Madison	916	376	\$ 2,739	\$ 1,204	\$ 4,000
Washington	1220	346			\$ 4,000
Total	12,371	3,990	\$ 207,110	\$ 17,264	\$ 298,000

Source: Youth Services Division, Public Health Seattle-King County; the 2003-2004 Sep – Dec revenue estimates are based on general data submitted by five sites, not on actual bills or collections. Ingraham’s patient revenue projections are estimates for a full academic year of operation.

The pilot studies at Sealth, Denny, and Franklin demonstrated the challenge of implementing billing throughout the program. The PSNHC clinics were unable to bill for any services at their community clinic sites as well as at the teen clinics during the pilot period because of billing system problems related to HIPAA-compliance. PSNHC has begun billing again and will be able to bill for services back to the start of the school year. Billing at Franklin did not take place because of difficulty finding a party to conduct the billing during the pilot phase and because of facility constraints. Efforts are currently underway to bill at Franklin through the Swedish Physician Division or Group Health. Swedish has also agreed to set up the billing process for the Ballard Teen Health Center.

Despite the challenges associated with patient billing, it is imperative that the program expands its billing efforts to diversify its funding base. There will be start-up costs and ongoing administrative costs to bill for services. While it is difficult to assess the true cost of billing, the Swedish Physician Division administrators suggest using 25% of revenues as a rough estimate. Actual costs will vary depending on patient volumes and the mix of payers. Start-up costs will include acquiring the necessary software, establishing computer line connections, and training staff.

Centralizing billing functions as much as possible will increase economies of scale. FQHC providers will need to bill for their own services, but non-FQHC providers could use a common billing service. The sponsors will also need to develop contracts with insurers who offer Healthy Option coverage, but those contracts could be negotiated on a system-wide basis. Developing an expanding patient revenue stream will require strong leadership from the Program Managers and operating sponsors.

Other Funding Sources

In addition to local government and patient revenues, there are other potential funding sources, such as the State and Federal governments, private foundations, and local private donors. A number of programs around the country receive some funding from their State governments, in addition to patient revenues from Medicaid. However, there are some significant hurdles to overcome in Washington. First, the State’s economy has not been strong and health care costs have been a significant inflationary force in the State budget. Second, the school-based health centers in Washington are almost all located in Seattle, so few other communities have a similar interest in the program. Building support for State funding will take strong advocacy, coalition building, and time. Given the strong network of community clinics around the State, it may be possible to develop some new allies, while teaching other communities about the value of the centers.

Table 4: 2002 State Survey by The Center for Health and Health Care in Schools

Type of Funding	# States	Funds	% Total
State General Funds	12	\$27.0 million	38%
Title V MCH Block Grants	13	\$10.4 million	15%
Tobacco Tax Dollars	4	\$12.6 million	18%
Tobacco Settlement Funds	8	\$12.4 million	17%
Other Sources		\$ 8.4 million	12%
Total	27	\$71.1 million	100%

Notes: States may provide more than one source of funds; Title V Maternal & Child Health Block Grants are Federal funds that are allocated to the states; other sources include Title XX Social Service Block Grants, Preventive Health and Health Services Block Grants, and public dollars from other programs

Another potential funding source, at least for expanding centers under the sponsorship of FQHC organizations, is the Federal government’s Bureau of Primary Health Care’s “new access points” initiative. Presumably, organizations like PSNHC, would be eligible for funding to expand to new SBHC sites, however, funding is limited to \$650,000 over a three-year period.

Private foundations are another source of funds for school-based health programs. During the 1990’s, the Robert Wood Johnson Foundation funded SBHC programs and research studies around the country. While the RWJ has shifted its attention to other health priorities, there may be other foundations that would be interested in funding implementation of system improvements related to billing and documentation, or special health education or mental health projects. Another strategy is to set up a small not-for-profit organization that is interested in promoting health in schools, and could combine advocacy with fund-raising. An alternative approach would be to help shape the agenda of existing children’s advocacy groups.

FUNDING - RECOMMENDATIONS

1. Establish the contractual requirement that all centers will bill for services. The Program Manager will help sponsor organizations implement billing at all sites by fall 2004.
 - Action Steps:
 - The Program Manager will meet with sponsors to discuss how to implement billing at their clinics most effectively and efficiently.
 - The Program Manager will provide technical assistance to each sponsor that is initiating billing to help them assess staffing needs and to develop efficient office procedures.
 - The Program Manager will provide technical assistance to all sponsors to ensure that they have successfully implemented look-up systems and procedures that provide accurate, timely information about each student's health insurance status.
 - The Program Manager will audit health insurance data for accuracy and timeliness.
 - The Program Manager will work with sponsors to set patient revenue targets for each site based on patient volumes, payer mix, and reimbursement rates.
 - Outcomes:
 - By 2004, all centers will be billing for services.
 - By the end of school year 2004-2005, patient revenues will exceed \$270,000, an increase of approximately 30% over billings in 2003-2004. By the end of school year 2005-2006, patient revenues will exceed \$350,000.
 - The percentage of clinic users enrolled in Medicaid and/or receiving services reimbursed by Take Charge will increase by 25% from school year 2003-2004 to school year 2004-2005.

2. Develop a centralized billing system for the non-FQHC sponsors. The Program Manager will develop an efficient centralized billing service.
 - Action Steps:
 - The Program Manager will meet with Swedish Physician Division to determine their ability and willingness to bill for all the non-FQHC clinics.
 - The Program Manager will explore alternative options if necessary, including using a third-party administrator, reevaluating Public Health's willingness to provide billing services, and implementing billing through the sponsoring organizations.
 - The Program Manager will benchmark billing system efficiency with other programs around the country.
 - The Program Manager will determine the best approach for implementing billing at all sites by July 1, 2004.

- Outcomes:
 - An effective and efficient billing system will be in place for school-based health centers by September 2004.
 - The system will meet or exceed benchmarks in billing performance, e.g. cost per service, percentage denials, timely billing, by July 2006.

- 3. Negotiate contractual arrangements with Medicaid managed care plans. The Program Manager will lead the effort to negotiate reimbursement for services provided to students who are covered under Healthy Options.
 - Action Steps:
 - The Program Manager will work with all sponsors to determine whether to negotiate a system-wide agreement or to have each sponsor negotiate its own agreement.
 - The Program Manager will review insurance information to determine how many students are covered under each Healthy Options plan and how many reimbursable services they have used in 2003-2004.
 - The Program Manager will directly negotiate for, or provide technical assistance, to each sponsor organization in negotiations with health plans that offer Healthy Options coverage.
 - The Program Manager will work with sponsors to establish revenue targets for students covered under Healthy Options.
 - The Program Manager will explore the potential for obtaining a Medicaid carve-out for mental health services provided as part of the EPSDT program requirements.
 - Outcomes:
 - Agreements with health plans for reimbursement for students with Healthy Options coverage will be in place by September 2004.
 - Revenue targets for Healthy Options reimbursement will be achieved in school year 2004-2005.

- 4. Negotiate financial support or reimbursement rates with commercial insurers. The Program Manager will lead the effort to obtain annual financial support from key insurers or to negotiate reimbursement for services for students who are covered under private commercial insurance, e.g. Premera and Regence.
 - Action Steps:
 - The Program Manager will gather information about commercially insured students and their use of services.
 - The Program Manager and the sponsors will determine the best approach to key health plans, i.e. financial support or billing for services, and then will meet with the health plans.
 - The Program Manager and the sponsors will establish revenue targets for commercial insurers.
 - Outcomes:
 - By school year 2004-2005, the program will achieve patient revenue targets or the financial contribution equivalent from commercial insurers.

5. Attract state funding for school-based health centers. The Program Manager and the sponsors will begin to develop political support for state funding.
 - Action Steps:
 - The Program Manager will contact successful programs around the country to determine what type of support they receive from the State and how they obtained their funding.
 - The Program Manager will contact other programs, community health centers, school districts, and other organizations in Washington state that might be interested in SBHCs and will convene a one-day conference to explore building a coalition to seek State-funding for SBHCs.
 - The Program Manager and the sponsors will meet with State officials to determine under what circumstances they would financially support SBHCs.
 - Outcomes:
 - In school year 2004-2005, The Program Manager and the sponsors will lay the groundwork for obtaining State funding to help support the program.
 - By school year 2006-2007, 10% of the financial support for the program will come from State funding.

6. Seek foundation support to assist with system-wide changes in billing and other administrative practices.
 - Action Steps:
 - The Program Manager will identify private and foundation funding sources that can potentially fund the development of billing systems and staff training.
 - The Program Manager will submit grant applications by July 1, 2004.
 - Outcomes:
 - The program will obtain additional funding to assist with billing system implementation and staff training in 2004-2005.

Program Model - Findings

Clinic Sponsors

One of the strengths of Seattle's school-based health program has been its Partnership model. Through this approach, the program has involved many prominent community health care organizations, which have made substantial contributions of in-kind services. The model has also fostered broader community support, and has created opportunities for schools to be linked to valuable community resources. Public Health has developed collegial relationships with sponsoring providers, and together they have worked on standards and quality assurance in medical and mental health services.

Although the Partnership model is fundamentally sound, by involving so many different sponsoring organizations, it has been very difficult to make the system operate efficiently. The organizations are very different from one another – a community clinic, a public health agency, a community hospital, a pre-paid medical group practice, two academic medical centers, and a pediatric specialty hospital and clinics. The sponsors

have different business interests, different service delivery models, and different organizational structures. Within the current program structure, change is possible, but it is time-consuming and potentially more difficult to achieve the desired outcomes. The structure adds administrative complexity and added costs by replicating the need for site management within seven different organizations. In contrast, Puget Sound Neighborhood Health Centers has one administrator managing 5 separate clinics.

In discussions with Public Health, the City, the sponsors, and other stakeholders, three system structure model options have emerged – (1) maintain the status quo, (2) contract with a single organization, or (3) contract with fewer organizations.

Status Quo

The primary benefit of maintaining the status quo is that it sustains the current service relationships at each school. Sponsors and school administrators know one another and generally have positive working relationships. The staff who work in each clinic work are employed by the sponsoring organization and may not be willing to shift to a different employer. The status quo also spreads the financial burden of the program to more organizations, making it less likely that sponsors will pull out. Sponsors already are covering 17% of the expenses of the program, and given current economic conditions, they are at risk of encountering greater revenue shortfalls in the future.

As stated earlier, the primary disadvantage of the status quo is that it does little to reduce the built-in inefficiencies of multiple administrators, billing systems, human resource policies, and other operational features. It also makes it more difficult to implement system change and gain economies of scale. Having more organizations participate in the program is also likely to create greater variation in performance, and make it more difficult to standardize health care and administrative practices.

Sole Contractor

At the opposite end of the continuum is contracting with one organization to manage and operate all the clinics. The advantage of this approach is that it has the greatest potential for operational efficiency. It dramatically simplifies clinic administration. It fosters standardization, e.g. one look-up system, one billing system, standard forms. It allows maximum flexibility in deploying staff, including cross coverage, substitute staffing for absences. If the contractor is an FQHC provider, such as PSNHC or Public Health, it would also maximize Medicaid reimbursement.

There are three significant disadvantages with this strategy. First, it creates significant contractual leverage for the agency providing the services. If the current structure is dismantled, it is likely to be difficult to attract current sponsors back to the program if they are needed in the future. Second, contracting with one agency places the full financial burden on that organization. For example, in 2002, PSNHC received \$926,000 from the City to operate five clinics with a combined budget of \$1,116,000. Assuming PSNHC operated all 14 clinics at a similar ratio of City funding to budget, its financial burden would grow to \$532,000 a year. While patient revenues would offset some of the expense, it is likely that PSNHC losses from the program would at least double.

The third disadvantage with the sole contractor strategy is that it loses the richness of a diverse provider base and it weakens overall community involvement with the program. The current sponsors bring a wide variety of skills and knowledge to the program that would be less readily available in a sole contractor model. In addition, the program's political clout is much greater with the support of prominent health care organizations that have a stake in the program's success.

Fewer Sponsors

Contracting with 3 to 4 organizations represents a middle ground between maintaining the status quo and moving to a sole contractor. While this approach will contribute to some duplication of effort, it will preserve the benefits of having a diverse sponsor group. It also will broaden the base of community and financial support. Potentially it could increase the stake that each partner has in the program, without being too costly to any one party or creating an imbalance in contract negotiations. Depending on how this change is implemented, it could also allow current sponsors to shift their role from direct operations to some other form of participation.

Contracting with FQHC Providers

During the study, several key decision-makers asked about the potential financial benefits of contracting solely with Federally-Qualified Health Center (FQHC) providers. FQHCs are federally designated programs that must meet a number of specific requirements, including governance structure requirements. Medicaid reimburses FQHC providers at higher rates because they offer social and other wrap-around services to their patients, and are required to see all individuals regardless of ability to pay. PSNHC and Public Health are the only FQHC sponsors in the school-based health program.

It is difficult to estimate the financial impact of FQHC reimbursement on potential patient revenues in the program. First, the FQHC enhancement is based on historical costs and varies by FQHC provider. Second, the enhancement differs for fee-for-service and managed care patients. Third, a number of services that the clinics provide, including most mental health services, are not covered by Medicaid, so the FQHC enhancement does not apply. Medicaid fee-for-service visits represent a relatively small percentage of the total visits at the school-based health centers. In reviewing data from PSNHC and Public Health, it appears that their reimbursement rates are two to two and a half times greater than standard Medicaid reimbursement. However, their clinics only derive 3 to 14% of their revenues from patient fees, and the value of their in-kind services exceeds their patient income.

While it is possible to increase patient revenues by contracting with FQHC sponsors, the consulting team believes that the costs of contracting exclusively with FQHC organizations outweigh the benefits. There are relatively few FQHC providers in the area, and other than Public Health, they are all community health clinics (CHCs). The CHCs do not necessarily have expertise in adolescent medicine, and they often do not have substantial financial resources with which to subsidize programs such as school-based health centers. While one or two CHC organizations may be willing and able to

participate in the program, including non-CHC organizations helps to diversify and stabilize the program's funding base. A preferable strategy to exclusively contracting with FQHC providers would be to align FQHC sponsors with clinics that have the largest Medicaid-eligible student populations.

Program Integration in the Schools

Over the past few years, the District, the City, Public Health, and a number of community organizations have been working together to develop a comprehensive approach to school health services. Planning projects like the Experience Wellness Project, have proposed closer collaboration among the partners and greater integration of staff and services to maximize resources and improve outcomes. Given the economic pressures on all the partners, the consultants recommend that the parties continue to work together to rationalize resources and coordinate programs.

The Seattle School District has supported the school-based health center program since its inception. The centers help supplement the limited resources that the District can invest in health personnel, and generally there has been good cooperation between District health employees, especially school nurses, and Teen Health Center employees. However, during the program assessment, the consultants found that there are valuable opportunities for improved integration of school health services with the school-based centers. In some schools, District staff and Health Center staff work as a team, sharing information, providing a degree of cross coverage, and coordinating efforts. In other schools, the staff work adjacent to one another, but share little direct information.

Recognizing that there are complex issues of confidentiality, differing privacy regulations within in health care and educational settings, and professional liability issues, the consultants believe that better coordination of health services can take place at the schools. The consultants recommend that the health staff and key administrators at each school meet regularly to coordinate programs and services. The District and the sponsors should enter into Memoranda of Understanding to clarify mutual expectations and to facilitate staff information sharing. Sponsors and District administrators should consider strategies to create common entry points for students and more shared triage at schools. They should also look at staffing, student use of services, and shared support across programs and disciplines.

Finally, the consultants would urge the District to formally acknowledge the value of the clinics by not charging them rent and by planning space for the clinics in all new or major renovation projects at comprehensive high schools and selected middle schools.

Program Management

There is a great need in the next few years to implement some significant changes in the school-based health program and to develop better business practices. Public Health has created contractual agreements with the sponsoring organizations that enumerate the scope of services, minimum staffing requirements, data reporting requirements, and a number of other operational factors. Public Health and the sponsors have also been

working to implement new forms that document activities, new look-up systems to better identify insurance eligibility, and medical and mental health care standards. These are valuable efforts that need to be sustained, and in some cases, expanded.

The consulting team believes that there is still significant room for improvement in documenting activities, using look-up systems, billing for services, and managing patient flow and provider productivity. The program's manager needs to provide leadership in managing change within the program, setting expectations for the sponsors, and providing technical assistance as needed to assure improved program business performance.

PROGRAM MODEL RECOMMENDATIONS

1. Reduce the number of clinic-sponsors from 7 to 3 or 4. The Program Manager will work with sponsor organizations to determine how they can most effectively participate in the school-based health programs
 - Action Steps:
 - The Program Manager will establish attributes and basic operating and administrative requirements of health care sponsorship, and will discuss with each sponsoring organization how they would like to participate in the program in the future.
 - The Program Manager will determine in consultation with the School District, the City, and the participating organizations which sponsors will provide health services at each site starting in September 2004.
 - The Program Manager will work with organizations that will no longer sponsor a clinic to see if there is a different role that they could play in supporting the program.
 - Outcomes:
 - Reduce the number of sponsoring organizations by school year 2005-2006.

2. Evaluate the costs and benefits of realigning schools and sponsors to maximize FQHC-reimbursement.
 - Action Steps:
 - The Program Manager will conduct a detailed financial analysis of the revenue potential under FQHC sponsorship for selected SBHC's.
 - The Program Manager will discuss with sponsors, school administrators, and the School District the pros and cons of realigning sponsorship to maximize reimbursement through FQHC.
 - The Program Manager will determine if sponsors should be realigned by school year 2005-2006.
 - Outcomes:
 - Informed decision about school-sponsor realignment.

3. The Program Manager must assume authority and accountability for implementing system changes – creating administrative improvements and developing more diverse revenue sources.
 - Action Steps:
 - The City will develop, in consultation with the Program Manager, sponsors, and the School District, annual performance objectives that will be enumerated in its contract with the Program Manager.
 - The Program Manager will report quarterly on progress in achieving its performance objectives.
 - Outcomes:
 - Clear expectations between the City and the Program Manager, and improved program performance.

4. The Seattle Public Schools should actively work to promote integration of services and support between District staff and SBHC staff
 - Action Steps:
 - The School District will assure that there is core staffing (school nurse and other regularly deployed health resources) at schools with school-based health centers.
 - The School District will work with the Program Manager and the sponsors to implement as many of the Experience Wellness Project recommendations as possible, especially those that increase system integration.
 - The School District will continue to work with principals and staff to promote integration between District health-related staff and SBHC-employed staff within each school.
 - The School District will foster professional staff coordination among health-related staff at elementary, middle, and high schools in geographic areas.
 - Outcomes:
 - More efficient use of resources and improved continuity and coordination of care for individual students.

5. The Seattle Public Schools should provide rent-free space for school-based health centers and should plan for centers in all new and major renovation projects at comprehensive high schools and selected middle schools.

Services and Staffing - Findings

The school-based health program provides general acute care, preventive health, reproductive health and mental health counseling services to students. Preventive health and mental health services are especially important because they are not easily accessible or well reimbursed. While some students only use the centers for episodic medical care, most of the health care team members proactively use routine encounters to gather and provide valuable health information.

Many of the staff who work in the clinics have special interest in and extensive experience working with adolescents. The professionalism and passion of the health care professionals who work in the Teen Health and Wellness Centers consistently impressed the consulting team. In addition, Public Health has been proactive and provided leadership in developing mental health and medical care standards and promoting quality assurance.

While the centers cannot meet all the health needs of students, there are two needs that are not adequately addressed – dental care and substance abuse counseling. Only two of the sponsors – PSNHC and Public Health provide dental services and none of the centers has room for a dental operatory. Students with severe dental needs are referred to community resources, but there is no coordinated program approach to dental care. The School District provides substance abuse interventionists at many of the high schools, but they are a limited resource and their practice is more oriented to triage than to therapy. PSNHC has worked with one of the high schools to fund a substance abuse counselor, but there is no comprehensive approach to substance abuse treatment that integrates the resources of the program with those of the Seattle Public Schools.

Another problem for students is discontinuity of medical care. The school-based health centers are only open during the school year, and are usually closed when school is not in session. Although students are encouraged to find a regular source of primary care, some are unable to do so or may feel they cannot afford a regular doctor. One of the benefits of signing up eligible students for Medicaid is that it removes a potential barrier to seeking care from a regular provider who is open year round.

Productivity

There is significant variation in staff productivity and costs per service across clinics. Unfortunately, some of the staff have not fully documented their activities because many of their services are not reimbursable or do not conform to a medical encounter form. In September 2003, Public Health introduced an activity form that better captures non-billable work, should as classroom presentations, informal counseling and mentoring activities. However, staff members are still getting accustomed to using the new forms and there is considerable variability in their use.

Historical visit reports have likely undercounted productivity, but the data that is available only documents moderate patient volumes. There also does not appear to be a correlation between student need and clinic utilization; some schools with high needs have lower utilization.

Table 5: School-Based Health Center Use 2002-2003

School	Sponsor	School Enrollment	THC Enrollment	% Enrolled	Users	% of School
Ballard	Swedish	1610	675	42%	317	20%
Cleveland	Harborview	736	568	77%	239	32%
Franklin	Group Health	1593	960	60%	574	36%
Garfield/Nova	Odessa Brown Clinic	1948	1009	52%	617	32%
Ingraham	Public Health	NA	NA	NA	NA	NA
Nathan Hale	Univ. of Washington	1738	1202	69%	360	21%
Rainier Beach	Public Health	710	352	50%	260	37%
Roosevelt	PSNHC	1670	915	55%	421	25%
Sealth	PSNHC	978	636	65%	473	48%
West Seattle	PSNHC	1053	817	78%	446	42%
Total		12036	7134	59%	3707	31%

Source: Youth Health Services, Public Health Seattle-King County, 2003

Table 6: Productivity Report September – December 2003

School	Medical Visits	Mental Health Visits	Medical Activities	Mental Health Activities	Medical Visits % Total	Total Visits & Activities	Total Per Service Day
Ballard	315	138	0	26	66%	477	6.4
Cleveland	359	199	4	56	58%	618	8.2
Franklin	584	214	36	24	58%	1001	13.3
Garfield	527	373	8	70	53%	986	13.1
Nathan Hale	426	235	7	18	58%	729	9.7
Rainier Beach	412	51	0	29	84%	493	6.6
Roosevelt	570	335	8	120	55%	1036	13.8
Sealth	588	305	0	43	63%	935	12.5
West Seattle	454	199	0	104	60%	757	10.1
Aki Kurose	293	222	12	59	50%	586	7.8
Denny	225	380	26	123	30%	750	10.0
Madison	221	122	10	162	43%	515	6.9
Washington	171	266	2	73	33%	512	6.8
Total	5,145	3,039	113	907	55%	9,395	9.6

Source: Youth Health Services, Public Health Seattle-King County, January 2004

Note 1: Visits per day are based on days that schools are open, but do not reflect staff absences due to illness, training, vacation or position vacancies. Clinics are generally staffed with 1 mental health worker and 1 nurse practitioner, but there are some exceptions. For example, Madison and Denny share a nurse practitioner, and Denny has two mental health staff.

Note 2: Medical and mental health visits are patient-specific encounters that include a diagnosis and a description of a medical or mental health counseling service. Medical and mental health activities include a wide variety of activities, including classroom presentations, assemblies, crisis interventions, field trips, peer mediation, mentoring, health fairs, group interventions, and other non-patient-specific office encounters.

SERVICES AND STAFFING - RECOMMENDATIONS

1. Clinics should be expected to achieve productivity standards and staffing at each center should be adjusted to reflect student use.
 - Action Steps:
 - With each sponsor, the Program Manager should review the billable and non-billable services they have provided, actual cost per visit and per user, and set targets for productivity improvements for 2004-2005.
 - The Program Manager, sponsors, and school administrators should review student demand for services and staffing levels at high cost centers and evaluate reductions in staffing or hours of operation.
 - The Program Manager should conduct periodic benchmarking with comparable programs around the country to ensure appropriate productivity and staffing standards.
 - Outcomes:
 - Greater productivity and efficiency as measured by visits per FTE and costs per visit.

2. Increase efforts to enroll eligible students in public-sponsored insurance programs
 - Action Steps:
 - The Program Manager will continue to train staff in use of look-up systems.
 - The Program Manager will work with DSHS and sponsors to increase staff training in how to enroll students in publicly-funded programs
 - The Program Manager will provide regular updates to staff regarding publicly funded and categorical grant programs
 - Outcomes:
 - More students will be linked to an ongoing medical care “home”
 - Revenues from publicly funded programs will increase

3. Continue to focus on quality improvement in mental health
 - Action Steps:
 - The Program Manager will continue to work with providers to develop quality assurance tools.
 - The Program Manager will continue to work with providers to improve screening and risk assessments.
 - The Program Manager will seek grant funding to support these efforts.
 - Outcomes:
 - Increased early intervention and greater consistency of care

Evaluation and Improvement

Public Health has routinely evaluated student and staff satisfaction with the school-based health center program. The results have consistently been very positive. In addition, the Seattle Public Schools' Health Education program, with funding from the federal Centers for Disease Control has conducted several very thorough Teen Health Surveys. However, the Seattle program, like many school-based health programs around the country, has little outcome data that measures the program's effectiveness. The program has also not set clear targets for numbers of participants, types of participants, productivity, and outcome measures. Although there are costs associated with conducting surveys and gathering data, the program would be stronger if it developed and implemented performance measures.

EVALUATION AND IMPROVEMENT - RECOMMENDATIONS

1. Public Health, the School District, and the City should combine resources to seek ongoing funding for periodic Teen Health Surveys.
 - Action Steps:
 - The School District should take the lead in securing funding for periodic Teen Health Surveys. The District and Public Health should approach local health insurers and the Alliance for Education as possible funding sources.
 - Outcomes:
 - Supports tracking trends in teen health behaviors and access to services.
2. The Program Manager and the sponsors should develop and implement an active Quality Improvement program
 - Action Steps:
 - Identify key access, productivity, and outcome measures, e.g.
 - % of students using the service
 - % of students on free and reduced lunch using the service
 - medical visits, mental health visits, other services
 - cost per visit
 - cost per user
 - 1 or 2 health outcome measures (e.g. teen pregnancy rates, % students with substance abuse problems)
 - Conduct benchmarking with other programs around the country.
 - Train staff in quality improvement techniques, develop measurement systems, identify opportunities for improvement, implement quality improvement efforts, and re-evaluate performance.
 - Outcomes:
 - Improved performance.

Acknowledgements

The Consulting Team would like to thank Mary Jean Ryan and Jen Chan, Office of Policy & Management, and Cheryl Swab, Finance Department, City of Seattle, for their guidance throughout the project; Dorothy Teeter, Public Health, Seattle-King County, Lin Carlson, Seattle Public Schools; Rebecca Salinas and Sid Sidorwicz, Office of Education, City of Seattle, for their co-sponsorship of the project; Linda St. Clair, TJ Cosgrove, and Robin Pfohman, Youth Health Services, Public Health, Seattle-King County for providing invaluable information about the program; Paul Tegenfeldt, Puget Sound Neighborhood Health Centers, Kris Hildebrandt and Kathy Wurzbacher, Group Health Cooperative, and the staffs at Denny Middle School, Franklin High School, and Sealth High School for participating in the pilots; and all the sponsors of the SBHCs - Group Health, Harborview, Odessa Brown/Childrens, Public Health, Puget Sound Neighborhood Health Centers, Swedish Medical Center, and the University of Washington - for their cooperation and for their commitment to the youth of Seattle.